STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255156	A. BUILDING _____ B. WING _____	02/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRENADA REHABILITATION AND HEALTHCARE CENTER	1966 HILL DRIVE GRENADA, MS 38901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey from 02/17/2020 to 02/20/2020. The SA determined the facility was not in compliance with requirements of participation in Medicare and Medicaid. The SA cited the regulatory deficiencies at F584, F641, F656, F761, and F812. At the time of survey, the facility had a census of 96, and held a license for 116 beds.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are	F 584		3/29/20

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

Electronically Signed | 03/29/2020

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.

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F 584	Continued From page 1 in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility policy review the facility failed to provide housekeeping and maintenance services necessary to maintain a safe, clean, comfortable, homelike environment for three (3) of four (4) halls observed. Findings include: Review of the facility's "Daily Patient Room Cleaning" policy, revised 09/05/2017, revealed, steps to cleaning rooms included: B) Do quick straighten up; C) Follow 5-Step room cleaning method - Empty trash; Horizontal Dusting; Spot Clean; Dust Mop Floor (Use dust mop to gather all trash and debris on floor, sweep to the door; pick up with dust pan); and Damp Mop floor with germicide solution, working from back corner to door. Every room is to be cleaned, it's the resident's home - treat it as such. During environmental rounds, on 02/18/2020 at	F 584	Preparation and submission of the plan of correction by Grenada Rehabilitation and Healthcare Center, does not constitute an admission or agreement to the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. This plan of corrections prepared and submitted solely pursuant to the requirements under state and federal laws. A Hall Baseboards: MSDH, the Division Director of Licensure and Certification, on March 26, 2020, stated that in-room replacing of baseboards on the A Hall should be postponed until the National Emergency Status is lifted and that this work would need to be completed 30 days following the lifting of the National Emergency Status and Grenada Rehabilitation and Healthcare Center would not receive any penalties related to	

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F 584	Continued From page 2 11:10 AM, the following observations were made: Hall A All Resident rooms were noted to have a thick layer of dirt and debris on the floor, near the baseboards, on the baseboards, and a larger concentration of dirt and debris in the corners of the resident rooms. Some of the debris appears to be stuck in the wax on the floors. Additional areas of concern included: Room A01 - The trim around the closet door was broken and pulled away from the wall. Room A03 - There was a burn hole in the tile in the middle of the room. Room A04 - There was a large gauged area on the wall behind the bed. Room A05 - Baseboard near the restroom door was peeling away from the wall, sticking out approximately two (2) inches. Room A08 - There were cracked tiles going into the restroom, and the faucet leaked in the restroom, and wouldn't turn completely off. Room A09 - Baseboard was pulling away from the wall underneath the air conditioning unit. Room A20 - End caps were missing on the bumper near the floor exposing sharp edges on both ends. Room A22 - The baseboard across from the restroom were peeling away from the wall approximately one and one-half inches.	F 584	this completion date. 1. On March 23, 2020 the Director of Housekeeping services and the housekeeping team completed cleaning of resident rooms on A Hall including removing dirt and debris on floors near the baseboards and cleaned and removed dirt and debris in corners. On March 23, 2020, the Director of Maintenance Services repaired the trim around the closet door in Room A01. On March, 23, 2020, the Director of Maintenance Services, repaired tile in the middle of room in Room A03. On March 24, 2020, the Director of Maintenance Services, repaired the wall area behind bed in Room A04. On March 23, 2020, the Director of Maintenance Services, repaired the baseboard near the restroom door in Room A05. On March 27, 2020, the Director of Maintenance Services, repaired the tile going in to the bathroom and repaired the bathroom faucet leak in Room A08. On March 23, 2020, the Director of Maintenance Services, repaired baseboard under the Air Conditioning unit in Room A09. On March 23, 2020, the Director of Maintenance Services, replaced the end caps on the bumpers near the floor and removed sharp edges in Room A020. On March 23, 2020, the Director of Maintenance Services, replaced baseboard across from restroom in Room A022. On March 25, 2020, the Director of Maintenance Services, on A Hall outside the Service Hallway Doors, under Exit sign, the drywall above the baseboard was replaced and the Exit door was	

