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	17DH	A. BUILDING: _____ B. WING _____	C 07/18/2024

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M 000	Initial Comments The State Agency (SA) conducted an annual re-certification survey along with a complaint investigation CI MS #25745 at the facility from 7/15/24 through 7/18/24. During the survey, the SA determined that the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements and cited M610, M640 and M815. There were no deficiencies cited related to CI MS #25745.	M 000		
M 610	45.21.2 Activities of daily living Activities of daily living. Each resident shall receive assistance as needed with activities of daily living to maintain the highest practicable well being. These shall include, but not be limited to: 1. Bath, dressing and grooming; 2. Transfer and ambulate; 3. Good nutrition, personal and oral hygiene; and 4. Toileting. This Statute is not met as evidenced by: Level II Based on observation, resident and staff interviews, record review and facility policy review, the facility failed to ensure Activities of Daily Living (ADL) care was provided daily as evidenced by a resident did not receive daily oral care for one (1) of 26 residents reviewed. Resident #93. Findings Include: Record review of the facility policy "Activities of	M 610	The Oral hygiene was completed by Licensed Practical Nurse #1 (LPN) on 7/16/24 for RI #93. 1:1 in-service for Certified Nursing Assistant #1 (CNA) completed by DON 7/16/24. The Care plan of the resident identifier RI #93 was reviewed and updated by the Quality Assurance LPN. The facility has determined that all residents have the potential to be affected.	8/26/24

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M 610	Continued From page 1 Daily Living (ADL)" revised 09/15/22 revealed " .... Policy Explanation and Compliance Guidelines ... 3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene..." On 07/15/24 at 10:55 AM, an interview with Resident #93 revealed she was admitted to the facility about three (3) months ago. She revealed the Certified Nursing Assistants (CNAs) gave her good baths, but she had a concern about her teeth not getting brushed. She revealed the CNAs had helped her brush her teeth a few times since she had been there and wasn't sure if they were supposed to help her with this. She stated, "If I ask, they will sometimes do it, but if I don't ask, it doesn't get done." Resident #93 revealed that she brushed her teeth once or twice a day when she was at home. She revealed that she had used a wet washcloth and paper towels to clean her teeth a few times in the facility, but they didn't get her teeth clean. She revealed that she knew that poor oral care could cause tooth decay and bad breath and she would like her teeth to be brushed every day. On 7/16/24 at 9:00 AM an observation and interview with Resident #93 revealed she was sitting up in her wheelchair in her room drinking coffee. She revealed that the CNAs had not helped her brush her teeth since one day last week. She revealed that if they would get her a toothbrush and toothpaste and set up for her, she could brush her own teeth. Resident #93 revealed that she had asked staff several times to get her a toothbrush and toothpaste so she could brush her teeth and they told her that they would get someone to do it or they gave other excuses and never returned. Resident #93 stated, "I guess	M 610	All nurses and Certified nursing assistants were in serviced beginning on 7/16/24 by the Staff Educator and Restorative Nurse on the importance of following the plan of care for Activities of Daily Livings (ADL) emphasizing Oral Care. The Restorative Nurse will conduct audits of five (5) residents per week for four (4) consecutive weeks. This audit will be reviewed at one monthly Quality Assurance meeting on 8/26/24 to substantiate compliance. Interdisciplinary Team (IDT) will review ADL documentation in the morning meeting starting on 8/1/24 and ongoing. DON will present findings from daily review in the QA meeting starting on 8/26/24 and every month for a minimum of three (3) months and until compliance is sustained.	

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M 610	Continued From page 2	M 610		

they got busy or forgot about it." She also revealed that she had her own teeth and stated, "I have good teeth but at this rate, they won't last much longer."

On 7/16/24 at 9:05 AM, an observation revealed Resident #93 had poor oral hygiene as evidenced by a yellow substance between her upper and lower teeth and gum line.

