STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255276	A. BUILDING _____ B. WING _____	09/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELHAVEN SENIOR CARE, LLC	1004 NORTH ST JACKSON, MS 39202

(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 recertification survey from September 23, 2019 through September 26, 2019. During the survey, the SA determined the facility was not in compliance with the Medicare and Medicaid requirements of participation. The SA cited F656, F689, F690, F726, F758, F761, F812, and F880. The facility census was 58 and the facility was licensed for 60 beds at the time of survey.	F 000		
F 656 SS=G	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the	F 656		10/25/19

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

Electronically Signed | 11/01/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 656	Continued From page 1 findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to implement the comprehensive care plan related to care observations, medication administration, and an incident related to a fall, for three (3) of 23 resident care plans reviewed. Resident #14 for catheter care, Resident #16 for falls, and Resident #18 for medication administration. Findings include: A review of the facility's "Care Plans-Comprehensive" policy, dated 10/2016, revealed: Our facility's Care Planning Interdisciplinary team develops and maintains a Comprehensive Care Plan for each resident that identifies the highest level of functioning the resident may be expected to attain. Each resident's Comprehensive Care Plan is designed to incorporate identified problem are; reflect	F 656	F 656 * Resident # 14 s care plan was reviewed by the Minimum Data Set (MDS) Nurse on 9/26/19 and includes proper catheter/peri care daily with soap and water. Resident #14 was observed receiving proper catheter/peri care by the Staff Development Nurse on 9/26/19. All residents who have catheters had care plan reviewed by the MDS Nurse on 9/26/19 and includes catheter/peri care with soap and water daily. Resident #16 s care plan was reviewed and revised to include to secure appropriately in facility van for safe transport when needed by the MDS Nurse on 10/31/19. All care plans were reviewed by the MDS Nurse on 10/31/19 for all residents who may potentially need facility van transport and were revised to include securing appropriately in facility van for safe	

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F 656	Continued From page 2 treatment goals, timetables, and objectives in measurable outcomes; identify the professional services that are responsible for each element of care; aid in preventing or reducing declines in the residents functional status and/or functional levels; and enhance the optimal functioning of the resident by focusing on a rehabilitative program. A review of the facility's "Following the Care Plan Policy", dated 2011, revealed it is the policy of this facility to follow a written and approved care plan for each resident. All employees will be trained upon hire and be required to follow the care plan. Resident 14 Review of Resident #14's comprehensive care plan, initiated 1/10/19, with a review date of 7/13/19, included an indwelling urinary catheter, which included interventions to provide peri-care and catheter care every day with soap and water (which would include providing the care correctly). On 9/23/19 at 10:37 AM, an observation revealed Resident #14 lying in bed with an indwelling urinary catheter to gravity drainage. On 9/24/19 at 2:53 PM, an observation revealed Certified Nursing Assistant (CNA) #3, with the assistance of CNA #2 and CNA #1, performed catheter care to Resident #14. CNA #3 wiped the left groin area in an upward motion and wiped the catheter tubing upward, without securing the tubing. CNAs #1 and CNA #2 repositioned Resident #14 onto her right side, while the catheter drainage bag remained hanging on the opposite side of the bed. CNA #3 wiped the resident's buttock areas in an upward motion twice on each side and up the middle between the buttocks twice, from the back toward the front	F 656	transport when needed. 54 of 57 were identified to potentially need facility van transport. Resident #18 s care plan was reviewed and revised by the MDS Nurse on 10/28/19. Resident #18 received dose reduction of Buspar on 9/26/19. Resident #18 was seen by (NP)Nurse Practitioner on 9/26/19 and had no adverse effects from Buspar not being reduced until 9/26/19. All pharmacy recommendations for gradual dose reductions (GDR s) were reviewed by the Director of Nursing (DON) on 9/26/19 and no other reductions were missed. All care plans for residents who receive psychotropic meds were reviewed by the MDS Nurse on 10/13/19 for dose reductions from July, 2019 forward with no other GDR s missed. * All resident have the potential to be affected by this deficient practice. * Transportation in-service was given per administrator on 6/10/19 regarding correctly securing resident in wheelchair for safe transportation with check off performed for staff who will be responsible for transporting residents. Care Plan updating in-service was on 10/29-10/31/19 by the Director of Nursing and Staff Development Nurse regarding care planning of all medication changes to all licensed nurses. Catheter/Peri care inservice was given on 10/29-10/31/19 by the Director of Nursing and Staff Development Nurse to all Licensed Nurses and Certified Nurses Aides (CNA s).	

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F 656	Continued From page 3 of the perineal area. On 09/25/19 at 1:23 PM, an interview with RN #2 revealed she would expect the CNAs to perform catheter care appropriately, to wipe in a downward motion of the groin areas instead of upward, to prevent cross contamination. RN #2 stated she expected the staff to secure the catheter tubing while wiping outward from meatus towards the urinary drainage bag, to prevent pulling on the catheter tubing, which could cause irritation and/or injury. Review of the facility's Face Sheet revealed the facility admitted Resident #14 on 1/8/19, with diagnosis of Retention of Urine. Resident #16 A review of the comprehensive care plan for Resident #16, initiated 4/17/18, revealed the resident is a high risk for falls related to (r/t) gait balance problems. The care plan indicated Resident #16 had a fall on 6/7/19, resulting in a major injury. The care plan did was not developed for securing the resident appropriately in the wheelchair for safe transport to dialysis via facility van. Review of a Facility Reported Incident (FRI), dated June 13, 2019, revealed Resident #16's wheelchair was not secured properly during transport in the facility van, which resulted in a fractured humerus for the resident. Resident #16 was transported by Certified Nurse aide (CNA) #6 on 6/7/19, from Dialysis to the facility, when Resident #16 slid out of her wheelchair. Resident #16 was found seated on the lift sling directly in front of her wheelchair. Resident #16's left arm was leaning on the inside wall of the van. LPN #4 assessed Resident #16 for injury, with findings of	F 656	* Peri care/Catheter care will be observed on 3 residents weekly x 8 weeks beginning the week of 11/4/19 by Director of Nursing or Staff Development Nurse to assure care performed correctly. Check off will be done prior to any new staff providing transportation and annually by the Administrator or Maintenance Supervisor. Observations were done weekly x 3 months beginning 6/10/19 for appropriately securing resident in facility van by the administrator. Audit will be performed by the Director of Nursing or Registered Nurse Supervisor for all admissions for care planning of securing wheelchair residents for safe transport x 3 months beginning week of 11/4/19. Audit will be performed to assure all med changes are care planned 2xwk x 8 weeks by the DON or MDS nurse beginning the week of 11/4/19. *Findings of audits and observations will be brought to the Quality Assurance Committee weekly by the DON and MDS nurse. Audit and observation findings will be brought to the Quality Assurance Committee weekly to assure continued compliance.	

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F 656	Continued From page 4 pain in the left arm. Using the lift sling already in place, three (3) employees lifted Resident #16, placed her back in her wheelchair, and continued transport to the facility. Upon arrival to the facility, Resident #16 was assessed with no bruising/swelling to the reported area of pain. Pain medication was administered and a stat X-ray was ordered, which revealed a fracture to the left humerus head. Resident #16 was transferred to the hospital and returned the next day with instructions to keep a sling in place. An interview on 09/26/19 at 11:25 AM, with RN #2/Minimum Data Set (MDS)/Care Plan nurse, revealed, "My expectations for a care plan is to create a plan of care and set goals and come up with interventions". She stated she expected everyone to provide the appropriate interventions to reach the Resident's goal. RN #2 stated, "If there is a care plan in place, I expect it to be followed". Resident #18 Review of Resident #18's comprehensive care plan, revised 1/19/18, revealed the use of anti-anxiety medications and antidepressant medications, with interventions to give medication as the physician ordered. Review of the Nurse Practitioner (NP) progress note for Resident #18, dated 8/7/19, revealed a note in response to a pharmacy recommendation, to decrease Buspar to 10 milligram (mg) twice a day. Review of Resident #18's orders and Medication Administration Record (MAR) for September 2019, revealed an order and medication	F 656		

