STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255096	A. BUILDING _____ B. WING _____	05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISVILLE HEALTHCARE LLC	543 EAST MAIN STREET/PO BOX 542 LOUISVILLE, MS 39339

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A standard survey was conducted by Ascellon on behalf of the MS State Department of Health from May 13, 2019 through May 16, 2019. The standard survey revealed that the facility was not in substantial compliance with the requirements of participation in Medicare/Medicaid. The following deficiencies resulted from the facility's noncompliance: F-656, F-684, F-761, F-801, and F-803. The facility's census on May 13, 2019 was 55 residents and held a license for 60 beds.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will	F 656		6/18/19

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

Electronically Signed | 06/19/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 656	Continued From page 1 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, interview, record review, and facility policy review, the facility failed to implement and follow the care plan treatment interventions, including air mattress settings to promote healing and failure to keep wounds covered, to meet the resident's needs for one (1) resident (Resident #29) out of 30 resident care plans reviewed. This deficient practice had the potential to result in wound infection and improper healing of the wound. Findings include: The facility provided the policy titled, "Care Plans - Comprehensive" dated 10/2016, which directed the care plan should, "3e. Reflect treatment goals, timetables and objectives in measurable outcomes; 3g. Aid in preventing or reducing declines in the resident's functional status and/or	F 656	F 656: The facility failed to implement and follow the care plan treatment interventions, including air mattress settings to promote healing and failure to keep wounds covered, to meet the needs of Resident #29. On 05/16/2019 at 2:00pm, the Registered Nurse Unit Manager went to the resident's room and corrected the setting on the air mattress to reflect the resident's proper weight, and the Wound Care Nurse went to the resident and performed proper wound care, ensuring wounds were cleaned and dressed per Physician orders. II. Steps taken to identify other residents having the potential to be affected by the	

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F 656	Continued From page 2 function levels; 3i. Reflect currently recognized standards of practice for problem areas and conditions. 5. Care plan interventions are designed after careful consideration of the relationship between he resident's problem areas and their causes ..." The facility provided the policy titled "Following the Care Plan Policy" dated 1/2011, which directed, "Policy. It is the policy of this facility to follow a written and approved care plan for each resident. All employees will be trained upon hire and be required to follow the care plan. Procedure ...all employees will follow the written care plan that is developed in order to assure the residents needs are met. Resident #29's care plans included the following directions to staff: - Resident has surgical wound to left ischium, dated 5/1/19. The interventions included the following directions to staff: Cleanse surgical wound to left ischium with wound cleanser - pat dry - apply Solosite gel to wound bed - apply Resinol to wound borders - pack with saline moistened gauze - cover with proximal silicone foam dressing daily. Maintain pressure reducing mattress. Practice good infection control. Keep wound clean and dry. -Resident has surgical wound to left lower buttock, dated 4/12/19. The interventions included the following directions to staff: Maintain pressure reducing mattress. Practice good infection control. Keep wound clean and dry. Wound treatment as ordered. Re-evaluate for effectiveness. Notify MD if treatment ineffective. -Alternating pressure mattress to bed for	F 656	same alleged deficient practice. Seven out of fifty five residents in the facility have orders for low air loss mattresses and ten out of fifty five residents in the facility require wound care with dressings are at risk for the alleged deficient practice. III. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? An in-service, directed by the Director of Nursing, was held on 06/17/2019 with all clinical staff of the facility to address following Care Plan interventions related to wound care and proper usage and instructions on settings for low air loss mattresses. The Director of Nursing and Assessment Coordinator Nurse will audit care plans monthly to ensure interventions are appropriate and obtainable. On 06/17/2019, the Registered Nurse Unit Manager will monitor residents daily to ensure proper wound care is being given, as directed by the Physician. Beginning on 06/17/2019, settings of low air loss mattresses will be monitored by nursing staff each shift, as listed on the Treatment Administration Record, to ensure proper settings are being maintained. IV. Monitoring the corrective actions (Quality Assurance Program) to ensure that the alleged deficient practice does not recur.	