During an interview on 7/16/24 at 1:30 PM, with Licensed Practical Nurse (LPN) #1 in Resident #93's room confirmed the yellow substance on Resident # 93's upper and lower teeth and gum line. LPN #1 stated "Her mouth looks pretty rough." LPN #1 revealed that mouth care should be done every day, she confirmed that Resident #93's teeth had not been cleaned and that she would get it taken care of now. LPN #1 revealed that failure to provide daily oral care to this resident could lead to gingivitis, loss of appetite, tooth decay, and other issues. She revealed that CNAs were responsible for completing daily personal hygiene and it included oral care.

On 7/16/24 at 1:35 PM, an interview with CNA #1 revealed personal hygiene included mouth care and was supposed to be provided every day. She revealed the CNAs helped residents brush their teeth, rinsed their mouth and provided mouthwash for the residents. CNA #1 revealed she didn't get here until 8:00 AM today and assumed the night shift CNA had taken care of Resident #93. CNA #1 looked at Resident #93's teeth and confirmed that her mouth care had not been done. She revealed that failure to provide mouth care could lead to gingivitis and other problems.

On 07/17/24 at 9:20 AM, an interview with the

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M 610	Continued From page 3 Director of Nursing (DON) revealed the CNAs were responsible for providing personal hygiene for all residents. She confirmed personal hygiene included oral care. She revealed that failing to provide oral care for Resident #93 was not healthy and agreed that it could lead to tooth decay, bad breath, and other health problems. She revealed mouth care was supposed to be done every day and as needed. The DON revealed the CNAs on night shift got some of the residents up before the day shift came in and the day shift CNAs got the rest up and stated, "I hate she's fallen through the cracks." She revealed they would resolve this issue now and that she wanted all their residents taken care of. Record review of Resident #93's Admission Record revealed an admission date of 04/03/24 with diagnoses that included Parkinson's Disease without Dyskinesia and Need for Assistance with Personal Care. Record review of Resident #93's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/09/24 under Section C revealed a Brief Interview for Mental Status (BIMS) score of 14 which indicated that she was cognitively intact. Section GG revealed she required partial to moderate assistance with oral hygiene.	M 610		
M 640	45.21.8 Accidents Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies.	M 640		8/26/24

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M 640	Continued From page 4 This Statute is not met as evidenced by: Level II Based on observation, Resident Representative (RR) and staff interview, record review and facility policy review the facility failed to prevent the possibility of an accident as evidenced by a physician ordered medication being found in a resident's bed for one (1) of 27 sampled residents. Resident #52 Findings Include: Review of the facility policy titled, "Medication Administration" with a revision date of 6/8/23 revealed under "Policy Explanation and Compliance Guidelines ...#16. Observe the resident consumption of medication". An interview and observation on 07/15/24 at 11:22 AM, with the RR for Resident #52 revealed she was making her mother's bed and found a blue pill in the sheets. This observation revealed she was holding the blue pill. She stated she had called for the nurse. She stated this is not the first time she has found medicine in her mother's bed, but it has been a while. An observation and interview on 7/15/24 at 11:25 AM, with Licensed Practical Nurse (LPN) #3 confirmed the blue pill found in Resident #52's bed was Levothyroxine150 micrograms (mcg). An observation at this time of the resident's medication cards confirmed this pill was Levothyroxine 150 mcg. She stated that it was supposed to have been given between 5-6 AM this morning. She stated the nurse should always stay with the resident to make sure the resident has swallowed all the medications. She stated	M 640	Medication was removed from the resident bed and the charge nurse disposed of the medication on 7/15/24. All residents have the potential to be affected. The Staff Educator began in-service with all direct care staff on 7/15/24 for nurses to remain at bedside until Medication Administration is complete, in accordance with the Medication Administration Policy. The QA Nurse will audit four (4) nurses weekly on medication administration for four (4) consecutive weeks, starting on 8/2/24. The audit will be presented to one monthly Quality Assurance meeting on 8/26/24 to substantiate compliance. Quality Assurance Nurses will audit Medication Administration every three (3) months starting in November and will present audit to the November QA meeting. Quarterly audits will be presented to the following months QA meeting on a permanent bases to sustain compliance.	