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F 656	Continued From page 5 administration for Buspar 10 mg by mouth three (3) times a day, with a order start date of 4/28/18, related to major depressive disorder-recurrent severe, with psychotic symptoms. During an interview on 09/25/19 at 02:46 PM, the Director of Nursing (DON) verified Resident #18's progress note/order by the NP on 8/7/19, to decrease Buspar to 10 mg by mouth twice a day from three (3) times a day. The DON also confirmed Resident #18 had current orders for Buspar 10 mg three (3) times a day. She said it was the Nursing Supervisor's responsibility to write the orders in the medical record the day the NP wrote them. Interview on 09/26/19 at 9:18 AM, with RN # 2 revealed she would only be aware to make the changes in the care plan when she received copies of the orders for the resident from medical records. She said she was not aware of any changes for Resident #18's medication. An interview on 09/26/19 at 11:05 AM, with the DON, revealed, "My expectations for the care plan is that it should address the needs of the residents and as their condition changes, it should be updated. The Care Plan should be clear and concise to each resident. The care plan should be followed by all staff that it pertains to".	F 656		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		10/25/19

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F 689	Continued From page 6 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to prevent injury related to a fall from a wheelchair during van transportation, as evidenced by not securing the resident properly in the wheelchair, prior to transport. This affected one (1) of three (3) residents reviewed for accidents, Resident #16. Resident #16 received a fracture to the left humerus head during the fall, resulting in X-rays and treatment at the local hospital. Findings include: Review of facility's "Incident/accident During Transport in the Facility Van" policy, dated 10/08, revealed: "It is the policy of this facility to transport residents per facility van, providing the safest reasonable environment and to implement the facility Incident/Accident policy for any injury to the resident during such transport". A review of a document provided by the facility titled "Operation Instructions Attaching the Combination Lap/Shoulder Belt", dated 2/11, revealed: Grasp the triangular fitting on the retractable belt and thread it down and through the gap between the wheelchair back and seat or side panel and seat. Grasp the triangular fitting on the push button buckle belt and thread it down and through the gap between the wheelchair back and seat or between the side panel and seat. Insert the buckle connector into the push button buckle. Tension the buckle connector belt	F 689	F689 * Resident #16 was assessed on date of incident by Licensed Practical Nurse (LPN). Resident #16 stated that her left arm was hurting. Nurse Practitioner (NP) was notified on date of incident and gave orders for a stat x-ray. X-ray results obtained for Resident #16 on date of incident showed a fracture to the left humorous head. Order was given by the Nurse Practitioner (NP) to send Resident #16 out to the hospital the night of the incident. Resident #16 returned to the facility the following day(06/08/2019) with discharge instructions to keep sling in place. An investigation of this incident was initiated by the Administrator on the date of the incident (06/07/19). Through the investigation, it was determined that Resident #16 was secured using the 4 point restraint system and seatbelt, however she was able to slide from her wheelchair due to many contributing factors: the space allowed between the chair and lap belt, road conditions, her small frame/ weight of 99 pounds, her inability to brace herself due to right sided weakness and exhaustion caused from dialysis, as well as the total lift sling which makes sliding from the chair more likely. CNA #6 was suspended on the date of incident by the Administrator pending investigation results, but CNA #6 never	

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F 689	Continued From page 7 comfortably using the web adjuster. Ensure that the lap belt is worn low across the front of the pelvis, bearing upon the bony structure of the body and that the push button buckle is located near the occupant's hip opposite of the side from where the shoulder belt is anchored. Pull on the lap belt to ensure attachment of the triangular fittings to the rear retractor studs and the connection of the push button buckle and buckle connector. When connecting the shoulder belt to the lap belt, always ensure that the push button buckle and buckle connector are located at the occupant's hip opposite of the vehicle sidewall where the shoulder belt anchorage is installed. Ensure that the lap belt buckle is located in such a way that it is clear and is not in contact with any of the wheelchair components or any structures during operation as to minimize any potential contact during its use or in case of an accident. Review of a Facility Reported Incident and initial/final investigation, dated 6/13/19, revealed Resident #16 slid out of her wheelchair while transported via facility van on 6/7/19, which resulted in a fractured left humerus for the resident. The investigation revealed the resident was not secured properly in the wheelchair during transport. Resident #16 was transported by Certified Nursing Assistant (CNA) #6 on 6/7/19, from Dialysis to the facility, when Resident #16 slid out of her wheelchair. Resident #16 was found seated on the lift sling, directly in front of her wheelchair, with her left arm leaning on the inside wall of the van. Assessment revealed no bruising/swelling to the reported area of pain in the left arm. Pain medication was administered and a stat X-ray was ordered upon return to the facility, which revealed a fracture to the left humerus head. Resident #16 was transferred to	F 689	returned to work. Resident #16 is being secured appropriately in wheelchair for safe transportation. All residents are being secured properly in wheelchairs to ensure the safety of each resident during transport in facility van. * Fifty three (53) residents being transported per facility van have the potential to be affected by this deficient practice. * Inservice was given by Administrator on 06/10/2019 and by Maintenance Supervisor on 10/30/2019 regarding correctly securing resident in wheelchair for safe transportation and check off performed for staff who will be responsible for transporting residents. The Administrator showed all transportation staff a video on 06/10/2019 demonstrating the proper use of restraint related to attaching the combination lap/shoulder belt on the "FF600 Retractor System" that is used in the facility van. Observations were performed by the Administrator weekly X 3 months to assure residents were properly secured in facility van for safe transport. Findings of observations were brought to the weekly Quality Assurance meeting by the Administrator. All transportation staff will be inserviced by the Maintenance Supervisor with check offs completed and video shown on the "FF600 Retractor System" on hire and annually to ensure that all residents being transported in the facility van are secured properly for safe transport.	

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F 689	Continued From page 8 the hospital and returned the next day, with discharge instructions to keep a sling in place. Review of the facility investigation, dated 6/13/19, through re-enactment, with CNA #6 demonstrating how she secured Resident #16 in the van on 6/7/19, showed that the 4-point restraint system and seat belt were used, however the seat belt as placed through the arm rests allowed space between the person sitting in the wheelchair and the lap belt. This would have allowed Resident #16 to slide out of the wheelchair during transport. A second re-enactment on 6/10/19, revealed the route taken during transport was very bumpy, uneven, and with many pot holes. The DON was secured in a wheelchair and had to brace herself with her feet to prevent sliding out of the wheelchair. The report determined Resident #16's fall and injury was a result of being improperly secured in the wheelchair prior to transport. An interview on 09/26/19 at 2:14 PM, with Resident #16, revealed that she did not remember the incident on the van. Review of X-rays, dated 6/7/19, of Resident #16's left clavicle, left shoulder, and left humerus revealed an acute fracture of the left humeral head. Review of a statement signed by the Administrator and Director of Nursing (DON), dated 6/10/19, revealed, "Resident #16 was interviewed by the Administrator and DON. When asked to tell the events of the van incident, Resident #16 stated that the driver hit a bump and she fell from her wheelchair and hurt her arm".	F 689	* Observation/monitoring for appropriately securing and positioning of resident in wheelchair was initiated by the Administrator on 06/21/2019. Any adverse findings related to safe transport of residents will be brought to the weekly QA meeting by the Administrator to address and resolve any issues.	

