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	255336	A. BUILDING _____ B. WING _____	03/05/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual survey from 3/2/21 through 3/5/21. During the survey the SA determined the facility was not in compliance with the Medicare and Medicaid Requirements for participation. The SA cited deficiencies at F880 related to the Wound Care Nurse failed to change gloves after touching multiple surfaces before starting wound care, F812 related to Dietary staff failed to sanitize equipment between usage, and F759 related to medication error. The facility held a license for 122 beds, with a census of 100.	F 000		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, record reviews, and facility policy review, the facility failed to maintain a medication error rate of less than five percent (5%) for one of six (6) medication administration observations. The medication error rate was seven (7) percent. Resident #66. Findings include: Review of the facility's policy titled, "Administration and Charting of Medications Policy", dated April 2019, revealed: It is the policy of this facility to administer medications per physician's order. All medications shall be	F 759	(1) For Resident #66, an assessment was performed immediately on identification of med error on 3/3/21, at 10:30 AM by the Assistant Director of Nurses (ADON) to include all vital signs, apical pulse, respiratory rate and rhythm, lung sounds, and assessment of lower extremities for edema. No adverse effects were identified as a result of the resident missing a dose of Lasix 20 mg, and Coreg 25 mg as evidenced by blood pressure and pulse within normal range for the resident, clear lung sounds, absence of peripheral edema, and regular apical pulse.	4/16/21

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

Electronically Signed | 04/01/2021

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F 759	Continued From page 1 administered and charted under the supervision of licensed personnel in accordance with laws and regulations governing such acts. Administer the medications and ensure that the resident swallows medications administered via oral route. On 03/03/21, at 08:45 AM, upon entrance into Resident # 66's room, with LPN #2, a medication cup was observed on the bedside table with two (2) pills in the cup. On 03/03/21, at 8:50 AM, interview with LPN #2 revealed the medication looks like her evening medication was not given on 3/2/21 by the medication nurse. LPN #2 compared the medication in the cup to Resident #66's medication and stated the medication is a Lasix 20 Milligrams (MG) and a Coreg 25 MG. LPN #2 revealed the nurse should have given her medication as ordered and it was not to be left on the bedside table unsupervised. LPN #2 revealed leaving medication unsupervised could cause problems for Resident #66 if she did not receive her medication, such as swelling or hypertension. On 03/02/21, at 11:00 AM, interview with the Director of Nurses (DON) revealed if a medication is prescribed the nurse should give it and should never leave medication at the bedside. This is not the standards of practice we perform at the facility. On 03/04/21, at 1:47 PM, an interview with LPN #3 revealed, "I was in the process of giving medication to Resident #66 but when I heard my name in the hall, I thought there was in emergency left the room and forgot to go back and give (Resident #66) her medication." LPN #3 stated that If Resident #66 did not receive her	F 759	On 3/3/21, the Staff Development Coordinator and Infection Preventionist assessed all 97 residents for the presence of medications at bedside. Zero of 97 were identified as having medications left at bedside. On 3/3/21, a Medication Variance Report for quality review was completed by Director of Nurses (DON) for Resident #66. On 3/3/21, the Medical Director and Pharmacist Consultant were notified of the missed medications by the Director of Nurses (DON). On 3/3/21, a one on one staff education was conducted by the Director of Nurses (DON) for Licensed Practical Nurse (LPN) #3 regarding the facility policy and standards of practice for medication administration. The education included ensuring the resident takes all medications and properly discarding any medication(s) not taken. (2) All residents have the potential to be affected by the practice of leaving medications at bedside. (3) On 3/8/21, the Quality Assurance and Assessment (QAA) Committee reviewed the facility policy for Administration and Charting of Medications and approved with no changes. In-services began on 3/8/21, by the Staff Development Coordinator, for all Registered Nurses (RN) and LPNs on proper medication administration. In-services will continue until all RNs and LPNs have been in-serviced. New nurses	