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F 656	Continued From page 3 maximum pressure relief due to skin breakdown, dated 4/12/19. The interventions directed staff: Maintain pressure reducing mattress through next review. Air mattress settings checked every shift. Based on resident's weight mattress setting is soft. Settings are based on resident's weight. Nine (9) observations over three (3) days revealed Resident #29's air mattress settings were set at less than 150 pounds, when the resident weighed 169 pounds, and the air mattress was set at "static" pressure. - 5/14/19 at 10:53 A.M. - 5/14/19 at 2:11 P.M. - 5/14/19 at 4:48 P.M. - 5/15/19 at 9:09 A.M. - 5/15/19 at 9:34 A.M. - 5/15/19 at 11:33 A.M. - 5/15/19 at 2:48 P.M. - 5/16/19 at 9:50 A.M. - 5/16/19 at 11:30 A.M. Wound care observation on 5/14/19 at 2:11 PM, revealed neither of the wounds (left ischium and left buttocks) were covered with a dressing upon removal of the resident's brief. It was determined that the two (2) surgical wounds were not covered for a period of over two (2) hours. Interview at that time with Certified Nursing Assistant (CNA) #1 revealed she was changing the resident's brief and then informed the nurse that the dressings were not on the wounds. Resident #29 was admitted to the facility on 3/14/18, with diagnoses that included Dementia, Right side Hemiplegia, Osteoarthritis, and a newer diagnosis on 4/2019, of Bullous Pemphigoid.	F 656	The Director of Nursing and Assessment Coordinator Nurse will audit care plans monthly to ensure interventions are appropriate and obtainable. The Registered Nurse Unit Manager will monitor residents daily to ensure proper wound care is being given, as directed by the Physician. Low air loss mattresses will be monitored by nursing staff each shift to ensure proper settings are being maintained. All findings will be reported monthly to the Quality Assurance Committee for three months or until compliance is achieved. The Quality Assurance Committee will make recommendations as needed.	

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F 656	Continued From page 4 Review of Resident #29's Annual Minimum Data Set (MDS) dated 3/26/19 recorded the resident required total assistance from staff for bed mobility, transfers, locomotion on and off the unit, dressing, eating, personal hygiene, and bathing, did not walk, was always incontinent of bowel and bladder, and did not have pressure ulcers, but did have skin tears. During an interview on 5/16/19 at 11:49 AM, Licensed Practical Nurse (LPN) #2, stated the care plan was not followed because the setting parameters were in the care plan, but not followed. LPN #2 further stated the wounds should never be uncovered, with the possible outcome of infection. LPN #2 stated, "The current wounds are moist, if they are not covering them or packing them, it could cause deterioration of the granulation tissue." During an interview on 5/16/19 at 11:58 AM, Registered Nurse (RN) #2 stated the wounds should not ever be uncovered, except when doing the treatment, to keep them from getting infected, and it could prevent healing. RN #2 stated the care plan was not being followed correctly, because the setting parameters were in the care plan, but not followed. During an interview on 5/16/19 at 12:40 PM, the Director of Nursing (DON) stated she expected them (nursing staff) first of all make sure the air mattress is working and functioning. "The proper functioning, they should follow the care plan. For all care they should look at the care plans." The DON further stated she expects the CNAs to tell the nurse if a dressing is not in place. The CNA should tell the nurse to remove the dressing if	F 656		

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F 656	Continued From page 5 soiled and have the nurse re-dress the wound. The DON stated the possible outcomes of no dressing for over two (2) hours for a bowel incontinent resident, the "Possibility of getting infected."	F 656		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that 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 observation, record review, interview, and review of facility policy, the facility failed to implement proper air mattress settings to promote healing of wounds and failed to follow the physician's order to keep the wounds covered, for one (1) resident, Resident #29, of four (4) residents sampled for wounds. Findings Included: Review of a facility policy titled "Wound Treatment Management", dated 2018, which directed, "To promote wound healing of various types of wounds it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders." Review of the manufacturer's User Manual for the	F 684	F 684: The facility compromised quality of care for Resident #29 by failing to implement proper air mattress settings to promote healing of wounds and failed to follow physician orders to keep the wounds covered. On 05/16/2019 at 2:00pm, the Registered Nurse Unit Manager went to the resident's room and corrected the setting on the air mattress to reflect the resident's proper weight, and the Wound Care Nurse went to the resident and performed proper wound care, ensuring wounds were cleaned and dressed per Physician orders. II. Steps taken to identify other residents having the potential to be affected by the	6/18/19

