STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255292	A. BUILDING _____ B. WING _____	09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY MANOR NURSING AND REHABILITATION	1935 NORTH THEOBOLD EXTENSION GREENVILLE, MS 38704

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey at the facility from 9/17/18 to 9/20/18. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements for participation. The SA cited the regulatory deficiencies F552, F641, F656, F657, F684, F689, F695, F812, F813, and F880. The census at the time of the survey was 48, and the facility was certified for 60 beds.	F 000		
F 552 SS=D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and	F 552	F552	10/20/18

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

Electronically Signed | 10/19/2018

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F 552	Continued From page 1 facility policy review, the facility failed to provide informed consent forms to the resident or resident representative for psychotropic use for two (15, 24) out of five residents reviewed for unnecessary medications; Residents #15 and #24. Specifically, the facility failed to ensure the resident or resident representative was informed of the risks and benefits of psychotropic medications provided to the resident. Findings: Resident #15 Review of the face sheet for Resident #15 revealed diagnoses including bipolar disorder, dementia, borderline personality disorder and dementia. The resident was admitted on 03/27/17. The resident's responsible party is: self. Review of the quarterly minimum data set (MDS) assessment, dated 06/15/18, revealed the resident had severe cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 3 of 15. Review of the care plan, dated 02/14/18, revealed potential for injury related to antianxiety medications. Interventions included: resident is prescribed Klonopin (a benzodiazepine used to treat panic attacks). Review of the care plan, dated 03/28/17, revealed potential for altered mood state related to depression. Interventions included: resident is prescribed Duloxetine HCL (an antidepressant). Review of the care plan, dated 03/28/17, revealed potential for altered mood state related to psychotropic disorder. Interventions included:	F 552	*Resident#15 and resident representative for resident #15 were informed of risks and benefits of psychotrophic medications prescribed on 10-17-18 by the Assessment Nurse. Resident #24 and resident representative for resident #24 were informed of risk and benefits of psychotrophic medications prescribed on 10-17-18 by the Nurse Case Manager. *25 of 49 residents were identified by the Director of Nursing to have the potential to be affected by the deficient practice. 25 of 49 residents and resident representatives were notified of risks and benefits associated with prescribed psychotrophic medications by the Treatment Nurse, Assessment Nurse, and/or Nurse Case Manager on 10-17-18 *An in-service was started on 10-10-2018 by the Director of Nursing on the policy/procedure on "Physician Orders" revised 9/18 to include notifications of residents with 5 of 8 Licensed Practical Nurses and 3 of 3 Registered Nurses and inservicing will continue with the other Licensed Practical Nurses until all inserviced by 10/20/2018. The Quality Assurance Committee reviewed the policy on "Physician Orders" with revision date of 9/18 on 10-16-18 and did not recommend any changes. *Notification of residents and resident representatives of risks and benefits of new psychotrophic medications will be monitored by the Director of Nursing, Staff Development/Treatment Nurse, Medical Records Nurse, Assessment Nurse, and/or Nurse Case Manager to ensure	

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F 552	Continued From page 2 resident is prescribed Seroquel (an antipsychotic). Review of the physician orders for September 2018 revealed: -02/14/18: Seroquel 100 milligram (mg) tablet-Give 1-½ tablet (150mg) by mouth at bedtime. -02/14/18: Klonopin 1mg tablet. Give 1 tablet by mouth at bedtime. Physician progress notes were reviewed from 11/06/17 and void of any documentation related to medication discussion attempts with the resident or resident representative. The director of nurses (DON) was interviewed on 09/20/18 at 10:11 AM. She stated they called the family for the start of medications and reviewed the risk and benefits at that time but there was no documentation. There was no tracking. They would also review the medication at the care conferences. At 12:16 PM, she stated there were no care conferences documented from January 2018 for resident #15. Resident #24 Review of the face sheet for Resident #24 revealed diagnoses including dementia. The resident was readmitted on 08/26/15. The resident's responsible party is: sister. Review of the care plan, dated 03/29/17, revealed potential for altered mood state related to psychotic disorder. Interventions included: Involve family as needed. Resident is on Klonopin. Review of the care plan review date: 07/17/18 quarterly. Indications for usage, side effects, potential adverse potential adverse reactions and non-pharmalogical interventions of resident's	F 552	compliance with facility policy/procedure related to documentation of notification of resident and resident representative of risks and benefits of new psychotrophic medications weekly for four weeks and monthly for two months and findings recorded on the medical record audit form and maintained by the Director of Nursing. The Quality Assurance Committee will evaluate the monitoring completed by the Director of Nursing, Medical Records Nurse, Staff Development/Treatment NUrse, Assessment Nurse, and/or Nurse Case Manager monthly for three months. * The corrective action will be completed 10/20/2018.	

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F 552	Continued From page 3 medications have been reviewed and discussed-"NO." (No other care conferences documented in the resident's chart.) Review of the physician orders for September 2018 revealed: -07/02/18: Klonopin 0.5mg tablet; give 1 tab (0.5mg) by mouth every morning, 1 tab (0.5mg) by mouth every night. Physician progress notes were reviewed from 05/05/18 and void of any documentation related to medication discussion attempts with the resident or resident representative. The director of nurses (DON) was interviewed on 09/20/18 at 10:11 AM. She stated there was no documentation the resident or resident representatives were informed of the risk/benefits of psychotropic medications. There was no tracking. Review of the Charting- Guidelines for "Follow Through Charting" policy, revised 11/17, revealed New medication ...Notify family of change of condition requiring new pharmacologic intervention; Counsel resident and/or representative on new therapy and document.	F 552		
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 observation, staff interview, record review, and facility policy review, the facility failed	F 641	F 641	10/20/18