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F 759	Continued From page 2 medication she could have an increase in swelling and hypertension. Record review of the Face Sheet revealed the facility admitted Resident #66 on 09/28/20, with the diagnoses of Edema, Hypertension, and Bradycardia. A review of physician orders revealed an order dated 9/28/20, for Lasix 20 milligrams (MG) one tablet by mouth two (2) times a day for edema and Coreg 25 milligrams (MG) one tablet by mouth two (2) times a day for Hypertension. A record review of a Nurses' Note dated 03/03/21 at 10:36 AM revealed no edema in upper or lower extremities and Blood Pressure (B/P) 111/56. A review of the Comprehensive Minimum Data Set (MDS) for Resident #66, with an Assessment Reference Date (ARD) of 12/28/20, revealed the MDS was coded in Section C0500, Brief Interview Mental for Mental Status (BIMS), Section C0600- revealed a score of 08, indicating moderately impaired cognition.	F 759	will be in-serviced on hire. (4) The Staff Development Coordinator or the DON will conduct two audits per day, three days per week to ensure no medications are left at bedside. Documentation of audits will be completed using the Medication Administration Quality Assurance (QA) Audit Tool. This audit tool includes observation of no meds left at bedside without an order. Corrective action will be taken at the time for issues identified. Audit reports will be reviewed by the Quality Assurance Performance Improvement (QAPI) Committee monthly beginning on 4/14/21 for three months. The QAPI Committee will make any recommendations or changes if needed to ensure compliance. See attached Medication Administration Quality Assurance (QA) Audit Tool.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent	F 812		4/16/21

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F 812	Continued From page 3 facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and facility policy reviews, the facility failed to properly sanitize the food processors for pureed diets which could affect 11 of 11 residents receiving puree diets for one (1)of three (3) days survey. Findings include: Review of the facility policy titled "Dietary Employee Hygiene and Personal Cleanliness", revealed, "Purpose: To maintain a high level of sanitation during all activities in the food service area...Test solutions with test strips regularly to ensure that they are maintaining the proper strength of sanitizer for food contact surfaces...Concentration - not using enough sanitizing agent will result in an inadequate reduction of microorganisms." On 03/03/21, 11:02 AM, during an Observation of the kitchen three compartment sink revealed a dietary staff member #1 was washing a food processor. Dietary staff member #1 washed the food processor in the soapy water, rinsed it in the second sink and placed the food processor in the third sink of clear water. The dietary member took the food processor out of the water and was walking away when the State Agency (SA) ask	F 812	(1) On 3/3/21, at 11:05 AM, Dietary Staff Member #1 replaced the empty sanitizer container on the three-compartment sink with a full container. On 3/3/21, a one on one staff education was conducted by the Dietary Manager for Dietary Staff Member #1 regarding the practice of visualizing the sanitizer container to ensure sanitizer is present prior to washing equipment in the three-compartment sink. (2) All residents consuming foods by mouth have the potential to be affected by the practice of improper food services equipment sanitation. (3) On 3/8/21, the Registered Dietician and Dietary Manager conducted verbal education to remaining Food Service staff regarding the practice of visualizing the sanitizer container to ensure sanitizer is present prior to washing equipment in the three-compartment sink. On 3/15/21, the Registered Dietician conducted a formal in-service for all Food Service staff regarding how to clean and sanitize in a three-compartment sink,	

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F 812	Continued From page 4	F 812		

the Dietary Staff Member #1 if she knew how to sanitize the equipment. Dietary Staff Member #1 placed the sanitizer strip in the water. The strip did not change color to indicate the recommended level of sanitizer necessary to sanitize items washed. The staff member placed the strip in the water again. The strip did not change colors. The dietary staff member turned on the sanitation machine and nothing came out. The dietary staff member looked under the sink and noticed the sanitation jug was empty.

On 03/03/21, 11:10 AM, an interview with Dietary Staff Member #1 revealed she did not know there was no sanitization solution in the sink. The Dietary Staff Member said the Cooks are responsible for making sure the sanitization solution was changed. The Dietary Staff Member confirmed by not sanitizing the equipment could cause food borne illness.

