STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015188	A. Building B. Wing	03/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jackson Health Care Facility	2616 North College Avenue Jackson, AL 36545

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33938 Based on observation, interview, record reviews, and review of facility's policy, the facility failed to provide appropriate treatment, care and services to address the resident's positioning needs in accordance with professional standards of practice, comprehensive care plan and physician's orders for one (1) out of 24 sampled residents (Residents #22). Observations on 3/23/21, 3/24/21 and 3/25/21 revealed Resident #22 was not turned and repositioned per the Physician's Order and care plan. Additionally, Resident #22 did not have his/her hand towels in his/her hands per the care plan. Findings include: Review of the facility's policy titled Care Planning Policy and Procedure, dated 02/2018, revealed the care plan is a guide for all staff on a course of action that will attain or maintain a resident's highest practicable level of well-being. The care plan will be written in accordance with professional standards of practices and documentation. Communication about care plan changes should be ongoing among interdisciplinary team members. Review of the facility's policy titled Writing, Transcribing, and Keying in Physicians Orders, dated 3/2002 and revised 3/2015, revealed the purpose was to provide a protocol for writing physician orders and a uniform system for keying physician orders, to assure preservation, integrity, and continuity of the medical record as a legal document. Orders are to be taken, recorded, and carried out by qualified licensed professional staff within their area of expertise. Review of the clinical record revealed Resident #22 was admitted to the facility on [DATE]. The resident was assessed on the Quarterly Minimum Data Set (MDS) assessment, dated 1/5/21, to have diagnoses which included Unspecified Dementia with Behavioral Disturbance, Coronavirus (COVID-19), Catatonic Disorder due to known Physiological Conditions, Epilepsy, Hypertension, Selective Mutism, Mental Disorder, Parkinson's Disease and Hypothyroidism. Resident #22 had a Brief Interview for Mental Status (BIMS) score of 99, which indicated the resident was severely cognitively impaired. The MDS assessment identified the resident's functional status for activities of daily living (ADLs) as indicating Resident #22 required total assistance from staff. The MDS revealed the resident had functional limitations in range of motion and impairment to the resident's upper and lower extremities on both sides. The MDS revealed Resident #22 did not participate in skilled therapies or restorative nursing programs during the assessment review period. Under Section G Functional Status, the resident was coded as requiring the assistance of two (2) persons with bed mobility. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Care Plan dated 5/24/19 with a revision date of 2/21, for Resident #22 revealed ADL functional/rehabilitation potential was identified as a problem deficit. The goal established stated, The resident will maintain with the same ability in self-care with ADLs through the next review. The approaches included Occupational Therapy (OT) consult PRN (as needed) to help establish a maintenance program for self-care with ADLs, turn and reposition with the assistance of one (1) person and sheet, and use positioning pillows/wedges to assist in resident comfort. Continued review of the care plan revealed an approach to place hand towels in both hands due to the resident keeping his/her hands held tightly. Review of Resident #22's Physician's Order dated 12/17/19 revealed turn and reposition every two (2) hours side to side, on back for meals only. Review of the Skilled Occupational Therapy (OT) Services Progress Notes revealed the services were provided as indicated with each physician's order. Review of the Discharge from Skilled OT Services Note on 6/12/19, revealed Resident #22's goal was not met (goal expected date of 6/24/19), and demonstrated AROM (active range of motion) of bilateral upper extremities from 0 to 0 (indicating the resident was unable to straighten out the upper extremities). The note revealed the resident made no improvement in overall strength and endurance. An observation of Resident #22 on 3/24/21 at 9:40 a.m., 11:45 a.m., and 1:30 p.m. revealed the resident had not been turned per physician ordered turn schedule and remained on his/her back and no hand towels were in each hand. An observation of Resident #22 on 3/25/21 at 10:00 a.m., revealed the resident was still positioned on his/her back and had not been turned and no hand towels were in each hand. An interview was conducted on 3/24/21 at 1:34 p.m. with the Therapy Supervisor who stated, For