STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255137	A. BUILDING _____ B. WING _____	05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NESHOBA COUNTY NURSING HOME	1001 HOLLAND AVENUE PHILADELPHIA, MS 39350

(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) COMPLETION DATE
F 000	INITIAL COMMENTS A standard recertification survey was conducted by Ascellon on behalf of the Mississippi State Department of Health, from 5/6/19 through 5/9/19. The standard survey revealed that the facility was not in substantial compliance with the requirements of participation in Medicare/Medicaid. The following deficiencies resulted from the facility's noncompliance: F-880 and F-925. The facility's census on May 6, 2019 was 159 residents, and the facility held a license for 160 beds.	F 000		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must 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. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following	F 880		6/14/19

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

Electronically Signed | 06/14/2019

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F 880	Continued From page 1 accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

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F 880	Continued From page 2 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and policy review, the facility failed to conduct an annual review of its Infection Prevention and Control Policies (IPCP). Four (4) of six (6) reviewed policies had not been reviewed and/or revised annually. Findings include: Review of the facility policy titled, "Policy and Procedure Development and Maintenance," no date, stated the facility shall provide optimum quality patient care and services .... each department (clinical and nonclinical) shall develop, implement and maintain department specific policies and procedures that outline how the department assesses and meets the needs of the customer/patient population. Approval and Review Process are applied to policies in the policy manager to automatically prompt review by appropriate team members and disciplines depending on the content of the policy. The process is scheduled to promote regular review with most policies having a 12- or 24-month cycle between scheduled reviews. Review of the following policies and procedures titled, "Immunization of Residents, Scabies, and Hand Hygiene" had not been reviewed and/or revised for 2018. The policy and procedure titled, "Immunization of Residents" had last been reviewed and/or revised on 10/26/17, the policy and procedure for "Scabies" had last been reviewed and/or revised on 10/26/17, and the	F 880	1. How corrective actions 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. 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 of the facility have the potential to be affected by the deficient practice. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? A. The policy titled Immunization of Residents was reviewed/revised by the Director of Nursing and was approved by the Nursing Home Administrator on 06/07/2019. The revision included changing the expiration parameters in the electronic policy manager to 12 months instead of 24 months to ensure the policy is reviewed annually. B. The policy titled Scabies was reviewed/revised by the Director of Nursing and was approved by the Nursing	

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F 880	Continued From page 3 policy and procedure for "Hand Hygiene" had last been reviewed and/or revised on 10/27/17. Review of the policy and procedure titled, "Transmission Based Precautions (Isolation)" did not have a date on when the policy and procedure was last reviewed and/or revised. Interview with Infection Control Registered Nurse #1 on 5/9/19 at 1:27 PM, revealed she has been in her position as the Infection Control Nurse since April 2018. She stated she had not reviewed and/or revised any of the IPCP policies and procedures on a yearly basis. She stated she was unaware the IPCP policies and procedures needed to be reviewed yearly, rather had been instructed by the facility they had to be updated every two (2) years. Interview with the Director of Nurses on 5/9/19 at 1:47 PM, revealed she thought the policy and procedures for the IPCP needed to be reviewed and/or revised every two (2) years. Interview with the Administrator on 5/9/19 at 3:18 PM, revealed Infection Control Registered Nurse #1 should review the IPCP yearly and then forward on to the Administrative Team for final approval. He stated the clinical IPCP policies and procedures should be reviewed and/or revised yearly for any changes or updates.	F 880	Home Administrator on 06/07/2019. The revision included changing the expiration parameters in the electronic policy manager to 12 months instead of 24 months to ensure the policy is reviewed annually. C. The policy titled Hand Hygiene was reviewed/revised by the Director of Nursing and was approved by the Nursing Home Administrator on 06/07/2019. The revision included changing the expiration parameters in the electronic policy manager to 12 months instead of 24 months to ensure the policy is reviewed annually. D. The policy titled Transmission Based Precautions (Isolation) was reviewed/revised by the Director of Nursing and was approved by the Nursing Home Administrator on 06/07/2019. The revision included changing the expiration parameters in the electronic policy manager to 12 months instead of 24 months to ensure the policy is reviewed annually. E. On 06/13/2019 the policy expiration date was revised by the Director of Nursing to 12 months on all Infection Control policies in the electronic policy manager to ensure that all Infection Control policies are reviewed annually. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur:	