During an interview on 03/05/21, at 10:17 AM, with Dietary #2 revealed she was responsible for checking the sanitation of the three compartment sink on 3/3/21. Dietary #2 said she was busy and had not checked the sanitation at that time. Dietary #2 said she had not washed any pots and pans at that time. Dietary #2 said it is the responsibility of everybody in the kitchen to check the sanitation prior to washing equipment. The sanitation is checked every day along with temperatures and placed on the log.

During an interview on 03/05/21, at 10:40 AM, the Dietary Manager confirmed Dietary #1 should have checked the sanitation prior to cleaning the food processor. Dietary #1 did not know to check the sanitation. The manager said the logs are done daily by the cook. The logs are checked

procedures for checking quaternary ammonium in sanitizing sink, and how to document on the newly developed 3-Well Sink Sanitizer Check Logs.
On 3/31/21, the Quality Assurance Performance Improvement (QAPI) Committee, Registered Dietician, and Dietary Workers met and conducted a Root Cause Analysis (RCA) to identify root causes of the three-compartment sink being out of sanitizer solution. The root cause was identified as all staff were not educated on checking levels of quaternary ammonium in sanitizing sink. The committee developed actions based on identified root causes.
On 3/31/21, the committee revised the Infection Control Policy for Food Services Department to expand guidance for proper sanitation. The committee also reviewed the new 3-Well Sink Sanitizer Check log without any changes. This log is used for documenting the visual check of the quaternary ammonium sanitizer levels before each use and replacing the container if it is found to be empty.
The committee reviewed the Temperature and Sanitizer Level Log and approved continued use without any changes. The Temperature and Sanitizer Level Log will be completed by the user of the three-compartment sink after each meal to verify appropriate quaternary ammonium sanitizer level. Corrective action will be taken at the time if levels are found to be less than 200 Parts Per Million (PPM).
The committee also developed a competency checklist to verify basic

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F 812	Continued From page 5 daily by the assistant dietary manager. The dietary manager confirmed by not sanitizing the food processor could cause the residents to get sick. The dietary manager also said the facility has eleven residents with pureed diets. During an interview on 03/05/21, at 11:19 AM, the Administrator confirmed Dietary #1 should have checked the sanitation prior to washing the food processor. The Administrator said this could cause the residents to get sick. Record review of a Dietary Inservice conducted 11/24/20, which included the three compartment sink sanitization, revealed Dietary #1 and #2 signed as attended. Record review of a Dietary Inservice conducted 3/2/21, which included the three compartment sink, revealed Dietary #1 and #2 signed as attended.	F 812	knowledge of food safety sanitation practices, including use and operation of the three-compartment sink, and log completion. The competency checklist will be completed for all current Food Services employees every six months, and for all newly hired Food Services employees within one week of hire and every six months thereafter. On 4/1/21, facility-wide training on Principles of Transmission- Based Precautions and Hand Hygiene from online infection prevention training courses offered by the CDC. Training will continue until all staff have received the required training. New employees will receive this education on hire. (4) Beginning on 4/1/21, the Dietary Manager or Lead Cook will conduct daily audits to verify the 3-Well Sanitizer Check Log and the Temperature and Sanitizer Level Log has been correctly completed. Corrective action will be taken at the time for issues identified. The Registered Dietician will audit the logs weekly for three months to verify correct completion and report to the Administrator for any issues identified. Audit reports will be reviewed by the Quality Assurance Performance Improvement (QAPI) Committee monthly for three months. The QAPI Committee will make any recommendations or changes if needed to ensure compliance.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		4/16/21

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F 880	Continued From page 6 §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 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,	F 880		

