STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255307	A. BUILDING _____ B. WING _____	10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN AGE NURSING HOME	2901 HIGHWAY 82 EAST GREENWOOD, MS 38930

(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 Survey Agency (SA) conducted an annual recertification survey from 10/16/17 to 10/19/17. During the survey, the SA determined the facility was not in compliance with the Centers for Medicare and Medicaid Services Conditions of Participation. The SA cited deficiencies at F322, F323, and F441. The facility is licensed for 150 beds and the census at the time of survey was 127.	F 000		
F 322 SS=D	NG TREATMENT/SERVICES - RESTORE EATING SKILLS CFR(s): 483.25(g)(4)(5) (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and (5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by:	F 322		11/16/17

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

Electronically Signed | 11/10/2017

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F 322	Continued From page 1 Based on observation, staff interview, record review and facility policy review, the facility failed to administer medications through a Percutaneous Endoscopic Gastrostomy (PEG) tube separately, to ensure comparability and to help prevent clogging, for two (2) of seven (7) medication observations (Residents #15 and #16). Findings include: Review of the facility "Administration of Medication via Asiatic/Gastrostomy Tube", policy, with a revision date of 7/19/15, revealed no directions that instructed staff to administer medications separately unless the resident is on fluid restriction. The policy revealed instructions that medications can be administered in a single medication administration if medications are compatible. Review of Mosby's Pocket Guide to Nursing Skills and Procedures, Perry and Potter, eighth edition, revealed under: Oral Medications: Nasogastric Tube Administration: Crush each tablet into a fine powder. Dissolve each tablet in separate cup of 30 milliliter (ml) of warm water. (Fine powder dissolves more easily, reducing chance of occluding feeding tube). To administer more than one (1) medication, give each separately, and flush between medication with 15 to 30 ml of water. (Allows for accurate identification of medication if dose is spilled. In addition, some medications may be incompatible). Resident #15: During a medication pass observation, on 10/16/17 at 3:45 PM, Licensed Practical Nurse (LPN) #2 administered medication to Resident	F 322	F322 1. Resident #15 was assessed by Director of Nursing on 10/19/17 for adverse effects of not administering medications separately through a Gastrostomy (PEG) tube. Resident #16 was assessed by Director of Nursing on 10/19/17 for adverse effects of not administering medications separately through a Gastrostomy tube. 2. All residents receiving medications through a Gastrostomy (PEG) tube have the potential to be affected by not administering medications separately. 3. Enteral Tube Medication Administration policy was revised 11/9/17 to include administering medications separately through a gastrostomy (PEG) tube. In-service training initiated 11/9/17 by the Director of Nursing for Registered Nurses and Licensed Practical Nurses on revised Enteral Tube Medication Administration policy. Nurses will be in-serviced on policy revision prior to working. Newly hired Registered Nurses and Licensed Practical Nurses hired on or after 11/9/17 will be checked off on orientation checklist for administering crush meds separately.	

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F 322	Continued From page 2 #15. LPN #2 prepared Resident #15's medication at her medication cart in the hall outside the resident's room. LPN #2 placed the Vitamin C and Methenamine HiPP in a small bag and crushed together and placed in a five (5) ounce plastic cup and mixed with 30 cubic centimeters (cc)'s of water. LPN #2 then poured the Potassium and ProStat in separate medication cups. LPN #2 flushed the PEG with 60 cc's of water, administered the crushed medications in a cup with water, administered the Potassium, ProStat, added some water to the Prostat due to it was thick and not draining down the syringe and ended with a flush of 50 cc's of water, all via the PEG. LPN #2 crushed medications together and administered them together, did not flush with water between the crushed medications, the Potassium or the ProStat. The facility admitted Resident #15 on 10/5/07, with diagnoses which include Anxiety, Alzheimer's Disease and Gastrostomy Status. Review of the Quarterly Minimum Data Set (MDS) for Resident #15, with an Assessment Reference Date (ARD) of 9/5/17, revealed a Brief Interview of Mental Status (BIMS) score of 7, which indicated severely impaired mental status. Section K revealed Resident #15 has a feeding tube. Resident #16: An observation on 10/16/17 at 4:36 PM, revealed Licensed Practical Nurse (LPN) #4 administered medications to Resident #16 through her PEG tube. LPN #4 combined Warfarin Sodium 3 milligrams (mg), one (1) tablet, Vitamin C 500 mg, one (1) tablet, and 30 milliliters (ml) of Pro T	F 322	4. Quality Assurance Committee reviewed deficiencies and possible corrective action 10/25/17 To ensure corrective action is achieved and sustained, three (3) med pass observations will be conducted weekly for 12 weeks by Unit Manager of medication administration through a Gastrostomy (PEG). Peg Tube Medication Observation checklist will be used to monitor compliance. The audits will be presented to the Quality Assurance Committee quarterly at a minimum or as often as needed to assure continued performance. Quality Assurance Committee reviewed Plan of Correction 11/9/17	

