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	50NC	A. BUILDING: _____ B. WING _____	12/15/2023

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NESHOBA COUNTY NURSING HOME	1001 HOLLAND AVENUE PHILADELPHIA, MS 39350

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M 000	Initial Comments The State Agency (SA) conducted an annual recertification survey and a complaint investigation (CI) MS #MS23354 at the facility from 12/12/23 through 12/15/23 . During the survey, the SA determined the facility was not in compliance with the Minimum Standards of Operation for Institutions for the Aged or Infirm, state licensure requirements and deficiencies were cited at M500, M635, M650 and M815. The SA found the facility to be in compliance related to CI MS #MS23354 related to abuse and no deficiencies were cited. The census at the time of the survey was 118 and the facility was licensed for 145 beds.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate	M 500		1/24/24

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M 500	Continued From page 1 medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion,	M 500		

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M 500	Continued From page 2 discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care;	M 500		

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M 500	Continued From page 3 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level II	M 500	1. How corrective action(s) will be	

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M 500	Continued From page 4 Based on observation, resident and staff interviews, record review and facility policy review the facility failed to 1) accommodate a resident's mobility needs for (3) three of (3) three sampled residents reviewed for mobility needs. (Resident #81, #82, and #83) and 2) provide dignity to residents as evidenced by leaving urinary catheter bags uncovered for two (2) of five (5) residents with a catheter. Resident #24 and Resident #89. Review of the facility policy titled, "Use of Assistive Device," revealed Policy: "The purpose of this policy is to provide a reliable process for the proper and consistent use of assistive devices for those residents requiring equipment to maintain or improve function and/or dignity." ... Policy Explanation and Compliance Guidelines: 1.) "Assistive devices are tool, products, types of equipment, or technology that may help individuals perform tasks and activities..." Findings include: Resident #82 An interview and observation on 12/12/23 at 11:10 AM, revealed the resident has a bariatric bed with no side rails. The resident stated, "I used to have half rails on my bed, and I could use them to pull myself up and around in the bed, but the facility took my rails off of my bed and I want them back". The resident confirmed that the facility said they were taking all rails off the beds because they have to. The resident confirmed that she is mobile and active and liked having the	M 500	accomplished for those residents found to have been affected by the deficient practice: Side rail assessment was completed on resident #82 and side rails were approved by interdisciplinary team 12/18/23. Side rails were installed 12/18/23. Side rail assessment was completed on resident #83 and side rails were approved by interdisciplinary team 12/18/23. Side rails were installed 12/18/23. Resident #81 had side rail assessment completed and interdisciplinary team recommended side rails on 12/14/23. Side rails were installed on 12/14/23. Resident # 81's care plan was updated to remove the trapeze bar on 12/14/23. Resident #24 catheter bag was covered by Charge Nurse on 12/13/23. Resident #89 catheter bag was covered by charge Nurse on 12/13/23. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: Facility acknowledges that all residents have the potential to be affected by the deficient practice. 3. What measures will be put into place or systemic changes made to ensure practice will not recur? On 12/29/23-1/3/24 the Administrator in	

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M 500	Continued From page 5 rails to help turn herself and reposition while in the bed. An interview, on 12/15/23 at 8:00 AM, with the Director of Nursing (DON), regarding removal of the side rails for Resident #82, the DON stated, " The resident has a bariatric bed and can move around". The DON confirmed that she was not aware the resident wanted her rails back or needed them back on. The DON confirmed that the facility was told by the Administrator to remove all the side rails from the beds. Record review of Bed Rail Use Assessment Form dated 07/06/2023 revealed that Resident # 82 benefits from the use of bed rails to assist resident with turning side to side and provides the resident with a feeling of comfort and security for fear of falling out of bed. The bed rail assessment also revealed that there was no potential risk of using the bed rails. A record review of the facility form LTC Physician Order Review/Renewal for Resident #82 revealed that she was admitted to the facility on 09/12/2022 with a diagnoses including Depression, Endogenous obesity, Weakness, and Osteoporosis. Record review of the Minimal Data Set (MDS) with an Assessment Reference Date (ARD) of 11/10/2023 revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact. Resident #83 An interview on 12/12/23 at 10:30 AM, with Resident #83 revealed "They took my side rails and now I don't have anything to hold on to when	M 500	training performed staff in-services on Resident Rights. Staff not present will be in-serviced on their return to work. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program. Beginning 1/3/24 Charge nurse will monitor for side rail placement matching recommendations of interdisciplinary team on side rail assessment. Charge nurse will monitor 5 residents per day for 2 weeks, then 5 residents 3 days a week for 2 weeks, then 5 residents weekly for 3 months. Monitor results will be presented to the Quality Assurance/Performance Improvement (QAPI) committee at the meeting scheduled for 1/24/24 and at subsequent QAPI meetings for 3 months. QAPI committee will then determine need for further monitoring. Beginning 1/3/24 Charge Nurse will monitor all residents with urinary catheter bags daily for 2 weeks, then 4 days a week for 2 weeks, then weekly for 3 months. Monitor results will be presented to the Quality Assurance/Performance Improvement (QAPI) committee at the meeting scheduled for 1/24/24 and at subsequent QAPI meetings for 3 months. QAPI committee will then determine need for further monitoring.	