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F 880	Continued From page 7 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 interviews, record reviews, and facility policy reviews the facility failed to prevent the possible spread of infection as evidenced by the wound care nurse touching multiple surfaces with contaminated gloves for one (1) of four (4) wound care observations. Resident #74. Findings Include: The facility's policy," Clean Dressing Change", reviewed date 3/11/2020 revealed, " To provide	F 880	(1) For Resident #74, a one on one in-service was conducted on 3/4/21 with LPN #1/Wound Care Nurse regarding the facility Infection Prevention and Control Program policy and standards of practice for proper wound care. This education was provided by the Director of Nurses (DON). After education, LPN #1/Wound Care Nurse competency for hand hygiene and proper infection control procedures during wound care was verified by the Staff Development Coordinator through	

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F 880	Continued From page 8 wound care in a manner to decrease potential for infection and/or cross-contamination." On 03/04/21, at 08:54 AM, an observation of wound care being done by Licensed Practical Nurse (LPN) #1/Wound Care Nurse. LPN #1/Wound Care Nurse applied clean gloves and closed the privacy curtain with right gloved hands. She picked up the bed control, adjusted the bed, and removed Resident #74's wound dressing without changing gloves. A record review of Resident #74's Face Sheet revealed resident was admitted on 5/29/20, with a primary diagnosis of unspecified Dementia Disturbance. A record review of the Physician order, dated 9/16/2020 revealed pressure ulcer of right buttock stage 4. A record review of the Physician Orders for March 2021, dated 3/3/21 revealed clean right ischial with Vashe (wound cleanser). Pat dry. Skin prep peri wound. Loosely pack wound with Aquacel AG et (and) cover with foam dressing. Change daily and prn (as needed) till healed. (Stage 4 Pressure Ulcer) A review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/17/20, revealed a Brief Interview for Mental Status (BIMS) was not done due to resident is rarely/ never understood. On 03/05/21, at 10:10 AM, in an interview with LPN#1/Wound Care Nurse stated I should have washed my hands and change gloves after I closed the curtain and let the bed up. She stated I	F 880	return demonstration on 3/9/21. (2) All residents receiving wound care have the potential to be affected by the practice of touching multiple surfaces with contaminated gloves. (3) On 3/8/21, the Quality Assurance and Assessment (QAA) Committee met and reviewed the Infection Prevention and Control Program policy, the Hand Hygiene Policy, and the policy for Clean Dressing Change. The policies were reviewed with no revisions. The committee reviewed the competency checklists for Wound Care and Hand Hygiene and approved with no revisions. Nurse competency for hand hygiene and proper infection control procedures during treatments, verified by the Staff Development Coordinator, began on 3/9/21, and will continue until all nurses have been verified as competent. Newly hired nurses will be verified competent on hire. In-services began for all Licensed Practical Nurses and Registered Nurses on 4/1/21, regarding the facility Infection Prevention and Control Program policy, the policy for Clean Dressing Change, as well as, facility-wide training on Principles of Transmission-Based Precautions and Hand Hygiene from online infection prevention training courses offered by the CDC. Training will continue until all staff have received the required training. New employees will receive this education on hire.	

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F 880	Continued From page 9 could have caused cross contamination and could have contaminated the wound. She stated that she has completed computer training on Infection Control. On 3/5/21, at 10:33 AM, in an interview with the Director of Nurses (DON), stated LPN #1/Wound Care Nurse should have not used gloves to close the curtain and raise the bed or she should have removed her gloves, washed her hands, and put clean gloves on. She stated that the LPN #1/Wound Care Nurse's actions could have caused cross contamination. A record review of LPN #1/Wound Care Nurse's competency check off list revealed she passed check off's on 12/16/2020. A record review revealed LPN #1/Wound Care Nurse's certificate of computer completion was dated 12/16/20.	F 880	(4) The Staff Development Coordinator and/or the Quality Assurance – Infection Prevention Nurse will conduct audits two times per week beginning 4/1/21 to verify proper infection control procedures are followed during resident treatments according to standards of practice and facility policy. Corrective action will be taken at the time for issues identified. Audit reports will be reviewed by the Quality Assurance Performance Improvement (QAPI) Committee monthly beginning on 4/14/21 for three months. The QAPI Committee will make any recommendations or changes if needed to ensure compliance.	