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F 880	Continued From page 4	F 880	A. The electronic policy manager will alert Infection Preventionist and/or Director of Nursing via automated email 35 days prior to policy expiration date. Infection Preventionist or Director of Nursing will have 14 days to review the policy and make revisions if needed. After the Infection Preventionist or Director of Nursing approves the review or revision, the electronic policy manager will alert Nursing Home Administrator via automated email for final approval. The Nursing Home Administrator will have 21 days to complete the approval process. Once the Nursing Home Administrator approves the policy, the electronic policy manager will automatically update the expiration date to be 12 months from the approval date. B. The Infection Preventionist will log onto the electronic policy manager monthly to visually check the tab "Expired Approvals" to ensure that no Infection Control policies exceeded the 12 month deadline for annual review. The Infection Preventionist will notify the Nursing Home Administrator immediately via email of any Infection Control Policy that is listed on the Expired Approvals tab. C. The Infection Preventionist will report policies that were on the Expired Approvals list to the Quality Assurance Performance Improvement committee at the meeting held every other month, for one year. The Quality Assurance Performance Improvement committee will discuss the need for continued monitoring	

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F 880	Continued From page 5	F 880	of Expired Approvals.	
F 925 SS=E	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility policy on pest control, the facility failed to maintain an effective pest control program so that the kitchen was free of flies. This had the potential to increase the risk of illness for residents that received food from the facility kitchen. The facility's census was 159 and there were nine (9) residents documented with feeding tubes; this indicated 150 residents received food from the kitchen. Findings include: Review of the undated facility policy entitled, "Pest Control", indicated, "If pests are seen in the kitchen, the food service manager or appropriate staff shall be informed, describing where the pest was seen and when. Appropriate action will be taken to eliminate any reported pest situation in the department... If a pest situation is reported, the contractor comes in as soon as possible to spray at the appointed times." During observation on 5/9/19 at 9:00 AM, flies flew around the preparation area where lunch was being prepared. A fly landed on a ladle that hung with other food preparation equipment over the food preparation table. There were two (2) fly-catching devices in the kitchen. One (1) was	F 925	1. How corrective actions 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. 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 and/or beverages from the Dietary Department of the facility have the potential to be affected by the deficient practice. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: A. On 5/23/19, the Board of Directors approved a Pest Control contract with a new pest control provider to replace the current pest control provider. The new pest control provider's service will begin July 1, 2019. The current pest control provider will continue service until June	6/14/19

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F 925	Continued From page 6 on the wall near the restroom and the other near where the meat slicer sat on a preparation table. Neither fly-catching devices were plugged in. The AC cord for the one near the restroom hung down along the wall with its prongs near the electrical outlet. The AC cord for the fly-catching device near the meat slicer had its cord on the food preparation table with part of it running under the meat slicer. During an interview on 5/9/19 at 9:30 AM, Cook #1 said she had seen flies in the kitchen at other times. In an interview on 5/9/19 at 9:33 AM, Cook #2 said she had seen flies in the kitchen at other times. She said she did not know why the devices on the walls to catch flies were not plugged in. She said she had seen them plugged in before. In an interview on 5/9/19 at 12:30 PM, the Dietary Manager indicated the fly-catching devices should be plugged in. The one by the restroom may have been knocked out by a food cart passing by and the one by the meat slicer may have been unplugged when staff was working with the meat slicer earlier. In an interview on 5/9/19 at 12:30 PM, the Service Representative for pest control indicated that the fly-catching device had to be plugged in and lit 24 hours per day and seven (7) days per week (24/7) in order to be effective. He indicated they were unplugged every month when he came to service the kitchen. He would replace the glue boards in the fly traps each month. The blue lamps in the fly trap attracted the flies and they get stuck to the glue board.	F 925	30, 2019. B. On 5/29/19, air curtains were installed on both sets of double doors to the kitchen, the door to the dish room and the exterior double doors to the loading dock to prevent insects from entering the kitchen. C. On 5/29/19, dedicated electrical outlets for the fly trap lights were installed above the ceiling tile on two of the fly trap lights, and the third was rerouted to be plugged into an outlet at ceiling height to ensure that fly trap lights will not be unplugged for other uses of the electrical outlet. D. On 5/30/19, 6/10/19, and 6/11/19, in-services on pest control in the kitchen were given by the Dietary Director. The in-services included instruction on observing for and disposing of pests, sanitizing areas and equipment exposed to pests, reporting pests to management, and entering sightings into the pest control log. Anyone absent because of illness, vacation or any other reason will be in-serviced on the day they 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 6/14/19,the Dietary Director and/or Supervisor will observe for pests in the kitchen daily. Any pest noted will be disposed of and/or reported in the pest	