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F 584	Continued From page 3 Outside of the Service Hallway Doors, under the Exit sign, there was a hole in the drywall above the baseboard. The door trim around the Exit door was pulling away from the wall. Hall B Room B01 - There were no closet doors, sheets were tied over the closet opening to protect their clothes and personal belongings. Room B07 - Residents had no closet doors to cover their clothing and personal belongings. The door trim around the B Wing Shower Room was chipped away, and jagged, and the door knob was loose and coming off the outside of the door. Outside of Room B11 and B12, from the doorway to the corner, there was a two inch by approximately nine-foot hole in the drywall above the bumper panel. The tile on the floor, just inside the door to the smoking exit, was bent and peeling up. The baseboard around the Coke machine was peeling away from the wall, and the tile on the floor next to the vending machine was gone. Room B23 -The tile outside the doorway was bowed up and peeling. Hall C Room C12 - The door frame around the restroom was bent, with sharp edges. Room C14 - The frame around the restroom door was pulled away from the wall.	F 584	repaired. On March 25, 2020, the Director of Maintenance Services, repaired the trim around the Exit door on A Hall. Hall B: On February 21, 2020, the Director of Maintenance Services, installed closet doors in Room B01. On February 21, 2020, the Director of Maintenance Services, installed closet doors in Room B07. On March 27, 2020, the Director of Maintenance Services, repaired the door trim around the B Wing Shower Room, tightened door knob, and removed all sharp edges. On March 25, 2020, the Director of Maintenance Services, outside Room B11 and B12 from the doorway to the corner, repaired the drywall. On March 25, 2020, the Director of Maintenance Services, repaired the tile just inside the door at the smoking exit. On March 27, 2020, the Director of Maintenance Services, repaired the baseboard around the vending machine and the tile was installed on the floor next to the vending machine. On March 25, 2020, the Director of Maintenance Services, replaced the tile outside the doorway in Room B23. Hall C: On March 26, 2020, the Director of Maintenance Services, repaired the door frame and the sharp edges were removed in Room C12. On March 24, 2020, the Director of Maintenance Services, repaired the frame around the restroom	

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F 584	Continued From page 4 Between Room C17 and C18, in the hallway, there was a hole in the drywall above the bumper panel approximately three (3) feet in length. Room C19 - The ceiling was cracked approximately four (4) feet long inside the doorway. Room C20 - Out side the door, the end caps were missing on the bumper panel exposing sharp edges. Outside the Large Dining room, the end caps were missing on the bumper panels exposing sharp edges. On 02/18/2020 at 2:40 PM, during an interview with the Administrator and Maintenance Director, the Administrator confirmed the facility did not have a written policy on how to report building items that needed to be replaced or repaired, like floor tiles, holes in the wall and trim. The Maintenance Director revealed the staff tells the Maintenance man when they see him, or they tell someone in management, and then they let him know in Stand-Up Meeting. During an interview with the Administrator, on 02/18/2020 at 3:15 PM, regarding the concerns with the cleanliness of the residents rooms, with special focus on the dirt and debris on the floors, as well as the structural issues were addressed. The Administrator stated, "I will have to work with housekeeping and maintenance to get this stuff fixed. I'm gonna have to start making some environmental rounds I see."	F 584	door in Room C14. On March 23, 2020, the Director of Maintenance Services, in Room C17 and C18 the drywall outside the door was repaired above bumper panel. On March 27, 2020, the Director of Maintenance Services, repaired the ceiling crack in Room C19. On March 24, 2020, the Director of Maintenance Services, outside the door of Room C20, installed the end caps and removed the sharp edges. On March 24, 2020, the Director of Maintenance Services, outside the large dining room installed the end caps on the bumper panels and sharp edges were removed. 2. Residents on Hall A, Hall B, Hall C have the potential to be impacted by this deficient practice. 3. On February 20, 2020, the Housekeeping District Manager for contracted housekeeping services, conducted an in-service training on removing dirt and debris on all floors near the baseboards and cleaning and removing dirt and debris in all corners. On February 19, 2020 the Director of Housekeeping services conducted an in-service training for the housekeeping employees on removing dirt and debris on floors near the baseboards and cleaning and removing dirt and debris in corners. The In-service training was provided on February 24, 2020, by the Regional Maintenance Director provided for the Director of Maintenance and again on March 26, 2020 on the use of our	

