STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255179	A. BUILDING _____ B. WING _____	10/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEAKESVILLE REHABILITATION AND NURSING CENTER, INC	1300 MELODY LANE/PO BOX 640 LEAKESVILLE, MS 39451

(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 re-certification survey from 10/22/19 to 10/24/19. The SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F625, F657, and F880. The Census at the time of survey was 58, and the facility was Licensed for beds 60.	F 000		
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the	F 625		11/15/19

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

Electronically Signed | 11/15/2019

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F 625	Continued From page 1 resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide the bed hold policy/agreement to the resident and/or the Responsible Party (RP) at the time of transfer to an acute care facility for three (3) of six (6) hospitalizations reviewed for Resident #22, Resident #5, and Resident #54. Findings include: Interview with the Facility's Administrator on 10/24/2019 at 4:33 PM, revealed the facility did not have a policy on bed holds, but is developing a policy at this time. Resident #5 Record review of the facility's, "Notice of Transfer", revealed Resident #5 was hospitalized three (3) times. The facility failed to send a bed hold letter to the RP or resident when Resident #5 was sent to the hospital on 7/31/2019, 8/16/2019, and 9/15/2019. In an interview on 10/24/19 at 4:33 PM, the Administrator revealed it is the responsibility of the Social Worker (SW) to send out the bed hold letters when the resident is transferred to the hospital. The Administrator stated the Social Worker is out on Family Medical Leave of Absence (FMLA). The Administrator confirmed the bed hold letters were not sent for Resident #5. The Administrator stated he was responsible for the bed hold letters while the Social Worker was out and stated he missed it.	F 625	1. On 10/24/19, the Administrator identified Resident #5, #22, and #54 and each Resident or Responsible Party was notified of facilities Bed Hold Notification. 2. All residents have the potential to be affected by this deficient practice. On 10/24/2019, the Administrator conducted a 100% audit of all residents transfers from the facility with the last three (3) months, The audit did not reveal any other residents not being notified of the facility's Bed Hold Notification. 3. On 10/25/2019, an in-serviced titled, "Bed Hold Notifications" was conducted by the Registered Nurse (RN) Consultant and Administrator for all nursing Staff. Beginning 10.24.19 The Administrator will identify daily any resident who has been transferred from the facility by documenting on the Transfer/Discharge Log. This Log will contain the Resident Name, Date of the Transfer, Type of Transfer, and Date Bed Hold Notification was sent to Resident/Responsible Party. A copy of the Bed Hold Notification (s) will be kept with the Transfer/Discharge Log. The Quality Assurance (QA) Nurse will review the Transfer/Discharge Log. The Quality Assurance (QA) Nurse will review the Transfer/Discharge Log weekly for (4) weeks and then monthly to ensure compliance. 4. The QA Nurse will submit the results of the reports each month to the QA	

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F 625	Continued From page 2 Resident #22 Review of the "Notice of Transfer or Discharge", revealed Resident #22 was sent to the Emergency Room (ER) on 8/25/19 and 9/9/19. There was no documented evidence of notification, in writing, of the bed hold agreement. On 10/24/19 at 4:33 PM, the Administrator confirmed Resident #22 or the RP was not provided written notification of a bed hold agreement/policy at the time of transfer to an acute care facility on 8/25/19 and 9/9/19. Resident #54 Review of the "Notice of Transfer or Discharge", revealed Resident #54 was transferred to the hospital 9/25/19, and on 10/18/19. On 10/24/19 at 4:33 PM, the Administrator confirmed Resident #54 or Resident #54's RP was not provided written notification of the bed hold agreement/policy at the time of transfer to an acute care facility on 9/25/2019, and again on 10/18/2019.	F 625	Committee for recommendations and /or changes as needed to ensure compliance.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the	F 657		11/15/19

