STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255344	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Quitman County Health & Rehab LLC	350 Getwell Drive Marks, MS 38646

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47158 Based on staff and resident interviews, record reviews, and facility policy review the facility failed to verify the documented advance directives signed by the Resident Representative (RR) were the preferences of a cognitively intact resident for one (1) of 16 Advance Directives reviewed. Resident #148. Findings Included: Review of the facility policy, titled Advanced Directives, revealed .Policy Interpretation and Implementation 1. Upon admission, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate and advance directive if he or she chooses to do so .4. If the resident becomes able to receive and understand this information later, he or she will be provided with the same written materials as described above, even if his or her legal representative has already been given the information . Record review of the Order Summary Report with active orders as of [DATE] revealed an order dated [DATE] Code Status; DNR (Do Not Resuscitate) EFF(effective) 081424. An additional order dated ,d+[DATE] revealed DNR. Record review of a Nurse Note dated [DATE] at 6:19 PM revealed .States that she is not a DNR . Record review of the Resident/Representative Consent for Cardiopulmonary Resuscitation (CPR) form, dated [DATE], indicated the RR, rather than the resident herself, had signed the document upon admission. The form contained a statement that read, I understand that CPR constitutes an extraordinary measure and SHOULD NOT be done on this resident . Record review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE] revealed Resident #148 had a Brief Interview for Mental Status (BIMS) score of 15, indicating she was cognitively intact. During an interview on [DATE] at 11:30 AM, Social Services stated that the Resident/Representative Consent for CPR was signed by the resident's representative at the time of admission and not by the resident. She admitted that she did not discuss CPR with Resident #148 upon admission. Considering Resident #148's BIMS score of 15, which demonstrates cognitive intactness, she agreed that she should have followed up with the resident directly to verify her preferences regarding CPR. (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with Resident #148 on [DATE] at 12:10 PM, the resident confirmed that no one had discussed CPR with her or asked for her wishes regarding resuscitation. She expressed that depending on the circumstances, she might want CPR performed. A review of the Admission Record revealed that Resident #148 was admitted to the facility on [DATE] with diagnoses that included Unspecified dementia.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45598 Based on observation, staff and resident interview, record review and facility policy review the facility failed to implement an Activity of Daily Living (ADL) care plan related to removal of facial hair (Resident #3) and nail care (Resident #44) for two (2) of 13 sampled residents. Findings Included: Record review of the facility policy, Care Plans, Comprehensive Person-Centered with revision date of March 2022 revealed, . A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident . Resident #3 Record review of Resident #3's Care Plan with a problem onset date of 04/19/2022 revealed .requires assistance with ADLs (Activities of Daily Living) . Approaches . Total assistance x 1 staff for all ADLs (Bed Mobility, Transfers, Locomotion, Dressing, Eating, Toileting, Hygiene, Bathing) . On 08/26/24 at 12:14 PM, an observation of Resident #3 revealed her sitting in her geri chair in the hall and she had scattered white facial hairs above her lip and two white chin hairs which were approximately one (1) inch long. On 08/27/24 at 8:45 AM, an observation of Resident #3 revealed her lying in her bed asleep and she had scattered white facial hairs above her upper lip and two chin hairs which were approximately one (1) inch long. On 08/27/24 at 10:27 AM, an interview with Certified Nursing Assistant (CNA)#1 revealed that Resident #1's scheduled shower days were Monday, Wednesday, and Friday and the CNAs were supposed to take care of facial hair during that time. CNA #1 confirmed that Resident #3 had white facial hair to her upper lip and chin and that her facial hair had not been shaved during her bath the day before. Record review of Resident #3's Admission Record revealed an admitted [DATE] with diagnoses that included Huntington's Disease, Dementia, and Heart Failure. Record review of Resident 3's MDS with an Assessment Reference Date (ARD) of 07/31/2024, Section C revealed a Brief Interview for Mental Status (BIMS) should not be conducted because the resident was rarely or never understood. Section GG - Functional Abilities and Goals revealed Resident #3 was dependent in maintaining personal hygiene. Resident #44 Record review of Resident #44's Care Plan with a problem onset undated, revealed .is at risk for impaired function/Daily ADL abilities and requires assistance to complete Activities of Daily Living (ADLs) .Approaches .Inspect nails daily, clean and cut as needed . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation on 08/26/24 at 12:17 PM, revealed Resident #44 sitting up in his wheelchair in his room and his fingernails were long, jagged and had a brown substance underneath them. His fingernails were approximately one-half (1/2) to three-fourths (3/4) inch long. Resident #44 revealed that they had not cut his nails in a while and stated, Sometimes I scratch myself. He also confirmed that the staff did not check his nails every day. On 08/27/24 at 10:24 AM, an interview with CNA #1 revealed that they were supposed to provide for resident needs such as nail care and shaving facial hair during their bath or shower time. She confirmed that Resident #44 had long, jagged nails with a brown substance underneath and that his nails should have been addressed yesterday during his shower time. CNA #1 revealed that not doing nail care could cause the resident to scratch himself, it could cause skin tears and possible infection. CNA #1 revealed Resident #44 should have gotten his shower yesterday on the evening shift on 08/26/24 and she agreed that Resident #44 had not received nail care and stated that it did not look like his nails had been cleaned or clipped. On 08/27/24 at 10:30 AM, an observation and interview with Registered Nurse (RN) Supervisor, confirmed that Resident #44's fingernails were long and jagged. She also confirmed the brown substance under his nails. The RN Supervisor revealed that personal hygiene included nail care, grooming, and facial hair and the CNAs were supposed take care of these needs during their baths or showers. The RN Supervisor revealed that long, jagged, and dirty fingernails could cause skin