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F 641	Continued From page 4 to accurately code Resident #19's Minimum Data Set (MDS) to include the Auto-PAP (Automatic Positive Airway Pressure) machine for one (1) of three (3) Auto-PAP machines reviewed. Findings include: A review of the facility's policy titled, "Resident Assessment", with a revision date of 05/11, revealed the completed assessment guides the staff in identifying key information about the resident and serves as a basis for identifying resident specific issues and objectives in order to develop a care plan. This process assists the resident in reaching the highest practicable physical and psychosocial well-being. Any healthcare professional that completes a portion of the assessment must sign and certify the accuracy of the portion of the assessment that they have completed. Review of Resident #19's Annual MDS, with Assessment Reference Date (ARD) of 07/02/18, revealed the Special Treatments, Procedures, and Programs Sections O0100G1 and 2 was unchecked for the use of a BiPAP (Bilevel Positive Airway Pressure or a CPAP (Continuous Positive Airway Pressure) machine. An observation, on 09/17/18 at 7:15 PM, revealed Resident #19 had an Auto-PAP machine at the bedside. An observation, on 09/20/18 at 8:10 AM, revealed the Auto-PAP machine was still present in Resident #19's room. Record review of Resident #19's September 2018 Physician's Orders revealed orders, dated	F 641	*Resident#19 Minimum Data Set was modified by the Assessment Nurse to include the auto-pap on 9/20/18. * 3 of 49 residents were identified by the Director of Nursing to have the potential to be affected by the deficient practice. 2 of 49 had their minimum data sets reviewed by the Assessment Nurse and Nurse Case Manager on 10/17/18 to ensure coding of bipap/cpap as ordered and neither needed a modification of their minimum data set for their bipap/cpap. * An in-service was started on 9/21/18 by the Director of Nursing on the policy/procedure on "Resident Assessments" revised 11/17 to include bipap/cpap/auto-pap in use with 1 of 1 Assessment Nurses and 1 of 1 Nurse Case Managers. The Quality Assurance Committee reviewed the policy on "Resident Assessment" with revision date of 11/17 on 10-16-18 and did not recommend any changes. *Correct coding of bipap.cpap/auto-paps on the resident minimum data set will be monitored by the Director of Nursing, Medical Records Nurse, and/or Administrator to ensure compliance with facility policy/procedure related to coding of bipap/cpap/auto-paps on the resident minimum data set weekly for four weeks and monthly for two months and findings recorded on the transmission meeting form maintained by the Director of Nursing. The Quality Assurance Committee will evaluate the monitoring completed by the Director of Nursing, Medical Records Nurse, and/or Administrator monthly for three months.	

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F 641	Continued From page 5 08/16/16, for the Auto-PAP every HS (Hour of Sleep) and as needed. Pressure 7/11, FIO2(Fraction of Inspired Oxygen) 40% (4L of O2) four liters of oxygen with a full face mask. On 9/20/18 at 10:45 AM, an interview with Registered Nurse (RN) #1/Minimum Data Set (MDS) Nurse, revealed it was an "over-site" (referring to the most recent comprehensive MDS assessment not being coded in section O100G for the Auto-PAP). RN #1 stated the MDS assessment was inaccurate, and she needed to get someone to open this MDS assessment for her to correct it. On 9/20/18 at 10:50 AM, an interview with the Director of Nurses (DON), revealed the most recent comprehensive MDS assessment should have been coded for the Auto-PAP, because that is part of his plan of care. She also stated that makes the MDS assessment inaccurate. A review of the facility's Face Sheet revealed, Resident #19 was admitted by the facility on 12/23/18, with the included diagnosis of Sleep Apnea.	F 641	* The corrective action will be completed 10/20/2018	
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	F 656		10/20/18

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F 656	Continued From page 6 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 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 observation, staff interview, record review, and facility policy review, the facility failed to develop a Comprehensive Care Plan for Resident #19's use of an Auto-PAP (Automatic Positive Airway Pressure) machine, and for Resident #29's smoking with supervision. This	F 656	F 656 *Resident #19 care plan was updated to reflect the storage and care for the auto-pap on 10/17/18 by the Assessment Nurse. Resident #29 care plan was	

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F 656	Continued From page 7 concern was identified for two (2) of 17 care plans reviewed. Findings include: Review of the facility's policy titled, "Care Plan Process", with the latest revision date of 08/17, revealed the Care Plan must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The care plan must be reviewed and revised periodically, on an ongoing basis to reflect the services provided or arranged, and must be consistent with each resident's written plan of care. The facility shall use the results of the assessments to develop, review, and revise the resident's comprehensive plan of care. The facility staff shall follow the care plan. A care plan that is based on a thorough assessment, effective clinical decision making, and is compatible with current standards of clinical practice can provide a strong basis for optimal approaches to quality of care and quality of life needs of individual residents. Resident #19 Review of Resident #19's Care Plan revealed the Problem/Need, dated 10/05/12, for (Name of Resident) requires oxygen therapy. Resident has Sleep Apnea and hx (History) of respiratory complications. The Approaches included: Auto-PAP every HS (Hour of Sleep) and as needed. Pressure 7/11, FIO2(Fraction of Inspired Oxygen) 40% (4L of O2) four liters of oxygen with a full face mask. The Approaches did not address the storage and care for the Auto PAP	F 656	implemented to reflect smoking with supervision on 9/20/18 by the Assessment Nurse. *12 of 49 residents were identified by the Director of Nursing to have the potential to be affected by this deficient practice. 3 of 49 residents had their care plans reviewed to ensure care and storage of bipaps/cpaps were included in interventions by the Assessment Nurse on 10/17/18 and 9 of 49 residents had their care plans reviewed to ensure smoking care plans were present by the Assessment Nurse on 9/20/18. *An in-service was conducted on 10/10/18 by the Director of Nursing on the policy/procedure on "Care Plan Process" revised 8/17 to include implementing care plans for smokers and updating care plans with care and storage of cpaps/bipaps with 5 of 8 Licensed Practical Nurses and 3 of 3 Registered Nurses and will continue until all Licensed Practical Nurses have been inserviced by 10/20/18. The Quality Assurance Committee reviewed the policy on "Care Plan Process" with revision date of 8/17 on 10/16/18 and did not recommend any changes. * Care plans will be monitored by the Director of Nursing, Medical Records, and/or Nurse Case Manager to ensure compliance with facility policy/procedure related to implementing care plans for smokers and updating care plans for care and storage of cpap/bipaps weekly for four weeks and monthly for two months and findings recorded on the medical record audit form and maintained by the	

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F 656	Continued From page 8 machine/mask. An observation, on 09/17/18 at 7:15 PM, revealed Resident #19 had an Automatic Positive Airway Pressure (Auto-PAP) machine at the bedside, with the face mask un-bagged, and lying on his bedside table. An observation, on 9/20/18 at 8:10 AM, revealed the Resident #19's Auto-PAP face mask was still un-bagged, and on his over-bed table. Record review of Resident #19's September 2018 Physician's Orders revealed orders, dated 08/16/16, for the Auto-PAP every HS (Hour of Sleep) and as needed. Pressure 7/11, FIO2(Fraction of Inspired Oxygen) 40% (4L of O2) four liters of oxygen with a full face mask. Review of Resident #29's September 2018 Electronic Medication Administration Record (EMAR) revealed, Auto-PAP headgear: Wash headgear weekly on Saturday by hand with warm soapy water, rinse, and let air dry. Auto-PAP machine: Wipe with soft damp cloth weekly on Saturday. Auto-PAP Humidifier: Clean chamber weekly on Saturday with white vinegar to prevent mold growth, be sure to rinse thoroughly with distilled or sterile water before using the humidifier. Change O2 water bottle on oxygen concentrator monthly. Change oxygen tubing weekly. The EMAR did not address the storage of the mask. An interview, on 09/19/18 at 12:00 PM, with RN#1/Minimum Data Set (MDS) Nurse, revealed she expected the staff to look at the care plan, and update it if changes come about, and to follow the care plan.	F 656	Director of Nursing. The Quality Assurance Committee will evaluate the monitoring completed by the Director of Nursing, Medical Records Nurse, and/or Nurse Case Manager monthly for three months. *The corrective action will be completed by 10/20/2018.	