residents who require hand towels in their hands, restorative staff are responsible for that. Resident #22 reached his/her maximum ability to improve on 6/12/19 and received OT from 5/27/19 through 6/12/19 and Physical Therapy (PT) from 5/27/19 through 6/12/19 as well. The Therapy Supervisor further stated, Resident #22 was admitted to the facility with the contractures from home and I did not order the hand towels for the resident's hand. An interview was conducted on 3/24/21 at 1:47 p.m. with Certified Nurse Aide (CNA) #1. CNA #1 stated, I bathed Resident #22 and placed him/her on his/her back. I did not turn Resident #22 until just before I came to speak with you. I have not been putting hand towels in his/her hands and as far as I know he/she has not had them in for a while. Continued interview revealed the CNA had a Caesarean Section six (6) months ago and it was painful when he/she turned the residents. The CNA further stated, Our turning schedule is on the back of our badge, but I left mine in the car. We are required to turn all residents who are bed bound every two (2) hours and I did not do that. An interview was conducted on 3/24/21 at 2:13 p.m. with CNA #2. CNA #2 stated, We are expected to turn the residents every two (2) hours and follow our turning schedules which are on our badges for all residents who are bed bound or if they request to be turned. I have not put towel rolls in Resident #22's hands for about three (3) months. I noticed it was not done by other staff, so I stopped doing it too. We are expected to follow the care plan for all residents, and I should have looked at it, but I did not. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 3/24/21 at 2:20 p.m. with Restorative Licensed Practical Nurse (LPN) #1 who stated, The wound care nurse placed the recommendation on the care plan to put hand towels in both hands of Resident #22. I only check the care plans quarterly unless something has changed and we discussed it, then I will update it and not wait until quarterly. According to therapy, her range of motion was 0 to 0, so a splint device was not recommended. I would agree that Resident #22 has not had the hand towels in place since the survey entry date, but I feel that her clinical condition is unavoidable. In an interview on 3/24/21 at 3:00 p.m., with the Director of Nursing (DON) revealed it was his/her expectation that staff follow the care plan and turning schedule for all residents. The DON stated, They [staff] are checked off on the skills check list and know to look at the care plan and follow it. Interview on 3/24/21 at 3:35 p.m. with the Wound Care Nurse (WCN) revealed he/she placed the recommendation on the care plan for the bilateral hand towels in each hand for Resident #22 due to his/her hands being closed which caused sweating. The WCN stated, I felt having the hand towels would prevent sweating and any potential for skin breakdown.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33938 Based on observation, interview, record review and facility policy review, the facility failed to ensure a resident with limited Range of Motion (ROM) received appropriate treatment and services to prevent further decrease in range of motion per the comprehensive care plan and physician's orders for one (1) of 24 sampled residents (Resident #51). Observations on 3/23/21, 3/24/21, and 3/25/21 of Resident #51 revealed the resident was not wearing the ROM devices per the care plan and physician's order to prevent further decline. Findings include: Review of the facility's policy titled Care Planning Policy and Procedure, dated 02/2018, revealed the care plan is a guide for all staff on a course of action that will attain or maintain a resident's highest practicable level of well-being. The care plan will be written in accordance with professional standards of practices and documentation. Communication about care plan changes should be ongoing among interdisciplinary team members. Review of the facility's policy titled Writing, Transcribing, and Keying in Physicians Orders, dated 3/2002 and revised 3/2015, revealed the purpose was to provide a protocol for writing physician orders and a uniform system for keying physician orders, to assure preservation, integrity, and continuity of the medical record as a legal document. Orders are to be taken, recorded, and carried out by qualified licensed professional staff within their area of expertise. Review of the clinical record revealed Resident #51 was admitted to the facility on [DATE]. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 11/27/2020, revealed diagnoses including Hypertensive Chronic Kidney Disease with Stage 1-4 Chronic Kidney, Non-Traumatic Intercranial Hemorrhage in Hemisphere, Subcortical, Hemiplegia following Cerebral Infarct affecting Left Non-dominant Side, Dysphagia, Dysarthria, Dystonia, Adult Failure to Thrive, Encounter for Gastrostomy, Acidosis and Dependence on Supplemental Oxygen. The resident had a Brief Interview for Mental Status (BIMS) score of 10 out of 15, indicating the resident was moderately impaired in cognition. The MDS assessment revealed Resident #51 was assessed to have no ambulation or locomotion activity during the review period. The resident was further assessed to have functional limitations in range of motion (ROM) to the lower extremities and no impairment on both sides of the upper extremities. The resident had received no skilled therapy services or restorative nursing services during the assessment review period. The resident was assessed to require total dependence of staff every time during the entire seven (7) day look back period. Review of the Care Plan for Resident #51, dated 2/14/2020 and revision date of 3/9/21, revealed a problem and . Under the approaches section, the following interventions were listed: Apply soft beaded splint to the left lower extremity after a.m. (morning) care; remove at night (HS); inspect skin for irritation/breakdown for fifteen (15) minutes; remove splint at bedtime, and apply right knee immobilizer after a.m. care. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Physician's Order, dated 12/7/2020, revealed Resident #51 was ordered to have a right knee immobilizer after a.m. care and inspect the skin for irritation for 15 minutes. Further review of the Physician's Order, dated 4/7/2020, revealed Resident #51 was to have a soft beaded splint to the left lower extremity daily after a.m. care. Review of the DW [NAME] Home Medical Equipment Invoice dated 3/25/21 at 8:56 a.m. revealed a purchase of one (1) each of an L1830 16-inch knee immobilizer canvas De-Royal/7041-02. Observation on 3/23/21 at 10:00 a.m. revealed Resident #51 was resting in bed without the splint devices in place. Further observations on 3/23/21 at 11:00 a.m., 1:00 p.m., 2:30 p.m. and 4:30 p.m. revealed the resident remained in bed without the splint devices in place. Observation on 3/24/21 at 10:50 a.m. revealed CNA #3 was providing care to Resident #51 with the beaded splint applied to the left knee, but not to the lower extremity. The resident did not have on the knee immobilizer. Observation on 3/24/21 at 12:20 p.m. with the Restorative Nurse revealed Resident #51 did not have the knee immobilizer on his/her right leg. Resident #51 had the soft beaded splint on his/her left knee; however, it was not applied to the lower extremity per the care plan. Observation on 3/25/21 at 8:15 a.m. and 8:30 a.m. revealed Resident #51 was resting in bed with no splint devices in place. Observation on 3/25/21 at 10:00 a.m. revealed Resident #51 was in bed with the soft beaded splint in place but the knee immobilizer was not in place. An interview was conducted on 3/24/21 at 10:30 a.m. with Restorative License Practical Nurse (LPN) #1. LPN #1 stated, Nurses on the floor are responsible for putting splints on the residents based on what is recommended from therapy. Once care plans are updated, the Certified Nursing Aides (CNAs) and restorative are to follow the care plan. My responsibility is to monitor activities of daily living (ADLs), notify the physician, and get orders for splint devices or therapy. Therapy and I communicate on what needs a resident may have. An interview was conducted on 3/24/21 at 11:15 a.m. with Certified Nurse Aide (CNA) #3 revealed he/she placed the soft beaded pad on Resident #51 daily after morning care and it stayed on until the resident was put to bed at night. CNA #3 stated, The splint is used to help prevent contractures. The only thing Resident #51 has on during the day is the soft beaded pad; the resident use to wear a knee immobilizer but about a month ago it went down to the laundry and never came back. I asked about getting a new one but they [therapy] wanted to see if Medicaid would pay for it. I have not heard anything since. An interview was conducted on 3/24/21 at 12:15 p.m. with the Rehab Director revealed if there were any issues with splints or devices, the restorative nurse was good about completing an evaluation. The Rehab Director stated, I can't remember if we were told recently about a missing splint device and I was never notified of the missing knee immobilizer by staff or the restorative nurse for Resident #51. The restorative nurse is responsible for informing me of any residents who may need a splint device. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 3/24/21 at 12:50 p.m. with the Administrator and Director of Nursing (DON) revealed it was their expectation that staff would have notified them when Resident #51 did not have the ordered knee immobilizer. The Administrator and DON further stated, If we had known this, we could have ordered one through our medical supply store or through our vendor and replaced it; we plan on getting the immobilizer tomorrow.