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M 640	Continued From page 5	M 640		

she would make the Registered Nurse (RN) supervisor aware.

An interview on 7/15/24 at 11:30 AM, with RN #1 confirmed the nurse giving the medications should always stay with the resident and make sure the resident has swallowed all medications.

An interview on 07/16/24 03:11 PM, with the Director of Nurses (DON) confirmed the medication nurses should always stay with the resident until they had swallowed all medications. She stated the purpose was to make sure the resident took all of their medication, and that no other resident would have access to it.

An interview on 7/16/24 at 8:50 PM, with LPN #5 revealed she was Resident #52's nurse on Sunday night 7/14/24 going into Monday morning 7/15/24 and confirmed she gave the resident her medicine while she was in her wheelchair. She stated she has only worked with this resident twice but was warned by other staff members that she tends to not swallow all her medications. She stated the purpose of staying with the resident to make sure they swallow the pills is to make sure they do not get choked on the medications, or that there are no medications left that other residents could find and take.

An interview on 7/16/24 at 9:04 PM, with LPN #6 revealed she was Resident #52's nurse on Saturday night 7/13/24 going into Sunday morning 7/14/24 and she gave the resident her medication while she was sitting in her wheelchair. She revealed she always stays with her resident while they take their medicines to make sure they swallow it all. She stated she had been warned about this resident not always wanting to swallow her medicines, so she was

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M 640	Continued From page 6 aware of that possibility, but she stayed with her. She stated that the purpose of staying with the resident while they take their medicines is because its physicians orders, they get the medicines they need and to make sure no other resident gets them. Review of Resident #52's "Admission Record" revealed the resident was admitted to the facility on 1/29/21 with medical diagnoses that included Alzheimer's disease. Review of the "Care Profile" for Resident #52 revealed a physician order dated 10/11/23 for "Levothyroxine TAB (tablet) 150 mcg Give 1 tablet by mouth one time a day." Record review of Resident #52's July 2024, Medication Administration Record (MAR) revealed Levothyroxine 150 mcg was documented as given daily through 7/16/24.	M 640		
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 interview, and facility policy review, the facility failed to prevent the possibility of cross contamination to food, as evidenced by failure to perform hand hygiene after picking up a soiled item off the floor during steam table temperature checks for one (1) of	M 815	The dietary staff member involved was in-serviced by the Staff Educator on 7/18/24. All residents have the potential to be affected. All dietary employees will be in-serviced by	8/26/24

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M 815	Continued From page 7 three (3) kitchen observations. Findings Include: Review of the facility policy titled "Infection Prevention and Control" with a revision date of 6/8/2023 revealed "Policy: This facility has established and maintains 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 as per accepted national standards and guidelines..." During an observation of the lunch meal steam table temperature checks on 7/17/2024 at 11:58 AM, Dietary Staff #1 dropped a pen on the floor. She retrieved the pen from the floor and continued to check and record the food temperatures without washing her hands. An interview with Dietary Staff #1, on 7/17/2024 at 12:08 PM, revealed she was nervous and should have stopped and washed her hands to prevent the spread of bacteria to the food. An interview with the Administrator, on 7/17/2024 at 12:36 PM, revealed Dietary Staff #1 should have got a new pen or washed her hands after retrieving the pen from the floor to continue temperature checks. He acknowledged bacteria could cross contaminate the food.	M 815	the Staff Educator starting on 8/1/24 on infection control, focusing on cross-contamination. The Infection Prevention nurse will observe the steam table prep for cross contamination three times weekly for four (4) consecutive weeks, starting on 8/2/24. The audit will be reviewed at one monthly Quality Assurance meeting on 8/26/24 to substantiate compliance. Quality Assurance Nurses will audit steam table prep for cross contamination every three (3) months starting in September and will present audit to the September QA meeting. Quarterly audits will be presented to the following months QA meeting on a permanent bases to sustain compliance.	