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F 656	Continued From page 9 A review of the facility's Face Sheet revealed, Resident #19 was admitted by the facility on 12/23/08, and was readmitted on 10/05/12, with the included diagnosis of Sleep Apnea. Resident #29 An interview, on 09/19/18 at 11:35 AM, with the Director of Nursing (DON) revealed a care plan should be initiated with any order change. The DON confirmed Resident #29 did not have a care plan for smoking. The DON stated she should have written an initial care plan for smoking for Resident #29, and she didn't know why she didn't write it. An interview with the Director of Nurses (DON), on 09/19/18 at 11:30 AM, revealed she wrote the Physician's Order, on 08/15/18, for Resident #29 to smoke with supervision at designated smoking breaks. The DON stated a smoking assessment should be done by the nurse who writes the order, and she did not do a smoking assessment for Resident #19. The DON said she guessed she forgot to do it. Review of Resident #29's Telephone Orders Physician Verbal Orders revealed an order, dated 08/15/18, for the resident to be supervised at designated smoking breaks. Further review of the order revealed the DON's signature, dated 08/15/18 at 4:00 PM, as the nurse receiving the order. Review of Resident #29's Smoking Assessment, dated 09/19/18, revealed Resident #29 was oriented to person, place, and time, and remains alert during the smoking process. The Smoking	F 656		

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F 656	Continued From page 10 Assessment's Interventions included: Staff issues cigarettes. Requires monitoring while smoking. The Intervention for requires a smoking apron was not checked. An interview, on 09/19/18 at 9:55 AM, with Resident #29 revealed he goes out to smoke at the designated smoke breaks, and he does not use an apron while he smokes. Resident #29 stated if he was that "screwed up", and needed an apron he would not be smoking. Resident #29 confirmed smoking breaks are staff supervised, and residents have an enclosed patio for smoking. Observations by this surveyor each day of the survey revealed the presence of facility staff supervision during designated smoke times. On 09/19/18 at 11:01 AM, an interview with Registered Nurse (RN) #1/Minimum Data Set (MDS) Nurse confirmed the order written, on 08/15/18, related to Resident #29's smoking. RN #1 stated she was responsible for doing the care plan with Resident #29's next MDS assessment, which is due in October. RN #1 stated the nurse who wrote the order was responsible for initiating the care plan. On 09/20/18 at 11:48 AM, an interview with the Activity Director (AD) revealed she did not know for sure if Resident #29 was supposed to use an apron, and if he did it should be documented in the resident's care plan. The AD stated she takes residents out to smoke, and the residents who use a smoking apron have their name on them. The AD reported she knew which residents who needed to wear the apron through verbal	F 656		

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F 656	Continued From page 11 communication with staff and residents.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, record review, and facility policy review, the facility failed to ensure the resident, or the resident representative participated in the care planning process for one (1) of 17 care plans	F 657	F 657 *Resident #1 had a care plan conference with the interdisciplinary team and resident representative was invited and	10/20/18

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F 657	Continued From page 12 reviewed; Resident #1. Specifically, the facility failed to ensure the resident and/or resident representative participated in residents care plan. Findings: Review of the face sheet for Resident #1 revealed diagnoses including difficulty in walking, chronic obstructive pulmonary disease, functional quadriplegia, dementia and depression. The resident was re-admitted on 02/19/18. Review of the quarterly minimum data set (MDS) assessment, dated 05/18/18, revealed the resident had intact cognition with a Brief Interview for Mental Status (BIMS) score of 15 of 15. The Care Plan Review, dated 08/23/18, revealed resident care conference. The nurse manager and the social services director attended. -Resident invited: Yes -Resident attended: No -Resident representative invited: blank -Resident representative attended: blank -Care plan reviewed with resident representative: No -Care plan reviewed with resident: No Resident #1 was interviewed on 09/17/18 at 7:45 PM. She stated she had never been to a care conference. Social Services Director (SSD) was interviewed on 09/19/18 at 12:04 PM. She stated she was new to the SSD position. She stated a care conference should be completed within three days of admission.	F 657	care plan was reviewed with resident representative via telephone on 10/17/18 and care plan was reviewed with resident in room on 10/18/18 *23 of 49 residents were identified by the Director of Nursing to have the potential to be affected by this deficient practice. 23 of 49 residents had their care plan conference scheduled with both the resident and resident representative invited to attend by the Social Services Director and all completed by 10/20/18. *An inservice was conducted on 9/21/18 by the Director of Nursing on the policy/procedure on "Care Plan Process" revised 5/11 to include completion of care plan reviews with residents and resident representatives and documenting on care plan review form with 2 of 9 members of the interdisciplinary team and will continue until all members of the interdisciplinary team are inserviced. The Quality Assurance Committee reviewed the policy on "Care Plan Process" with revision date of 8/17 on 10/16/18 and did not note any changes. *Care plans review forms will be monitored by the Director of Nursing, Medical Records, and/or Nurse Case Manager to ensure compliance with facility policy/procedure related to completion of care plan reviews to include the resident and resident representative in the care plan review form weekly for four weeks and monthly for two months and findings recorded on the medical audit form maintained by the Director of Nursing. The Quality Assurance Committee will evaluate the monitoring	

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F 657	Continued From page 13 The MDS coordinator registered nurse (RN) #1 was interviewed on 09/19/18 at 12:08 PM. She stated the first conference was completed within 14 days. A group of staff got together for the conference. At 2:26 PM, she stated the care conference was when they would give a copy of the care plan to the resident. This resident should have had a conference in February, May and August. They could not find any further documentation of care conferences occurring for this resident or representative. Resident #1 was interviewed again on 09/19/18 at 3:34 PM. She stated she had not been involved in the care conferences since she was admitted. The director of nurses (DON) was interviewed on 09/20/18 at 9:11 AM. She said this resident's daughter went to the care conference. The resident always declined. At 11:28 AM, she was unable to find any documentation of a care conference taking place at any time other than August. There was no documentation of care conference discussions with the family or resident. Review of the Care Plan Process, revised on 08/17, revealed a well developed and executed assessment and care plan reflects the resident/resident representative input and goals for health care ...communicate with the resident or his/her family or representative regarding the resident, care plans, and their wishes.	F 657	completed by the Director of Nursing, Medical Records Nurse, and/or Nurse Case Manager monthly for three months. *The corrective action will be completed 10/20/2018.	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that	F 684		10/20/18