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F 684	Continued From page 6 Med-Aire Essential 14508 8" Alternating Pressure & Low Air Loss Mattress System, dated 2014, which directed, Intended Use: "The Med-Aire Essential 14508 pump and mattress are intended to help reduce the incidence of pressure ulcers while optimizing patient comfort. Pressure Adjust knob adjustable by patient's weight: Turn the Pressure Adjust Knob to set a comfortable pressure level by using the weight scale as a guide. (The User Manual included a graphic of the Pressure Adjust Knob indicating the setting at 'Weight of Patient'). Step 9. Turn the Pressure Adjust Knob to set a comfortable pressure level using the weight scale as a guide. 10. Press the static button to set it in static mode, and the Static indicator will come on. The static mode will be started within approximately 6 minutes. Press the Static button again to switch back to alternating mode." Observations of Resident #29 on the following dates and times revealed the resident's air mattress settings were as follows: - 5/14/19 at 10:53 AM revealed the resident in bed, turned to the left. The air mattress setting was less than 150, the other settings were "static" and "normal pressure." - 5/14/19 at 2:11 PM, revealed the resident in bed, turned to the left. The air mattress setting was less than 150, approximately one-third of the way down toward 125, and the other settings were "static" and "normal pressure." - 5/14/19 at 4:48 PM revealed the resident in bed, turned to the left. The air mattress setting was less than 150, and the other settings were "static" and "normal pressure." - 5/15/19 at 9:09 AM revealed the resident in bed on his right side. The air mattress setting was less than 150, and the other settings were "static"	F 684	same alleged deficient practice. Seven out of fifty five residents in the facility have orders for low air loss mattresses and ten out of fifty five residents in the facility require wound care with dressings are at risk for the alleged deficient practice. III. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? An in-service, directed by the Director of Nursing, was held on 06/17/2019 with all clinical staff of the facility to address following Care Plan interventions related to wound care, following Physician orders related to wound care, proper usage and instructions on settings for low air loss mattresses. Certified Nurse Aides were instructed to notify the Registered Nurse or Wound Care Nurse if wound dressing come off during care. The Unit Manager (Registered Nurse) will monitor residents daily to ensure proper wound care is being given, as directed by the Physician for three months. Settings of all low air loss mattresses in use will be monitored by nursing staff each shift to ensure proper settings are being maintained for three months. IV. Monitoring the corrective actions (Quality Assurance Program) to ensure that the alleged deficient practice does not recur.	

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F 684	Continued From page 7 and "normal pressure." - 5/15/19 at 9:34 AM revealed the resident in bed turned to the right. The air mattress setting was less than 150, and the other settings were "static" and "normal pressure." - 5/15/19 at 11:33 AM revealed the resident in bed turned to the left. The air mattress setting was less than 150, and the other settings were "static" and "normal pressure." - 5/15/19 at 2:48 PM revealed the resident in bed turned to the right. The air mattress setting was less than 150, and the other settings were "static" and "normal pressure." - 5/16/19 at 9:50 AM revealed the resident in bed. The air mattress setting was less than 150, and the other settings were "static" and "normal pressure." - 5/16/19 at 11:30 AM revealed the resident in bed. The air mattress setting was less than 150, and the other settings were "static" and "normal pressure." On 5/14/19 at 2:11 PM, wound care observation revealed Certified Nursing Assistant (CNA) #1 and CNA #2 removed the resident's brief for wound care. Observation of the inside of the brief revealed one (1) balled up gauze (which appeared to be wound packing) and neither of the wounds (left ischium and left buttocks) were covered with a dressing. Both CNAs and Registered Nurse (RN) #1 as well as Licensed Practical Nurse (LPN) #2 verified there were no dressings on the left buttock wound or the left ischium wound, and there were no dressings in the resident's brief. During an interview at that time, CNA #1 stated she changed the resident's brief about 9:00 AM and the two (2) wounds were covered with dressings. CNA #1 stated the Hospice CNA came in about 11:00 AM to give the	F 684	The Unit Manager (Registered Nurse) will monitor residents daily for three months to ensure proper wound care is being given, as directed by the Physician. Settings of all low air loss mattresses in use will be monitored by nursing staff each shift, as stated on Treatment Administration Record, to ensure proper settings are being maintained. All findings will be reported to the Director of Nursing who will report weekly to the Quality Assurance Committee for three months or until compliance is achieved. Quality Assurance Committee will make recommendations as needed.	