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F 322	Continued From page 3 Gold (a protein supplement), into one (1) cup and administered them through the PEG tube. She did not administer them separately with a flush in between each medication. Record review of Resident #16's Face Sheet revealed the resident was admitted to the facility on 12/19/12, with diagnoses of Unspecified Convulsions, Type 2 Diabetes Mellitus, Aphasia, Hypertension, Gastrostomy Status, and Cerebral Infarction. Review of the annual MDS with an ARD of 9/5/17, revealed Resident #16 had a BIMS score of zero (0), indicating severely impaired cognitive skills for daily decision making. During an interview, on 10/18/17 at 3:00 PM, the Director of Nursing (DON) confirmed medications through a PEG should be given separately and flushed with water between each one, with the exception if a resident had fluid restrictions. The DON confirmed Resident #15 and #16 did not have an order for fluid restriction. The DON revealed she thought that having an order that allowed medications to be mixed would be enough to allow them to be administered together. An interview with the Pharmacy Consultant on 10/18/17, at 11:09 AM, revealed that he was aware of the regulation requiring all PEG medications to be administered separately and that he felt this was a gray area. He stated that his understanding was that it was suggested, not required, while in the gray area before the new regulations were released. He stated that it is also his understanding that as long as the Facility Policy covered the administration of the	F 322		

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F 322	Continued From page 4 medications together, it would be acceptable. When asked if he had reviewed all residents with PEG tube medications to ensure the medications were compatible, he stated "No", that he does a general review monthly.	F 322		
F 323 SS=E	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3) (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, Staff interview and facility policy review the facility failed to store hazardous	F 323	F 323	11/16/17

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F 323	Continued From page 5 chemicals in a manner to prevent the potential injury to residents as evidenced by two (2) of Five (5) chemical storage areas unlocked and two (2) of three (3) housekeeping carts unlocked. Findings include: Review of facility's "Hazardous Chemical Storage Policy", dated 04/15, revealed hazardous chemicals shall be maintained in a safe, clean and locked location when not in use. Hazardous chemicals will be maintained in a locked storage area at all times. Hazardous chemicals in use shall remain under direct control by facility personnel while in common traffic areas. Hazardous materials placed on "cleaning carts" shall be locked in the provided container after each use or not when in direct use by facility personnel. Observation on 10/16/16 at 11:40 AM, revealed an unlocked Housekeeping Supply closet. This closet door had a napkin stuffed into the door jamb to prevent it from locking. The unlocked closet contained one (1) 33.8 ounce bag of lotion soap (for a dispenser) and one (1) can of enforcer insect spray. The supply closet was in close proximity of the nurse's station, where it was in direct view of the staff at the station. There were no residents observed wandering in the area or attempting to get into the supply closet. Review of the Safety Data Sheet for the "Purge III metered flying insect killer" (date 6/2/15) revealed this product is harmful if swallowed or if absorbed through the skin. During an interview on 10/16/17 at 11:40 AM, Housekeeping Staff #1 revealed she did not know	F 323	1. Housekeeping supply closet door lock on green wing was replaced 10/16/17. No resident was affected. Blue wing storage room was locked and sign placed on door to keep door locked at all times by pushing the L (Lock) button. The Huskey SV Disinfectant was removed until an auto lock could be secured and installed. No Resident was affected. Housekeeper #5 received 1:1 in-service education on 10/16/17 by the Housekeeping Supervisor on Locking of Housekeeping carts and no personal items on cart. No Resident was affected. Housekeeping #2 received 1:1 in-service education on 10/16/17 by the Housekeeping Supervisor on Locking of Housekeeping cart. No Resident was affected. 2. All residents have the potential to be affected by hazardous chemicals not stored in a manner to prevent injury. All housekeeping supply closet locks were checked for proper functioning 10/16/17. Key pad auto lock was installed on blue storage room door 11/3/17. 3. In-service training for all Housekeeping staff initiated on 10/16/17 by Administrator on storage of chemicals under lock,	