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F 684	Continued From page 14 applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to provide needed care and services; professional standards of practice for blood sugar control for one (15) of two residents reviewed for insulin/blood sugar management; Resident #15. Specifically, the facility failed to ensure the physician was notified of a blood sugar level greater than 200; according to the physician order. Findings: Review of the face sheet for Resident #15 revealed diagnoses type 2 diabetes mellitus without complications and type 2 diabetes mellitus with foot ulcer. Resident #15 was admitted on 03/17/17. Review of the care plan, dated 03/28/17, revealed diagnosis of diabetes mellitus (DM). Interventions included blood glucose finger stick (BGFS) four times a day. If blood sugar is greater than 200, notify medical doctor (MD). Review of the physician orders for September 2018 revealed: -06/13/17: BGFS four times a day. If blood sugar is greater than 200 notify MD.	F 684	F 684 *Resident #15 physician and resident representative were notified of blood sugar levels that required physician notification on 10/18/18 by the Director of Nursing. *18 of 49 residents were identified by the Director of Nursing to have the potential to be affected by this deficient practice. 18 of 49 residents had their blood sugar levels reviewed on 10/18/18 by the Director of Nursing, Nurse Case Manager, Medical Records Nurse, Treatment Nurse, and or Assessment Nurse and 0 residents had a value that required physician notification other than resident #15. *An inservice was conducted on 10/10/18 by the Director of Nursing on the policy/procedure on "Physician Orders" revised 9/18 to include notification of physician for blood sugar levels that require physician notification with 5 of 8 Licensed Practical Nurses and 3 of 3 Registered Nurses and inservicing will continue until all Licensed Practical Nurses are inserviced. The Quality Assurance Committee reviewed the policy on "Physician Orders" with revision date of 9/18 on 10/16/18 and did not	

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F 684	Continued From page 15 Review of the electronic medication administration record (EMAR) for September 2018 blood sugars revealed: -09/01/18: 6:00 AM- 308; 4:00 PM- 224; 8:00 PM- 220 -09/03/18: 6:00 AM- 220; 11:00 AM- 220; 8:00 PM- 228 -09/04/18: 6:00 AM- 259 -09/07/18: 4:00 PM- 244 -09/08/18: 6:00 AM- 208 -09/09/18: 6:00 AM- 290 -09/10/18: 6:00 AM- 266 -09/16/18: 6:00 AM- 279 Review of the electronic medication administration record (EMAR) for August 2018 blood sugars revealed: -08/04/18: 6:00 AM- 284 -08/05/18: 6:00 AM- 401 -08/06/18: 6:00 AM- 342 -08/09/18: 4:00 PM- 205 -08/11/18: 6:00 AM- 212 -08/12/18: 6:00 AM- 293 -08/15/18: 6:00 AM- 271 -08/16/18: 8:00 PM- 212 -08/17/18: 8:00 PM- 324 -08/18/18: 6:00 AM- 241 -08/19/18: 6:00 AM- 248 -08/20/18: 6:00 AM- 371 -08/22/18: 6:00 AM- 257 -08/25/18: 6:00 AM- 254 -08/29/18: 4:00 PM- 275 -08/30/18: 6:00 AM- 256; 4:00 PM- 285 -08/31/18: 8:00 PM- 207 Review of the electronic medication administration record (EMAR) for July 2018 blood sugars revealed:	F 684	recommend any changes. *Blood Sugar levels will be monitored by the Director of Nursing, Medical Records Nurse, Treatment Nurse, Assessment Nurse, and/or Nurse Case Manager to ensure compliance with facility policy/procedure related to notification of physician for blood sugar levels that require physician notification weekly for four weeks and monthly for two months and findings recorded on the medical record audit form and maintained by the Director of Nursing. The Quality Assurance Committee will evaluate the monitoring completed by the Director or Nursing, Medical Records, Treatment Nurse, Treatment Nurse, Assessment Nurses, and/or Nurse Case Manager monthly for three months. *The corrective action will be completed 10/20/2018.	

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F 684	Continued From page 16 -07/01/18: 6:00 AM- 287 -07/05/18: 8:00 PM- 245 -07/08/18: 6:00 AM- 233 -07/09/18: 6:00 AM- 264; 11:00 AM- 239 -07/11/18: 6:00 AM- 262; 8:00 PM- 212 -07/12/18: 6:00 AM- 302; -07/14/18: 6:00 AM- 303 -07/15/18: 6:00 AM- 258 -07/16/18: 6:00 AM- 219; 8:00 PM- 243 -07/17/18: 6:00 AM- 217; 4:00 PM- 236; 8:00 PM- 296 -07/18/18: 6:00 AM- 280 -07/19/18: 8:00 PM- 211 -07/21/18: 6:00 AM- 291; 8:00 PM- 212 -07/22/18: 6:00 AM- 232; 4:00 PM- 264 -07/28/18: 6:00 AM- 227 -07/29/18: 8:00 PM- 224 -07/30/18: 6:00 AM- 271 -07/31/18: 6:00 AM- 216 Nurses notes reviewed and were void of any documentation of MD contact on blood sugars greater than 200 per MD order. The director of nurses (DON) was interviewed on 09/19/18 at 12:03 PM. She stated the notification to the MD should have been in the nurse's notes. At 3:37 PM, she confirmed there was no documentation of MD contact for any of the blood sugars noted to be above 200; per MD order.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		10/20/18

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F 689	Continued From page 17 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, facility policy review, and record review, the facility failed to perform a smoking assessment for Resident #29 to safeguard against the potential hazards for burns and/or fires. This concern was identified for one of eight (1 of 8) residents who smoked, and resided in the facility. Findings include: Review of the facility's policy titled, "Smoking Policies and Regulations", with the latest revision date of 04/15, revealed the decision with regard to smoking is a personal matter, and should be treated as such. However, the administration of this facility realizes that smoking is a source of possible fires, and therefore have developed these policies and procedures to insure the safety of the residents. All smokers will have a Smoking Screen completed, and appropriate interventions implemented and placed on the Care Plan. Residents who smoke will be identified, and placed in the computer-generated log with interventions noted. The log will be kept at the nurses station. Smokers will be screened on admission/readmission, and in the observation period of each Minimum Data Set (MDS). Review of Resident #29's Telephone Orders Physician Verbal Orders revealed an order, dated 08/15/18, for the resident to be supervised at designated smoking breaks. Further review of the	F 689	F689 *Resident #29 smoking assessment was completed on 9/19/18 by the Director of Nursing. *9 of 49 residents were identified by the Director of Nursing to have the potential to be affected by this deficient practice. 9 of 49 residents smoking assessments were reviewed by the Director of Nursing on 10/18/18 and all have a smoking assessment completed. *An inservice was conducted on 10/10/18 by the Director of Nursing on the policy/procedure on "Smoking Policies and Regulations" revised 4/15 to include completion of a smoking assessment for all smokers prior to smoking with 5 of 8 Licensed Practical Nurses and 3 of 3 Registered Nurses and inservicing will continue until all Licensed Practical Nurses are inserviced. The Quality Assurance Committee reviewed the policy on "Smoking Policies and Regulations" with revision date of 4/15 on 10/16/18 and did not recommend any changes. *Smoking assessments will be monitored by the Director of Nursing, Medical Records Nurse, Treatment Nurse, Assessment Nurse, and/or Nurse Case Manager to ensure compliance with facility policy/procedure related to completion of a smoking assessment prior to a resident smoking weekly for four weeks and monthly for two months and	