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F 684	Continued From page 8 resident a bed bath. CNA #1 stated she saw the Hospice CNA leave the building about 12:00 noon. CNA #1 further stated the Hospice CNA did not report to her that the resident's wounds were uncovered and had no dressings. Resident #29 was admitted to the facility on 3/14/18, with diagnoses that included Dementia, Right side Hemiplegia, Osteoarthritis, and a newer diagnosis on 4/2019, of Bullous Pemphigoid. Review of the resident's "Weekly Body Audit assessment", dated 3/26/19, recorded two (2) of the findings included a raised area on the left lateral hip (left ischium), and a blister on the left buttock. Record review of the Physician's Notes dated 3/16/19, 4/4/19, and 4/30/19, recorded the left ischium wound and the left buttock wound originated from bullous pemphigoid blisters (autoimmune disorder) and were not pressure ulcers or pressure injuries. The 4/4/19 physician's note recorded, "Keep covered at all times with Duoderm/Bactroban." Review of Resident #29's care plans documented the following: Resident has surgical wound to left ischium dated 5/1/19. The interventions directed staff: - Cleanse surgical wound to left ischium with wound cleanser - pat dry - apply Solosite gel to wound bed - apply Resinol to wound borders - pack with saline moistened gauze - cover with proximal silicone foam dressing daily. - Maintain pressure reducing mattress. - Practice good infection control. Keep wound clean and dry.	F 684		

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F 684	Continued From page 9 Resident has surgical wound to left lower buttock dated 4/12/19. The interventions directed staff: -Ensure adequate hydration and nutrition. Dietary to assess for nutritional needs. -Maintain pressure reducing mattress. -Practice good infection control. Keep wound clean and dry. -Wound treatment as ordered. Re-evaluate for effectiveness. Notify MD if treatment ineffective. Alternating pressure mattress to bed for maximum pressure relief due to skin breakdown, dated 4/12/19. The interventions directed staff: - Maintain pressure reducing mattress through next review. - Air mattress settings checked every shift. - Based on resident's weight mattress setting is soft. - Settings are based on resident's weight. Review of the Treatment Administration Record (TAR) dated 5/1/19-5/31/19 recorded, "Alternating pressure mattress to bed for maximum relief every shift, start date 4/9/19." Review of the hospital records dated 4/15/19 - 4/29/19 recorded the two (2) bullous pemphigoid wounds were debrided surgically before the resident readmitted to the facility. The resident had been admitted to the hospital for an upper respiratory infection. Upon return to the facility, the "Weekly Wound Observation Reports" dated 5/3/19, documented the left ischium wound measured 3.0 cm (centimeters) long x (by) 3.5 cm wide x 2.0 cm deep. The left buttock wound measured 6.0 cm long x 4.0 cm wide x 3.8 cm deep.	F 684		

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F 684	Continued From page 10 Review of the resident's weight record to determine the correct air mattress settings revealed weights were done monthly since February 2008 with weights ranging from 159-191 pounds. The most current weight was recorded on 5/9/19 the resident weighed 169 pounds. The order for the air mattress dated 4/9/19, recorded, "Alternating pressure mattress to bed for maximum relief. Every shift." During an interview on 5/15/19 at 9:34 AM, the Hospice CNA stated she gave the resident a bed bath yesterday and was there from about 11:00 AM - 12:00 Noon. The CNA further stated she reported to two (2) nurses at the desk that the resident had soiled dressings which she removed during the bath, and the resident currently did not have dressings on the two (2) wounds. During an interview on 5/16/19 at 11:35 AM, CNA #3 stated CNAs were supposed to look at the air mattress setting and report to the nurse if it isn't right. CNA #3 stated that for Resident #29, "He has wounds, so if the air mattress isn't set right for his weight it could affect his wounds, like not let them heal right, or he might get new ones." During an interview on 5/16/19 at 11:38 AM, LPN #1 stated air mattress settings are set by the resident's weight. "I look at it to make sure it's working and turned on, and functioning." LPN #1 further stated the treatment nurse was the one responsible for the setting, and LPN #1 only checks to see if the air mattress is functioning every shift. At 11:42 A.M., observation of Resident #29's air mattress setting with LPN #1 revealed the setting less than 150. LPN #1	F 684		

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F 684	Continued From page 11	F 684		

stated, "It's under 150. It should be at 169 which is his weight." LPN #1 verified there were no weights under 150 pounds recorded in the medical record. LPN #1 stated, "The air mattress is supposed to relieve pressure from current wounds. It's a prevention help to keep him from getting wounds."