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F 584	Continued From page 5	F 584	electronic maintenance reporting system. On February 25, 2020, the Director of Maintenance, provided training on the electronic maintenance work order reporting system to the facility employees and this training will be included for new employees in orientation. 4. Beginning the week of March 23, 2020, the Housekeeping Supervisor will conduct five (5) audits per week to ensure dirt and debris is removed from floors near the baseboards and in the corners of the rooms, for four (4) weeks, then weekly for four (4) weeks, monthly for two (2) months and quarterly thereafter. The Housekeeping Supervisor will submit a report to the Quality Assurance Performance Improvement committee for further recommendation monthly for three (3) months. The Administrator is responsible for ongoing monitoring and overall compliance. Beginning the week of March 23, 2020, the Director of Maintenance Services will conduct five (5) audits per week in regards to the maintenance repairs listed in this plan will conduct five (5) audits per week for four (4) weeks, then weekly for four 4)weeks, monthly for two (2)months and quarterly thereafter. The Director of Maintenance Service will submit a report to the Quality Assurance Performance Improvement committee for further recommendation monthly for three (3) months. The Administrator is responsible for ongoing monitoring and overall compliance. Due to National Emergency a thirty (30)	

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F 584	Continued From page 6	F 584	day extension is requested and repairs will be completed within thirty (30) days of the emergency being lifted.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility statement, the facility failed to accurately code a Minimum Data Set (MDS) related to discharge status, for one (1) of 22 MDS assessments reviewed, Resident #90. Findings include: A review of the facility's typed statement, dated 02/20/2020, revealed, the facility does not have a MDS policy. The facility follows the guidelines of the Centers for Medicare and Medicaid (CMS) Resident Assessment Instrument (RAI) Manual for accuracy and completion o the MDS process. Review of Resident #90's Discharge Return Not Anticipated MDS assessment with an Assessment Reference Date (ARD) of 01/01/2020, revealed Section A2100 (Discharge Status) was coded to reflect the resident was discharged to an Acute Hospital. Review of Resident #90's Nursing Discharge Summary, dated 01/01/2020, revealed the resident was discharged home on 01/01/2020 with home health services.	F 641	Preparation and submission of the plan of correction by Grenada Rehabilitation and Healthcare Center, does not constitute an admission or agreement to the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. This plan of corrections prepared and submitted solely pursuant to the requirements under state and federal laws. 1. On February 21, 2020 Resident #90□s Minimum Data Set (MDS) discharge assessment was corrected to reflect discharge home as discharge status of Resident #90 by the MDS nurse. 2. An Audit was conducted by the MDS Registered Nurse #1 and the MDS Registered Nurse #2 by reviewing MDS assessments for residents discharged in the last three (3) months to confirm accurate coding of section A2100 (Discharge Status); no negative findings identified. 3. On March 23, 2020 in-service training was conducted by the Regional MDS Case Mix Specialist on MDS coding	3/29/20

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F 641	Continued From page 7 During an interview, with Registered Nurse (RN) #3, on 02/20/2020 at 1:50 PM, she stated, "The family took her home." RN #3 revealed the inaccurate coding of Resident #90's MDS assessment "was just a mistake." A review of Resident #90's "Admission Record" revealed, she was admitted by the facility, on 11/13/2019, with diagnoses of Type 2 Diabetes Mellitus, Chronic Obstructive Pulmonary Disease with Acute Exacerbation, Pneumonia, Femur Fracture, and Malnutrition.	F 641	accuracy from Resident Assessment Instrument (RAI) manual for the MDS Registered Nurse #1 and the MDS Registered Nurse #2. 4. Beginning the week of March 23, 2020, the Director of Nursing will conduct three (3) audits per week for four (4)weeks to ensure MDS section A2100 is coded accurately and then monthly for three (3) months. A report will be submitted to the Quality Assurance Performance Improvement Committee monthly for three (3) months by the Director of Nursing for review and further recommendation. The Administrator is responsible for ongoing monitoring and compliance.	
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	F 656		3/29/20

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F 656	Continued From page 8 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 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 facility policy review, record review and staff interview the facility failed to implement the care plan related to a diet order for one (1) of 22 residents care plans reviewed, Resident #89. Findings include: Review of the facility's "Care Plans, Comprehensive Person-Centered" policy, dated December 2016, revealed: "A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident."	F 656	Preparation and submission of the plan of correction by Grenada Rehabilitation and Healthcare Center, does not constitute an admission or agreement to the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. This plan of corrections prepared and submitted solely pursuant to the requirements under state and federal laws. 1. On February 20, 2020, Resident #89 was assessed by the Director of Nursing (DON) and provided with a regular mechanical soft texture, no meat diet. No	