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M 500	Continued From page 6 I get up. It's hard for me to hold on to my table and the arm of the bedside commode when I'm trying to transfer to the commode." She revealed she had complained about this and was told it was because of the "State" that the side rail was removed. She revealed I've even tried to hold on to the bedside table, but it moves around and isn't safe. An interview on 12/13/23 at 2:30 PM, Resident #83 revealed that maintenance came in one day and just removed them. She revealed Registered Nurse (RN) #4 came in and said that the "State" said it was a new rule and we had to take them off. She revealed I told her and anyone who would listen to me that I needed the bar to hold onto. She stated I used it to hold onto when I got up out of bed to use the bedside commode and to position myself in the bed. The resident revealed nobody came back in to see what I needed to help me with positioning since they took them away. An interview on 12/13/23 at 3:50 PM, with the Director of Nurses (DON) revealed Resident #83 was assessed for side rails on 6/28/23 but the side rail wasn't removed until 8/30/23. The DON confirmed that Resident #83 had been positioning herself using the rail and using it to get to her bedside commode but since she could get up on her own, we removed the side rails because that's what we thought we were supposed to do. She stated we didn't give the resident the option of signing a consent form to keep the side rails because she could get in and out of bed. The DON confirmed that according to the Bed Rail Use Assessment that was completed on 8/30/23, the resident had requested to keep her side rails and confirmed it was for mobility/transferring assistance. She confirmed that nothing was put in	M 500		

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M 500	Continued From page 7	M 500		

place for mobility or transferring assistance when the side rails were removed.

An interview on 12/13/23 at 4:00 PM, with Licensed Practical Nurse (LPN) #1 confirmed that the resident had requested to keep the rails and that she was using them for mobility and transferring.

Record review of Bed Rail Use Assessment Form with date of assessment 6/28/23 revealed, that the Resident #83 requested to keep rails for Mobility/transferring assistance. Under Benefit(s) to using the bed rails(s) Assists resident with turning side to side, provides resident with a feeling of comfort and security for fear of falling out of bed, and assists with balance while attempting to stand/standing was marked "Yes."

Record review of the Physician Order Review/Renewal revealed Resident #83 was admitted to the facility on 06/24/20 with diagnoses that included Risk for falls, Primary osteoarthritis of left knee, Osteoporosis, and Osteoarthritis.

Record review of Resident #83's MDS with ARD of 10/19/23, revealed a BIMS score of 14 which indicates the resident is cognitively intact.

Review of facility policy titled, "Resident Rights," revealed, "The resident has the right to a dignified existence ...8. Privacy and confidentiality: The resident has a right to personal privacy ..."

Review of a statement on facility letterhead dated 12/14/23 and signed by the Director of Nursing (DON) revealed, "We do not currently have included in our policy that catheter bags have to be covered in dignity bag."