During interview on 5/16/19 at 11:49 AM, LPN #2 stated the air mattress setting was based on weight and was a prophylactic intervention to prevent pressure areas and deep tissue injuries. LPN #2 stated for the resident's current wounds, it helps alleviate some of the pressure that he might have, and everyone is responsible to check the settings, including the CNAs and the charge nurse should check it whenever she goes in the room. LPN #2 stated the care plan was not followed because the setting parameters are in the care plan. LPN #2 further stated the wounds should never be uncovered, with the possible outcome of infection. LPN #2 stated, "The current wounds are moist, if they are not covering them or packing them, it could cause deterioration of the granulation tissue."

During an interview on 5/16/19 at 11:58 AM, RN #2 stated the air mattress was to keep pressure off the resident's bony prominences to prevent more wounds. For current wounds it keeps them from getting worse. Air mattress settings, we were taught to go by the resident's weight. Any nurse going in should check it during the day. "If the air mattress is too soft, I would think it would defeat the purpose of support." The wounds should not ever be uncovered, except when doing the treatment, to keep them from getting infected, and it could prevent healing. RN #2 stated the care plan was not being followed correctly,

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F 684	Continued From page 12 because the setting parameters are in the care plan. During interview on 5/16/19 at 12:40 PM, the Director of Nursing (DON) stated the air mattress should relieve pressure to prevent increased further issues or more wounds from forming and should be set by weight. All nursing staff was responsible to monitor the settings every shift according to the TAR, and there was no setting in the TAR. The orders say alternating air mattress, no settings described. The DON stated she expects them (nursing staff) first of all make sure it's on, working and functioning. "The proper functioning, they should follow the care plan. For all care they should look at the care plans." The DON further stated she expects the CNAs to tell the nurse if a dressing was not in place, and the hospice CNA should do the same. The DON stated that the CNA should tell the nurse to remove the dressing if soiled and have the nurse re-dress the wound, also the hospice CNA should do the same. The DON stated the possible outcomes of no dressing for two (2) or more hours for a bowel incontinent resident, the "Possibility of getting infected." During interview on 5/16/19 at 2:27 PM, Resident #29's physician (MD) stated the air mattress should off load some parts of the body and alternating that. The MD further stated the resident's setting needs to be corrected, and stated, "I think it should be done right. If unchecked longer than four (4) days, [the resident] could have worsened wounds, poor wound healing, and progressing wounds. I think they'll get septic eventually and die from that." When asked about the uncovered wounds, the MD stated, "They should never be opened,	F 684		

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F 684	Continued From page 13 always covered. They shouldn't be open, only during wound care twice a day and any time they are [incontinent]. [Resident #29's] wounds should be packed and covered at all times. I'm not speculating on the outcomes. The CNA should have reported it right away." The facility failed to properly set the air mattress according to the resident's weight and on an alternating status and failed to keep the wounds covered with a dressing for more than two (2) hours.	F 684		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the	F 761		6/18/19

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F 761	Continued From page 14 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility policy review, the facility failed to ensure medications and supplies were available for administration and resident use in two (2) of two (2) medication rooms. Findings include: Review of the facility policy titled, "Checking Stock Medications and Supplies for Manufacturer Expiration Dates" dated 4/2017, directed "Policy: It is the policy of this facility to check for medications and medical supplies expiration dates monthly. The facility will check the manufacturer's expiration dates once a month and as needed prior to dispensing medications or using supplies for resident care. Procedure: When nursing staff are performing the End of Month Medication Order Review each month, all stock medication will be checked for the manufacturers (sic) expirations dates. These medications include all stock medications that are maintained on any facility med [medication] cart, as well as any stock room medications that have yet to be placed on a cart. During this process, if any medication is found to be expired, it will immediately be removed from the med cart or stock room and given to the Director of Nursing for proper disposal in accordance to the 'Destruction on Non-Controlled Medication' policy. Also, during every medication pass, the nurse dispensing medications will check the bottle for the manufacturers (sic) expiration on all stock medications individually prior to administering to a resident. All medical supplies used for resident	F 761	F 761: The facility failed to ensure medications and supplies were available for administration and resident use in two medication/supply rooms. On 05/14/2019, both medication rooms and supply rooms were checked by the Director of Nursing, and all medications, biologicals and supplies that were expired were immediately discarded by the Director of Nursing. II. Steps taken to identify other residents having the potential to be affected by the same alleged deficient practice. All residents in this facility are at risk for the results of the alleged deficient practice. III. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? An in-service, directed by the Director of Nursing, was held on 06/17/2019 with all clinical staff of the facility to address proper labeling and storage of drugs, biologicals, and medical supplies in the medication/storage rooms. The Registered Nurse Unit Manager will be responsible for checking the medication/supply rooms on a weekly	