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F 689	Continued From page 9 During an interview, via phone, on 09/25/19 at 3:37 PM, CNA #6 stated that she was trained to put the lap belt in front of the arms of the wheelchair. She stated on the day of the transport, she buckled the wheelchair with the belt in front of the arms of the wheelchair and Resident #16 slid out of the chair. CNA #6 stated that she did not secure the shoulder strap to the chair. Instead, she just pulled it across the resident's left shoulder, because she was trained to put it that way. Further interview via phone on 09/26/19 at 10:08 AM, with CNA #6, revealed "I just pulled the shoulder strap across the resident's left shoulder and I did not run it through the wheelchair arm to secure it to her chair. I placed the lap belt in front of the wheelchair arms. The strap was not through the arms of the wheelchair". She stated, "I didn't know about a video until the incident". Review of a statement written by LPN #4, dated 6/7/19, revealed she arrived at the scene and noticed Resident #16 was located on the floor of the van, sitting directly in front of her wheelchair. The wheelchair was locked and secured in place and Resident #16 was sitting upright with the lift sling directly up under her in the proper position. LPN #4 assessed Resident #16 and did not notice any bleeding. However, Resident #16 stated that her left arm was hurting. On 09/25/19 at 2:52 PM, an attempt was made to contact LPN #4, with a message that the phone had calling restrictions, with no ability to leave a message. During an interview, via phone, on 09/25/19 at 2:59 PM, CNA #7 stated that she did not know	F 689		

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F 689	Continued From page 10	F 689		

how Resident #16 slid out of her chair, but when she got to the van, Resident #16 was sitting on the floor in front of her wheelchair. CNA #7 stated that she could not say if the belts were secured appropriately, but the chair had not moved from the spot where the wheelchair goes; wasn't turned over or crooked, and sitting where it normally sat.

During an interview on 09/25/19 at 3:05 PM, CNA # 4, stated she had been employed at the facility for approximately five (5) years and they were trained to put the seat lap belt in front of the wheelchair during transport and the shoulder strap across the resident's shoulder, without securing it across the wheelchair. CNA #4 stated that after the incident with the Resident #16, the previous Administrator showed staff a video of the proper technique of securing a wheelchair during transport, and the Maintenance man demonstrated the proper way to secure a wheelchair during transport. CNA #4 stated that she realized after the video that they were doing it wrong. CNA #4 stated that now they secure the strap through the arms of the wheelchair.

Further interview with CNA #4 on 09/25/19 at 5:01 PM, revealed that she guessed the previous Administrator had videos that were available prior to the incident, but staff didn't watch the videos until after the incident with Resident #16. CNA #4 stated that she was trained by the previous transportation driver on how to secure the wheelchair in a van. She stated that she was trained to pull the lap strap across the front of the arms of the wheelchair and not secure the back safety shoulder strap on the wheelchair, just pull it across the resident's shoulder and buckle it. CNA #4 stated that she trained CNA #6 like she had

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F 689	Continued From page 11 been trained. She stated that she had been in transportation for five (5) years and this is the first time that she could remember an incident happening on the van. She stated that anyone can load a resident on the van, but it is the transportation team's responsibility to strap the resident safely in position. An observation on 09/26/19 at 9:50 AM, with Transportation CNA #4, revealed demonstration of how she trained CNA #6 to secure a resident in a wheelchair during transport in the van. CNA #4 placed the four (4) floor straps onto the wheelchair and secured them by turning a knob to tighten the four (4) straps. CNA #4 placed the shoulder strap, which was on the left side of the van, across the resident's left shoulder, not securing it in any way to the chair. CNA #4 placed the lap strap in front of the wheelchair arms and secured it to the wheelchair. CNA #4 stated, "And that's how I was trained to do it before the incident with Resident #16, and before watching the video." CNA #4 stated since she'd watched the video, she learned the shoulder strap was to come directly over the left shoulder and through the left arm of the wheelchair. She stated she never knew until after watching the video, that it was supposed to be ran through the arm of the wheelchair to secure the resident in the chair. She stated the lap strap was placed in front of the arms of the wheelchair, and it should have been ran through the arms of the wheelchair and secured to the wheelchair. CNA #4 stated, in her opinion, Resident #16 could have slid out of the chair, with the shoulder strap not being applied correctly, because the strap would not have caught her the way we were placing the strap just across her shoulder. She stated the lap strap being placed in front of the arms of the	F 689		

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F 689	Continued From page 12 wheelchair and not through the arms of the wheelchair would have not helped catch her from sliding out either. During an interview on 09/25/19 at 3:08 PM, CNA #5 revealed that she had been working at the facility for approximately 18 months. CNA #5 stated that she was checked off on putting the lap belt in front of the wheelchair and placing the shoulder strap across the shoulder of a resident, not through the arms of the wheelchair. In a further interview on 09/25/19 at 6:11 PM, CNA #5 revealed that she didn't know about any training videos of how to secure a resident in the van, and wasn't shown the videos until after the incident with Resident #16. CNA #5 stated she was trained by the prior Staff Development Nurse and by CNA #4, to put the strap across the front of the arms of the wheelchair, but she wasn't shown to use the shoulder strap on the chair. During an interview on 09/25/19 at 4:04 PM, Maintenance #1 stated that he trained the CNA's properly on the placement of the straps on a wheelchair during a transport, after the incident with Resident #16, and after the video was shown by the previous Administrator. Maintenance #1 was unaware of videos prior to the incident. An interview on 09/26/19 at 3:03 PM, with the Administrator, revealed she didn't think there was a video prior to the incident for Resident #16, that was used for training specifically for wheelchair safety. She stated she thought it was a "you tube" video that was pulled for training purposes. The Administrator stated she would attempt to call the prior Administrator to verify. Further interview revealed she was unable to reach the prior Administrator.	F 689		

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F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, record	F 690	F 690	10/25/19

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F 690	Continued From page 14 reviews, and facility policy review, the facility failed to provide urinary Catheter Care in a manner to prevent possible Urinary Tract Infection (UTI) and/or trauma, for one (1) of two (2) resident catheter care observations, Resident #14. Findings include: Review of the facility's "Catheter Care Instructions" policy, with a revision date of 12/2009, revealed for a female, use one (1) area of the washcloth for each downward, cleaning stroke. A review of the Mississippi Nurse Aide Candidate Handbook, page 35, dated July 2018, revealed while holding catheter at the meatus, without tugging, cleanse, rinse, and dry at least four (4) inches of the catheter from meatus, moving in only one (1) direction-away from the meatus. On 9/23/19 at 10:37 AM, observation revealed Resident #14 lying in bed talking to herself, with an indwelling urinary catheter to gravity drainage. On 9/24/19 at 2:53 PM, observation of catheter care, performed by Certified Nursing Assistant (CNA) #3, with CNA #1 and CNA #2 present, revealed the resident lying supine. CNA #3 wiped across the top of Resident #14's groin area, down the resident's right groin area, down the resident's left groin area, then down the middle of the resident's vaginal area, once. She wiped the left groin area in an upward motion and then wiped the catheter tubing, without securing the catheter at the meatus. CNA #1 and CNA #2 repositioned Resident #14 onto her right side, while the	F 690	* Resident #14 was assessed by the Director Of Nursing on 9/25/19 with no signs and symptoms of infections or adverse effects noted from improper catheter/peri care. Certified Nursing Assistant (CNA) #3 was given 1:1 education by the Director of Nursing (DON) on 9/25/19 regarding proper catheter/peri care and was observed providing care on 9/25/19 at 8:30am. Resident #14 is having catheter care/peri care provided correctly. All residents who require catheter and peri care are having this care provided correctly. * All resident who have catheters and those who require catheter/peri care have the potential to be affected by this deficient practice. * All Licensed Nursing Staff were in-serviced on providing proper peri care/catheter care on 10/29-10/31/19 by the Director of Nursing and Staff Development Nurse. All Certified Nursing Assistants (CNA s) were checked off providing catheter/peri care correctly by the Director of Nursing, Staff Development Nurse or licensed LPNs on 10/29-10/31/19. Observations on peri care/catheter care will de done on 3 residents weekly x 8 weeks by the Director of Nursing or Staff Development Nurse beginning week of 11/4/19 with findings brought to the Quality Assurance Committee weekly by the Director of Nursing. * Findings will be brought to the Quality Assurance Committee weekly by the Director Of Nursing to assure continued compliance.	