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F 925	Continued From page 7 Review of the customer service reports showed the facility kitchen had been serviced for flies on 8/28/18, 10/16/18, 12/19/18, 1/16/19, 2/28/19, 3/20/19 and 4/17/19. However, the reports did not reflect the catching machines were not plugged in at the time of service. In an interview on 5/9/19 at 1:00 PM, the Administrator indicated the issue with the fly traps not being plugged in was going to be eliminated by perhaps hardwiring the devices.	F 925	control log book. The Maintenance Director will communicate entries in the log book to the pest control vendor as needed between monthly visits. Beginning 6/14/19, the Dietary Director or Supervisor will monitor fly trap lights, to ensure that they are plugged in and that the lights are working, twice a day x four weeks, then daily until the September Quality Assurance Performance Improvement meeting. The monitor findings will be brought before the Quality Assurance Performance Improvement committee at the September meeting for discussion to determine the need for continued monitoring.	

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	255137	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/09/2019**

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K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility meets the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). There were no LSC deficiencies cited during this survey.	K 000		

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E 000	Initial Comments *EMERGENCY PREPAREDNESS* Survey conducted on 5/9/19 reveals the above facility does not meet all applicable Federal, State and local emergency preparedness requirements. Deficiencies were identified.	E 000		
E 015 SS=E	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):]	E 015		6/11/19

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E 015	Continued From page 1 Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on document review, inspection and interview, the facility failed to maintain and update the emergency preparedness (EP) policies and procedures per requirements of 42 CFR §483.73(b) (1). Findings Include: On May 9, 2019 at 11:45 AM, the facility failed to provide updated policies and procedures containing the amount of water supply in the facility. Documentation review revealed the EP policies and procedures stated the facility shall have 3 gallons per each of the 160-patient capacity (totaling 480 gallons needed for patients only) and 3 gallons for employees for the reserve water, but observation revealed 126 gallons of reserve water was in the facility on the day of survey.	E 015	1. How corrective actions 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. 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 have the potential to be affected by the deficient practice. 3. What measures will be put into place	

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E 015	Continued From page 2 The finding was acknowledged by the Administrator and Maintenance Supervisor verified this observation during the exit interview on May 9, 2019.	E 015	or systemic changes made to ensure that the deficient practice will not recur? On 05/09/2019 the EOP was revised to include a formula to determine the amount of drinking water needed on hand. The amount needed per formula is 792 gallons. On 05/10/2019 180 five gallon bottles (900 gallons) of drinking water was delivered and set up on racks in a temperature controlled room. This amount exceeds the requirements of the formula. On 05/20/2019 Southern Business Supply of Meridian emailed a letter committing to maintain a minimum of 900 gallons of drinking water on site at all times. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program. The facility EOP planner will monitor the amount of water on hand on a monthly basis and will report to the Administrator immediately if there is less than the required amount.	