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F 656	Continued From page 9 Record review of Resident #89's care plan, initiated on 11/25/2019, revealed a focus area for a nutritional problem, with an intervention to provide, serve diet as ordered - Regular diet, Mechanical Soft Texture, Regular consistency no meats, added on 02/18/2020. During an interview and observation, on 02/20/2020 at 9:00 AM, revealed, Resident #89 did not have a breakfast tray in his room. An interview with Certified Nursing Assistant (CNA) #1, in the hallway, revealed, she stated Resident #89 did not get a tray at any meal, due to "he won't swallow." On 02/20/2020 at 9:50 AM, during an interview, the Assistant Director of Nursing (ADON) stated, "Since he (Resident #89) hasn't received a tray, his care plan has not been implemented."	F 656	injury or harm noted in assessment. On February 20, 2020, the Director of Nursing and/or Minimal Data Set (MDS) coordinator revised Resident #89□s care plan to reflect current nutritional status of regular, mechanical soft no meat diet and appropriate goal. On February 20, 2020 and February 23, 2020, the MDS coordinator was in-serviced on revising nutritional care plans to reflect current status/orders by the Director of Nursing Services. 2. An audit of nutrition related care plans was conducted by the Director of Nursing, the Assistant Director of Nursing (ADON) and the MDS RNs #1 and #2 on February 20, 20202, no discrepancies noted. 3. Beginning on February 20, 2020 and February 23, 2020, the Staff Development Coordinator (SDC) conducted the in-serviced with clinical nursing staff on revising care plans when residents have a change to reflect their current status. 4. Beginning the week of March 23, 2020, the Director of Nursing and the Assistant Director of Nursing will conduct five (5) audits per week for four (4) weeks to ensure care plans related to diet orders are revised timely, then weekly for four (4) weeks, then monthly for three (3) months. Findings will be submitted to the Quality Assurance Performance Improvement Committee for three (3) months by the Director of Nursing for review and further recommendation. The Director of Nursing is responsible for ongoing monitoring and	

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F 656	Continued From page 10	F 656	compliance.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility policy review, the facility failed to properly label opened medications and discard expired medications within the manufacturer's recommended time frame for two (2) of three (3) medication carts, and one (1) of four (4) medication storage rooms.	F 761	Preparation and submission of the plan of correction by Grenada Rehabilitation and Healthcare Center, does not constitute an admission or agreement to the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. This plan of corrections	3/29/20

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(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 761	Continued From page 11 Findings include: Review of the facility's "Storage of Medications" policy, revised April 2019, revealed: "The facility stores all drugs and biologicals in a safe, secure, and orderly manner. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed." Review of the facility's "Diabetic Care" policy, revised September 2014, revealed: "Steps in the Procedure (Insulin Injections via Syringe)...4. Check expiration date, if drawing from an opened multi-dose vial. If opening a new vial, record expiration date and time on the vial (follow manufacturer recommendations for expiration after opening)." A review of the facility's statement, dated 02/20/2020 and signed by the Director of Nursing (DON), revealed the facility does not have a policy on removal or disposal of ointments or creams that are presently past the dated shelf life expectancy. Medication Storage Room On 02/17/2020 at 1:22 PM, an observation of the storage room (located in the "white house" behind the facility), along with the Director of Nursing (DON), revealed: Four (4) tubes of barrier cream, with an expiration date of 01/03/2019 and seven (7) tubes of skin repair cream, with expiration dates of 04/2019. The DON confirmed the items were all with expired dates and should have been discarded before the expiration date. The DON revealed she was not sure who was responsible for checking the supplies and checking for expired items.	F 761	prepared and submitted solely pursuant to the requirements under state and federal laws. 1. On February 17, 2020, the Director of Nursing and the Assistant Director of Nursing disposed of four (4) tubes of expired barrier cream and seven (7) tubes of expired skin repair cream from central supply. On February 17, 2020, the Director of Nursing Services disposed of one (1) opened vial of Novolin 70/30 insulin, one (1) opened Novolog Flex Pen, and one (1) opened NovoLog FlexPen without proper labeling, two (2) opened vials of NovoLog, two (2) open vials of Humalog insulin, one (1) opened vial of Lantus that were dated outside of manufactures recommended date for use from the C Hall Nurses cart and one (1) opened vial of Lispro from A Hall Nurses cart that was dated outside of manufactures recommended date of use. 2. On February 17, 2020, the Director of Nursing and the Assistant Director of Nursing identified residents receiving supplemental insulin on C hall and one (1) resident on A Hall that received supplemental insulin. Identified residents were assessed by the Director of Nursing on February 17, 2020; no injury or negative effects were identified from receiving insulin. On February 20, 2020 the Director of Nursing and the Assistant Director of Nursing, conducted an audit of supply rooms, medication carts and treatment carts; no additional expired items identified.	