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F 690	Continued From page 15 catheter drainage bag remained hanging on the opposite side of the bed (taut). CNA #3 wiped the resident's buttock areas in an upward motion two (2) times on each side, the up the middle between the buttocks twice, from back to front. During an interview, on 9/24/19 at 3:25 PM, CNA #2 stated when CNA #3 wiped in an upward motion, she should have wiped in a downward motion, because of cross-contamination. She stated when CNA #3 did not secure the catheter tubing, that would cause "tugging" on the catheter tubing. She also stated when she and CNA #2 repositioned Resident #14 onto her right side, and left the catheter drainage bag hanging on the opposite side of the bed, that could have caused the catheter tubing to pull. On 9/24/19 at 3:30 PM, an interview with CNA #1 revealed CNA #3 should not have wiped the resident's left groin area in an upward motion because she caused cross-contamination. She stated when CNA #3 wiped the resident's catheter tubing without securing the tubing, that caused the catheter tubing to pull at the insertion site. She also stated when she and CNA #1 repositioned the resident onto her right side, and left the catheter drainage bag hanging on the opposite side of the bed, that caused the catheter tubing to pull tight. On 9/24/19 at 4:28 PM, an interview with Registered Nurse (RN) #1 revealed when CNA #3 cleaned the resident's catheter tubing without securing it, that could cause dislodgement or irritation to the resident's urethra and increase the chance for an infection. She stated the catheter tubing should always be stabilized while being cleaned. RN #1 also stated when CNA #3 wiped	F 690		

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F 690	Continued From page 16 Resident 14's left groin area in an upward motion, she should have wiped from front to back to prevent possible Ecoli from getting in the resident's urine/urethra. She stated when CNA #1 and CNA #2 repositioned the resident onto her right side and left the catheter drainage bag hanging on the opposite side of the bed, that could cause pulling and possible dislodgement of the catheter. On 9/25/19 at 9:30 AM, an interview with CNA #3 revealed when she wiped the resident's left groin area the second time, in an upward motion, she was "putting it back in" and crossed-contaminated the area. She stated when she wiped the catheter tubing the second time, without securing the tubing, she could have caused the catheter tubing to come out. Record review of the physician orders, with an onset date of 8/2/19, revealed Resident #14 had orders for a Foley Catheter #16/30 milliliter (ML) balloon, change as needed (PRN) obstruction, dislodgement, or leakage, as needed related to diagnosis of Other Retention of Urine. Foley Catheter care every day. Review of the facility's Face Sheet revealed the facility admitted Resident #14 on 1/8/19, with a diagnosis of Retention of Urine.	F 690		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest	F 726		10/25/19

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F 726	Continued From page 17 practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review the facility failed to complete competency training for one (1) of 24 nurses employed, Licensed Practical Nurse (LPN) #3. LPN #3 was designated as the Wound Care Nurse and did not have a competency check off for wound care and infection control practices. Findings include: Review of the facility's "Policy and Practice	F 726	F 726 * Resident #47 was assessed by the Director of Nursing (DON) on 9/26/19 with no signs and symptoms of infection and no adverse effects of improper peg site/wound care provided on 9/25/19 at approximately 10:00am. Three (3) other residents had peg site care provided by Licensed Practical Nurse #3(LPN) on 9/25/19 and were assessed for adverse effects or signs and symptoms on infection with no adverse effects or signs	

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F 726	Continued From page 18 Guideline: Use of Staff Competency Form" policy, dated 9/2017, revealed the facility was to ensure the staff have the specific competencies and skill sets necessary to care for the residents needs. The facility Staff Development Nurse or Assistant Director of Nursing (ADON) is responsible for assuring the competency check list is completed for all applicable staff members. Review of personnel files revealed there was no competency checklist found for LPN #3, regarding wound care. LPN #3 was the designated Wound Care Nurse. Review of a statement, signed and dated by the Administrator (ADM) on 9/26/19, revealed LPN #3 did not have a competency check off that could be located for wound care. An observation 09/25/19 at 10:11 AM, revealed LPN #3 performed wound care to Resident #47's Percutaneous Endoscopic Gastrostomy (PEG) tube stoma. Observation revealed LPN #3 did not practice wound care in a way to prevent infections. She used multiple layers of gloves during the care, without performing hand hygiene prior to donning the gloves. She used gauze to clean the stoma area, then folded the gauze over, allowing the used side of the gauze to touch the area of the stoma that was just cleaned, and patted the stoma again. LPN #3 removed one (1) pair (layer) of the gloves, then applied a clean drain sponge gauze to the stoma, and secured it with tape. Interview with LPN #3 on 9/26/19 at 8:35 AM, revealed she had never been checked off on doing wound care. She confirmed not following infection control guidelines by not washing her	F 726	and symptoms of infection noted. Medical Doctor (MD) notified of improper care provided with orders to notify of any adverse effects noted. Resident #47 is having peg site care provided appropriately. LPN #3 was given 1:1 in-service on wound care, handwashing and gloving procedures on 9/26/19 by the Registered Nurse Supervisor. LPN #3 is able to provide appropriate wound care. Licensed Practical Nurse #3 was given three (3) days of shadowing Register Nurse Supervisor between 9/27, 9/28 and 9/29/19 providing peg site care and was checked off providing peg site care on 9/30/19 by the Register Nurse Supervisor. * All residents who have peg tubes have the potential to be affected by this deficient practice. * All licensed nurses were given an in-service regarding providing proper wound and peg site care by the Director of Nursing 10/29-10/31/19. Licensed Nurses were checked off providing proper wound care by the Director of Nursing and Staff Development Nurse between 10/29/19 and 10/31/19. Wound care dressing changes will be observed 2xwk x 8 weeks by the DON, RN Supervisor or Staff Development Nurse beginning week of 11/4/19. * Findings will be brought to the Quality Assurance Committee weekly by the Director of Nursing to assure continued compliance.	

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F 726	Continued From page 19 hands prior to donning gloves and by using the same gauze to clean part of the PEG stoma for Resident #47. An interview on 09/25/19 at 2:35 PM, with Registered Nurse (RN) #1/Staff Development/Infection control Nurse, revealed, "I cannot find LPN #3's competency where she was checked off on Infection Control, wound care, hand washing, and proper gloving". Interview on 09/26/19 at 10:02 AM, with Registered Nurse (RN) #1/Staff Development Nurse, revealed she started working at the facility about three (3) weeks ago. RN #1 said she and the Administrator looked for the personnel file for Licensed Practical Nurse (LPN) #3, the Wound Care Nurse, and could not locate the her competencies or her file. Interview on 09/26/19 at 12:07 PM, with the Administrator (ADM), revealed the policy of the facility was to complete the competencies of staff on hire, and routinely, as required. The ADM said the facility assessment included the annual performance appraisals for all new staff members and would be a part of the employee file. The ADM said LPN #3 was hired prior to her start as ADM, but the responsibility for the completion of the competencies was with the Staff Development Nurse. Review of a signed statement, dated 9/26/19, by the Administrator, revealed LPN #3's competency skills checklist could not be located.	F 726		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs.	F 758		10/25/19

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F 758	Continued From page 20 §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and	F 758		

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F 758	Continued From page 21 indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to complete a Gradual Dose Reduction (GDR), related to a psychotropic medication, for one (1) of five (5) unnecessary medications reviewed, Resident #18. Findings include: Review of the facility's "Medication Monitoring" policy, not dated, revealed a GDR would be be attempted at least twice in one (1) year before concluding the dosage reduction was clinically contraindicated. Review of Resident #18's GDR's, completed since admission, revealed Resident #18 had not had a GDR attempted, related to Buspar. Review of the progress note, revealed the Nurse Practitioner (NP) documented on 8/7/19, to decrease Resident #18's Buspar from 10 milligram (mg) three (3) times daily, to Buspar 10 mg twice daily, but this was not documented in the resident's current September 2019 orders. Review of Resident #18's current orders for September 2019, revealed an order for Buspar 10 mg by mouth three (3) times a day, with an order	F 758	F 758 • Resident #18 received a GDR (Gradual Dose Reduction) for Buspar on 9/26/19. All residents will receive a GDR attempt twice yearly unless clinically contraindicated. All Pharmacy Consultant recommendations are being reviewed and answered per Medical Doctor (MD) or Nurse Practitioner (NP) within seven (7) working days. NP was notified of GDR not being done on 9/26/19 for Resident #18. Resident #18 was assessed by NP on 9/26/19 with no adverse effects noted from failing to carry out GDR when ordered. • All residents with GDR's have the potential to be affected by this deficient practice. • Consulting Pharmacy policy and procedure was reviewed and revised 10/28/19 to include that facility will receive MD orders or implement recommendations within seven (7) working days. Policy revision was brought to the Quality Assurance Committee on 10/29/19 and approved by QA committee and Medical Director. In-service given to licensed nurses by the Director of Nursing	