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M 500	Continued From page 8 Resident #24 An observation and interview on 12/12/23 at 12:01 PM, revealed Resident #24 sitting in her wheelchair. A urinary catheter bag with no privacy cover was observed hanging on the bottom of the back of the wheelchair. Observation and interview on 12/13/23 at 2:55 PM, observed Resident #24 lying in bed with the catheter bag placed in front of the privacy bag and not in the privacy covering. On 12/13/23 at 3:05 PM an observation and interview with the Director of Nursing (DON) confirmed the catheter bag is always to be in a privacy bag, if we are out of privacy bags, we use a pillowcase. She revealed this makes no sense for the catheter to be placed in front of the privacy bag instead of in it. Record review of the form LTC Physician Order Review/Renewal revealed Urinary Catheter Care with original order date of 08/28/23 ensure catheter bag is covered for dignity. Record review of Resident #24's LTC Physician Order Review/Renewal revealed she was admitted to the facility on 04/08/21 with diagnoses that included Bladder retention, Acquired hydronephrosis and Chronic renal failure. Record review of Resident #24's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 10/23/23, revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact. Resident #89	M 500		

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M 500	Continued From page 9 An observation on 12/12/23 at 10:45 AM, revealed Resident #89 lying in bed with a urinary catheter bag with no privacy covering hanging from the left side of the bottom of the bed visible from the hallway. Record review of the LTC Physician Order Review/Renewal physician orders physician order's dated 11/26/23 revealed, twice a day (BID), ensure catheter bag is covered for dignity. During an interview on 12/13/23 at 3:22 PM with the Director of Nursing (DON) confirmed that the urinary catheter bag is always to be covered in a privacy bag because that is a dignity and privacy issue for the resident. She revealed all nursing staff know that the catheter bags are supposed to be kept covered. She confirmed when the unit managers make their rounds, they are continually reminding the aides to make sure the bags are covered for privacy. Record review of Resident #89's LTC Physician Order Review/Renewal revealed she was admitted to the facility on 4/21/22 with diagnoses that included Indwelling Foley Catheter present and Congestive Heart failure. Record review of Resident #89's MDS with ARD of 10/3/23, revealed a BIMS score of 12 which indicates the resident had moderate cognitive impairment.	M 500		
M 635	45.21.7 Gastric feeding Gastric feeding. Residents who are eating alone or with assistance are not fed by a gastric tube unless their clinical condition indicates that the use of a gastric feeding tube is unavoidable. The	M 635		1/24/24

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M 635	Continued From page 10 residents who are fed by a gastric tube receive the treatment and services to prevent complications or to restore if possible, normal eating skills. This Statute is not met as evidenced by: Level II Based on observation, staff interview, record review, and facility policy review the facility failed to provide a PEG (percutaneous endoscopic gastrostomy) tube feeding as ordered for one (1) of five (5) residents with PEG tubes observed during survey. Resident #54. Findings include: A review of the facility policy titled " Standard Guidelines for Enteral Nutrition", revealed, "...Provide the enteral feedings as ordered." An observation, on 12/13/23 at 7:30 AM of Resident #54's feeding pump at bedside, is observed as being turned off at that time. No feeding was infusing at current time and the bag was empty. The feeding bag hanging had the date of 12/12/23 and 1700 written on it. An interview, on 12/13/23 at 7:35 AM with Licensed Practical Nurse (LPN) #1 confirmed that the bag hanging had 12/12/23 1700 written on it and that it is empty and that the pump is cut off. LPN #1 confirmed that the resident not having his feeding could cause him to be dehydrated or have weight loss. A record review of Resident #54's Physician Order revealed "...Jevity 1.5 at 60ml(milliliters)/hour continuous via PEG." An interview, on 12/13/23 at 8:15 AM, with LPN	M 635	1. How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident #54 had feeding pump resumed as ordered on 12/13/23. Registered Nurse assessed resident 12/13/23. Resident showed no ill effects from deficient practice. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: Facility acknowledges that all residents that received tube feedings by feeding pump have the potential to be affected by the deficient practice. 3. What measures will be put into place or systemic changes made to ensure practice will not recur? On 12/29/23-1/3/24 the Administrator in training performed staff in-services for Registered Nurses (RN) and License Practical Nurses (LPN) on assuring that each resident with a feeding pump has the pump running at the rate ordered by physician. RNs and LPNs not present will be in-serviced on their return to work.	