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F 761	Continued From page 15 care (that have expiration dates) will be checked monthly for the manufacturers (sic) expiration dates immediately following the medication expiration checks. Any supply that has an expired manufacturers (sic) expiration date will be immediately removed from use and give to the Director of Nursing for proper disposal." On 5/14/19 at 4:20 PM, the Main Hall Medication Storage Room was inspected with Registered Nurse (RN) #2. The following expired supplies were found in the cupboard above the sink: One (1) package containing 35 green top vacutainer tubes with an expiration date of 4/4/2019. There were 11 vacutainer tubes missing from the package. An interview with RN #2 during the inspection revealed the facility had just received the package of vacutainer tubes from the hospital last week. RN #2 stated the package of vacutainer tubes was missing several tubes when the package was delivered to the facility. Further observation in the Medication Storage Room revealed the following expired supplies in the blood draw basket: One (1) green top vacutainer tube with an expiration date of 4/4/19, and three (3) blue top vacutainer tubes with an expiration date of 2/28/19. Further observation in the Medication Storage Room revealed the following expired supplies in the drawer: Ten (10) blue top vacutainer tubes with an expiration date of 1/31/19; One (1) Novofine Autocover 0.3 x 8.0 millimeter (mm) needle with an expiration date of 1/2019; one (1) bottle of low control solution yellow top with an expiration date of 10/2017; and one (1) bottle of high control solution red top with an expiration date of 9/2017.	F 761	basis, beginning on 06/17/2019, to ensure all medications, biologicals and supplies are within date. All expired medications, biologicals and supplies will be immediately discarded by the Registered Nurse Unit Manager. IV. Monitoring the corrective actions (Quality Assurance Program) to ensure that the alleged deficient practice does not recur. The Director of Nursing will check each medication/supply room on a monthly basis to ensure the Registered Nurse Unit Manager is checking and discarding all expired medications, biologicals and supplies. The Director of Nursing will report findings to the Quality Assurance Committee weekly for three months or until compliance is achieved. The Quality Assurance Committee will make recommendations as needed.	

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F 761	Continued From page 16 Interview on 5/14/19 at 4:36 PM, with RN #2 revealed the nurses goes through the medication room for expired medications and supplies once a week. On 5/14/19 at 4:38 PM, Hall 2 medication room was reviewed with RN #2. The following expired medications were found in the cupboard: Nine (9) packages of Blephadex eye lid wipes (a medication to help relieve the symptoms of inflamed, red, itchy or dandruff-like scales to the eye lids) eyelid wipes with an expiration date of 4/2019 and one (1) bottle of Arglaes powder (for wounds delivers controlled release antimicrobial silver into the wound bed) five (5) grams with an expiration date of 1/2019. In an interview on 5/14/19 at 4:55 PM, the Director of Nursing (DON) stated that the expired control solutions are for a glucometer machine the facility does not use or have. On 5/15/19 9:20 AM, in an interview, the DON stated the medications and supplies come in either Wednesday or Thursday and at this time the nursing staff check for outdates and restock the medications and supplies. The DON stated the package of green top vacutainers tubes had come from the local hospital last week. The package of green top vacutainer tubes arrived from the hospital to the facility with several missing tubes. The DON stated the facility had not drawn any residents blood or used the expired green top vacutainer tubes.	F 761		
F 801 SS=C	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2)	F 801		6/18/19

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F 801	Continued From page 17 §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to	F 801		

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F 801	Continued From page 18 November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who- (i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is: (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure a Certified Dietary Manager with appropriate credentials was employed. This deficient practice had the potential to effect 50 of 55 residents who received meals in the facility.	F 801	F 801: The facility failed to ensure a Certified Dietary Manager with appropriate credentials was employed. On 06/18/2019, the facility began taking	

