MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34JC	A. BUILDING: _____ B. WING _____	10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JONES CO REST HOME	683 COUNTY HOME ROAD ELLISVILLE, MS 39437

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) conducted an annual recertification survey at the facility from 10/23/2023 through 10/26/2023. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirement and cited M815 and M1570.	M 000		
M 815	45.29.1 Safe Food Handling Procedures Safe Food Handling Procedures. Food shall be prepared, held, and served according to current Mississippi State Department of Health Food Code Regulations. This Statute is not met as evidenced by: Level II Based on observation, staff interviews and facility policy review, the facility failed to store food in accordance with professional standards for food service safety related to food items not dated with a use-by date, food items not discarded by the use-by date, spoiled foods not discarded, food items without an identifying label, food items improperly stored, and food items opened and not sealed for one (1) of three (3) kitchen observations and had the potential to affect all residents who receive food items from the kitchen. Findings Include: A review of the facility's policy, "Food and Supply Storage", revised 1/22, revealed, "... All food ...shall be stored in such a manner as to prevent contamination ...Procedures ...Cover, label and date unused portions and open packages	M 815	F812 (1) The Dietary Manager discarded the expired, opened, undated, unlabeled and any expired foods on 10/23/23. (2) All residents have the potential to be affected by not discarding expired, opened, undated, unlabeled foods. (3) On 11/14/23, the Quality Assurance and Assessment Committee met and revised the food safety policy. On 10/24/23, the Dietary Manager conducted verbal education to all Food Service staff present regarding food safety practices. On 11/15/23, the Dietary Manager conducted a formal in-service for all Food Service staff regarding the revised policy and food safety practices including, but not limited to, proper food scoop storage, properly dating food items with a use by date, discarding food items by the use-by	12/6/23

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M 815	Continued From page 1 ...Discard food past the use-by or expiration date ...Dry Storage ...Foods that must be opened must be store in ...approved containers that have tight-fitting lids ...Hang scoop. Scoops may be stored in bins on a scoop holder ...Refrigerated Stored ... ...sort produce daily to remove spoiled pieces ..." On 10/23/23 at 11:45 AM, a tour of the kitchen with the Chef revealed the following: 1. An observation of the dry storage bins revealed a scoop that was not stored in the designated holder and was lying on top of the sugar. 2. An observation of the contents of Refrigerator #1 revealed one (1) opened carton of prune juice that had a "date opened" label of 10/4/23 and indicated the juice was good through 10/7/23. There were two (2) opened cartons of thickened orange juice and one (1) opened carton of thickened dairy beverage with no label indicating the use-by date. The Chef stated that he would discard the expired/opened and undated items. 3. An observation of Refrigerator #2 revealed one (1) unopened ham with no label indicating the use-by date or a manufacturer's expiration date. There were two (2) containers of strawberries covered with white biological growth. There were three (3) 10-pound packages of meat with no identifying label and no use-by date. The Chef stated the meat was ground beef. There was one (1) sheet pan of rolls with no use-by date. The Chef explained that he would throw away the spoiled strawberries and unlabeled items. 4. An observation of the Freezer revealed one	M 815	date, discarding food items by the use-by date, monitoring for and discarding spoiled foods, identifying food items with labeling, properly storing food items, properly storing and sealing opened food items. The contract with the current Food Services provider will terminate on 11/30/23, and all newly hired staff will be in-serviced on hire. (4) Beginning on 11/15/23, the Dietary Manager or Assistant Dietary Manager will conduct weekly audits to identify food safety issues. Corrective Action will be taken at the time for any issues identified. These audits will continue for eight (8) weeks. The Registered Dietician will complete sanitation and food safety audits monthly, beginning 12/4/23. Corrective action will be taken at the time for any issues identified. Audit reports will be reviewed by the Quality Assurance Committee monthly, beginning 12/5/23, until such time substantial compliance has been achieved as determined by the committee. The Quality Assurance Committee will make any recommendations or changes if needed to ensure compliance.	

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M 815	Continued From page 2 (1) opened bag of French fries with no use-by date on the package. 5. An observation of the dry food storage area revealed one (1) opened bottle of lemon juice with a manufacturer's label that indicated "refrigerate after opening." There was one (1) opened plastic bag of corn starch, which was unsealed, and the product was visible. There was one (1) box of quick creamy wheat, the top flap of the box was opened, unsealed, and the product was visible. On 10/25/23, at 10:12 AM, an interview with the Dietary Manager (DM), revealed her expectation is that expired foods be discarded, the dry food storage items be securely sealed and properly stored. The DM acknowledged that the food items could cause the residents to get sick. The DM stated the scoop being left on top of the sugar and the strawberries covered in white biological growth were unacceptable. On 10/26/23 at 09:34 AM, in an interview with the Administrator, she confirmed that her expectation was that food should be labeled and monitored daily for expiration dates.	M 815		
M1570	48.58.1 Infection Control The following infection control standards shall be met: 1. The facility must maintain and document an effective infection control program that protects patients, families, visitors, and facility personnel by preventing and controlling infections and communicable diseases.	M1570		12/6/23

