STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255253	A. BUILDING _____ B. WING _____	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICKSBURG CONVALESCENT CENTER	1708 CHERRY STREET VICKSBURG, MS 39180

(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 at the facility from 12/9/19 to 12/12/2019. During the survey, the SA determined the facility was not in compliance with the requirements of participation for Medicare and Medicaid, and cited deficiencies at F656, F690, F732, and F812. The census at the time of the survey was 81, and the facility was certified for 100 beds.	F 000		
F 656 SS=D	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		12/30/19

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

Electronically Signed | 12/31/2019

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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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 record review, facility policy review and staff interviews, the facility failed to develop a Care Plan for catheter care for one (1) of four (4) residents with catheters, Resident #41. Findings include: Review of the facility's "Comprehensive Care Plan" policy, dated 03/2019, revealed:, Standard: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. Policy Explanation and Compliance Guidelines: 6. The comprehensive care plan will describe at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's	F 656	1. On 12/11/19 at 4:30 pm, the Plan of Care of the resident identified was reviewed and updated by the Minimum Data Set Coordinator as indicated to include catheter care. 2. The facility has determined that all residents with an indwelling catheter have the potential to be affected. 3. The Administrator, Director of Nursing, Staff Educator, and Minimum Data Set Coordinator reviewed the "Comprehensive Care Plan" policy to ensure the policy addressed the development and implementation of a comprehensive person centered care plan for each resident and it was determined that no revisions were needed to the policy. An in-service/education was completed on 12/11/19 for the Minimum	

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F 656	Continued From page 2 highest practicable physical, mental, and psychosocial well-being. d. The resident's goals for admission, desired outcomes, and preferences for future discharge. 9. The comprehensive care plan will include measurable objectives and timeframes to meet the needs identified in the resident's comprehensive assessment. the objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented, as needed. Review of Resident #41's care plan revealed the Focus: Resident #41 has an indwelling catheter (cath) related to (r/t) stage 3 sacral wound. Resident has a stage 4 (wound) to the left elbow. Date initiated: 10/23/19. The Desired Outcome was Resident #41 will remain free from catheter-related trauma through review dated of 01/30/2020. Further review of the Interventions/Tasks revealed there was no intervention/tasks to provide catheter care. The Interventions/Tasks only spoke to the presence of the 16 fr (french) indwelling Foley catheter with a 10 cc (cubic centimeter) bulb, keep the catheter bag and tubing below the bladder level and away from the entrance room door, monitor and document intake and output, monitor for pain/discomfort due to the catheter, monitor/record/report signs and symptoms (s/s) for Urinary Tract Infection (UTI) to the MD (Medical Doctor), and observe for s/s of discomfort on urination and frequency. On 12/11/19, at 11:00 AM, an observation during Resident #41's catheter care provided by Certified Nursing Assistant (CNA) #1 revealed CNA #1 wiped back to front along the left labia major, back to front along the right labia major and back to front between the labia minor with	F 656	Data Set team and Licensed Nursing staff by the Staff Educator and Minimum Data Set Coordinator regarding the comprehensive care plan which shall include measurable objectives and timeframes to meet the needs identified in the resident's comprehensive assessment. 4. The Plan of Care will be reviewed upon admission and with each following required assessment for any resident with an indwelling catheter by the Minimum Data Set staff. Any trends or patterns will be presented to the Quality Assurance Performance Improvement Committee monthly times three months, then ongoing as issues are identified for any action needed.	

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F 656	Continued From page 3	F 656		

each step of the cleaning process to include cleansing, rinsing and drying. CNA #1 grasped the Foley Catheter at the connection to the drainage bag tubing, instead of at the catheter insertion site at the meatus, and wiped downward from the catheter insertion site three (3) times to include cleansing, rinsing, and drying the Foley Catheter tubing.

