STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255267	A. BUILDING _____ B. WING _____	02/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARKSDALE NURSING CENTER	1120 RITCHIE AVE CLARKSDALE, MS 38614

(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 The State Agency conducted an annual recertification survey, along with a complaint investigation, MS #17456, from 2/1/21 through 2/4/21. During the survey, the SA determined that the facility was not in compliance with the requirements for participation in Medicare and Medicaid. The SA cited F693 and F880. The SA did not substantiate MS #17456 for assessment/monitor, quality of care and pressure ulcers with no citations related to the complaint. The census at the time of survey was 54 and the facility was licensed for 90 beds.	F 000		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.	F 693		3/31/21

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

Electronically Signed | 03/04/2021

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F 693	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to check placement for a Percutaneous Enteral Gastrostomy (PEG) tube for one (1) of two (2) residents observed during administration of medication through a PEG tube (Resident #51). Findings include: Review of the facility's "Administering Medications Through Nasogastric or Gastrostomy Tube" policy, revised March 2018, revealed upon the order of the attending physician medication will be administered through Nasogastric / Gastrostomy tube when a patient is unable to swallow medications or has a Nasogastric Gastrostomy tube for nourishment. #6 noted the procedure revealed to verify proper tube placement by aspirating gastrointestinal contents. Under points to remember, #2 noted to check and document for proper placement of tube every shift and before administering medication. On 2/2/21 at 9:51 AM, during medication pass Licensed Practical Nurse (LPN) #3 failed to check placement of the Percutaneous Enteral Gastrostomy tube (PEG) prior to administering medications. On 2/2/21 at 10:00 AM, an interview with LPN #3 confirmed that she did not check placement of the tube. LPN #3 stated that she just forgot to do it. She stated that she should always check the placement to be sure it is in the right place. LPN #3 stated she had been in-serviced and checked	F 693	Tube Feeding Mgmt/Restore Eating Skills 1) Resident #51 is doing well and suffered no adverse effects from failure to check the Percutaneous Enteral Gastrostomy (PEG) tube placement prior to administering medication. Tube reassessed and residual checked prior to administration of noon medication by Licensed Practical Nurse #3. 2) All eight residents with Percutaneous Enteral Gastrostomy tubes have the potential to be affected by this deficient practice. All eight tubes were checked for placement prior to medication administration by scheduled Licensed Practical Nurses on February 2, 2021. 3) Licensed Practical Nurse #3 was in-serviced on the policy Administering Medications Through Nasogastric or Gastrostomy Tube Policy including checking placement of percutaneous enteral Gastrostomy tube prior to administration of medications/feedings on February 2, 2021, by the Director of Nurses. All other nurses both Registered and Licensed Practical nurses were in-serviced on February 24, 2021, February 25, 2021, Februay 28, 2021, March 2, 2021 and March 3, 2021 on the policy Administering Medications Through Nasogastric or Gastrostomy Tube by the Director of Nurses and RN Assessment Nurse. The Pharmacy Consultant did a return demonstration with Licensed	