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	255156	A. BUILDING _____ B. WING _____	02/20/2020

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F 761	Continued From page 12 On 02/20/2020 at 9:07 AM, an interview with Licensed Practical Nurse (LPN) #2/Wound Nurse, revealed, she was responsible for removing any expired wound or skin supplies. LPN #2 confirmed there was no policy or procedure to check for expired supplies and discard them when necessary but they were going to implement a procedure. LPN #2 revealed using any expired creams or ointments could cause harm to the resident. Medication Cart - Hall C On 02/17/2020 at 12:45 PM, during an observation the "Long C" medication cart, revealed, one (1) opened vial of Novolin 70/30 insulin, 1 opened FlexPen and 1 opened NovoLog FlexPen, which did not indicated an open date. The observation also included 1 opened vial of Humalog insulin dated 01/07/2020; two (2) opened vials of NovoLog insulin, dated 01/11/2020; 2 opened vials of Humalog insulin, dated 01/18/2020; 1 opened vial of Lantus insulin, dated 01/17/2020; and 1 opened vial of NovoLog insulin, dated 01/18/2020, all of which were past the 28 days discard date. On 02/17/2020, at 1:00 PM, an interview with Licensed Practical Nurse (LPN) #1, revealed, the date the vial or pen was opened and the expiration date, should be written on the insulin. LPN #1 stated the insulin should be discarded after 28 days. On 02/20/2020 at 8:40 AM, during an interview with the Director of Nursing (DON), she stated the charge nurse was responsible for checking the carts Monday through Friday, and that an in-service had just been held on that issue. The DON stated the date opened and the expiration	F 761	3. On February 17, 2020 and February 23, 2020, the Director of Nursing in-serviced the Licensed Practical Nurse (LPN) #1 and the (LPN) #3 on disposing of expired medications and labeling of medications when opened and the Licensed Practical Nurse #2 on keeping inventory and disposing of creams/ointments before listed expiration date. The In-Servicing for clinical staff was completed on February 23, 2020, by the Staff Development Coordinator (SDC), in regards to labeling opened medications and discarding expired medications and barrier creams within the manufacturer□s recommended time frame. 4. Beginning the week of March 23, 2020 the Director of Nursing Services and the Assistant Director of Nursing Services will conduct five (5) audits a week for expired medications and labeling/dating of medication for four (4) weeks, then weekly for four (4) weeks, monthly for two (2) months and quarterly thereafter. Findings will be submitted to the Quality Assurance Performance Improvement Manager for review and further recommendation monthly for three (3) months by the Director of Nurses. The Director of Nurses is responsible for ongoing monitoring and overall compliance.	

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F 761	Continued From page 13 date should be written on the insulin vial or pen, and that they should be discarded per manufacturer's recommendations. Review of the manufacturer's instructions for Humalog (Insulin Lispro), dated December 2018, revealed, after Insulin Lispro vials have been opened, throw away all opened vials after 28 days of use, even if there is insulin left in the vial. Review of the package insert for Lantus (Insulin Glargine for injection), revised July 2015, revealed, "Do not use LANTUS after the expiration date stamped on the label or 28 days after you first use it." Review of the manufacturer's package insert for NovoLog insulin, revised 12/2018, revealed, after vials have been opened, throw away all opened NovoLog vials after 28 days, even if they still have insulin in them. Medication Cart - Hall A An interview and observation of the medication cart on Hall A, on 02/17/2020 at 1:55 PM, with LPN #3, revealed, a multi-use vial of Insulin Lispro, with a handwritten, opened date of 01/07/2020, on the label. LPN #3 stated the insulin should have been discarded 30 days after opening. Review of manufacturer's guidelines for Insulin Lispro, dated December 2018, revealed: "Throw away all opened vials after 28 days of use, even if there is insulin left in the vial."	F 761		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements.	F 812		3/29/20