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F 689	Continued From page 18 order revealed the DON's signature, dated 08/15/18 at 4:00 PM, as the nurse receiving the order. Review of Resident #29's Smoking Assessment, dated 09/19/18, revealed the assessment was not completed until 25 days after the Physician's Order was received on 08/15/18. The Smoking Assessment revealed Resident #29 was oriented to person, place, and time, and remains alert during the smoking process. The Smoking Assessment's Interventions included: Staff issues cigarettes. Requires monitoring while smoking. The Intervention for requires a smoking apron was not checked. On 09/20/18 at 11:35 AM, an interview with the Director of Nurses (DON) confirmed not having a smoking assessment could put the resident at risk for burns. The DON stated the staff needed to have access to information such as a smoking assessment and a care plan to refer to in order to provide smoking safety measures for the resident. The DON stated she guessed she forgot to do Resident #29's smoking assessment, and the smoking assessment should have been done by the nurse who wrote the order. The Director of Nursing (DON) revealed a care plan should be initiated with any order change. The DON confirmed Resident #29 did not have a care plan for smoking, and she should have written an initial care plan for smoking for Resident #29 when she received the new order on 08/15/18. The DON stated she didn't know why she didn't write the care plan. On 09/19/18 at 9:55 AM, an interview with Resident #29 revealed he was alert and oriented. Resident #29 stated he goes out to smoke at the	F 689	findings recorded on the medical record audit form and maintained by the Director of Nursing. The Quality Assurance Committee will evaluate the monitoring completed by the Director of Nursing, Medical Records Nurse, Treatment Nurse, Assessment Nurse, and/or Nurse Case Manager monthly for three months. *The corrective action will be completed 10/20/2018.	

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F 689	Continued From page 19 designated times to smoke, and he does not use a smoking apron, and if he was that "screwed up", and needed an apron he would not be smoking. Resident #29 confirmed smoking breaks are staff supervised, and residents have an enclosed patio for smoking. Resident #29 stated he had been smoking since he was 11 or 12 years old, and had tried to quit, but due to so much going on, he decided "What the heck", and started back. Observations by this surveyor each day of the survey revealed the presence of facility staff during designated smoke times. An interview, on 09/19/18 at 11:01 AM, with Registered Nurse (RN) #1, revealed an order was written, on 08/15/18, for Resident #1 to smoke in the designated areas with supervision. RN #1 stated she was responsible for doing the Resident #29's Care Plan with the Minimum Data Set (MDS) assessment, which was due in October. RN #1 stated the nurse who wrote the order was responsible for initiating the Care Plan. On 09/19/18 at 11:30 AM, an interview with the Director of Nursing (DON) confirmed she wrote the order for Resident #29 to smoke on 08/15/18. The DON stated she guessed she just forgot to do Resident #29's smoking assessment. The DON stated a smoking assessment should be done by the nurse who writes the order, and she did not do a smoking assessment at that time for Resident #29. On 09/19/18 at 11:58 AM, an interview with Licensed Practical Nurse (LPN) #1, revealed she was responsible for checking orders every day. LPN #1 stated the order was entered in the	F 689		

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F 689	Continued From page 20 computer, but it does not show up on the monthly orders. LPN #1 said the order does print out on the Activities of Daily Living sheet. A review of Resident #29's September 2018 Physician's Orders revealed there was not an order to supervise Resident #29 at designated smoke breaks. Review of the facility's Physician Order List for Smokers revealed the eight (8) residents identified for supervision at designated smoke breaks, and Resident #29's name was included as of 08/15/18. Review of Resident #29's Completed Care Tasks (ADLs) sheet, dated 09/19/18, revealed the resident's participation in smoke breaks was not included as a Task. On 09/20/18 at 11:04 AM, review of the facility's computer generated Smoker's Log book located at the Nurses Station revealed Resident #29 was listed as a smoker. During an interview, on 09/20/18 at 11:48 AM, the Activity Director (AD) confirmed she takes the residents out to smoke. The AD stated if Resident #29 was suppose to wear an apron, it would be on his care plan, however the AD said she was not sure if Resident #29 was suppose to wear a smoking apron or not. The AD reported the resident names are on the smoking aprons for those who are designated to wear an apron. The AD said this information was known through verbal communication with staff and residents.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)	F 695		10/20/18

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F 695	Continued From page 21 § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to store Resident #19's Automatic Positive Airway Pressure (Auto PAP) mask in a manner to prevent the possibility of a respiratory infection. This concern was identified for one of three (1 of 3) residents who used Positive Airway Pressure masks. Findings include: On 9/17/18 at 7:15 PM, an observation revealed Resident #19's Automatic Positive Airway Pressure (Auto-PAP) mask was un-bagged, and lying on his bedside table. On 9/20/18 at 8:10 AM, an observation revealed Resident #19's Auto-PAP mask was un-bagged, and lying on his over-bed table. On 9/20/18 at 9:05 AM, an interview with Registered Nurse (RN) #1, revealed the Auto-PAP mask is not supposed to be un-bagged. RN #1 stated it should be cleaned after each use, and put in a bag, because of bacteria, which could cause an infection. On 9/20/18 at 9:18 AM, an interview with the Director of Nurses (DON), revealed Resident	F 695	F 695 POC *Resident #19 auto-pap mask was placed into a plastic bag after cleaning on 9/20/18 by the Director of Nursing. *3 of 49 residents were identified by the Director of Nursing to have the potential to be affected by this deficient practice. 3 of 49 residents bipap/cpap/auto-pap masks were bagged when not in use when observed by the Director of Nursing. *An inservice was conducted on 10/10/2018 by the Director of Nursing on the policy/procedure on "Infection Control Oxygen Equipment Cleaning" revised 3/18 to include storage of bipap/cpap/auto-pap masks when not in use with 5 of 8 Licensed Practical Nurses and 3 of 3 Registered Nurses and inservicing will continue until all Licensed Practical Nurses are inserviced. The Quality Assurance Committee reviewed the policy on "Infection Control Oxygen Equipment Cleaning" with revision date of 3/18 on 10/16/18 and did not recommend any changes. *Storage of bipap/cpap/auto-pap masks when not in use will be monitored by the	