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F 693	Continued From page 2 off on PEG tubes. On 2/3/21 at 4:45 PM, an interview, with the Staff Development Nurse, revealed she did periodic check offs with the nurses, but did not always document them. On 2/3/21 at 4:50 PM, an interview with the Director of Nursing, revealed that the nurse should always check placement before using the PEG tube. She stated this is to make sure it is in the right place. The DON stated the nurse should check placement with air or aspirating stomach contents because something could go into the lungs if the tube is not in the right place. Record review of the physician's order, dated 1/31/19, revealed to check PEG-tube placement every shift, and before medication administration. Record review of an In-service Training, dated 5/30/18, revealed LPN #3 performed a demonstration of medications per tube. Review of Resident #51's Facesheet revealed an admission date of 11/3/11 with diagnoses which included Type 2 Diabetes with Hyperglycemia, Dementia with Lewy Body and Gastrostomy Status.	F 693	Practical Nurse #3 on March 2, 2021 to assure this deficient practice does not reoccur. All nurses both registered and practical licensed will have a return demonstration verifying placement of percutaneous enteral Gastrostomy tubes by the Director of Nurses by March 22, 2021. Check off for correctly checking percutaneous Enteral Gastrostomy tubes prior to administering medications or feeding will be included in annual competency evaluations for all registered and practical licensed nurses. The facility Quality Assurance Committee, which included the Director of Nurses, Medicare Nurse, Quality Improvement nurse, Administrator and Medical Director, met on February 2, 2021 and reviewed policy and procedure Administering Medications Through Nasogastric or Gastrostomy Tube Policy. Checking placement of percutaneous enteral gastrostomy tubes prior to medication administration will be monitored by the Director of Nurses and Pharmacy Consultant one time a week times four weeks then monthly times two months then quarterly beginning March 2, 2021. The Director of Nurses will report any concerns to the Quality Assurance Committee beginning February 26, 2021. 4) The Director of Nurses will report any concerns to the Quality Assurance Committee monthly times three months then quarterly times one year. If problems are identified with current corrective action plan, the Quality Assurance Committee will revise the corrective action plan as needed until substantial compliance is	

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F 693	Continued From page 3	F 693	achieved.	
F 880 SS=D	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 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	F 880		3/31/21

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F 880	Continued From page 4 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. §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 observation, staff interview, record review, and facility policy review, the facility failed to ensure oxygen tubing was changed timely to prevent a potential infection for two (2) of five (5) residents with oxygen, failed to adhere to infection control practices related to donning (putting on) and doffing (removing) proper Personal Protective Equipment (PPE) (Residents	F 880	Infection Prevention & Control 1) Resident #23 and resident #35 did not experience any adverse effects from failure to date their oxygen tubing. Agency Licensed Practical Nurse shift 1 (12 hours) assessed the residents with no adverse effects noted on February 2,	

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F 880	Continued From page 5 #23 and 35), failure to disinfect a medication cart prior to removing from the COVID-19 Unit buffering zone for one (1) of four (4) days of observation and failed to administer eye drops in a manner to prevent infection for one (1) of seven (7) residents observed for medication administration (Resident #1). Findings include: Respiratory Care: Review of the facility's "Infection Control Oxygen Equipment" policy, with a revision date of 3/18, revealed oxygen tubing should be replaced every 7 days. On 02/01/21, at 12:15 PM, on the initial tour, an observation of Resident #35 revealed the resident lying in bed with oxygen on via nasal cannula (NC) at 2 liters per minute. There was no date found on the tubing noting the date the tubing was changed. On 02/02/21, at 2:25 PM, an observation of Resident #35 revealed the resident's oxygen tubing was on per NC at 2 liters per minute revealed there was no date on the tubing documenting when the tubing was changed. On 02/03/21, at 3:45 PM, an observation and interview with Licensed Practical Nurse (LPN) #1 of Resident #35 revealed the resident's NC oxygen tubing did not have a date documenting when it was applied. LPN #1 revealed the staff is supposed to change the tubing every Sunday on the evening shift and put a date on the tubing, to	F 880	2021, February 3, 2021 and February 4, 2021. The agency Licensed Practical Nurse on 2nd shift also assessed on February 2, 2021, February 3, 2021 and February 4, 2021 with no adverse effects. No signs or symptoms of respiratory distress, decrease in oxygen saturation, elevated temperature or lung congestions occurred. Tubing was changed and dated on February 3, 2021, on resident #23 and resident #35. All oxygen tubing was checked on February 3, 2021 by the Director of Nurses and Quality Improvement RN for correct changing and dating of tubes.Oxygen orders for all residents were checked on February 4, 2021. On February 4, 2021 all Oxygen care plans were reviewed and updated to address the changing and dating of oxygen tubing. Orders have been entered for changing and dating the oxygen tubing on resident #23 and resident #35 on February 4, 2021. An order was entered on resident #23 for administering oxygen on February 4, 2021. The medication cart cleaned outside of the Covid-19 buffer zone was recleaned by the Director of Nurses. She placed the medication cart in the Covid-19 unit where it will stay and not be brought out. No adverse effects occurred from failure of properly donning and doffing of Personal Protective Equipment (PPE) in the Covid-19 unit. Resident #1 is doing well and suffered no adverse effects from failure to follow policy on administering eye drops. 2) All residents with oxygen and eye drops have the potential to be affected by this	