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F 812	Continued From page 14 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 maintain a clean and sanitary environment and store food in a manner to prevent the likelihood of foodborne illnesses for one (1) of one (1) kitchen tour. Findings include: Review of the facility's "Environment" policy, revised 9/2017, revealed: "All food preparation areas, food service areas, and dining areas will be maintained in a clean and sanitary condition. Procedures: 1. The Dining Services Director will ensure that the kitchen is maintained in a clean and sanitary manner, including floors, walls, ceilings, lighting, and ventilation. 2. The Dining Service Director will ensure that all employees are knowledgeable in the proper procedures for cleaning and sanitizing of all food service	F 812	Preparation and submission of the plan of correction by Grenada Rehabilitation and Healthcare Center, does not constitute an admission or agreement to the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. This plan of corrections prepared and submitted solely pursuant to the requirements under state and federal laws. 1. On February 17, 2020 the Director of Food Services threw away two (2) bags of Cinnamon Rolls, one (1) large container of thickened sweet tea, one (1) large container of Italian Dressing , and one (1) small bag of ham pieces. On February 17, 2020, the Director of Food Services threw away one (1) bag of breaded	

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F 812	Continued From page 15 equipment and surfaces. 3. All food contact surfaces will be cleaned and sanitized after each use. 4. The Dining Services Director will ensure that a routine cleaning schedule is in place for all cooking equipment, food storage areas, and surfaces." Review of the facility's " Food Storage: Dry Goods" policy, revised 9/2017, revealed: "All dry goods will be appropriately stored in accordance with the FDA (Food and Drug Administration) Food Code." Storage areas will be neat, arranged for easy identification, and date marked as appropriate. Review of the facility's "Food Storage: Cold Foods" policy, revised 4/2018, revealed: "All Time/Temperature Control for Safety (TCS) foods, frozen and refrigerated, will be appropriately stored in accordance with guidelines of the FDA Food Code." All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination. During an observation of the kitchen, on 02/17/2020 at 11:54 AM, the following items were observed opened and undated and equipment was noted to be unclean. The following food storage areas were observed: Refrigerator - Two (2) bags of Cinnamon Rolls, a large tub of Italian Salad Dressing, a large container of thickened Sweet Tea, and a small bag of ham pieces. Freezer - One (1) large bag of breaded chicken patties and 1 large package of hotdogs.	F 812	chicken patties, and one (1) pack of hotdogs from freezer #1. On February 17, 2020 the Director of Food Services threw away; two (2) partial loaves of bread, and one (1) pack of hamburger buns from dry food storage area. On February 18, 2020, the Food Service District Manager, cleaned convention oven double doors. On February 18, 2020, the Director of Food Services, cleaned ice machine located in the kitchen. On February 18, 2020, the Director of Food Services cleaned the juice dispenser rack located kitchen. On February 18, 2020 the Director of Food Services cleaned the food and liquid off wall behind the drying racks in the dish room. On February 18, 2020, the Director of Maintenance scraped off all chipped paint off the floor and repainted the wall in the dish room by the drying racks. On February 18, 2020 the Director of Food Services, threw away ice scoop and holder and Replaced ice scoop and ice scoop holder with new scoop and holder. On February 18, 2020 the Director of Food Services, cleaned outside and inside lid of ice machine removing all food and liquid. On February 18, 2020 the Director of Food Services, cleaned portable food serving buffet table in large dining room and removed all residue from the sides, and removed water and calcium deposits 2. An audit was completed and issues identified were addressed; residents that receive meals from the dietary department have the potential to be impacted by the deficient practice.	