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F 695	Continued From page 22 #19's Auto PAP mask needed to be in a bag. The DON stated she needed to go put the mask in a bag it if it's not already bagged, and in-service the staff on that. The DON stated this could be an infection issue. Record review of Resident #19's September 2018 Physician's Orders revealed orders, dated 08/16/16, for the Auto-PAP every HS (Hour of Sleep) and as needed. Pressure 7/11, FIO2(Fraction of Inspired Oxygen) 40% (4L of O2) four liters of oxygen with a full face mask. Review of Resident #29's September 2018 Electronic Medication Administration Record (EMAR) revealed, Auto-PAP headgear: Wash headgear weekly on Saturday by hand with warm soapy water, rinse, and let air dry. Auto-PAP machine: Wipe with soft damp cloth weekly on Saturday. Auto-PAP Humidifier: Clean chamber weekly on Saturday with white vinegar to prevent mold growth, be sure to rinse thoroughly with distilled or sterile water before using the humidifier. Change O2 water bottle on oxygen concentrator monthly. Change oxygen tubing weekly. The EMAR did not address the storage of the mask. A review of the facility's Face Sheet revealed, Resident #19 was admitted by the facility on 12/23/08, and readmitted him on 10/05/12, with the included diagnosis of Sleep Apnea.	F 695	Director of Nursing, Medical Records Nurse, Treatment Nurse, Assessment Nurse, and/or Nurse Case Manager to ensure compliance with facility policy/procedure recorded on the medical record audit form and maintained by the Director of Nursing. The Quality Assurance Committee will evaluate the monitoring completed by the Director of Nursing, Medical Records Nurse, Treatment Nurse, Assessment Nurse, and/or Nurse Case Manager monthly for three months. *The corrective action will be completed 10/20/2018.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		10/20/18

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	255292	A. BUILDING _____ B. WING _____	09/20/2018

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F 812	Continued From page 23 §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 observations, record review, staff interviews and facility policy review, the facility failed to prepare and serve food in accordance with professional standards for food service safety in one of one kitchens. Specifically, the facility failed to ensure proper cold storage temperatures, cleanliness in the kitchen, and ensure an air gap was present for the prevention of contamination. Findings: a. Cold storage temperatures: Review of the Refrigerator/Freezer Temperature Log for refrigerator #2 revealed: -09/19/18: 45 degrees AM -09/18/18: 45 degrees AM -09/16/18: 42 degrees AM -09/11/18: 42 degrees AM	F 812	F 812 *All items were removed from the ice cream freezer on 9/18/18 by the Dietary Manager. Ice cream freezer was cleaned and Freon added on 09/20/18 by outside contractor. All items were removed from the refrigerator #2 on 9/18/2018 by the Dietary Manager. Refrigerator #2 was cleaned and Freon added on 9/20/18 by outside contractor. Air gaps were added to the kitchen on 10/19 by outside contractor to prevent back flow of sewage into the kitchen sinks. Wall near three part sink was cleaned on 9/20/18 by dietary. * 49 of 49 residents were identified to have the potential to be affected by this deficient practice. * An in-service was started on 10/8 on "Food Procurement,	

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F 812	Continued From page 24 -09/10/18: 42 degrees AM -09/05/18: 42 degrees AM -09/04/18: 42 degrees AM -09/03/18: 42 degrees AM; 42 degrees PM -09/02/18: 42 degrees AM -08/30/18: 42 degrees PM -08/28/18: 50 degrees AM; 42 degrees PM -08/22/18: 42 degrees AM -08/19/18: 50 degrees AM -07/18/18: 42 degrees PM Review of the Refrigerator/Freezer Temperature Log for the ice cream box revealed: -09/18/18: 17 degrees AM -09/03/18: 10 degrees PM -09/01/18: 10 degrees AM The kitchen was observed on 09/17/18 at 6:52 PM. Refrigerator #2 was 45 degrees. The ice cream freezer was 12 degrees and the ice cream containers were soft, not frozen. Cook #2 was interviewed on 09/19/18 at 8:53 AM. She stated the dietary manager (DM) was on vacation. Refrigerator #2 was observed at 44 degrees. There were containers of pasteurized eggs, raw meat, and sour cream stored in the refrigerator. The ice cream freezer was 12 degrees and the ice cream containers were soft to the touch, not frozen. The kitchen was observed again on 09/19/18 at 9:33 AM. Refrigerator #2 was 44 degrees. At 9:44 AM, refrigerator #2 was 48 degrees. The refrigerator contained tuna, cold cut meats and eggs. Cook #2 was interviewed on 09/19/18 at 11:15 AM. She stated she was unsure when the DM	F 812	Store/Prepare/Serve-Sanitary with by the Dietary Manager on recording refrigerator and ice cream temperatures daily and reporting to the Dietary Manager and discrepancies and cleanliness in the kitchen. Maintenance assured air gaps were installed in the kitchen. *Refrigerator and ice cream box temperatures will be monitored by the Dietary Manager and Administrator for four weeks and monthly for two months and findings recorded in the temperature log book and maintained by the Dietary Manager. The Quality Assurance Committee will evaluate the monitoring completed by the Dietary Manager and Administrator monthly for three months. * The corrective action will be completed 10/20/2018.	

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F 812	Continued From page 25 was going to be back from vacation. There was no kitchen manager when she was gone. The kitchen was observed on 09/19/18 at 3:10 PM. Refrigerator #2 was observed at 55 degrees. The ice cream freezer was observed at 12 degrees. The ice cream was again soft, not frozen. The DM was interviewed at 3:21 PM. She stated there was too much ice cream in the freezer. She thought that was why the temperature was so high. She confirmed the temperature and the softness of the ice cream. She would have someone look at it. She stated, "Should be frozen." The DM was interviewed on 09/20/18 at 11:04 AM. She stated the refrigerator was measuring 40-42 degrees before she got the refrigerator and freezer fixed. The storage units were now working correctly. Review of the Storage of Refrigerated Food policy, revised 05/18, revealed the temperature of the refrigerators is set to keep the internal time/temperature-controlled food at 41 degrees Fahrenheit or lower, unless otherwise indicated by the manufacturer. b. Cleanliness The kitchen was observed on 09/17/18 at 6:52 PM. There were tongs and spoodles (large spoon) stored on the wall near the three-pan sink (three compartment sink) and behind the Robot Coupe (for pureeing foods) station. The wall was observed to be dirty with liquid food spatter. The kitchen was observed again on 09/19/18 at 8:53 AM. The wall was still observed dirty with	F 812		