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F 323	Continued From page 6 how the napkin got lodged in the doorjamb, she did not work the weekend. She stated that the lock was working on her last shift. During an interview on 10/16/17 at 11:40 AM, Registered Nurse (RN) #2 revealed she did not know if the door was unlocked to the Housekeeping supply closet because she never goes in or out of that door. She had not seen residents attempt to go in or out the closet. During an interview on 10/16/17 at 4:00 PM, RN #1 revealed she had worked the previous Saturday and Sunday shift from 8:00 AM to 7:00 PM as Supervisor. She recalled the "Green Hall" Housekeeping closet lock was working fine because she saw Housekeeping staff using the key pad to unlock the door. RN #1 revealed the Housekeeping closet door is supposed to be locked at all times for the protection of the Residents. During an interview on 10/19/17 at 09:30 AM, Maintenance Staff #4 revealed he was notified that morning (10/16/17) the Housekeeping door on Green Hall was broken and would not open with key pad once it was shut. He revealed his department is notified about repair needs that are filled out per staff and he did not receive a work order on this door. On 10/16/17 at 11:50 AM, an observation on the Blue Hall, revealed a housekeeping cart was unlocked, the door open, and keys in the door. Housekeeper #5 was observed walking toward the housekeeping cart on the Blue Hall. On 10/16/17 at 11:50 AM, an interview with Housekeeper #5 revealed, "I just did it, this is the	F 323	reporting any malfunction equipment, and no food/personal items on cart. Inservice initiated for all staff 11/1/17 by Administrator on review of Hazard Chemical Storage Policy and reporting equipment issues. 4. Quality Assurance Committee reviewed deficiencies and possible corrective action 10/25/17 To monitor for compliance, the Administrator or designee will complete daily random checks of three (3) Housekeeping Carts Monday through□ Friday for 4 weeks then three (3) carts a week Monday through Friday for 2 weeks. The audits will be presented to the Quality Assurance Committee quarterly at a minimum or as often as needed to assure continued performance. Storage closets with chemicals have auto locks. To monitor for proper functioning, door checks will be performed daily by patrol staff. Door Checks form will be used to monitor for proper functioning. The Quality Assurance Committee reviewed Plan of Correction 11/9/17.	

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F 323	Continued From page 7 first time". Housekeeper #5 revealed that she had been employed for six (6) months and "was in-serviced when she started to work about keeping the cart locked. Housekeeper #5 confirmed contents of the cart and revealed that "The purse and water is mine." Observation of the housekeeping cart on Blue Hall, with Housekeeper #5 on 10/16/17 at 11:50 AM, revealed the cart contained the following items and the hazardous information: 1. Sani-wipes (blue lid): hazard precautions causes serious eye irritation 2. Comet Liquid 32 ounces: hazard precautions causes eye irritation 3. Glass cleanser one (1) quart spray: hazardous precautions extremely flammable, may cause skin and eye irritation, may cause respiratory irritation in inhaled 4. Lysol surface disinfectant aerosol 17 ounces: hazardous precautions flammable, may cause eye and respiratory tract irritation 5. Pexory II bath and surface cleaner 32 ounces: hazardous precautions causes skin and serious eye irritation 6. A purse (handbag) 7. Smart Water 2 ounce bottle On 10/17/17 at 10:55 AM, an interview with Housekeeper #3 (Supervisor) revealed, "We in-serviced last week about not putting food, drinks or personal items in the cart. The keys are never to be left in the cart. If the lock is broken they are to tell me and we will replace it. (Name of Housekeeper#5) on the Blue Hall is new but she should have known better." On 10/17/17 at 11:10 AM, an interview with the	F 323		

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F 323	Continued From page 8 facility Administrator revealed, "They (housekeeping) know they are not supposed to have personal items in the carts. The carts are to be locked at all times, no keys in the door. We have had in-services from time to time to cover this." On 10/16/17 at 11:55 AM, a tour of Blue Hall revealed a storage room's door was unlocked and was opened by pushing on the door. Immediately to the right, after entering the door, was a cardboard box that was closed, but not sealed, and contained four (4), one (1) gallon, containers of "Huskey SV Disinfectant". The storage room is on the Blue hall which was currently being remodeled and all the rooms were empty except for two (2) rooms. The resident in room 78 has a BIMS score of 9, could not ambulate and required assistance to be pushed in a wheelchair. The resident in room 97 had a BIMS score of 15, and required limited assistance of one (1) person with ambulation. Record Review of the Safety Data Sheet on "Huskey 800 Neutral Disinfectant Cleaner" revealed may cause skin irritation, serious eye damage and harmful if swallowed. On 10/16/17 at 11:55 AM, an interview with Registered Nurse (RN) #3 revealed she did not know how long the storage room door had been unlocked on Blue Hall. There is a keypad to unlock the door and a button had to be pushed when leaving the room to lock the door. RN #3 revealed she did not make rounds to check locked doors and was not sure who did and the last person that entered the room must not have locked the door properly. RN #3 revealed she had never seen any resident's entering the storage room.	F 323		