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M1570	Continued From page 3 2. The facility must have an active surveillance program that includes specific measures for prevention, early detection, control, education, and investigation of infections and communicable diseases in the facility. There must be a mechanism to evaluate the effectiveness of the program(s) and take corrective action when necessary. The program must include implementation of nationally recognized systems of infection control guidelines to avoid sources and transmission of infections and communicable diseases. 3. The facility must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions. This Statute is not met as evidenced by: Level II Based on observation, staff interviews, record review, and facility policy review, the facility failed to ensure staff washed or sanitized hands during Percutaneous Endoscopic Gastrostomy (PEG) site care for one (1) of two (2) residents reviewed with PEG tubes. Resident # 38 Findings Include: Review of the facility's policy, "Infection Prevention and Control Program Policy, revised 8/22/2019, revealed, "Purpose: To establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections ..." During PEG site care, on 10/24/23 at 10:20 AM,	M1570	F880 (1) For Resident #38, one on one verbal education was conducted on 10/25/23, with Licensed Practical Nurse (LPN) #1 regarding the facility Infection Prevention and Control Program policy and standards of practice for proper hand hygiene and glove changes while performing treatments, including during peg site care. This education was provided by the Director of Nurses (DON). A one on one in-service was conducted on 11/14/23, with Licensed Practical Nurse (LPN) #1 regarding the facility Infection Prevention and Control Program policy and standards of practice for proper hand hygiene and glove changes while performing treatments, including during peg site care. This education was provided by the Quality Assurance Infection Preventionist (QA-IP). On 11/14/23, LPN #1	

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M1570	Continued From page 4 for Resident # 38, Licensed Practical Nurse (LPN) #1 did not wash or sanitize her hands or change her gloves after removing the soiled dressing from the PEG site. She used the same gloves to clean the site. LPN #1 also did not wash or sanitize her hands before she donned a clean pair of gloves and applied the treatment to the PEG site. On 10/25/23 at 02:38 PM, in an interview with LPN #1, she confirmed that she should have discarded her gloves after she had removed the soiled dressing from the PEG site. She stated she should have washed or sanitized her hands before and applied clean gloves prior to cleaning the PEG site and before she applied a clean dressing. She explained that her actions could have led to the resident acquiring an infection. Record review of the "Transfer and Discharge Report" revealed the facility admitted Resident #38 on 6/15/23 with diagnosis of Adult Failure to Thrive and Dysphagia. Record review of the "Order Listing Report" revealed Resident #38 had a Physician's Order with an order date of 01/23/2023 to "Clean peg site with normal saline, pat dry, apply hydrophilic foam under peg bumper daily ..." On 10/26/23 at 09:45 AM, in an interview with the Director of Nursing (DON), he stated that LPN #1 should have performed hand hygiene after removing the soiled dressing, applied clean gloves, and then cleaned the PEG site. She should have performed hand hygiene after touching the dressing and between gloves changes. She should have changed gloves after touching the bed remote. The DON stated there is a good possibility that her actions could cause	M1570	demonstrated competency for hand hygiene, glove changes, and infection prevention and control procedures during treatment verified by the QA-IP through return demonstration. (2) All residents have the potential to be affected by improper hand hygiene and glove changes while performing treatments, including peg site care. (3) On 11/14/23, the Quality Assurance and Assessment (QAA) Committee met and reviewed the Infection Prevention and Control (IPC) policy and the Gastrostomy Tube Proper Cleaning Technique policy. No recommendations were made to revise the IPC policy. The QAA Committee recommended revisions to the Gastrostomy Tube Proper Cleaning Technique policy to include care of peg sites requiring medications performed by competent licensed nurse. The policy was revised and a competency checklist tool for peg site care was developed by QAA at that time. In-services began on 11/15/23, by the QA-IP and the DON with all Registered Nurses (RNs) and Licensed Practical Nurses (LPNs) to review the Infection Prevention and Control policy and the Gastrostomy Tube Proper Cleaning Technique policies. In-services will continue until all LPNs and RNs have been in-serviced. After education and training, competency will be verified through return demonstration and documented by the QA-IP, DON, or the Wound Nurse. New RNs and LPNs will be in-serviced and competency verified by	

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M1570	Continued From page 5 the resident to get an infection. On 10/26/23 at 10:07 AM, in an interview with Registered Nurse #1 (RN)/Infection Preventionist, she confirmed LPN #1 should have performed hand hygiene between glove changes and should have discarded her gloves after removing and discarding the soiled dressing because of infection control issues.	M1570	the QA-IP, DON, or the Wound Nurse upon hire. (4) The QA-IP, DON, or the Wound Nurse will conduct three audits two times weekly for 8 weeks beginning 11/15/23, to verify proper infection control procedures are followed during resident treatments according to standards of practice and facility policy. Corrective actions will be taken at the time for issues identified. Audit reports will be reviewed by the Quality Assurance Committee monthly, beginning 12/5/23. The Quality Assurance and Assessment Committee will make any recommendations and/or changes if needed to ensure compliance.	