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F 812	Continued From page 26 liquid food spatter. The shelving underneath the bins of potatoes and onions were observed dirty with food debris. The cabinets near the Robot Coupe station was sticky to the touch. The DM was interviewed on 09/20/18 at 11:04 AM. She stated they completed deep cleaning about once a month and as needed. She also said they were going to paint the kitchen. She confirmed the area was dirty. c. Air gap The kitchen was observed from 09/17/18 through 09/20/18 and no air gaps were present in the plumbing (open space/gap in plumbing to prevent backflow of sewage into the kitchen sinks). Review of the 2018 International Plumbing Code, chapter 8 (section 802) Indirect/special waste revealed equipment and fixtures utilized for the storage, preparation and handling of food shall discharge through an indirect waste pipe by means of an air gap. Each well of a multiple-compartment sink shall discharge independently to a waste receptor. Review of the Sanitary Conditions of the Food Service Department, revised 05/18, revealed sinks are installed with an air gap to separate a water supply outlet from any potentially contaminated source. The DM was interviewed on 09/20/18 at 11:04 AM. She stated she reported the lack of air gaps to maintenance and regional staff.	F 812		
F 813 SS=F	Personal Food Policy CFR(s): 483.60(i)(3)	F 813		10/20/18

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F 813	Continued From page 27 §483.60(i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility policy review, the facility failed to develop a policy for food brought to residents by family and other visitors; storing food brought in by family or visitors in a way that is either separate or easily distinguishable from facility food; and helping family and visitors understand safe food handling practices (such as safe cooling/reheating processes, hot/cold holding temperatures, preventing cross contamination, hand hygiene, etc.) for 42 of 42 residents. Findings: Review of the Food From Outside Sources policy provided by the dietary manager (DM) #1 on 09/20/18 at 11:50 AM, revised on 05/18, revealed: -The facility procures food based on current menu from sources approved or considered satisfactory by federal, state, or local authorities. -Food is purchased or acquired only from suppliers who obtain their products from licensed, reputable sources and manufacturers who inspect goods and adhere to all applicable health regulations. -Foods are not purchased from independent vendors who are not licensed such as a local farmer selling produce. -Residents may accept precooked foods from family members. Family members may bring in foods for a specific resident and may share with other residents.	F 813	F 813 *Policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption was mailed to effected residents, family members, and hand delivered to all other residents on 10/09/2018 by the Social Service Director. *49 of 49 residents have the potential to be effected by this deficient practice. The residents and residents representatives were notified by via mail of risks of food brought into the facility by family or other visitors and storing food bought in by family or other visitors to keep it distinguishable for facility food and helping family and visitors understand safe food handling practices. *An in-service was started on 10/11/18 by the Dietary Manager on policy "Rules for Food Brought in by Visitors dated 9/18/ *Notifications to residents and family members on the risks of food brought into the facility by family or visitors will be monitored by the Social Service Director/Director of Nurses/Administrator weekly for four weeks and monthly for two months. Any findings will be brought to the Quality Assurance Committee monthly for three months	

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F 813	Continued From page 28 (This policy did not meet the required criteria for food brought in from outside source.) Review of the Housekeeping policy, revised on 02/16, revealed resident personal refrigerators maintained in resident rooms will be checked on a weekly basis to ensure cleanliness and proper storage of perishable items. (This policy did not meet the required criteria for food brought in from outside source.) The facility was observed from 09/17/18 through 09/20/18. Several resident's rooms contained private refrigerators with potential for food brought in from outside sources. The DM #1 was interviewed on 09/20/18 at 1:00 PM. She confirmed she did not have a policy for food brought in from the outside; meeting the regulatory requirements. They had not educated the families and visitors on proper food handling practices.	F 813	* The corrective action will be completed 10/20/2018.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		10/20/18

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F 880	Continued From page 29 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility 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.	F 880		

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F 880	Continued From page 30 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff interviews and facility policy review, the facility failed to ensure proper infection control procedures for contact isolation for one (39) of one residents on contact isolation.; Resident #39. Specifically, the facility failed to ensure staff entered a contact isolation room with the proper personal protective equipment (PPE) and ensure proper chemicals were used throughout the cleaning process. Findings: Review of the face sheet for Resident #39 revealed diagnoses including enterocolitis due to Clostridium difficile (c-diff), cognitive communication deficit, unspecified dementia and Alzheimer's disease. Review of the 60-day minimum data set (MDS) assessment, dated 08/08/18, revealed the resident had severe cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 3 of 15. Review of the care plan, dated 06/12/18, revealed	F 880	F 880 *On 9/21/18 housekeeper #2 cleaned resident #39 room using proper personal protective equipment and proper chemicals, Director of Nursing conducted a one on one inservice with Housekeeper #2 on the proper chemicals and personal protective equipment to use to clean a contact isolation room. *1 of 49 resident was identified by the Director of Nursing to have the potential to be effected by this deficient practice. *An inservice was conducted by the Director of Nursing on 10/10/2018 on the use of personal protective equipment and the use of proper chemicals to clean an isolation resident's room. *The use of proper chemicals and personal protective equipment will be monitored weekly by the Director of Nurses/Administrator for four weeks and monthly for two months. * The corrective action will be completed 10/20/2018.	

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F 880	Continued From page 31 an infection- clostridium difficile. Interventions included: Contact isolation due to Clostridium Difficile. Review of the chart notes revealed: -09/19/18: Critical value of positive c-diff. Faxed to medical doctor (MD). -09/07/18: Unable to complete BIMS. Review of the physician progress notes revealed: -06/28/18: Admitted with c-diff. -07/26/18: Still trying to clear c-diff infection. -08/30/18: Continues on Vancomycin for c-diff. Otherwise stable. Review of the physician orders revealed: -08/23/18: Vancomycin 125 milligram (mg)/2.5 milliliter (ml) oral (250mg/5ml)- give 5ml by mouth three times a day for 14 days. -07/05/18: Acidophilus ...give two tablets by mouth twice a day. Review of the physician telephone orders revealed: 09/08/18: Mix one packet of diff-stat with 30cc of water and administer immediately after mixing by mouth. Resident #39 was observed on 09/18/19 at 9:34 AM. She was in her bed. Housekeeper #2 was observed in the resident's room without PPE. She had a rag in her hand and was cleaning the surface areas of the room, including the blinds. She did not have a gown, mask or gloves on throughout observation. Housekeeper #2 was interviewed on 09/18/18 at 9:34 AM. When asked if this resident was on contact isolation, she stated "I don't know." When asked what areas of the room she usually	F 880		

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F 880	Continued From page 32	F 880		

cleaned, she stated she cleaned the bedside table, the blinds, bed side rails and bathroom. She would take the trash out and mop the floors. At 9:47 AM, she said she was taught to use PPE, but she didn't like the gowns. It would cut into her skin, wrist area. She would spray disinfectant on herself before she went into the room. She got the spray herself. It was not from the facility.