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M 635	Continued From page 11 #1 confirmed that she had just hung the Jevity 1.5 at 60cc/hour. LPN stated, "There wasn't any feeding at the nurse's station, we had to get it from the kitchen, and they just brought it to the nursing station". LPN #1 stated, "I called the night nurse, LPN #2 to see when the feeding ran out and she said it ran out at 6:00 AM on 12/13/23 and that she didn't have any more to put in the bag because the kitchen had not brought the feeding to the nurse's station". An interview, on 12/13/23 at 3:30 PM with the Administrator in Training (AIT), confirmed that Resident #54 should receive Jevity 1.5, 60cc/hour continuous. AIT stated " They should have ordered the Jevity 1.5 from the kitchen on 12/12/23 so that they would not run out. AIT confirmed that the nurses also have a key to the kitchen so they could have gone and got it themselves from the kitchen". An interview on 12/14/23 at 3:15 PM with Registered Dietician (RD), regarding the weight loss for the resident and she stated that the resident had a 180-day weight loss of 15 percent. The RD stated that the weight loss occurred before the resident received his peg tube on 09/29/23 and the resident has not had any weight loss in the last month. An interview, on 12/14/23 at 6:00 PM with LPN #3 confirmed that she had placed 3 cans of Jevity 1.5 (711 milliliters) in his bag for his peg feeding at approximately 5:00 PM on 12/12/23 and that it should have lasted approximately 12 hours. An interview on 12/14/23 at 6:30 PM with LPN #2 confirmed that Resident #54's feeding pump ran out of feeding at approximately 6:00 AM on 12/13/23 and that the feeding that was ordered	M 635	4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program. Beginning 1/3/24 Charge Nurse will monitor all residents with feeding pumps daily for 2 weeks, then 4 days a week for 2 weeks, then weekly for 3 months. Monitor results will be presented to the Quality Assurance/Performance Improvement (QAPI) committee at the meeting scheduled for 1/24/24 and at subsequent QAPI meetings for 3 months. QAPI committee will then determine need for further monitoring.	

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M 635	Continued From page 12 from the kitchen had not come to the nursing station to refill the bag. A review of the LTC (Long-Term Care) Order Review /Renewal form for Resident #54 revealed that he admitted to the facility on 03/23/23 with diagnoses chronic obstructive pulmonary disease, constipation, and vascular dementia. Record review of the Minimal Data Set (MDS) with an Assessment Reference Date (ARD) of 10/26/23 revealed a Brief Interview for Mental Status (BIMS) score of 04 which indicated Resident #54 was severely cognitively impaired.	M 635		
M 650	45.21.10 Hydration Hydration. Each resident shall be provided sufficient fluid intake to maintain proper hydration and health. This Statute is not met as evidenced by: Level II Based on resident and staff interview, record review and facility policy review the facility failed to accommodate hydration needs for a resident when a water pitcher was not in accessible reach of the resident for (1) one of 109 residents with water pitchers. (Resident # 50) Findings include: Review of the facility policy titled, "Hydration," revealed Policy: Water will be placed where it is easily accessible to the resident." ... During an observation down Hallway 1 on	M 650	1. How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident # 50 had water pitcher placed within reach on 12/12/23. On 12/12/23 Registered Nurse assessed resident. Resident had no apparent ill effects from deficient practice. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice:	1/24/24

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	50NC	A. BUILDING: _____ B. WING _____	12/15/2023

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M 650	Continued From page 13 12/12/23 at 10:25 AM, Resident #50 was overheard hollering out for help from his room. Upon entering the room Resident #50 was observed sitting in a reclining wheelchair. When asked if he needed help, the resident stated, "I need some water." The water pitcher was located on a bedside table that was across the room from where the resident was sitting in his chair. The State Agency went directly to the nurse station and notified a staff member that Resident #50 requested a drink of water. She replied, "We'll get him some." During the continued initial survey rounds on 12/12/23 at 10:45 AM, Resident #50 was heard from the hallway stating, "I'm so thirsty so thirsty somebody please get me some water." Upon entrance to the room Resident #50 revealed again he could not reach his water pitcher and needed someone to get it for him because he is unable to get it. An observation revealed the water pitcher was sitting on the bedside table across the room from the resident. An observation and interview with Registered Nurse (RN) #3 on 12/12/23 at 10:48 AM, she confirmed Resident #50 was unable to reach his water pitcher and was unable to propel his wheelchair and get to the water pitcher. RN #3 also confirmed Resident #50 is capable of of drinking from the water pitcher independently and the water pitcher should have been placed in residents reach at all times and the revealed concerns from the resident not having his water in reach is that it placed the resident at risk for increased thirst and possibly dehydration. An interview with the Director of Nursing on 12/13/23 at 2:45 PM, she revealed Resident #50 should have had his water pitcher always placed	M 650	The facility acknowledges that all residents that are receiving hydration/nutrition by mouth have the potential to be affected by the deficient practice. 3. What measures will be put into place or systemic changes made to ensure practice will not recur? Staff in-services were performed by the Administrator in Training on 12/29/23-1/3/24 on importance of making sure that all resident's water pitchers are within reach. Any employee not present will be in-serviced on their return to work. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program. Beginning 1/3/24 Charge nurse will monitor for water pitcher being within reach. Charge nurse will monitor 5 residents per day for 2 weeks, then 5 residents 3 days a week for 2 weeks, then 5 residents weekly for 3 months. Monitor results will be presented to the Quality Assurance/Performance Improvement (QAPI) committee at the meeting scheduled for 1/24/24 and at subsequent QAPI meetings for 3 months. QAPI committee will then determine need for further monitoring.	