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F 880	Continued From page 6 document when the tubing was changed. The date should be near the end of the tubing where it connects to the concentrator. LPN #1 revealed she had been in- serviced on changing oxygen tubing and documenting on the tubing the date it is changed. LPN #1 revealed she does not know why a date was not on the tubing and was not sure when the tubing was changed. LPN #1 revealed if the tubing was not changed every week it could cause the resident to get an infection. On 02/04/21, at 09:43 AM, an interview with the Director of Nursing (DON) revealed all oxygen tubing was to be replaced every 7 days and there was a place on the Medication Administration Record (MAR) to document it is changed on Sundays. The DON revealed the staff had been in-serviced on changing oxygen tubing and if the tubing was not changed it gets dirty and nasty and can cause an infection. The DON looked on Resident #35's physician's orders and on the MAR for documentation of changing the oxygen tubing. No order or record of oxygen tubing being changed was found. The DON confirmed there was no order written for changing the oxygen tubing, no place on the MAR to document the changing of the oxygen tubing and no intervention on the care plan. The DON confirmed she did not have any way of knowing if or when the tubing was changed. Review of Resident #35's Facesheet revealed a diagnosis of Acute Bronchitis. Review of Resident #35's February 2021 physician's orders revealed an order written on 1/11/21 for O2 @ 2L BNC (oxygen at two liters by nasal cannula) as needed for Dyspnea and there	F 880	deficient practice. All residents have the potential to be affected by the deficient practices on infection control. 3) Registered Nurse #1 has been in-serviced on the policy Example of Safe Donning and Removal of Personal Protective Equipment, Eye and Ear Medication, Instillation Of and General Infection Prevention and Control Nursing Policies and cleaning Disinfecting Equipment for the Covid zone on March 2, 2021 by the Director of Nurses. All nurses both registered and licensed practical nurses were in-serviced on Example of Safe Donning and Removal of Personal Protective Equipment, Eye and Ear Medication, Instillation of and General Infection Prevention and Control Nursing Policies, Infection Control on Oxygen Equipment Policies on February 24, 2021, February 25, 2021, February 28, 2021, March 2, 2021 and March 3, 2021 by the Director of Nurses. The Pharmacy Consultant did a return demonstration on proper eye drop administration with Registered Nurse #1 on March 2, 2021 to assure this deficient practice does not reoccur. All nurses both registered and licensed will have a return demonstration verifying proper instillation of eye drops by the Director of Nurses by March 22, 2021. The facility Quality Assurance Committee, which included the Director of Nurses, the Administrative Assistant, Medicare Nurse Case Manager, Assessment RN, Department Heads and the Medical Director met on February 26, 2021 and	