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F 657	Continued From page 3 resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to revise the Care Plan for Resident #22; one (1) of eighteen (18) Care Plans reviewed. Findings include: The facility's policy, "Care Plans-Comprehensive", revised June 2017, revealed the resident Care Plans are ongoing and are revised as information about the resident and the resident's condition change. Review of Resident #22's current Care Plan revealed no revision for contact isolation that was ordered 10/4/2019. As a result, the Direct Care staff were not provided written interventions in the Care Plan to address contact isolation. Review of Resident #22's October 2019 Physician's Orders revealed a new order for	F 657	1. On 10/24/2019, Resident #22's Care Plan was reviewed and updated by the Care Plan Nurse to reflect interventions for direct care staff to address contact isolation precautions. 2. All residents have the potential to be affected by this deficient practice. A 100% audit was completed by the Director of Nursing (DON) on 10/24/2019 to determine if any resident (s) requiring isolation had been affected on the date of the survey. Two(2) Residents were on isolation on 10.24.19 to include Resident #22 which revealed no revision to include contact isolation. The other resident, who was on isolation, had a care plan updated to include contact isolation. 3. On 10/24/19, the Staff Development Nurse initiated and in-service on the facility's policy and procedure titled "Comprehensive Care Planning" for all	

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F 657	Continued From page 4 Contact Isolation, that began on 10/4/19. In an interview on 10/24/2019 at 2:15 PM, Registered Nurse (RN) #1 and RN #2 both confirmed the Care Plan was not revised to include interventions for the new order for contact isolation for Resident #22.	F 657	nursing staff, to ensure that nursing staff will care plan all physician orders received and care plan information about the resident and the resident's conditions ongoing. In-services will be completed by 11/15/19. Nursing staff will care plan all physician orders received, and information about the resident and/or changes in condition ongoing. Care plans will be reviewed and revised by the Interdisciplinary Team after each resident assessment and quarterly review assessment 4. The Quality Assurance (QA) Nurse will monitor all care plans of residents who have physician orders for any type of isolation precautions weekly to ensure physician orders for isolation are being followed. The QA Nurse will submit weekly isolation monitoring reports to Administrator to monitor performance of the correction plan. The Quality Assurance Nurse (QA) will submit finding to the Quality Assurance Committee Quarterly. The Quality Assurance Committee will review the corrective action plan and will make recommendations or changes as need for compliance.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable	F 880		11/15/19

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F 880	Continued From page 5 diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, 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	F 880		

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F 880	Continued From page 6 must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to prevent the possible spread of infection during the administration of one (1) of 38 medications administered for Resident #48. Findings Include: Review of the facility's, "Procedure for Instillation of Eye Drops", policy, undated, revealed that the proper technique when administering ophthalmic medication is to replace the cap immediately after use. Review of the facility's, "Infection Control" policy, revised July 2017, revealed the Infection Control Policies are intended to help prevent and manage transmission of diseases and infections.	F 880	1. On 10/24/2019, the eye medication for Resident #48 was removed from the medication cart by Licensed Practical Nurse (LPN#1) and placed into the discontinued and destroyed medication container. On 10/25/2019. the eye drop medication was destroyed by Licensed Practical Nurse (LPN) #1 and new bottle of eye drops was obtained from the pharmacy. 2. All residents receiving eye drops have the potential to be affected by this deficient practice. 3. On 10/24/19, the Staff Development Nurse initiated an in-service on the policy and procedure titled "Procedure for Instillation of Eye Drops" with all nurses to ensure eye drops are administered to	