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M 650	Continued From page 14 in his reach. She confirmed by not having the water pitcher in reach staff were not meeting the residents needs and placed the resident at increased risk for dehydration. Review of the LTC (Long-Term Care) Order Review /Renewal Form Resident #87 was admitted by the facility on 11/07/19 with diagnoses of Self- Care deficit and at risk for deficient fluid volume. Record review of the Minimum Data Set (MDS) Section C with an Assessment Reference Date (ARD) of 11/08/23, revealed that Resident # 50 had a Brief Interview for Mental Status (BIMS) score of 11 which indicated that he was moderately cognitively impaired.	M 650		
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 Widespread Based on observation, staff interviews, and facility policy review, the facility failed to ensure food items in the kitchen refrigerators were dated and labeled and failed to ensure kitchen equipment was clean for two (2) of three (3) kitchen tours. Findings Include: Record review of the facility policy titled, "Food	M 815	1. How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: No specific resident was identified to be affected by the deficient practice. 12/12/23 Dietary staff members discarded all unlabeled and undated food items from all refrigerators.	1/24/24

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M 815	Continued From page 15 Storage" undated, revealed Food is stored, prepared and transported at appropriate temperatures and by methods designed to prevent contamination or cross contamination ...13. Leftover food is stored in covered containers or wrapped carefully and securely. Each item is clearly labeled and dated before being refrigerated. Leftover food is used within 3 days or discarded. f ...Meat, fish, and poultry should be stored on lower shelves..." Record review of the facility policy titled, "Ice" undated, revealed, "Ice will be produced and handled in a manner to keep it free from contamination ...2. Ice machines will be maintained in a clean and sanitary condition to prevent ice contamination. Record review of the Weekly Cleaning Schedule, undated, revealed under Task to be completed, 3 compartment Refrigerator, 2 compartment Refrigerator. No Date/initials were recorded on the schedule. An observation and interview during the initial tour of the kitchen on 12/12/23 at 10:00 AM, with Dietary worker #1 revealed a 2-compartment refrigerator with two (2) opened, undated 5-pound (lb) containers with a manufacturing label of Tuna Salad. An undated 5 lb clear container with a manufacturer label of Chicken Salad. A 5 lb opened and undated clear container with a manufacturer label of Pimento cheese. A bag of rolls identified by Dietary Worker #1, that was unlabeled and undated. Dietary Worker #1 confirmed these food items are always supposed to be dated and labeled. She revealed foods out of date could make a resident sick. The inside of the refrigerator was noted with food substances on the bottom of the refrigerator. Dietary Worker	M 815	12/12/23 dietary staff cleaned the 2 compartment and 3 compartment refrigerators. 12/13/23 maintenance staff cleaned the ice machine, defrosted and cleaned the ice bin, and cleaned the filters on the ice machine. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: The facility acknowledges that all residents that receive food/beverages from the dietary department have the potential to be affected by the deficient practice. 3. What measures will be put into place or systemic changes made to ensure practice will not recur? 12/13/23 a new ice bin was ordered for the ice machine. 12/27/23 new ice bin installed. On 12/18/23 Dietary Director performed in-service on labeling and dating food items. Staff not present will be in-serviced on their return to work. On 12/18/23 Dietary Director performed in-service on cleaning ice machine to maintenance employee responsible for cleaning ice machine. On 12/18/23 Dietary Director performed in-service on the cleaning schedule and	