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F 801	Continued From page 19 Findings include: During the initial tour of the kitchen on 5/13/19 at 8:50 AM, the Dietary Manager (DM) was asked if she was certified as a Dietary Manager. She stated that she did not have the credentials yet and had just recently signed up for the classes to get her credentials because she thought she had five (5) years to obtain it. The DM also stated she had been employed at the facility for 10 years as the cook and had been designated as the Dietary Manager in May of 2017. She stated that the Registered Dietitian was not full-time and came to the facility once a month but will come twice a month to help her with her classes she had signed up for. She was asked to provide verification of registration for the courses. A review of the registration provided by the DM revealed confirmation dated 4/25/19, for her courses at Auburn University offices of continuing education for the Dietary Manager Independent Study Program. The confirmation contained information about accessing module 1-24 and her student ID number. In an interview conducted with the Registered Dietitian (RD) on 5/15/19 at 11:45 AM, she stated she was employed as a contractor by an outside company and was scheduled for one (1) day a month at the facility. The RD stated she had been consulting at this facility since August 2018. She also stated she was aware that the DM was not currently credentialed and was past the deadline. She further stated she had been encouraging enrollment in the courses and confirmed she will be increasing time at the facility to preceptor the DM in her courses. She also stated that the program was typically a two	F 801	action to locate a Certified Dietary Manager to manage the Dietary Department. II. Steps taken to identify other residents having the potential to be affected by the same alleged deficient practice. Fifty out of fifty-five residents in the facility are at risk for the results of the alleged deficient practice. III. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? On 06/18/2019, the facility Administrator posted a position on www.indeed.com for the facility advertising for a Certified Dietary Manager, a Certified Food Service Manager or someone who has an associate's or higher degree in food service management or restaurant management from an accredited institution of higher learning. After interviews of the applicants, a qualified Manager will be hired to run the day to day operations of the dietary department. IV. Monitoring the corrective actions (Quality Assurance Program) to ensure that the alleged deficient practice does not recur. The Administrator will interview for the position for a Certified Dietary Manager once candidates apply. The Administrator	

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F 801	Continued From page 20 (2)-year program. On 5/16/19 at 10:00 AM, in an interview with the Administrator, he stated that he was aware the DM was not certified and was enrolled in the courses. He also stated he was told by the consulting company that she would have five (5) years to obtain her certification because she had been employed by the facility for 10 years. He did confirm that she had been designated as the DM in May of 2017, which would put her in a 1-year window of completion to be completed by November of 2018. During this interview the Administrator and surveyor checked the Association of Nutrition and Foodservice Professionals (ANFP) website. The following information was confirmed; "As of November 28, 2017, newly-hired Food Service Directors must meet the qualifications specified in the regulations and are no longer within the one-year window for obtaining certification. The Certified Dietary Manager, Certified Food Protection Professional (CDM, CFPP) credential is now listed as the primary qualification for the Director of Food and Nutrition Services in the absence of a full-time dietitian." The regulation was also reviewed with the Administrator for clarification of the required deadline which states; (i) For designations prior to November 28, 2016, meets the following requirements no later than five (5) years after November 28, 2016, or no later than 1 year after November 28, 2016, for designations after November 28, 2016." The Administrator confirmed that the DM had been designated in her current position in May of 2017.	F 801	will report to the Quality Assurance Committee monthly or until compliance is achieved on the findings of the interview process. The Quality Assurance Committee will make recommendations as needed.	

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F 803	Continued From page 21	F 803		
F 803 SS=D	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility emergency menus, it was determined the facility failed to follow the approved menu for 50 of 55 residents in the facility. Findings include: A review of the facility's emergency food supply	F 803	F 803: The facility failed to follow the approved menu set in place for emergency provisions. On 05/15/2019 at 1:15pm, the Dietary Manager located the menu for emergency preparedness, and placed an order to fully stock the required items to	6/18/19