On 12/11/19 at 11:10 AM, in an interview with CNA #1, CNA #1 stated she was taught to wipe back to front on females during catheter care. CNA #1 stated the catheter should be held by the connector to the drainage tubing to prevent the catheter from being pulled out during care.

Record review of the Medication Review Report dated 12/11/19, revealed Resident #41 had an order for an indwelling catheter for wound/skin protection due to a stage 3 sacral wound. The start date for the order was 10/23/19.

On 12/11/19 at 4:00 PM, an interview with the Assistant Director of Nursing (ADON), revealed Registered Nurse (RN) #1 was responsible for care plans, so the ADON could not speak to care plans.

On 12/11/19 at 4:07 PM, an interview with Registered Nurse #1, (RN) confirmed there was no catheter care intervention for cleaning Resident #41's Foley catheter included on the care plan and the catheter care should be care planned.

Review of the Admission Record for Resident #41 revealed the resident was admitted by the facility, on 10/22/19, with a primary diagnosis of Encounter for Orthopedic Aftercare Following

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F 656	Continued From page 4 Surgical Amputation, and secondary diagnoses to include but not limited to Acquired Absence of Left Leg Above Knee, Unspecified Severe Protein Calorie Malnutrition, Pressure Ulcer of Sacral Region Stage 3, and Urinary Tract Infection. Record review of the Minimum Data Set (MDS) Admission Assessment with an Assessment Reference Date (ARD) of 10/29/10, revealed a Brief Interview for Mental Status Score of 99, and the Cognitive Skills for Daily Decision Making was coded a 3, which indicated severe cognitive impairment, never or rarely made decisions. The MDS also revealed Resident #41 was coded for the presence of an indwelling catheter (which included a suprapubic catheter and/or nephrostomy tube) .	F 656		
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	F 690		12/30/19

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F 690	Continued From page 5 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, record review, staff interview and facility policy review the facility failed to provide catheter care in a manner to prevent the possibility for a Urinary Tract Infection (UTI) for one (1) of four (4) residents reviewed with catheters, Resident #41. Findings include: Review of the facility's statement on letterhead, dated 12/11/19, revealed, "The Perineal Care standard dated May 2014 is the Policy and Procedure for Perineal Care". Review of the Perineal Care Standard, revised May 2014, revealed: Perineal Care, for a female resident: a. Using washcloth/personal wipes, clean in a downward motion (front to back) and from center to thighs (center to side to side). b. Separate labia with non-dominant hand to expose urethral and vaginal openings; and wash area	F 690	1. On 12/11/19 at 12:30 pm, Resident #41 was assessed by the Registered Nurse for adverse effects of improper catheter care and it was determined no adverse effects were identified. Resident #41 was immediately provided proper catheter care per facility policy by Certified Nursing Assistant #1 and observed by Registered Nurse. 2. All residents with an indwelling catheter have the potential to be affected by this deficient practice. 3. "The Perineal Care" standard was reviewed and revised on 12/11/19 by the Administrator, Director of Nursing, Medical Director, and Staff Educator to include an attestation statement by the employee and observer for the return demonstration of the competencies for	

