| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 255164 | A. Building<br>B. Wing | 05/15/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Jefferson County Nursing Home | 910 Main Street<br>Fayette, MS 39069 |

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| F 0644<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.<br><br>Based on interviews, record reviews, and facility policy review, the facility failed to complete a significant change assessment and submit a required Level II Preadmission Screening and Resident Review (PASRR) for one (1) of two (2) residents reviewed for PASRR (Resident #16). Specifically, the facility failed to submit a PASRR Level II and complete a significant change assessment after Resident #16 was diagnosed with major mental illness, including bipolar disorder and Major Depressive Disorder, Recurrent, Severe with Psychotic Symptoms.<br><br>Findings Include:<br><br>A review of the facility's Pre-admission Screen policy revealed: Preadmission Screening and Resident Review (PASRR) aims to ensure individuals are not inappropriately placed in nursing homes for long-term care and to provide them with the services they need in those settings .<br><br>A record review of Resident #16's Pre-admission Screen (PAS), dated 7/25/11, revealed no major mental illness at the time of screening.<br><br>A record review of Resident #16's record revealed that a Level II PASRR was submitted on 4/1/22 related to an intellectual developmental disability.<br><br>A record review of Resident #16's admission Record revealed an admission date of 8/9/2011, with new diagnoses of bipolar disorder and Major Depressive Disorder, Recurrent, Severe with Psychotic Symptoms with an onset date of 7/17/23.<br><br>Further record review of Resident #16's clinical record revealed that a Level II PASRR was not submitted in response to the new diagnoses of major mental illness, and a significant change assessment was not completed as required.<br><br>On 05/13/25 at 9:42 AM, during an interview, Registered Nurse (RN) #1, charge nurse, confirmed that a significant change assessment was not completed for Resident #16 following the new diagnoses of bipolar disorder and Major Depressive Disorder, Recurrent, Severe with Psychotic Symptoms. She acknowledged that it should have been done.<br><br>On 05/13/25 at 3:43 PM, during an interview, the Social Services staff member stated that Resident #16 had the above mental health diagnoses and acknowledged that a significant change should have been completed at that time. She stated that completing a significant change ensures the resident receives the appropriate services and that staff are informed of the resident's needs.<br><br>(continued on next page) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|

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| F 0644<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A record review of Resident #16's Minimum Data Set (MDS) with Assessment Reference Date (ARD) 4/10/25 revealed the resident was severely cognitively impaired. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>Based on interviews, record reviews, and facility policy review, the facility failed to implement the comprehensive care plan as developed for one (1) of two (2) residents reviewed for skin conditions (Resident #34). Specifically, the facility failed to carry out weekly skin evaluations as required by the resident 's care plan and physician orders.<br><br>Findings include:<br><br>A record review of the facility's Comprehensive Care Plan policy with a revision date of 1/2025 revealed: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that include measurable objectives and time frames to meet a resident's medical, nursing .<br><br>A record review of Resident #34's Comprehensive Care Plan initiated 4/22/25 revealed skin impairment related to moisture-acquired skin damage to the buttocks. The care plan directed staff to Monitor and Document weekly.<br><br>A record review of Resident #34's weekly skin evaluations revealed they were not completed during April 2025.<br><br>A record review of Resident #34's electronic Treatment Administration Record (eTAR) revealed: Weekly skin assessments every Wednesday date initiated 10/1/24. Wednesday 4/16/25 was not initialed as completed.<br><br>In an interview with the Director of Nursing (DON) on 5/13/25 at 4:03 PM, she stated that weekly skin evaluations should be completed and documented weekly. She stated the purpose of the skin evaluation is to help staff identify any new breakdowns and to evaluate and treat skin accordingly. She confirmed that Registered Nurse (RN) #1 did not follow the care plan.<br><br>On 05/14/25 at 3:09 PM, during an interview, RN #1 (Charge Nurse) acknowledged it was her responsibility to complete the weekly skin evaluations and stated she did not follow the care plan.<br><br>On 5/14/25 at 1:05 PM, in an interview, RN #2, the facility's Minimum Data Set (MDS) Nurse, stated the care plan is created to guide staff in delivering care. She confirmed RN #1 did not follow the care plan related to weekly skin evaluations. She stated Resident #34 cannot receive quality care if the care plan is not followed.<br><br>A record review of Resident #34's Minimum Data Set (MDS) with Assessment Reference Date (ARD) 2/28/25 revealed the resident was severely cognitively impaired.<br><br>A record review of Resident #34's weekly skin evaluation dated 5/7/25 noted moisture-associated skin damage to the buttocks, further supporting the need for ongoing evaluation and documentation as outlined in the care plan.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A record review of Resident #34's admission Record revealed an admission date of 3/16/22 with diagnoses including non-pressure chronic ulcer of other part of left foot with unspecified severity and atherosclerosis of native arteries of other extremities with ulceration. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>Based on interviews, record reviews, and facility policy reviews, the facility failed to ensure that care and services were provided in accordance with professional standards of practice for one (1) of two (2) residents reviewed for skin conditions (Resident #34). Specifically, the facility failed to ensure that weekly skin assessments were completed and documented as ordered by the physician and in accordance with facility policy, resulting in a lack of monitoring for skin breakdown.