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F 758	Continued From page 22 start date of 4/28/18, related to the diagnosis of Major Depressive Disorder recurrent severe with psychotic symptoms. This indicated that Resident #18 received Buspar three (3) times per day for 17 months, without a GDR. Interview on 09/25/19 at 2:46 PM, with the Director of Nursing (DON), verified Resident #18's progress note had orders to decrease Buspar to 10 mg by mouth twice a day from three (3) times a day on 8/7/19. The DON also confirmed Resident #19 had a current order for Buspar 10 mg three (3) times a day. She said it was the Nursing Supervisor's responsibility to write the orders the day the NP visited and made the recommendation; and the Supervisor should review the progress notes the day of the visit. The DON pointed to the progress note and said, "That should have been the GDR". The DON confirmed the GDR had not been implemented. During an interview on 09/25/19 at 3:11 PM, The NP stated she wrote the order for a reduction in Buspar for Resident #18, because of a pharmacy recommendation she had reviewed. The NP stated she usually left her recommendations in the communication book for the nurses, and the expectation was for the order to be written in the medical record the day it was ordered. The NP said she had not been notified that the orders had not been written. During further interview on 09/26/19 at 12:16 PM, the NP revealed she had visited Resident #18 and did not believe the resident had any ill effects from no having the dose reduction of Buspar, as the resident was in the same mental state as always. The NP stated she had written another order today to be started at the lower dose. She stated the policy of the facility was to complete GDR's according to	F 758	(DON) and Staff development nurse 10/29 -10/31/19 regarding GDR and pharmacy consultant recommendation process. Audit will be performed by the DON on all pharmacy consultant recommendations x 3 months beginning 11/4/19 to assure responses received and any orders carried out within seven (7) working days. * All findings will be brought the Quality Assurance committee weekly by the Director of Nursing (DON) to assure continued compliance.	

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F 758	Continued From page 23 resident needs and guidelines, but she didn't know what happened with the order to reduce the Buspar after she wrote it; the order could not be found. Interview on 09/26/19 at 9:02 AM, with Registered Nurse (RN) #3/Supervisor, revealed she was working the day the NP had written the progress note to decrease the Buspar 10 mg to twice a day for Resident #18. RN #3 said usually the pharmacist recommendations, ordered by the NP or the physician, were put in the communication book; then she would look in that book daily to write the orders the same day. RN #3 said that she was made aware of the recommendations on 9/24/19, by Medical Records, who was talking to the NP about the orders. She stated she does not routinely check progress notes for orders. Review of "Admission Record" revealed Resident # 18 was admitted on 1/18/18, with diagnosis of major depression disorder and dementia. An observation on 09/26/19 at 11:14 AM, revealed Resident #18 in her room awake, alert and smiling when spoken to. Resident #18 did not respond to any questions but was alert and watched with her eyes.	F 758		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 761		10/25/19

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F 761	Continued From page 24 §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to accurately label medication to prevent possible medication errors for two (2) of five (5) resident medication pass observations, Resident #51 and Resident #10. Findings include: A review of the facility's "Preparation for Medication Administration" policy, not dated, revealed prior to administration, the medication and dosage schedule on the resident's Medication Administration Record (MAR) is compared to the medication label. If the label and MAR are different, and the container is not flagged, indicating a change in directions, or if there is any other reason to question the dosage or directions, the physician's orders are checked	F 761	F 761 * Residents #51 and #10 are receiving medications in a manner to prevent possible medication errors. All residents are receiving medication in a manner to prevent possible medication errors. Resident #51 was assessed for pain/discomfort at dialysis access site on 9/24/19 at approximately 9:00am per Director of Nursing (DON) with no pain or discomfort verbalized. Medical Doctor (MD) notified of site incorrect on Lidocaine and orders received to clarify that Lidocaine should be applied to left subclavian catheter site on 9/25/19 at 8:00AM. Label on Lidocaine has a direction change sticker applied per Licensed Practical Nurse (LPN) to match the Medication Administration Record	

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F 761	Continued From page 25 for the correct dosage schedule. Resident #51: On 9/24/19 at 8:10 AM, an observation of medication pass for Resident #51's Lidocaine and Prilocaine 2.5 percent (%)/2.5% cream, revealed Licensed Practical Nurse (LPN) #1 applied the topical medication to Resident #51's left chest wall area. Review of the label on the cream, read: Lidocaine and Prilocaine cream: apply to upper extremity (UE) fistula one (1) time a day every Tuesday, Thursday, and Saturday (Tu-Th-Sat), before dialysis, to prevent access pain. Review of the September 2019 MAR, for Resident #51's Lidocaine and Prilocaine cream, documented: apply to upper extremity (UE) fistula one (1) time a day every Tuesday, Thursday, and Saturday (Tu-Th-Sat), before dialysis, to prevent access pain. On 9/24/19 at 8:45 AM, an interview with LPN #1 revealed, Resident #51's Medication Administration Record (MAR) and the label on the cream should document to apply the Lidocaine/Prilocaine to the resident's chest area, because she does not have an upper extremity fistula now. Review of a physician's order, dated 9/25/19, revealed Resident #51 was ordered Lidocaine-Prilocaine Cream 2.5%-2.5%, topically to the left subclavian catheter once daily, prior to dialysis, to prevent access pain (Tues/Thurs/Sat). On 9/25/19 at 2:00 PM, an interview with LPN #2 revealed Resident #51's medication label was not accurate. She stated the label and the MAR should document to apply to the chest area,	F 761	(MAR)/Treatment Administration Record (TAR). Resident #10 received correct dose of Baclofen but MD was notified that label on medication did not match Medication Administration Record (MAR) orders. Orders were received to clarify and match medication on hand on 9/25/19 at 2:05 PM for Baclofen per Licensed Practical Nurse(LPN). * All residents have the potential to be affected by this deficient practice. * In-service by given to licensed nurses on 10/29/19-10/31/19 by the Director of Nursing. All medications were reviewed on 10/30/19-10/31/19 by 7/3 shift LPN to assure all labels matched the MAR/TAR. There were no other medications found that did not match MAR/TAR. Medications received from pharmacy will be verified by the receiving nurse to assure label on medication matches the MAR/TAR upon receipt. Medication change orders that require label change will have label change sticker applied by the nurse noting the order. The label will be verified by nurse giving medication at each med pass. The Director of Nursing or Registered Nurse Supervisor will audit all medication changes weekly x 8 weeks to assure direction change labels are applied as needed. * Findings will be brought to the Quality Assurance Committee weekly by the Director of Nursing (DON) to assure continued compliance.	