The director of nurses (DON) was interviewed on 09/20/18 at 8:48 AM. She said this resident was on contact isolation when she arrived. She was taken off isolation with a negative c-diff about a month ago. She was placed back on isolation when she became positive again with c-diff. She had foul smelling stool. She was restarted on antibiotics. She was unsure if a special chemical was needed to clean the room. They completed in-services with the staff regarding infection control. She confirmed there was no benefit in the staff member spraying herself with disinfectant spray.

The housekeeping supervisor was interviewed on 09/20/18 at 10:00 AM. He stated they used three chemicals to clean the rooms. They used CDC-10; NABC and DMQ. He said he had the bleach locked up and his staff had not asked for the bleach in the past month or two. He stated for contact isolation, they needed to get dressed in a gown, mask and gloves.

Housekeeper #2 was interviewed again on 09/20/18 at 10:29 AM. She stated she used CDC-10 for cleaning the side rails, blinds and the tables. She used NABC hard surface disinfecting wipes for the bathroom and DMQ for mopping the floors.

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F 880	Continued From page 33 The DON was interviewed again on 09/20/18 at 1:41 PM. She stated for c-diff infection, they needed to use Clorox Germicidal Bleach. The chemicals used by the housekeeping staff did not have the same properties. They were supposed to use this Clorox product to clean this resident's room and they were not using it. For this resident, it (c-diff) could spread when using the wrong chemical. Review of the Procedure for Isolation: Isolation Precautions policy, revised on 04/14, revealed Contact precautions: In addition to standard precautions, use contact precautions for residents known or suspected to be infected with microorganisms that can be easily transmitted by direct or indirect contact, such as handling environmental surfaces or resident-care items...Inform staff members of the need for isolation precautions A) Explain procedures that must be initiated and maintained. B) Provide education as appropriate.	F 880		

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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 221 SS=D	Patient Sleeping Room Doors CFR(s): NFPA 101 Patient Sleeping Room Doors Locks on patient sleeping room doors are not permitted unless the key-locking device that restricts access from the corridor does not restrict egress from the patient room, or the locking arrangement is permitted for patient clinical, security or safety needs in accordance with 18.2.2.2.5 or 19.2.2.2.5. 18.2.2.2, 19.2.2.2, TIA 12-4 This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to properly maintain patient sleeping room doors as directed by NFPA 101 section 19.2.2.2.5. This deficiency affected none of the residents as it was not a resident use area. Findings include: On September 18, 2018 at 10:40 AM, observation revealed double keyed dead bolts on the front and rear exit doors of the facility. These double keyed dead bolts restricted exit egress from the inside of the facility.	K 221	K221 *On September 18th, maintenance removed the double keyed dead bolts on the front and rear exit doors of the facility. *49 of 49 residents could be effected by this deficient of practice as identified by the Director of Nurses. *An inservice was held on 10/18/2018 by Maintenance for dietary staff on exit door exit and entrance and the need for proper devices to secure the doors and to not have double keyed dead bolts. *Maintenance will monitor door secure systems weekly for four weeks and monthly for two months. Any findings will be reported to the Quality Assurance	10/20/18

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

Electronically Signed | 10/19/2018

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
	255292	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/18/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY MANOR NURSING AND REHABILITATION	**1935 NORTH THEOBOLD EXTENSION GREENVILLE, MS 38704**

(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
K 221	Continued From page 1	K 221	Committee monthly for three months. *The corrective action will be completed 10/20/18.	
K 231 SS=D	Means of Egress Capacity CFR(s): NFPA 101 Means of Egress Capacity The capacity of required means of egress is in accordance with 7.3. 18.2.3.1, 19.2.3.1 This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to properly protect hazardous areas NFPA 101 section 19.3.2.1. This deficiency affect two (2) of six (6) smoke compartments and 18 of 42 residents in the facility on the day of survey. Findings Include: During the building inspection on September 18, 2018 between 10:20 AM and 11:15 AM, observation revealed the following deficiencies in hazardous areas of the facility: 1. Bio-Hazard Room door near Room W-21 did not properly close to a positive latch position. 2. Medical Records Room door lacked an automatic door closer 3. Hopper Room door contain holes and was not smoke tight These hazardous area doors were incapable of resisting the passage of smoke throughout the facility.	K 231	K 231 *Biohazard room door near room W-21 was adjusted by Maintenance on 9/18/18 to properly close to a positive latch position. An automatic door closer was installed on the medical records door by maintenance on 9/18/18. The hopper room door was repaired and adjusted on 9/18/18. *49 of 49 residents were identified as having the potential of being affected by this deficient practice. *Items noted to be out of compliance and since corrected was brought to the Quality Assurance Committee on 10/16/18. *Maintenance will monitor to assure doors close to a positive latch position, automatic door closers are present and functioning and to assure doors do not have holes in them throughout the facility weekly for four weeks and monthly for two months. Any findings will be brought to Quality Assurance Committee monthly for three months. *The corrective action will be completed	10/20/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255292	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/18/2018**

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LEGACY MANOR NURSING AND REHABILITATION	**1935 NORTH THEOBOLD EXTENSION GREENVILLE, MS 38704**

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K 231	Continued From page 2	K 231	on 10/20/18.	
K 232 SS=D	Aisle, Corridor, or Ramp Width CFR(s): NFPA 101 Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to provide clear and unobstructed corridors as directed by NFPA 101 section 19.2.3.4. This deficiency affected one (1) of six (6) smoke compartments and 11 of 42 residents in the facility on the day of survey. Findings include: On September 18, 2018 at 10:15 AM, observation revealed the corridor near the West Wing nurse station was blocked and obstructed by a 44 inch wide cased opening doorway. This case opening once contained a door separating the corridor on the West Wing of the facility.	K 232	K 232 *Cased opening doorway located on corridor near the West Wing nurse station was increased in width to match other corridor door widths within the facility on 10/19/18. *11 of 49 residents were identified as having the potential to be effected by this deficient practice by the Director of Nurses. *The immediate need to increase the width of the door in the corridor near the West Wing nurse station was brought to the Quality Assurance Committee on 10/16/18. *Maintenance will monitor all corridors and door widths within the facility weekly for four weeks and monthly for two months. * The corrective action will be completed on 10/20/2018.	10/20/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255292	A. BUILDING _____ B. WING _____	09/18/2018

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E 000	Initial Comments *EMERGENCY PREPAREDNESS* Survey conducted on 9/18/18 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were identified.	E 000		

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

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