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F 880	Continued From page 7 was no order found to change the oxygen tubing. Review of Resident #35's MAR revealed there was no entry for nursing to document the changing of the oxygen tubing. Resident #23 02/01/21 11:47 AM during the initial tour of the COVID-19 Unit, Resident #23 was noted wearing oxygen via nasal cannula with a humidification bottle attached. Neither the bottle or the oxygen tubing were dated. An additional observation was made at 3:00 PM, that Resident #23's oxygen cannula remained in place, and the tubing was still not dated. There was no nurse on the COVID-19 Unit at this time. When Certified Nursing Assistant (CNA) #1 was asked how long Resident #23 had been on oxygen, she stated she had been on it for several days. Review of Resident #23's medical record revealed there was no order in place to administer oxygen, so there was no way to validate how long the oxygen had been in place. On 2/1/21 at 5:45 PM, an interview with the DON, and Infection Control nurse both agreed the oxygen was supposed to be dated and changed every 7 days. The DON said they had began the standing order the facility had for oxygen at 2 liters per nasal cannula, and had failed to write the order for it. The DON stated they needed to change the tubing every 7 days to keep germs from growing in the tubing, especially since it was humidified air. Review of Resident #23's Facesheet revealed an admission of 03/28/2016 with diagnoses which included Polyneuropathy, Atrialfibrillation,	F 880	reviewed policy and procedures Example of Safe Donning and Removal of Personal Protective Equipment, Eye and Ear Medication, Instillation Of, General Infection Prevention and Control Nursing, Infection control of Oxygen Equipment policies. Checking of oxygen tubing will be monitored by the Director of Nurses and the RN Supervisor one time a week times four weeks then monthly times two months then quarterly times one year beginning February 3, 2021. Donning and doffing of Personal Protective Equipment will be monitored by the RN Supervisor and the Director of Nurses on daily rounds until there are no Covid-19 cases. If Covid-19 reoccurs the monitoring will resume immediately. The Director of Nurses will report any concerns to the Quality Assurance Committee beginning on February 26, 2021. Quality Assurance meeting was held on February 26, 2021. No further recommendations were offered after explaining the tags and what had been done to correct them. 4) The Director of Nurses or the Administrator will report any concerns to the Quality Assurance Committee monthly times three months then quarterly times one year. If problems are identified with current corrective action plan, the Quality Assurance Committee will revise the corrective action plan as needed until substantial compliance is achieved.	

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F 880	Continued From page 8	F 880		

Diabetes Mellitus Type 2, Adjustment Disorder with mixed Anxiety and Depressed Mood, Impulse Disorder, Schizoaffective Disorder, Chronic Kidney Disease. Resident #23 normally stayed on the Alzheimer's Unit of the facility, however, was currently on the COVID-19 Unit, and was not interview.
Infection Control Related to Proper PPE Usage:

Review of the facility's "Infection Prevention and Control Program" policy, dated 06-2014, revealed, "Policy: It is the policy of this facility to minimize exposures to respiratory pathogens and promptly identify residents with Clinical Features and an Epidemiological Risk for the COVID-19 and to adhere to Transmission Based Precautions, including the use of eye protection. Note: All healthcare personnel will be correctly trained and capable of implementing infection control procedures and adhere to requirements... Set-Up Zone for Patient Placement: COVID Zone: Dedicated COVID-19 Team - Nurse and a CNA no other staff (may use housekeeper with additional IC training based on size of unit). Group tasks - med admin, turning, etc. - to eliminate multiple trips. Utilize COVID exposed equipment only...Conserve PPE - the goal is staff protection since all residents are COVID-19 positive and no other infectious process has been identified. The same gown and shoe covering is worn by the same HCP (health care personnel) when interacting with more than one patient known to be infected with the same infectious disease when these patients are housed in the same location (i.e., COVID-19 patients residing in an isolation cohort). Limit only essential personnel to enter the COVID zone with appropriate PPE and respiratory protection. PPE includes: Gloves, Gown, Goggles, and Respiratory Protection.

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F 880	Continued From page 9	F 880		

Perform hand hygiene after discarding."

On 02/01/2021 at 11:20 AM, during an initial tour of the COVID-19 Unit the facility had established a designated COVID-19 unit which consisted of a double door, which remained closed, and 15 feet inside the double door was a plastic wall barrier before the resident rooms began. This 15 foot area prior to the plastic wall was deemed by the facility as the "buffer zone", where staff were to don their PPE before entering the plastic wall which was deemed the official start of the COVID-19 Unit.