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F 690	Continued From page 6 downward from front to back using clean surface of washcloth for each swipe. Note: If the resident has an indwelling catheter, gently wash the juncture of the tubing from the urethra down the catheter about three (3) inches. On 12/11/19 at 11:00 AM, an observation revealed Resident #41's catheter care was provided by Certified Nursing Assistant (CNA) #1. CNA #1 wiped back to front along the left labia major, back to front along the right labia major and back to front between the labia minor with each step of the cleaning process to include cleansing, rinsing and drying. CNA #1 grasped the Foley Catheter at the connection to the drainage bag tubing, instead of at the catheter insertion site at the meatus and wiped downward from the direction of the catheter insertion site three (3) times to include cleansing, rinsing, and drying the Foley Catheter tubing. On 12/11/19 at 11:10 AM, an interview with CNA #1 revealed she was taught to wipe back to front on females during catheter care. CNA #1 stated the catheter should be held by the connector to the drainage tubing to prevent the catheter from being pulled out during care. An interview with Registered Nurse (RN) #3/Staff Education Nurse, on 12/11/19, at 12:00 PM, revealed RN #3 stated females should be wiped from front to back during catheter care and the catheter should be secured at the meatus to prevent pulling it out with the bulb inflated, which could cause stretching of the urethra and increased risk of infection. Review of the Perineal Care: Performance Checklist Female revealed,CNA #1 had	F 690	perineal care. Inservice provided to all Licensed Nurses and Certified Nursing Assistants with return demonstration observed by the Staffing Educator from 12/17/19 through 12/19/19. All Certified Nursing Assistants and Licensed Nurses performed satisfactory catheter care upon return demonstration observed by the Staff Educator. 4. The Staff Educator will randomly select a resident with an indwelling catheter weekly for sixty days and observe the Certified Nursing Assistant assigned to that resident for proper catheter care. After this sixty day period, annual observation of catheter care with return demonstration will be conducted with all Licensed Nurses and Certified Nursing Assistants. Any trends or patterns will be presented to the Quality Assurance Performance Improvement Committee monthly times three months, then ongoing as issues are identified for any action needed.	

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F 690	Continued From page 7 completed a performance check off with an "Acceptable" grade conducted by RN #3 on 5/7/19. The performance evaluation included female catheter care per agency policy. Review of the Medication Review Report, dated 12/11/19, revealed Resident #41 had an indwelling catheter, for wound/shin protection due to a stage 3 sacral wound, with a start date of 10/23/19. Review of the Admission Record for Resident #41 revealed the resident was admitted by the facility, on 10/22/19, with a primary diagnosis of Encounter for Orthopedic Aftercare Following Surgical Amputation, and secondary diagnoses to include but not limited to Acquired Absence of Left Leg Above Knee, Unspecified Severe Protein Calorie Malnutrition, Pressure Ulcer of Sacral Region Stage 3, and Urinary Tract Infection. Review of the Minimum Data Set (MDS) Admission Assessment with an Assessment Reference Date (ARD) of 10/29/10, revealed a Brief Interview for Mental Status Score of 99, and the Cognitive Skills for Daily Decision Making was coded a 3, which indicated severe cognitive impairment, never or rarely made decisions. The MDS also revealed Resident #41 was coded for the presence of an indwelling catheter (which included a suprapubic catheter and/or nephrostomy tube) .	F 690		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily	F 732		12/30/19

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F 732	Continued From page 8 basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview and facility policy review, the facility failed to post staffing in an easily accessible area for residents and visitors for one (1) of two (2)	F 732	1. On 12/12/19, the Administrator immediately placed the Nurse Staff Posting form in the designated location in the First floor lobby area to ensure that	

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F 732	Continued From page 9 observations. Findings include: Review of the facility's "Facility Staff Posting Information" policy, dated 10/2019, revealed the facility will post the nurse staffing total number at the beginning of each shift. The information posted will be clear, readable and in a readily accessible area to residents and visitors. On 12/12/19 at 11:32 AM an observation and review of the staff posting revealed the staffing information was located on the ledge of the 1st floor nursing station, on a clip board and was upside down. On 12/12/19 at 11:59 AM, an interview with the Assistant Director of Nursing (ADON) confirmed the staff posting was located at the nursing station, on the ledge, upside down. The ADON revealed the facility did not have it posted on the wall because this was the resident's home and she felt it would not be home like to have the staff posting on the wall. The ADON revealed visitors would not likely walk up and turn over a clip board looking for staffing information. An interview, on 12/12/19 at 12:15 PM, with the Administrator confirmed the placement of the staff posting was not easily accessible to visitors and residents, and she would move it immediately.	F 732	the information is readily accessible to residents and visitors. 2. This deficient practice effects any residents and/or visitors who may wish to review the daily staff posting information in a readily accessible area. 3. The Administrator reviewed the facility policy "Facility Staff Posting Information" dated 10/2019 and it was determined no revisions were needed. On 12/12/19, the Administrator educated the Director of Nursing, Assistant Director of Nursing, Staffing Coordinator, and Charge Nurses on the facility process for posting staffing information requirement. A facility staffing posting validation checklist will be utilized daily by the Charge Nurse to ensure compliance with this requirement. 4. The validation checklist will be reviewed by the Staffing Coordinator/Designee weekly for 90 days to ensure compliance.Any trends or patterns will be presented to the Quality Assurance Performance Improvement Committee monthly times three months, then ongoing as issues are identified for any action needed.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements.	F 812		12/30/19