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F 812	Continued From page 16 Dry Food Storage - Two (2) partial loaves of bread and 1 package of hamburger buns. During an interview with the Dietary Services Manager, on 02/17/2020 at 12:15 PM, he stated, "Some of those items were used this morning, but they aren't dated like they should be. I will take care of them now." Kitchen Equipment During an observation of the oven, it was noted with a large amount of carbon build up on the door and shelves inside the oven. The convection oven, with double swing doors, had a sticky brown/orange build-up on the windows of the oven doors, and burnt food debris on the bottom of the oven inside. The ice machine, located inside the kitchen, had food debris, and liquids splashed on the side of the machine. The rack that the juice dispenser was sitting on, had dried juices dripped down the side, and dirt and food debris stuck in the sticky residue. The wall behind the drying racks, in the dishwashing room, had a large amount of food and liquid splashed and dried on the wall. There was peeling and chipping paint coming off the wall and onto the floor next to the clean equipment drying racks. During an observation, on 02/17/2020 at 1:51 PM, of the ice machine, in the Large Dining Room, the ice scoop holder, attached to the ice machine, had approximately 3 inches of standing water and food debris floating around the ice scoop. The outside of the ice machine had splatters of food and liquids that had run down the surface of the lid, and on the sides of the ice machine. The portable serving buffet, also located in the Large Dining Room, had a greasy residue along the sides of the water wells, and standing water with	F 812	3. On February 18, 2020, the Food Service District Manager, in-serviced the Director of Food Service on Proper Labeling and Dating of items in refrigerator, freezers and dry storage areas and cleaning and sanitizing equipment. On February 17, 2020 and February 23, 2020, the Director of Food Services in serviced dining service employees on Proper Labeling and Dating of items and cleaning sanitizing equipment. 4. Beginning the week of March 23, 2020, the Administrator will conduct audits in regards to proper storage, accurate labeling, and dating of perishable and non-perishable food items and proper cleaning of equipment listed in this plan, five (5) audits per week for four (4) weeks, then weekly for four (4) weeks, monthly for two (2) months and quarterly thereafter. The Administrator will submit a report to the Quality Assurance Performance Improvement committee monthly for three (3) months for further recommendations. The Administrator is responsible for ongoing monitoring and overall compliance.	

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F 812	Continued From page 17 a large amount of calcium deposits floating in the water, and along the sides of the wells. The buffet was pushed up against the wall, and dining service had ended. During an interview with the Administrator and the Dietary Service Manager on 02/18/2020 at 2:15 PM, the Dietary Services Manager stated, "There is a schedule for everything to get cleaned in the kitchen and the dining rooms. I have been so short staffed for the last couple months, we ain't been keeping up on all the logs and cleaning stuff like we should. "	F 812		

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	255156	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/19/2020**

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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 352 SS=F	Sprinkler System - Supervisory Signals CFR(s): NFPA 101 Sprinkler System - Supervisory Signals Automatic sprinkler system supervisory attachments are installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm and Signaling Code, and provide a signal that sounds and is displayed at a continuously attended location or approved remote facility when sprinkler operation is impaired. 9.7.2.1, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation and interviews, the facility failed to provide a fire sprinkler system that initiates the fire alarm system in accordance to NFPA 72 section 17.12.12. The deficient practice affected the entire facility on day of survey. Findings include: During testing on 2/19/2020 at 11:40 AM, observation revealed the initiate of the fire sprinkler system (via inspector test valve) did not activate the fire alarm system. The fire sprinkler system was incapable of activating the fire alarm system within the minimum requirement of 90 seconds. The sprinkler inspector valve test was	K 352	Preparation and submission of the plan of correction by Grenada Rehabilitation and Healthcare Center, does not constitute an admission or agreement to the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. This plan of corrections prepared and submitted solely pursuant to the requirements under state and federal laws. K 352 1. On February 21, 2020 contracted sprinkler service company was onsite and repaired the sprinkler alarm system so that the when initiation of the fire sprinkler	3/29/20

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

Electronically Signed — 03/29/2020

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.

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K 352	Continued From page 1 performed for the time duration of 125 seconds.	K 352	system was done, the fire alarm system would activate. The fire alarm system responded within 90 seconds during sprinkler tests. 2. Residents have the potential to be impacted by this deficient practice. 3. On February 21, 2020 Administrator and contracted sprinkler Service Company provided additional training to Director of Maintenance related to the sprinkler system and testing of system for proper functioning and calling to repair when needed. 4. Director of Maintenance, beginning the week of March 23, 2020, will test the sprinkler system to ensure proper functioning. The Director of Maintenance will conduct five (5) tests per week for four (4) weeks, then weekly for four (4) weeks, monthly for two (2) months and quarterly thereafter. Director of Maintenance will submit a report to the Quality Assurance Performance Improvement committee monthly for three (3) months for further recommendation. The Administrator is responsible for ongoing monitoring and overall compliance.	

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E 000	Initial Comments *EMERGENCY PREPAREDNESS* Survey conducted on 02/19/20 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

Electronically Signed | 03/29/2020

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