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M 815	Continued From page 16 #1 confirmed the inside of the refrigerator needed to be cleaned. She revealed no cleaning schedule is being used but revealed we need to use one to make sure things are getting done. An observation of the three (3) compartment refrigerator revealed a half tomato identified by Dietary Worker #1 wrapped in clear plastic wrap was unlabeled and undated. She revealed this needs to go into the trash. A large clear bag was identified by Dietary Worker #1 as cheddar cheese with no label or date. A brown shipping box with no label or date was observed sitting on the third shelf of the refrigerator, Dietary Worker #1 identified the food as a thawing turkey. She revealed this shouldn't be on this shelf but should be on the bottom shelf and should be labeled and dated. A rectangular metal pan unlabeled and undated, Dietary Worker #1 identified the food as chopped turkey. She confirmed this should be labeled and dated so we know how long it's been here. An observation of the bottom of the refrigerator was noted with dried and liquid substances throughout. The outside of the refrigerator was noted with dried substances and smudges. Dietary Worker #1 confirmed this refrigerator needs a good cleaning also. An observation inside the ice maker revealed the white plastic covering was noted with black and brown speckled substances. Dietary Worker #2 revealed maintenance is supposed to clean the inside of the ice makers. We wipe down the outside. She confirmed there was a black and brown substance inside of the icemaker and revealed that it shouldn't be there, and she wasn't sure when it was last cleaned. During an interview and observation on 12/13/23 at 9:50 AM, the Dietary Manager (DM) revealed I was out yesterday, but they told me of the stuff that was found. The DM revealed there is a	M 815	the importance of keeping the schedule correct and up to date. Staff not present will be in-serviced on their return to work. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program. Beginning 1/3/24 Dietary Director will monitor labeling and dating on all opened food items daily for 3 weeks, then weekly for 3 months. Monitor results will be presented to the Quality Assurance/Performance Improvement (QAPI) committee at the meeting scheduled for 1/24/24 and at subsequent QAPI meetings for 3 months. QAPI committee will then determine need for further monitoring. The Dietary Supervisor will monitor in the absence of the Dietary Director. Beginning 1/3/24 Dietary Director will monitor the completion of the cleaning schedule daily for 3 weeks, then weekly for 3 months. Monitor results will be presented to the Quality Assurance/Performance Improvement (QAPI) committee at the meeting scheduled for 1/24/24 and at subsequent QAPI meetings for 3 months. QAPI committee will then determine need for further monitoring. The Dietary Supervisor will monitor in the absence of the Dietary Director. Beginning 1/3/24 the Infection Preventionist will monitor cleanliness of	

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M 815	Continued From page 17 cleaning schedule, but we don't use it. The staff know they are supposed to keep the equipment clean and the food items are always to be labeled and dated. During an observation of the ice maker, the DM confirmed there were black and brown specks of substance. He revealed I'm not sure when it was last cleaned but it needs to be cleaned. He revealed he is ultimately responsible for ensuring the kitchen equipment is kept clean and that includes the ice maker. He revealed maintenance is responsible for cleaning it monthly. During an interview and observation on 12/13/23 at 10:00 AM, the Maintenance Supervisor revealed it is the responsibility of the maintenance department to clean and sanitize the ice maker monthly. He confirmed that the ice maker had a lot of black substances inside and revealed it looked like mold. He confirmed it doesn't look like it has been cleaned in a while. During an interview and observation on 12/13/23 at 10:10 AM, Maintenance Worker #2 confirmed that we are responsible for cleaning the inside of the ice maker monthly. He confirmed that the ice maker doesn't look clean and that the black substance throughout the top looks like mildew. He confirmed, "I guess I didn't clean it and it could potentially cause sickness to a patient." An interview and record review of the cleaning schedule on 12/14/23 at 11:00 AM, the DM confirmed all kitchen equipment is on the cleaning schedule form, but we haven't been using the form. He revealed it's the responsibility of all the dietary workers to clean the equipment but ultimately, it's my responsibility to make sure that everything is in place to ensure the tasks are completed.	M 815	ice machines at Station 1, Station 2, Station 3/4 and in kitchen, 2 times a week for 3wks, then weekly for 3 weeks, then monthly for 3 months. Monitor results will be presented to the Quality Assurance/Performance Improvement (QAPI) committee at the meeting scheduled for 1/24/24 and at subsequent QAPI meetings for 3 months. QAPI committee will then determine need for further monitoring.	

MSDH - Health Facilities Licensure and Certification

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