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F 761	Continued From page 26 because the resident no longer had a fistula in the upper extremity. Resident #10: On 9/24/19 at 11:00 AM, an observation revealed LPN #1 administered Resident #10's medication and the card for Baclofen documented 10 milligram (MG)-give 1/2 tablet by mouth two (2) times a day; while the MAR documented for Baclofen 5 MG give one (1) tablet by mouth two (2) times a day. On 9/24/19 at 1:35 PM, an interview with LPN #2 revealed the medication label does not match the physician's order and she would get that corrected for Resident #10's Baclofen. On 9/25/19 at 2:05 PM, an interview with the Director of Nursing (DON), revealed there is room for an error when the medication label and MAR don't match where and how the medication is administered. She stated the resident's medication card should have matched the medication that given to Resident #51. The DON also stated the Baclofen medication card label for Resident #10 should match what is on the MAR.	F 761		
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.	F 812		10/25/19

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F 812	Continued From page 27 (ii) This provision does not prohibit or prevent 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 interview, record review, and facility policy review, the facility failed to follow proper sanitation and food handling practices, to ensure food safety requirements during tray line and meal prep, for two (2) of three (3) observations. This was evidenced by heavy grease build-up on equipment, lack of hand hygiene/hair containment, not sanitizing food thermometers, and dirty utensils. Findings include: Review of a facility's "Cleaning and Sanitizing Equipment" policy, dated 10/17, revealed "All equipment is kept clean and food contact surfaces are cleaned and sanitized. All food contact surfaces and work tables are cleaned an sanitized after every use and at any time that contamination may occur. Equipment is cleaned and sanitized using the proper procedures". Review of the facility's "Cleaning Schedule" policy, dated 10/17, revealed: The Dietary Manager (DM) shall establish a cleaning schedule for the food service department to ensure that food is stored and prepared under	F 812	F812 * The dirty cloth and fork sitting on the tray line was removed by Dietary worker #2 on 09/23/2019. The grease build up on equipment was address/cleaned on 09/23/2019 by all Dietary Staff on schedule. The vent of hood was cleaned on 09/23/2019 by the Dietary Staff on schedule. The Dietary Manager counseled the Dietary Staff on kitchen cleaning schedule to ensure that food is stored and prepared under sanitary conditions. On September 24, 2019, the Dietary Manager counseled the Dietary Staff on wearing hairnets. On September 30, 2019, the Dietary Manager scheduled the vent of hood to be cleaned by the Contracted Vent Hood Cleaning Company on 11/17/2019. On 09/24/2019, the Dietary Manager counseled Dietary Staff on the use of gloves and hand hygiene. On 09/24/2019, the Dietary Manager, counseled Dietary Staff on proper thermometer care to avoid cross contamination. An in-service was given on The facility is storing, preparing,	

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F 812	Continued From page 28 sanitary conditions. The cleaning schedule is posted in the food service department. The DM schedules the task and provides procedure for proper cleaning and sanitizing the equipment. Review of the facility's "Employee Work Practices" policy, dated 10/17, revealed, "Food service employees shall follow sanitary practices to prevent the spread of food borne illnesses". Procedures are to follow proper hand practices for sanitizing hands, single use gloving, and wearing proper work attire, including hats and/or hairnets. Review of the facility's "Hand and Single Use Glove Sanitation Practices" policy, dated 10/17, revealed, "Contact with food with bare hands is not allowed. Food service employees wash their hands after the following activities: when beginning work, before handling raw food, and before touching anything that may contaminate hands such as unsanitized equipment, work surfaces or washcloths. Hands should be washed before putting on gloves and after removing gloves, between handling dirty and clean dishes and utensils, before distributing food at meals, snacks, or activities involving food and before serving food. Review of the facility's "Guidelines for Using Thermometers" policy, dated 10/17, revealed, "The facility shall monitor temperatures of hazardous foods to maintain quality and safety of food served using appropriate thermometer. Thermometers are washed, rinsed, sanitized and air dried before and after each use to prevent cross contamination". Review of a document, provided and signed by	F 812	handling, distributing and serving food according to standards for food service safety and sanitary conditions. Cleaning and sanitizing schedules are being used by dietary staff and monitored by the Dietary Manager to ensure food safety and to avoid cross contamination. All dietary staff are trained on food safety requirements and sanitation standards. * 57 Residents have the potential to be affected by this deficit practice. * On 10/29-10/30/2019, the Dietary Manager inserviced all dietary staff on storing, preparing, distributing and serving food in accordance with professional standards for Food Service Safety and cleaning and sanitizing schedules and procedures. The Dietary Manager will in-service all dietary staff monthly x 3 beginning November 2019, on hire, annually and as needed to ensure that proper food safety requirements are being met. Cleaning schedules were address by the Dietary manager on 09/30/2019 to ensure staff cleaning responsibilities. Residents were assessed for any s/s of adverse effects from deficient practices for following proper sanitation and food handling practices discovered on 09/24/2019 by the Dietary Manager on 09/24/2019. No adverse findings were presented. * Beginning October 21, 2019 the Dietary Manager will monitor dietary staff weekly x 3 months to ensure that food safety requirements and sanitation	

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F 812	Continued From page 29 the Dietary Manager, dated 09/24/19, revealed: While checking temperatures on the food, make sure the person doing the testing has gloves on and wipes off thermometer with an alcohol pad after each food. Observation on 09/23/19 at 10:05 AM, on entrance into the kitchen, revealed a dirty cloth with a dirty fork was sitting on the serving tray line in a metal compartment. Grease build up was observed on the vent hood over the fryer. (Review of documentation revealed the vent hood was last cleaned in May 2019, and scheduled to be cleaned again in Nov 2019). The fryer had old grease with large food particles in the grease. A sticker on the fryer had a cleaning date of 9/15/19. The Conventional oven had a build-up of grease in the bottom of the oven. An observation in the kitchen on 09/23/19 at 10:15 AM, revealed food in the bottom of the water in the tray line. There was an oil film on top of the water in the tray line. A dish towel was lying in an empty tray on the tray line along with a dirty fork. The toaster was observed with a grease build up on the outside, while the inside of the toaster contained a build-up of crumbs, as was the shelf where the toaster sat. Pieces of shredded paper and dust were observed on the shelf. The inside of the microwave had a grease build up around the edges of the microwave and the mixer had a build-up of grease around the base of the mixer. An observation on 09/23/19 at 10:30 AM, revealed the coffee pot had a black build up between the machine and the strainer that holds the coffee and filter.	F 812	standards are being met. Any adverse findings will be brought to the weekly QA committee to assure continued compliance.	

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F 812	Continued From page 30 An observation on 09/24/19 at 10:50 AM, revealed Dietary Worker (DW) #1 flouring raw chicken with her gloved hands. DW #1 removed gloves and obtained a thermometer to check the temperature of the food, without hand hygiene. DW #1 asked DW #2 to take over the flouring of the raw chicken. DW #2 did not wash her hands or glove before handling and flouring the uncooked chicken. An observation on 09/24/19 at 11:05 AM, revealed three (3) dietary staff preparing the lunch meal, without gloves, and two (2) care staff members in the kitchen was not wearing a hairnet. The Dietary staff moved from task to task, preparing gravy mixture and handling tea glasses without gloving or washing hands. DW #1 obtained a juice glass, filled the glass with ice water and attempted to calibrate the thermometer. DW #1 could not calibrate the thermometer to 32 degrees, so she took the thermometer in her left bare hand, holding it by the probe, and attempted to turn the temperature dial with her right bare hand. DW #1 could not get the thermometer dial to turn so she laid the thermometer on a paper napkin on the serving line tray and got more ice water. Once calibrated, without washing her hands or gloving, DW #1 checked the temperature of the foods. DW #1 took the thermometer and placed it into the rice and then the squash casserole, without cleaning the probe. After probing the casserole, she wiped the probe with a wadded paper napkin she had in her left hand, and placed the thermometer into the chopped chicken. Without cleaning the thermometer, DW #1 placed the thermometer into the pureed chicken, then wiped the thermometer with the same wadded paper napkin in her hand. DW #1 laid the thermometer onto the	F 812		

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F 812	Continued From page 31	F 812		

serving line tray with the probe touching the tray. DW #1 retrieved the probe from the tray and temped the sweet peas, wiped the probe with the napkin, and placed it into the baked pork chops, then the gravy. DW #1 wiped the thermometer with the wadded paper napkin and temped the fried chicken. DW #1 placed the thermometer into the sleeve without cleaning the thermometer. Without washing her hands, DW #1 returned to the tray line.

An observation on 09/24/19 at 11:20 AM, revealed DW #2 washed her hands, went to the clean rack, and picked up plates and plate covers with her bare hands, holding them next to her uniform to steady the load. DW #2, without washing her hands or gloving, reached to take each plate, and allowed her thumb to touch the inside of each plate before placing the plates onto the cart for distribution to A Hall. Once taken to A Hall, the Dietary Manager (DM) was asked to check the temperature of the food on the last tray on the cart. The DM obtained the thermometer from the kitchen, and without cleaning the thermometer probe, began to check the temperatures on the tray going from one food to another without cleaning the thermometer in between the different foods. After the DM finished checking the temperatures of the foods on the plate, the tray was then served.