During an observation on 02/01/2021, at 11:45 AM, Registered Nurse (RN) #1, came onto the unit to pass medications. RN #1 had placed the medication cart in the "buffer zone" outside of the plastic curtain and had brought medications in for one of the residents. When exiting the COVID-19 Unit, through the plastic wall, RN #1 did not take the gown off prior to entering the buffer zone, and began obtaining another residents medications from the cart. This same pattern of failure to remove the gown prior to exiting the COVID-19 Unit occurred an additional seven (7) times throughout the medication pass. When asked by the State Agency (SA) if that was the protocol for passing medications on the COVID-19 Unit, RN #1 said she was told by the Director of Nursing (DON) to "park her cart outside the plastic, and as long as she washed her hands and use gloves, she could come in and out of the plastic to the medication cart without donning and doffing new PPE between every resident." The SA then asked RN #1 if the cart had been contaminated going in and out of the COVID-19 Unit without removing the gown, and RN #1 replied, "Yes Ma'am, I had planned to clean it." After the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880	Continued From page 10	F 880		

medication pass, RN #1 was observed to push the medication cart out of the buffer zone approximately 10 feet to the nurses station, and proceeded to clean the cart from top to bottom. There were no staff or residents near the nurses station at the time.

On 02/01/2021 at 5:45 PM, during an interview with the Executive Director (ED), DON, and Infection Control nurse, all three (3) of them indicated it was not appropriate for the nurse to be coming in and out of the plastic curtain with the same gown on into the buffer area to obtain medications from the cart, and she should have taken the gown off prior to exiting the COVID-19 Unit and put another one on before re-entering the COVID-19 Unit behind the plastic wall. They all three (3) agreed the COVID-19 Unit started at the plastic wall, and the nurse should have cleaned the medication cart, top to bottom, before bringing it out of the buffer zone to the nurses station. When asked by the SA what could have resulted from this practice, the Infection Prevention Nurse replied, "If she had not cleaned the cart thoroughly, the nurse could have carried COVID-19 down the hallway to other residents." When asked by the SA about dedicated staffing on the COVID-19 Unit, the DON replied, "We try to do that, but some days we don't have enough nurses to make that happen, like today."

Medication Administration

Review of the facility's "Eye and Ear Medication, Installation of" policy, dated 10/2017, revealed, "Procedure: Installation of Eye Drops: 12. Invert eye-drop dispense, or draw up solution with a medicine dropper (if using a dropper, ensure that you do not contaminate the container with the

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARKSDALE NURSING CENTER	1120 RITCHIE AVE CLARKSDALE, MS 38614

(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 880	Continued From page 11	F 880		

dropper - follow principles of asepsis.)"

02/04/21 at 1:49 PM during an observation of a medication pass, Resident #1 was noted to have an order for "Simbrinza 1% - 0.2% eye drops: Instill 1gtt (drop) in both eyes twice a day; wash hands before and after drop administration; wait 5 minutes before each drop." Registered Nurse (RN) #1 gathered supplies at the cart and entered Resident #1's room. RN #1 washed her hands and handed the resident a tissue to wipe her eyes. RN #1 administered drops into Resident #1's right eye, and then when attempting to reach across to place the drops in her left eye she was observed to touch Resident #1's eyeball with the tip of the dropper while administering her eye drops into her left eye. RN #1 did not clean the dropper before placing the cap on the eye drop bottle and placing it in the medication cart. When asked by the state agency if she had touched resident #1's eye with the eyedropper, RN #1 stated, she didn't think she had touched her eye but couldn't really see it from her angle. She agreed the dropper should have been wiped with an alcohol pad and cleaned prior to being capped and placed back in the cart.

Resident #1 was admitted to the facility on 09/10/2019 with diagnoses which included Diabetes, Hypertension, Hyperlipidemia, Glaucoma, Dry Eye Syndrome, Gastroesophageal Reflux Disease, Peripheral Vascular Disease, Metabolic Encephalopathy, Acquired Absence Of The Left and Right Legs Above The Knee. Resident #1 was not interviewable.