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F 323	Continued From page 9 On 10/16/17 at 12:05 PM, an interview with Certified Nursing Assistant (CNA) #1 revealed the storage room door should always be locked and sometimes she finds it locked and sometimes it is not locked. Observation on 10/16/17 at 12:25 PM, revealed an unattended housekeeping cart sitting in the doorway of Room 107 on the Yellow hall with the keys in the door where chemicals were stored. No Residents were in Room 107 at the time of this observation. Housekeeper #2 was seen walking from the end of the Yellow hall towards her cart. Supplies on the cart included: 1. Peroxy II spray, 2. Comet 3. Chlorox wipes, 4. Glass cleaner, 5. Lysol Disinfectant Cleaner 6. Odo-Ban Spray. In an interview, on 10/16/17 at 12:27 PM, Housekeeper #2 confirmed she had left her keys in the cart. She stated she normally locked the cart and put the key in her pocket but she just forgot. Housekeeper #2 stated she had walked to the end of the hall to turn the fan off and was coming right back. Housekeeper #2 confirmed that someone could have gotten supplies off her cart while she was away. There were no residents observed wandering around the hall or near the housekeeping cart. On 10/16/17 at 12:30 PM, an interview with the facility Administrator revealed the facility had an in-service two (2) months prior on Hazard Communication and the facility's MSDS (Material Safety Data Sheets).	F 323		

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F 323	Continued From page 10 On 10/16/17 at 12:54 PM, an interview with the Administrator revealed there had not been any incidents with a resident involving any chemicals or any supplies that should be locked up.	F 323		
F 441 SS=D	INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.80(a)(1)(2)(4)(e)(f) (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: (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 (facility assessment implementation is Phase 2); (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;	F 441		11/16/17

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F 441	Continued From page 11 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility policy review and record review, the facility failed to ensure that medications were handled in a manner to prevent the possible spread of	F 441	F441 1. LPN #3 was given 1:1 in service	

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F 441	Continued From page 12 infection for one (1) of seven (7) medication passes observed, Unsampled Resident A. Findings include: Review of facility's"Specific Medication Administration Procedures, IIB1: Administration Procedures for All Medications Policy", not dated, revealed: To administer medications in a safe and effective manner - G. Use a barrier (e.g., clean disposable tray or plastic cup) to carry medication containers into the resident's room. An observation on 10/17/17, at 9:00 AM, revealed Licensed Practical Nurse (LPN) #3 placed Symbicort and ProAir inhalers into her pocket and transported them into Unsampled Resident A's room. After the medications were administered to the resident, LPN #3 placed the inhalers back into the medication cart without cleaning them. During a staff interview with LPN #3 on 10/19/17 at 8:50 AM, she stated "I put them in my pocket. They were in the box". She also stated that she realized that the pocket is a dirty area and it is an infection control issue. A staff interview with LPN #4, Staff Coordinator, on 10/19/17 at 9:00 AM, revealed the resident could get an infection because of putting inhalers into a pocket, because the pocket is not germ free. She stated that going from the pocket to putting the inhalers into the resident's mouth, with the resident already coughing, could cause more coughing. She confirmed that it would cause cross contamination of the medication cart when the inhalers were placed back into the cart, after they had been in a pocket.	F 441	education on a personnel file note form on 11/9/17 by Director of Nursing on transporting medications in and out of resident's room. Unsampled Resident A was assessed by the Director of Nursing on 10/19/17 for adverse effects of improper handling of medication 2. All residents receiving medications have the potential to be affected by not handling medication properly during transport into a resident□s room. 3. In-service initiated by Director of Nursing for Registered Nurses and Licensed Practical Nurses on 11/9/17 on review of Oral Inhalation Policy and Proper handling of Medications. 4. Quality Assurance Committee reviewed deficiencies and possible corrective action 10/25/17. To monitor for compliance, three (3) medication pass audits will be conducted weekly for 12 weeks by Unit Manager to include observation of transport of medications and handling of medications. Med Pass Observation Audit form will be used to monitor compliance. Observation audits will be reviewed by the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255307	A. BUILDING _____ B. WING _____	10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN AGE NURSING HOME	2901 HIGHWAY 82 EAST GREENWOOD, MS 38930

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F 441	Continued From page 13 Review of the Face Sheet, for Unsampled Resident #A, revealed the facility admitted the resident 11/15/13, with diagnoses of Chronic Obstructive Pulmonary Disease and Type 2 Diabetes Mellitus. Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/22/17, revealed a Brief Interview for Mental Status score of 14, indicating no cognitive impairment. A review of an, "In-service Education Report", dated 7/31/17, presented by the Director of Nursing (DON), entitled, "Infection Prevention - Things we can do as a health care provider to prevent and control the extent of infections: - Properly handle medications, treatment supplies, food items, linen, and medical equipment to decrease risk of contamination", revealed that LPN #3 attended the in-service.	F 441	Quality Assurance Committee quarterly or as often as needed to assure continued performance. Quality Assurance Committee reviewed Plan of Correction 11/9/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255307	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/19/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN AGE NURSING HOME	**2901 HIGHWAY 82 EAST** **GREENWOOD, MS 38930**

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K 000	INITIAL COMMENTS 42 CFR 438.70(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

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.