tears, abrasions, and she agreed that it could cause infection if nails were not cared for properly. She also agreed that Resident #44's nails were not clipped nor cleaned during his shower he received the day before and stated, I will get someone on this now. On 08/27/24 at 10:40 AM, an interview with Administrator (ADM) revealed that personal hygiene included mouth care, nail care, and shaving facial hair on men and ladies. She revealed that during resident showers, it was the CNAs responsibility to check the fingernails and to take care of facial hair. She revealed that the CNAs were supposed to check the residents from head to toe while they had them in the shower and take care of any concerns which included fingernails and facial hair. She revealed that they were also supposed to report any other concerns to the nurse. The ADM confirmed Resident #3 and Resident #44's ADL Care Plan was not followed related to nail care and removal of facial hair. On 08/27/24 at 2:52 PM, an interview with Minimum Data Set (MDS) Coordinator revealed that the purpose of the comprehensive care plan was to ensure continuity of care for the residents. She confirmed that Resident #3's ADL care plan was not implemented related to her personal hygiene needs which included removal of facial hair. She also agreed that Resident #44's Care Plan was not followed when the staff failed to clean and clip his fingernails. Record review of Resident #44's Admission Record revealed an initial admitted [DATE] with diagnoses that included Cerebral Infarction, Dysphagia and Chronic Systolic Heart Failure. Record review of Resident #44's Physician Orders revealed an order with start date of 07/01/2024, to inspect nails daily, clean, and cut as needed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #44's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/26/2024. Section C - Cognitive Patterns, revealed a Brief Interview for Mental Status (BIMS) Score of 07 which indicated Resident #44 had severe cognitive deficits. Section GG- Functional Abilities and Goals revealed that he was dependent on staff to maintain personal hygiene.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45598 Based on observation, staff and resident interview, record review and facility policy review the facility failed to provide Activity of Daily Living (ADL) care related to removal of facial hair (Resident #3) and nail care (Resident #44) for two (2) of 13 sampled residents. Findings Included: Record review of the facility policy titled Activities of Daily Living (ADL)s with revision date of March 2018, revealed Policy Statement: Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene . Resident #3 An observation on 08/26/24 at 12:14 PM, revealed Resident #3 sitting in her geri chair in the hall and she had scattered white facial hairs above her upper lip and two white chin hairs that were approximately one (1) inch long. An observation on 08/27/24 at 8:45 AM, revealed Resident #3 lying in her room asleep. She had scattered white facial hairs above her upper lip and two chin hairs that were approximately 1 inch long. During an interview on 08/27/24 at 10:27 AM, Certified Nursing Assistant (CNA) #1 revealed that Resident #3's scheduled shower days were Mondays, Wednesdays, and Fridays. She confirmed that Resident #3 had white facial hair on her upper lip and chin and she revealed that her facial hair should have been shaved during her bath the day before. CNA #1 confirmed that her facial hair had not been taken care of. Record review of Resident #3's Admission Record revealed that she admitted to the facility on [DATE] with diagnoses that included Huntington's Disease, Dementia, and Heart Failure. Record review of Resident 3's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/31/2024, Section C revealed a Brief Interview for Mental Status (BIMS) should not be conducted because the resident was rarely or never understood. Section GG - Functional Abilities and Goals revealed Resident #3 was dependent in maintaining personal hygiene. Resident #44 During an observation on 08/26/24 at 12:17 PM, revealed Resident #44 sitting up in his wheelchair in his room and his fingernails were long, jagged and had a brown substance underneath them. His fingernails were approximately one-half to three-fourths inch long. Resident #44 revealed that they had not cut his nails in a while and stated, Sometimes I scratch myself. He also confirmed that the staff did not check his nails every day. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/27/24 at 10:24 AM, CNA #1 revealed that they were supposed to provide for the resident's needs such as nail care and shaving facial hair during their bath or shower time. She confirmed Resident #44 had long, jagged nails with brown substance underneath and that his nails should have been addressed yesterday during his shower time. CNA #1 revealed that by not doing nail care could cause the resident to scratch himself, it could cause skin tears and possible infection. CNA #1 revealed that Resident #44 should have gotten his shower yesterday on the evening shift on 08/26/24 and stated that it did not look like his nails had been cleaned or clipped. On 08/27/24 at 10:30 AM, during an observation and interview with the Registered Nurse (RN) Supervisor, confirmed that Resident #44's fingernails were long, jagged and had brown substance underneath. The RN Supervisor revealed that personal hygiene included nail care, grooming, and facial hair and that the CNAs were supposed take care of these needs during their baths or showers. The RN Supervisor revealed that long, jagged, and dirty fingernails could cause skin tears, abrasions, and she agreed that it could cause infection if nails were not cared for properly. She also agreed that Resident #44's nails were not clipped nor cleaned during his shower he received the day before and stated, I will get someone on this now. During an interview on 08/27/24 at 10:40 AM, the Administrator (ADM) revealed that personal hygiene included nail care and shaving facial hair on men and ladies. She revealed that during resident showers, it was the CNAs responsibility to check the residents from head to toe and to take care of any issues that included fingernails and facial hair. Record review of Resident #44's Admission Record revealed an initial admitted [DATE] with diagnoses that included Cerebral Infarction, Dysphagia, and Chronic Systolic Heart Failure. Record review of Resident #44's Physician Orders revealed an order with start date of 07/01/2024, to inspect nails daily, clean, and cut as needed. Record review of Resident #44's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/26/2024. Section C - Cognitive Patterns, revealed a Brief Interview for Mental Status (BIMS) Score of 07 which indicated Resident #44 had severe cognitive deficits. Section GG- Functional Abilities and Goals revealed that he was dependent on staff to maintain personal hygiene.