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F 812	Continued From page 10 The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent 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, and facility policy review, the facility failed to discard out of date foods, provide proper sanitation during food handling, and properly clean cooking utensils as evidenced by expired food items in the refrigerator, prepping foods with contaminated gloves and the presence cookware with heavy grease buildup for two (2) of two (2) kitchen tours. Findings include: Review of the facility's "Food Storage Labeling" policy, revised 10/2019, revealed the facility will ensure the safety and quality of food by following good storage labeling procedures. Procedure 3b. revealed foods stored in storage units will be surveyed routinely to identify and discard foods that have passed its manufacturer use-by-date or expiration date.	F 812	1. On 12/11/19 at 11:30 am, One (1) five (5) pound opened Ricotta cheese container with a pinkish -orange film over the top of the cheese, expiration date 9/19 ; two (2) five (5) pound containers of Ricotta cheese with an expiration date of 11/13/19; one third of a quart of buttermilk, expiration date 12/8/19; one (1) five (5) pound container of cottage cheese, expired on 10/8/19 ; and two (2) five (5) pound containers of Pimento cheese, expired on 10-26-19 the expired foods identified were immediately removed from the refrigerator by the Dietary Manager. All food storage units were thoroughly assessed on 12/11/19 at 1:00 pm by the Dietary Manager, Registered Dietitian, and Administrator for manufacturer's use-by-date or expiration	

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F 812	Continued From page 11 Review of the facility's "Dining Service Operational Standards for Purchasing, Cooking, and Storage" policy, revised 10/2019, revealed the facility stores, prepares, distributes, and serves food under sanitary conditions to prevent the spread of food borne illness and reduce those practices that result in food contamination and comprised food safety. Procedure 6d. revealed to wash hands before handling food, after handling raw food, and after any interruption that may contaminate hands. Review of the facility's "Manual Warewashing" policy, revised 10/2019, revealed dining service pots and pans that cannot fit in a dish machine are cleaned and sanitized in the three-compartment sink. Procedure #2 revealed to rinse, scrape, and soak all items before washing. Procedure #3 revealed to use a brush, cloth, or nylon scrub pad to loosen remaining soil. An observation, of the kitchen on 12/9/19 at 11:20 AM, and a revisit on 12/11/19 at 11:15 AM, revealed the following out of date foods in the walk in refrigerator: One (1) five (5) pound opened Ricotta cheese container with a pinkish -orange film over the top of the cheese, expiration date 9/19 ; two (2) five (5) pound containers of Ricotta cheese with an expiration date of 11/13/19; one third of a quart of buttermilk, expiration date 12/8/19; one (1) five (5) pound container of cottage cheese, expired on 10/8/19 ; and two (2) five (5) pound containers of Pimento cheese, expired on 10-26-19. An interview, on 12/11/19 at 11:15 AM, with the Dietary Manager (DM), revealed it is everyone's responsibility to check dates, but ultimately it was	F 812	date and no other issues were identified. On 12/11/19, the Dietary Aide was immediately in-serviced by the Dietary Manager on proper sanitation techniques including handwashing, changing of contaminated gloves, and procedure for exiting and returning to the food preparation area. On 12/11/19 at 1:00 pm, the cookware- a large skillet, five large baking pans, and two small baking pans were removed from the kitchen immediately by the Dietary Manager. The Dietary Aides and Cooks were immediately educated by the Dietary Manager and Staff Educator on the "Manual Warewashing" policy. 2. The facility has determined that sixty nine residents have the potential to be affected by this deficient practice. 3. On 12/13/19, the Administrator, Director of Nursing, Dietary Manager, Medical Director, and Staff Educator reviewed facility policies for "Food Storage Labeling", "Dining Service Operational Standards for Purchasing, Cooking, and Storage", and "Manual Warewashing". All policies were determined to meet the requirements and no revisions were needed. On 12/17/19, all dietary staff were in-serviced by the Dietary Manager and Staff Educator and completed a return demonstration competency check off on the facilities policies and guidelines for food storage labeling; dining service operational standards regarding sanitary conditions to prevent the spread of food borne illness and reduce those practices	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255253	A. BUILDING _____ B. WING _____	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICKSBURG CONVALESCENT CENTER	1708 CHERRY STREET VICKSBURG, MS 39180