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F 880	Continued From page 7 During an observation on 10/24/2019 at 8:56 AM, of an eye drop administration, Licensed Practical Nurse (LPN) # 1 placed the uncapped eye drops bottle onto Resident # 48's bed covers. LPN # 1 then re-capped the eye drop bottle without cleaning the tip. LPN #1 placed the bottle back into the package and then returned it to the inside of the medication cart. In an interview on 10/24/19 at 9:00 AM, Licensed Practical Nurse (LPN) #1 confirmed she placed the uncapped eye drop bottle on the resident's bed. LPN #1 stated, "I knew as soon as I did it, that I messed up". LPN #1 confirmed she let the uncapped eye drop bottle touch a contaminated surface and this could have the potential to cause an eye infection to the resident. In an interview on 10/24/2019 at 4:25 PM, the Director of Nursing (DON) confirmed she considered the tip of the eye drop bottle to be contaminated if it touched the bed linen and should be discarded. In a review of the, "Nursing Competence Self-Assessment Tool", signed and dated 7/9/19, by LPN #1, revealed that she was knowledgeable in the administration of eye drops.	F 880	prevent the possible spread of infection. In-service will be completed by 11/15/2019. On 10/28/19 the Quality Assurance (QA) /Infection Prevention Nurse will observe medication administration of eye drops weekly for (4) weeks, then monthly for (6) months, and then annually. 4. The QA/Infection Prevention Nurse will submit weekly monitoring report to the Administrator for (4) weeks, then every month for (6) months and then annually to ensure corrective measures are effective. The Quality Assurance (QA)/Infection Prevention Nurse will submit findings to the QA Committee quarterly . The QA Committee will review the corrective action plan and make recommendations and/or changes as needed to ensure compliance.	

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	255179	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/23/2019**

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K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility must meet the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA) ...	K 000		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to properly perform fire drills as per NFPA 101 section 19.7.1.2. This deficiency affected all residents in the facility on the day of survey. Findings include: On October 23, 2019 at 10:20 AM, observation revealed the facility could not provide documentation of a fire drill conducted for any shift in the following yearly quarters: 1. 4th quarter of 2018	K 712	1. On 10/23/19 the missing fire drills were identified and it was noted that the facility had made corrective measures and 3rd quarter Fire Drill of 2019 had been completed. 2. On 10/23/19 an in-service was conducted by the Administrator for all Maintenance Employees on Fire Drills and Timing of Fire Drills. 3. The Maintenance Director will conduct Quarterly Fire Drills. The Maintenance Director will report and submit each Quarterly Fire Drill to the Administrator to ensure compliance.	11/15/19

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K 712	Continued From page 1 2. 1st quarter of 2019 3. 2nd quarter of 2019 Fire drills shall be conducted one per shift per quarter of the last calendar/ current year.	K 712	4. The Administrator will report each Quarterly Fire Drill to the Quality Assurance Committee on a quarterly basis for review for compliance and to make any needed up dates or needed changes.	

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E 000	Initial Comments ********** Survey conducted on 10/23/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were cited.	E 000		

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MSDH - Health Facilities Licensure and Certification

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M1245	45.41.1 Date of Construction & Life Safety... Date of Construction and Life Safety Code Compliance. 1. Buildings constructed after the effective date of these regulations shall comply with the edition of the Life Safety Code (NFPA 101) effective on the date of construction. 2. Buildings constructed prior to the effective date of these regulations shall comply with Chapter 13 of the Life Safety Code (NFPA 101), 1985 edition. This Statute is not met as evidenced by: Based on record review and interviews, the facility failed to properly perform fire drills as per NFPA 101 section 19.7.1.2. This deficiency affected all residents in the facility on the day of survey. Findings include: On October 23, 2019 at 10:20 AM, observation revealed the facility could not provide documentation of a fire drill conducted for any shift in the following yearly quarters: 1. 4th quarter of 2018 2. 1st quarter of 2019 3. 2nd quarter of 2019 Fire drills shall be conducted one per shift per quarter of the last calendar/ current year.	M1245	1. On 10/23/19 the missing fire drills were identified and it was noted that the facility had made corrective measures and 3rd quarter Fire Drill of 2019 had been completed. 2. On 10/23/19 an in-service was conducted by the Administrator for all Maintenance Employees on Fire Drills and Timing of Fire Drills. 3. The Maintenance Director will conduct Quarterly Fire Drills. The Maintenance Director will report and submit each Quarterly Fire Drill to the Administrator to ensure compliance. 4. The Administrator will report each Quarterly Fire Drill to the Quality Assurance Committee on a quarterly basis for review for compliance and to make any needed up dates or needed changes.	11/15/19

Mississippi State Department of Health

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