MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	76GC	A. BUILDING: _____ B. WING _____	09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY MANOR NURSING AND REHABILITAT	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) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) conducted a recertification survey from 09/17/18 to 09/20/18. During the survey the SA determined the facility was not in compliance with the Minimum Standards for The Institutions For The Aged And Infirm. The SA cited the state statutes M500, M655, and M815. The census at the time of entrance was 55, and the facility was certified for 60 beds.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his	M 500		10/20/18

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	76GC	A. BUILDING: _____ B. WING _____	09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY MANOR NURSING AND REHABILITAT	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) COMPLETE DATE
M 500	Continued From page 1 medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	76GC	A. BUILDING: _____ B. WING _____	09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY MANOR NURSING AND REHABILITAT	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) COMPLETE DATE
M 500	Continued From page 2 facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	76GC	A. BUILDING: _____ B. WING _____	09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY MANOR NURSING AND REHABILITAT	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) COMPLETE DATE
M 500	Continued From page 3 unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level II 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	M 500	M 500 *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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	76GC	A. BUILDING: _____ B. WING _____	09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY MANOR NURSING AND REHABILITAT	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) COMPLETE DATE
M 500	Continued From page 4 Positive Airway Pressure) machine, and for Resident #29's smoking with supervision. This concern was identified for two (2) of 17 care plans reviewed, 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. 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:	M 500	implemented to reflect smoking with supervision on 9/20/18 by the Assessment Nurse. 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. *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. 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 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	76GC	A. BUILDING: _____ B. WING _____	09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY MANOR NURSING AND REHABILITAT	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) COMPLETE DATE
M 500	Continued From page 5 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 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	M 500	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. 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. * 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 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. 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	76GC	A. BUILDING: _____ B. WING _____	09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY MANOR NURSING AND REHABILITAT	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) COMPLETE DATE
M 500	Continued From page 6 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. 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,	M 500	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 by 10/20/2018.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	76GC	A. BUILDING: _____ B. WING _____	09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY MANOR NURSING AND REHABILITAT	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) COMPLETE DATE
M 500	Continued From page 7 dated 09/19/18, 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. 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.	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	76GC	A. BUILDING: _____ B. WING _____	09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY MANOR NURSING AND REHABILITAT	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) COMPLETE DATE
M 500	Continued From page 8 The AD reported she knew which residents who needed to wear the apron through verbal communication with staff and residents. 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: 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	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	76GC	A. BUILDING: _____ B. WING _____	09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY MANOR NURSING AND REHABILITAT	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) COMPLETE DATE
M 500	Continued From page 9 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 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.	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	76GC	A. BUILDING: _____ B. WING _____	09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY MANOR NURSING AND REHABILITAT	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) COMPLETE DATE
M 500	Continued From page 10 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.	M 500		
M 655	45.21.11 Special needs Special needs. Each resident with special needs shall receive proper treatment and care. These special needs shall include, but are not limited to injections; parenteral and enteral fluids; colostomy, ureterostomy, ileostomy care; tracheostomy care; tracheal suction; respiratory care; foot care; and prostheses. This Statute is not met as evidenced by: Level II 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.	M 655	M 655 *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	10/20/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	76GC	A. BUILDING: _____ B. WING _____	09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY MANOR NURSING AND REHABILITAT	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) COMPLETE DATE
M 655	Continued From page 11 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 #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	M 655	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 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	76GC	A. BUILDING: _____ B. WING _____	09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY MANOR NURSING AND REHABILITAT	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) COMPLETE DATE
M 655	Continued From page 12 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.	M 655		
M 815	45.29.1 Safe Food Handling Procedures Safe Food Handling Procedures. Food shall be prepared, held, and served according to current Mississippi State Department of Health Food Code Regulations. This Statute is not met as evidenced by: Level II 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:	M 815	M 815 *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.	10/20/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	76GC	A. BUILDING: _____ B. WING _____	09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY MANOR NURSING AND REHABILITAT	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) COMPLETE DATE
M 815	Continued From page 13 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 -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	M 815	* 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, 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	76GC	A. BUILDING: _____ B. WING _____	09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY MANOR NURSING AND REHABILITAT	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) COMPLETE DATE
M 815	Continued From page 14 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 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	M 815		

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	76GC	A. BUILDING: _____ B. WING _____	09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY MANOR NURSING AND REHABILITAT	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) COMPLETE DATE
M 815	Continued From page 15 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 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	M 815		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	76GC	A. BUILDING: _____ B. WING _____	09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY MANOR NURSING AND REHABILITAT	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) COMPLETE DATE
M 815	Continued From page 16 to maintenance and regional staff.	M 815		