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F 812	Continued From page 12 her responsibility because she is the manager. The DM stated they need to be checking food expiration dates closer every day. She stated this could cause people to get sick. An observation, on 12/11/19 at 11:45 AM, with the Dietary Manager (DM) during the tray line prep, revealed the Dietary Aide (DA) prepping parsley in a large bowl that was to be placed on the lunch trays. The parsley was being stemmed. The DA stemmed several pieces of parsley with gloves on then moved to another table and picked up the tray cards and a box of plastic wrap taking them back to prep table and started prepping the parsley again. He then assisted with the tray line by placing the parsley and tray cards on the plates and picking up the plate covers. The dietary aide did not change gloves and wash his hands at any time during this process. An interview, on 12/11/19 at 11:50 AM, with the dietary aide (DA),. confirmed his gloves were not clean when he touched the parsley. He stated this could cause illness or infection. An interview, on 12/11/19 at 11:55 AM, with the DM, revealed the DA should have changed his gloves and washed his hands before touching the parsley. The DM confirmed the DA's gloves were contaminated by touching the plastic wrap and the tray cards .She stated the only thing the DA should have been doing was putting the parsley on the trays. The DM stated she felt he was just nervous. An observation, on 12/11/19 at 12:05 PM, revealed a large skillet sitting on the stove with an approximate two (2) inch ring of dark brownish black build-up around the inside of the top of the	F 812	that result in food contamination and compromised food safety; and manual warewashing. A tray line and sanitation checklist will be utilized by the Dietary Manager and Registered Dietitian. Daily logs to monitor the proper food storage labeling and manual warewashing will be completed by the dietary staff. 4. The Dietary Manager will complete the tray line and sanitation checklist weekly for ninety days, the Registered Dietitian will complete the tray line and sanitation checklist monthly to ensure compliance with this requirement. After completion of the ninety days, the Dietary Manager and Registered Dietitian will complete the tray line and sanitation checklist monthly and report findings to the Quality Assurance Performance Improvement Committee to address any actions as indicated.	

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	255253	A. BUILDING _____ B. WING _____	12/12/2019

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F 812	Continued From page 13 skillet and the outer sides and bottom were thickly coated with a rough black build-up. The observation also revealed five (5) large and two (2) small baking pans coated on the outside and bottom with a dark brownish build-up. An interview, on 12/11/19 with the DM, revealed the skillet and the pans should be scrubbed to remove the burned-on grease. The DM stated it is possible that some of the black buildup on the skillet could come off in the food. She also stated the build up on the skillet and pans could cause a fire during cooking.	F 812		

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	255253	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/11/2019**

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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 | 01/02/2020

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255253	A. BUILDING _____ B. WING _____	12/11/2019

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E 000	Initial Comments ********** Survey conducted on 12/11/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were cited.	E 000		

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

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