MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25BN	A. BUILDING: _____ B. WING _____	09/26/2019

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BELHAVEN SENIOR CARE, LLC	1004 NORTH ST JACKSON, MS 39202

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M 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 Mississippi Regulations for Minimum Standards for Institutions for Aged or Infirm with deficiencies cited at M520, M620, M640, M715, and M815. The facility census was 58 and the facility was licensed for 60 beds at the time of survey.	M 000		
M 520 SS=D	45.18.3 Training Records Training Records. A written record shall be maintained of all orientation and in-service training sessions. This Statute is not met as evidenced by: Level II 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 policy titled, "Policy and Practice Guideline: Use of Staff Competency Form", 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	M 520	M 520 * 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 care provided on 9/25/19 at approximately 10:00am. Three (3) other residents had peg site care provided by 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. Medical Doctor was notified of improper care provided with orders to notify of any adverse effects noted. Resident #47 is having wound care provided appropriately. Licensed Practical Nurse (LPN) #3 was	10/25/19

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M 520	Continued From page 1 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 PEG tube stoma. Observation revealed the LPN didn't 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 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	M 520	given 1:1 in-service on 9/26/19 by the Register Nurse (RN) supervisor. LPN #3 is able to provide appropriate wound care. LPN #3 was given three (3) days of shadowing RN 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. * 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 (DON) 10/29-10/31/19. Licensed nurses were checked off providing proper wound care by the DON 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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M 520	Continued From page 2 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.	M 520		
M 620 SS=D	45.21.4 Urinary incontinence Urinary incontinence. Residents with urinary incontinence shall be assessed for need of bladder retraining program. An indwelling catheter will not be used unless the resident ' s clinical condition indicates that catheterization is necessary. These residents shall receive treatment and services to prevent urinary tract infections. Level II	M 620	M 620 • Resident #14 was assessed by the	10/25/19

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M 620	Continued From page 3 Based on observation, staff interviews, record 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 catheter drainage bag remained hanging on the	M 620	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 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 DON and Staff development nurse. All Certified Nursing Assistants (CNA's) were checked off providing catheter/peri care correctly by the DON, 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 DON or Staff Development nurse beginning week of 11/4/19. • Findings will be brought to the Quality Assurance Committee weekly by the DON to assure continued compliance.	

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M 620	Continued From page 4 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 Resident 14's left groin area in an upward motion, she should have wiped from front to back to	M 620		

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M 620	Continued From page 5 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.	M 620		
M 640	45.21.8 Accidents Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies.	M 640		11/18/19

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M 640	Continued From page 6 This Statute is not met as evidenced by: Level III 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 the 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 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	M 640	M640 * 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 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	

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M 640	Continued From page 7 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 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	M 640	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. * 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	

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M 640	Continued From page 8 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". 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	M 640	meeting by the Administrator to address and resolve any issues.	

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M 640	Continued From page 9 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 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	M 640		

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M 640	Continued From page 10 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 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.	M 640		

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M 640	Continued From page 11 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 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	M 640		

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M 640	Continued From page 12 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.	M 640		
M 715	45.24.4 Labeling of drugs Labeling of drugs. Each facility shall follow the Mississippi State Board of Pharmacy labeling requirements. This Statute is not met as evidenced by:	M 715		10/25/19

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M 715	Continued From page 13 Level II 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 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	M 715	M 715 • 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 (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 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 DON. 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	

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M 715	Continued From page 14 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, 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	M 715	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 DON or Registered Nurse (RN) 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 QA committee weekly by the DON to ensure continued compliance.	

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M 715	Continued From page 15 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.	M 715		
M 815	45.29.1 Safe Food Handling Procedures Safe Food Handling Procedures. Food shall be prepared, held, and served according to current Mississippi State Department of Health Food Code Regulations. This Statute is not met as evidenced by: Level II Based on observation, staff interview, 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 the 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".	M 815	M815 * 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	10/25/19

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M 815	Continued From page 16 Review of the facility's "Cleaning Schedule", 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 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.	M 815	Staff on proper thermometer care to avoid cross contamination. An in-service was given on The facility is storing, preparing, 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	

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M 815	Continued From page 17 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 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,	M 815	weekly x 3 months to ensure that food safety requirements and sanitation standards are being met. Any adverse findings will be brought to the weekly QA committee to assure continued compliance.	

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M 815	Continued From page 18 revealed the coffee pot had a black build up between the machine and the strainer that holds the coffee and filter. 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	M 815		

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M 815	Continued From page 19 into the pureed chicken, then wiped the thermometer with the same wadded paper napkin in her hand. DW #1 laid the thermometer onto the 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	M 815		

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M 815	Continued From page 20 legible. DW #2 confirmed the toaster was dirty. 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	M 815		

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M 815	Continued From page 21 be cleaned after each use". The DM stated the 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	M 815		

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M 815	Continued From page 22 #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".	M 815		