<br><br>Findings include:<br><br>A record review of the facility's Skin Assessment policy dated 1/2025 revealed: It is our policy to perform a full body skin assessment as part of our systemic approach to pressure injury, prevention and management. The policy includes the following procedural guidelines .: A full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse upon admission, re-admission, and weekly thereafter.<br><br>A record review of Resident #34's weekly skin evaluations revealed that they were not completed during April 2025.<br><br>A record review of Resident #34's weekly skin evaluation dated 5/7/25 revealed moisture-associated skin damage to the buttocks.<br><br>A record review of the Weekly Skin Report dated 4/25/25 revealed Resident #34 was not listed as having a buttocks abrasion; however, it was listed on the 5/2/25 report.<br><br>On 5/13/25 at 4:03 PM, in an interview with the Director of Nursing (DON), she stated the weekly skin evaluations should be completed and documented weekly. She stated she expects staff to perform and document them consistently. She explained that the purpose of the skin evaluations is for staff to identify any new skin breakdown and to evaluate and treat the skin accordingly. She stated that Registered Nurse (RN) #1 told her that she had completed the evaluations on a scratch sheet but forgot to enter them into the computer and could no longer locate the notes. The DON stated that if there is no documentation, it indicates the task was not completed.<br><br>On 5/14/25 at 11:00 AM, an observation of wound care and a weekly skin evaluation was conducted by RN #1. Care was provided within standards of practice. During the skin evaluation, RN #1 assessed the buttocks area, which revealed four areas of healed pink skin and one open area. There were no signs of infection or drainage noted.<br><br>On 5/14/25 at 3:09 PM, in an interview, RN #1 (Charge Nurse) stated it is her responsibility to complete the weekly skin evaluations. She stated she typically writes the results on the back of the report and enters them into the computer afterward. She acknowledged that the purpose of the evaluations is to identify any skin conditions, wound progression, or deterioration. She confirmed that although she performed the evaluations, she failed to enter them into the computer.<br><br>A record review of Resident #34's Electronic Treatment Record (ETAR) revealed: Weekly skin assessments every Wednesday and cleanse moisture acquired skin damage to buttocks with normal saline, pat dry, apply calazine cream, apply nonadherent gauze and cover with bordered gauze twice daily. This review revealed that care for the open area on the buttocks was initiated on 4/21/25.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A record review of Resident #34's Progress Notes dated 4/21/25 revealed: Cleanse open area to buttocks with normal saline, pat dry, apply calazine cream, apply nonadherent gauze and cover with bordered gauze twice daily and as needed until healed.<br><br>A record review of Resident #34's Minimum Data Set (MDS) with Assessment Reference Date (ARD) 2/28/25 revealed the resident was severely cognitively impaired.<br><br>A record review of Resident #34's admission Record revealed an admission date of 3/16/22, with diagnoses including non-pressure chronic ulcer of other part of left foot with unspecified severity and atherosclerosis of native arteries of other extremities with ulceration. |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>Based on observation, interviews, record reviews, and facility policy reviews, the facility failed to ensure incontinent residents received appropriate care and services to prevent the possibility of a urinary tract infection for one (1) of two (2) residents observed for incontinent care (Resident #8). Specifically, the facility failed to provide timely incontinence care and maintain cleanliness, which placed the resident at risk for skin breakdown and urinary tract infection.<br><br>Findings Include:<br><br>A record review of the facility's Perineal Care policy with a revision date of 1/2025 revealed: It is the practice of this facility to provide perineal care to all incontinent residents during routine bath and as needed in order to promote cleanliness and comfort, prevent infection to the extent possible and to prevent and assess for skin breakdown .<br><br>On 05/13/25 at 3:15 PM, an observation of peri-care being performed by Certified Nursing Assistant (CNA) #1, assisted by CNA #2, revealed CNA #1 removed Resident #8's brief, which was heavily soiled with amber-colored urine and emitted a strong urine odor. The resident's wheelchair and pants were also soaked in urine.<br><br>On 05/13/25 at 3:32 PM, in an interview, CNA #1 confirmed the brief was heavily soiled with amber-colored urine. She confirmed the resident 's chair and pants were also heavily soiled. She stated she was assisting CNA #2 and did not know when the resident was last checked or changed.<br><br>On 05/13/25 at 3:36 PM, CNA #2 confirmed in an interview that the chair, pants, and brief were heavily soiled with urine. She stated she changed Resident #8 around 10:30 AM, right before lunch. CNA #2 acknowledged she was supposed to check the resident every two hours but had not done so because she was busy. She confirmed that the resident had not received peri-care for over four and a half hours. CNA #2 stated she is expected to provide peri-care every two hours. She acknowledged the resident could develop a urinary tract infection and skin infection from the delay in care.<br><br>On 05/14/25 at 11:50 AM, the Director of Nursing (DON) stated in an interview that Resident #8 should be checked and changed every two hours if soiled. She further stated that if a resident is a heavier wetter, they should be checked every hour. She confirmed that her expectation of CNAs is to check and change residents every two hours to ensure they remain dry and clean. The DON acknowledged that residents left soiled for extended periods are at risk for skin breakdown and skin infections.<br><br>A record review of Resident #8's admission Record revealed an original admission date of 08/22/06, with diagnoses including acute kidney failure and mild intellectual disabilities.<br><br>A record review of the Minimum Data Set (MDS) for Resident #8, conducted 3/20/25, revealed a Brief Interview for Mental Status (BIMS) score of 3, indicating the resident was severely cognitively impaired and reliant on staff for care. |