An interview on 09/23/19 at 10:21 AM, with DW #2 revealed, "We were off this weekend and we came back to find the serving line trays very dirty". DW #2 stated they are supposed to put cleaning stickers on the tray line showing when things were cleaned last, but the dates aren't legible. DW #2 confirmed the toaster was dirty.

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F 812	Continued From page 32 An interview on 09/23/19 at 10:25 AM, with DW #1, revealed there were no cleaning logs, they had started putting stickers on the appliances when cleaned. DW #1 stated, "We were off this weekend and we came back to a dirty freezer, oven, cooler, fryer, and serving tray line". DW #1 confirmed the build-up on the stove hood, and stated it needed cleaning. An interview on 09/23/19 at 12:15 PM, with DW #1, revealed there was a man who comes to clean the stove vent, and confirmed no one cleaned in-between, if needed. DW #1 verified there was food left in the fryer and stated the last time the fryer was cleaned was 9/15/19. DW #1 stated the fryer was supposed to be cleaned on Sundays. An interview on 09/24/19 at 11:45 AM, with the DM, revealed, "We use a sticker to place on the kitchen equipment showing the day we clean it. All equipment should be cleaned using the cleaning schedule. They are supposed to write it down too". The DM confirmed there was no cleaning schedule posted. The last dietary cleaning schedule the Dietary Manager had on the computer was dated February 2019. The DM stated, "It is my responsibility to put the cleaning schedule out for the staff. The February schedule is the last one I have". No current cleaning log was provided by the facility. The DM stated, "The staff is supposed to wash their hands after every task. They are supposed to wear gloves and hairnets when handling food. I'm not sure who cleans the oven vent in between the contract company coming every six (6) months and cleaning it. I'm not sure if it is dietary staff or maintenance person. I expect the equipment to be cleaned after each use". The DM stated the	F 812		

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F 812	Continued From page 33	F 812		

water in the serving line compartment should be drained daily and the water used to maintain the temperature of the food should be clean and changed daily. The DM stated the dirty cloth, with the dirty fork sitting in the serving line in the metal pan, was an Infection Control Issue. He stated that DW #1 should have wiped the thermometer with an alcohol wipe between each different food, because wiping with a paper napkin could have caused cross contamination with the food; some people are allergic to different foods so a reaction could happen. He stated that DW #1 should have washed her hands and worn gloves.

An interview on 09/26/19 at 09:05 AM, with the Administrator, revealed, "My expectation is for the kitchen to be spotless regardless of who is in the kitchen". The Administrator stated, "I consider the staff slack, with no regards to residents having sanitary clean food". The Administrator stated that she believed the shift that left the food in the tray line and fryer was the weekend shift from Sunday. The Administrator stated that DW #1 should have tested the food appropriately; cleaning the thermometer from one food to another. The Administrator stated, "This is not acceptable"

An interview on 09/26/19 at 12:20 PM, with DW #1, revealed that she was supposed to clean the thermometer between each testing of different foods, but she didn't have any alcohol wipes to do it. She confirmed hair nets should be used and hands washed after each task. She confirmed the dirty equipment and the grease build up in the kitchen. She confirmed gloves should be worn when handling food.

An interview on 09/26/19 at 12:20 PM, with DW

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELHAVEN SENIOR CARE, LLC	1004 NORTH ST JACKSON, MS 39202

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F 812	Continued From page 34 #2 revealed, "You should wash your hands after each task. I didn't have gloves on when I was frying the chicken. I don't remember when I washed my hands, but I wash them when I come in every morning first thing". DW #2 stated the thermometer is supposed to be cleaned after testing each food. DW #2 confirmed there was food in the deep fryer and old grease, and stated, "It was filthy". She confirmed the grease build up on the and the dirty tray line water. DW #2 stated, "I don't wear gloves when I put plates on the cart, but I do place my thumb on the top of the plate when I take it from the line. I can see where I should be wearing gloves".	F 812		
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		10/25/19

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F 880	Continued From page 35 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 36 §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 prevent the possible spread of infection during care observation for four (4) of seven (7) residents observed, Resident #14, Resident #16, Resident #47, and Resident #30. Findings include: Review of the facility's "Infection Prevention and Control Program" policy, not dated, revealed the facility's hand hygiene protocol included: "All staff shall wash their hands when coming on duty, between resident contacts, after handling contaminated objects, after Personal Protective Equipment (PPE) removal, before/after eating, before/after toileting, and before going off duty. Staff shall wash their hands before and after performing resident care procedures. Hands shall be washed in accordance with our facility's established had washing procedure. All contaminated disposable items shall be discarded in a waste receptacle lined with a RED plastic bag. Resident #14 Observation on 9/24/19 at 2:53 PM, revealed Certified Nursing Assistant (CNA) #3 provided catheter care to Resident #14, with the assistance of CNA #2 and CNA #1. Resident #14 was supine. CNA #3 wiped across the top of the Resident #14's groin area, down the resident's right groin area, down the resident's left groin	F 880	F880 * Resident #14 was assessed by the Director Of Nursing (DON) on 9/25/19 with no signs and symptoms of infections or adverse effects noted from improper catheter/peri care. Certified Nurses Aid #3 (CNA was given 1:1 education by the Director of Nursing (DON) on 9/25/19 regarding proper catheter/peri care and was observed providing care on 9/25/19 at 8:30am. Resident #14 is having catheter care/peri care provided correctly. All residents who require catheter and peri care are having this care provided correctly. Residents #14, #16, #30 and #47 were assessed by the Director of Nursing (DON) on 9/26/19 with no signs and symptoms of infection and no adverse effects of improper peg site/wound care provided on 9/25/19 at approximately 10:00am. Three (3) other residents had peg site/wound care provided by Licensed Practical Nursing (LPN) #3 on 9/25/19 and were assessed for adverse effects or signs and symptoms on infection with no adverse effects or signs and symptoms of infection noted. The Medical Doctor(MD) was notified of improper care provided with orders to notify of any adverse effects noted. Resident #47 is having peg site care provided appropriately. Residents #14, #16 and #30 care having wound	

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F 880	Continued From page 37 area and then down the middle of the resident's vaginal area. She then wiped the left groin area in an upward motion and wiped the catheter tubing, without securing the catheter tubing. CNAs #1 and CNA #2 repositioned Resident #14 onto her right side, while the catheter drainage bag remained hanging on the opposite side of the bed. CNA #3 wiped the resident's buttock areas in an upward motion, then wiped each side and up the middle between the buttocks twice, from back to front. CNA #3 then applied a clean brief to the resident, placed the soiled linen in a clean plastic bag, and sat the plastic bag on the floor bedside the resident's bed. On 9/24/19 at 3:25 PM, an interview with CNA #2 revealed when CNA #3 wiped in an upward motion, she should have wiped in a downward motion because of cross contamination. On 9/24/19 at 3:30 PM, an interview with CNA #1 revealed CNA #3 should not have wiped the resident's left groin area in an upward motion, because she caused cross contamination going from back to front. On 9/24/19 at 4:28 PM, an interview with Registered Nurse (RN) #1 revealed, when CNA #3 cleaned the resident's catheter tubing without securing it, that could cause dislodgement or irritation to the resident's urethra and increase the chance for an infection. She stated the catheter tubing should always be stabilized when the staff is cleaning it. RN #1 also stated CNA #3 should have wiped Resident 14's left groin from front to back to prevent possible Ecoli (infection) from getting in the resident's urine. On 9/25/19 at 9:30 AM, an interview with CNA #3	F 880	care provided appropriately. Licensed Practical Nurse(LPN) #3 was given 1:1 in-service on wound care including handwashing and proving gloving procedures on 9/26/19 by the RN supervisor. LPN #3 is able to provide appropriate wound care. LPN #3 was given three (3) days of shadowing Register Nurse Supervisor between 9/27, 9/28 and 9/29/19 providing peg site care and was checked off providing peg site/wound care on 9/30/19 by the RN Supervisor. * All residents have the potential to be affected by this deficient practice. * In-services regarding peri-care/catheter care, and wound care were provided to Licensed Nurses 10/29/19-10/31/19 by the Director of Nursing (DON). Certified Nursing Assistants (CNA s) were checked off on peri-care and catheter care by the Director of Nursing and the 3/11 Licensed Practical Nurse (LPN). Licensed Nurses were checked off on proper wound care which included hand hygiene and gloves by the Director of Nursing on 10/29/19-10/31/19. Peri-care/catheter care observations were started week of 11/4/19 by the Director of Nursing on 3 residents a week x 8 weeks. Wound care observations were started week of 11/4/19 by the Registered Nurse (RN) Supervisor or DON 2xwk x 8 weeks. * Findings will be brought to the Quality Assurance committee weekly by	

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F 880	Continued From page 38 revealed when she wiped the resident's left groin area the second time, in an upward motion, she cross-contaminated the area. She stated when she wiped the catheter tubing the second time without securing the tubing, she could have caused the catheter tubing to come out. She also stated when she placed the plastic bag with the soiled linen on the resident's floor, she caused cross contamination; she guessed she was nervous. A review of the facility's Face Sheet revealed the facility admitted Resident #14 on 1/8/19, with a diagnosis of Retention of Urine. Resident #16 An observation on 09/25/19 at 09:10 AM, revealed when Licensed Practical Nurse (LPN) #3 entered Resident #16's room to provide wound care to her right heel, she applied gloves without washing her hands. She wiped the over bed table, removed and donned new gloves, placed several packs of pre-packaged gauze, and other supplies, including a tube of Dermasyn, on the barrier. LPN #3, using the same gloves, removed the right heel boot, removed gloves and exited the room. LPN #3 returned and applied three (3) sets of gloves on her hands. LPN #3 stated she used three (3) pairs of gloves so she could peel one (1) pair off and continue with care. She stated, "When I take the dirty off, I have clean gloves under them". LPN #3 arranged her supplies, layered seven (7) dry gauze squares on top of the abdominal pad, applied a nonstick pad on top of the gauze, and then applied Dermasyn to the nonstick pad. LPN #3 removed the dirty dressing from Resident #16's right heel and discarded it into a red biohazard bag. LPN #3 removed the top layer of gloves, cleaned and	F 880	the Director of Nursing to assure continued compliance.	

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F 880	Continued From page 39	F 880		

dried the wound, and applied the clean dressing to the heel. LPN #3 removed her gloves, exited the room, returned to the room, donned two (2) sets of gloves and secured the dressing to the heel. LPN #3 removed one (1) set of gloves and pushed the over bed table onto the roommate's side of room with the un-used supplies (6 individual bottles of normal Saline and 5 un-opened gauze) still lying on the barrier. LPN #3 gathered the remaining normal saline, gauze, and the tube of Dermasyn from the over bed table, placed them on top of the wound cart, then took them to another resident's room for wound care.

An interview on 09/25/19 at 2:35 PM, with Registered Nurse (RN) #1/Staff Development/Infection control Nurse, revealed, "I cannot find LPN #3's competency where she was checked off on Infection Control, wound care, hand washing, and proper gloving".

An interview on 09/26/19 at 08:35 AM, with LPN #3, revealed she had worn multiple gloves, that she'd always done that, and could see where it might be cross-contamination due to possible pin-holes. She stated, "You are supposed to wash your hands between dirty to clean". She stated she did use the same tube of Dermasyn cream on different residents and remembered carrying the tube into different rooms. She stated, "I thought about squeezing some into a med cup, but I really didn't know what to do. I didn't wash my hands during the care, but I removed my dirty gloves to the next pair of clean gloves. I thought that was ok".

An interview on 09/26/19 at 08:35 AM, with RN #1, revealed that LPN #3 not washing her hands

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F 880	Continued From page 40 and gloving properly during wound care was an Infection Control Issue, and stated, "It could have caused cross contamination". RN # 1 stated that LPN #3 removing supplies from one room to another is a cross contamination issue; once supplies go into a room they are considered dirty and must be destroyed. An interview on 09/26/19 at 8:10 AM, with the Director of Nursing (DON), revealed that LPN not washing her hands, and wearing several pairs of gloves during wound care, removing a layer at a time, was an infection control issue. She stated, "It could have caused cross contamination. I don't even understand wearing several pairs of gloves. It certainly is not our policy. Once the supplies are in the room, they are considered dirty, and should not be brought out of the room. They should be discarded". An interview on 09/26/19 at 11:22 AM, with CNA #2, revealed that she saw LPN #3 wearing several pairs of gloves and as she took off one pair of gloves, she always had another pair under them. CNA #2 stated she did not see LPN #3 wash her hands during care of Resident #16. Resident #47 An observation on 09/25/19 at 10:11 AM, revealed LPN #3 gloved in the hallway, without performing hand hygiene, reached into her pocket, and obtained the wound cart keys. LPN #3 reached into the cart and obtained a germicidal wipe, entered Resident #47's room, and wiped the over-bed table. LPN #3 removed her gloves and without performing hand hygiene, obtained two (2) paper towels and placed the paper towels on the over bed table as a barrier. LPN #3 donned two (2) pairs of gloves, poured	F 880		

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F 880	Continued From page 41 normal saline onto some gauze, and wiped wiped the Resident's Percutaneous Endoscopic Gastrostomy (PEG) stoma. LPN #3 took a dry gauze and patted the stoma, then slightly folded the gauze over, allowing the used side of the gauze to touch the area of the stoma just cleaned, and patted the stoma again. LPN #3 removed one (1) pair of the gloves and applied a clean drain sponge gauze to the stoma and secured it with tape. LPN #3 never washed her hands during the procedure. An interview on 09/26/19 at 08:35 AM, with RN #1, revealed that LPN #3 not washing her hands and gloving properly during wound/stoma care was an Infection Control Issue. RN #1 stated that LPN #3 should not have folded the gauze and used it to wipe the stoma a second time, as this could have caused cross-contamination to the site. An interview on 09/26/19 at 8:10 AM, with the DON, revealed that LPN #3 folding the gauze and wiping with it again is an infection control issue; it could have caused cross-contamination. The DON confirmed LPN #3 wearing two (2) pairs of gloves and not washing her hands was unacceptable during care, because that could be cross-contamination also. She stated it was not policy to wear several pairs of gloves during care. The DON stated that LPN #3 is going to need extensive training on wound care and Infection control. An interview on 09/26/19 at 8:35 AM, with LPN #3 revealed, "I remember wearing two (2) pairs of gloves and that is cross contamination. I've always done that though". LPN #3 confirmed hand hygiene should be performed between dirty	F 880		

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F 880	Continued From page 42 to clean. She stated there could be a pin hole in the gloves and something could get on the pair under it. LPN #3 stated, "I didn't wash my hands during the care, but I removed my dirty gloves to the next pair of clean gloves. I thought that was ok". LPN #3 stated that she remembered folding the gauze over and patting the wound with it during the PEG stoma care. Resident #30 Observation of Resident #30's wound care, on 09/25/19 at 10:17 AM, revealed LPN #3/Wound Nurse, performed wound care with the use of multiple gloves and did not wash her hands/change gloves during the wound care procedure to the resident's left heel. On 09/26/19 at 08:11 AM, interview with the DON, confirmed an infection control issue for LPN #3 not washing her hands/changing gloves, and using multiple pair of gloves during wound care treatment for Resident #30. On 09/26/19 at 08:35 AM, interview with RN #1, Infection Control Nurse, Staff Development Nurse, regarding the Wound Care Nurse's procedure of wound care and not changing gloves/not washing hands during procedure, revealed it could cause cross-contamination and other infection throughout facility. On 09/26/19 at 09:12 AM, interview with LPN #3, revealed she did not wash her hands during the wound care procedure for Resident #30's heel. She stated it may be cross-contamination by not washing hands throughout the procedure, and only changing or adding new gloves.	F 880		

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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		

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

Electronically Signed | 10/31/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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E 000	Initial Comments *EMERGENCY PREPAREDNESS* Survey conducted on 09/25/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were cited.	E 000		

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