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F 803	Continued From page 22 policy revised on 10/17, and titled "Emergency and Disaster Planning" documented the intent of the policy as "Emergency and disaster plans for interruption of service that are available and are followed to ensure that adequate nourishment will be provided to residents and staff. Basic safety and sanitation principles for storage, preparation and service of food and securing food and supplies from appropriate sources are followed. Procedures: Section 3 Planning for an emergency: a. The DM shall keep on hand at all times: "A minimum of three (3) day's supply of non-perishable food. Stock is rotated as necessary; "A minimum of three (3) day's supply of disposable meal service items; and "Disaster supplies (see suggestions for foods to keep on hand for an emergency in Appendix). b. The DM shall keep on hand during hurricane and winter storm seasons a minimum of five (5) day's supply of non-perishable food. Section 7: Menu Planning for an emergency a. Plan menus in advance to use foods that are perishable, other potentially hazardous foods, and foods on hand that are designated as disaster food supply. b. Menus should include familiar and acceptable items, especially "comfort" foods. An adequate amount of coffee for residents, staff, family members and volunteers especially important. c. Menus should include modifications for special needs, diabetes mellitus, dialysis, those who need a sodium restriction. Liberalize diets as much as possible during an emergency period. The following list of foods was included in the policy to meet the minimum requirements of the three (3)-day menu for 100 people:	F 803	have a three day emergency supply of food within the facility. II. Steps taken to identify other residents having the potential to be affected by the same alleged deficient practice. Fifty out of fifty-five residents in the facility are at risk for the results of the alleged deficient practice. III. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? On 05/15/2019, the policy and the menu related to emergency food supply was reviewed by the Dietary Manager and the facility Administrator. On 05/15/2019, the Dietary Manager placed an order with the facilities contracted food service company obtaining all items needed to have a full three day emergency supply of non-perishable food in-house. Upon completing inventory each Monday, the Dietary Manager will ensure that the Dietary Department will maintain the full three day emergency supply of food, and will replenish the supply as it is used. IV. Monitoring the corrective actions (Quality Assurance Program) to ensure that the alleged deficient practice does not recur. Beginning on 05/20/2019, the Dietary Manager will monitor the emergency food	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISVILLE HEALTHCARE LLC	543 EAST MAIN STREET/PO BOX 542 LOUISVILLE, MS 39339

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 803	Continued From page 23 Fruit juice 13, 48oz. (ounce) box Dry cereal 18 ¾ quarts Instant grits (two) 2 bulk packages Vegetable Beef Soup 20, #50 cans Chicken Noodle Soup 12, #50 cans Tomato Soup 12, #50 cans Tuna (four) 4, #10 cans Cheese 6 ½ pounds Ravioli (four) 4, #10 cans Green Beans (four) 4, #10 cans Green Peas (four) 4, #10 cans Beets (four) 4, #10 cans Peach Slices (four) 4, #10 cans Pear Halves (four) 4, #10 cans Pineapple Slices (four) 4, #10 cans Fruit Cocktail (four) 4, #10 cans Peanut Butter 18 ¾ pounds Jelly (nine) 9 cups Rice (six) 6 pounds Crackers 600 (two) 2-pack Bread 30 loaves (32 oz) Dry Milk 10 gallons On 5/13/19 at 3:10 PM, an inspection of the facility's emergency food supply revealed the following: no designated area for storage of the emergency food supply. In an interview with the Dietary Manager (DM) during this inspection she stated that she had just started to gather some food for the facility's emergency supply. She stated they had to use some of the ravioli and had not yet replaced it. The menu for the emergency supply was requested with the policy/protocol for the facility's emergency supply requirements. During an inspection of the emergency food supply on 5/14/19 at 10:35 AM, the following items were observed in the food storage:	F 803	supply during her inventory on a weekly basis ensuring the proper supply is maintained. The Dietary Manager will report all findings to the Quality Assurance Committee monthly for three months. The Quality Assurance Committee will make recommendations as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255096	A. BUILDING _____ B. WING _____	05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISVILLE HEALTHCARE LLC	543 EAST MAIN STREET/PO BOX 542 LOUISVILLE, MS 39339

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 803	Continued From page 24 Eight (8) - #50 cans of Tomato soup with a serving size of 12 (1/2 cup) Seven (7) - #50 cans of Cream of Chicken soup with a serving size of 12 (1/2 cup) Twelve (12) - #50 cans of Cream of Mushroom soup with a serving size of 12 (1/2 cup) One (1) - #50 can of Cream of Celery soup with a serving size of 12 (1/2cup) Three (3) - #10 cans of Ravioli with a serving size of 12 (1cup) Two (2) - five (5) pound (lb.) tubs of Peanut Butter In an interview on 5/15/19 at 10:35 AM, with the DM, she revealed that she could not locate or was not sure where to find the emergency supply policy. She stated that she was sure they had one provided by the consulting company that provided their menus. The DM also stated that would be the policy they would be using to implement their emergency menus. An interview with the Registered Dietitian (RD) on 5/15/19 at 11:45 AM, revealed that she was not aware that there was not a designated emergency food supply. She stated that the policy for the emergency food supply was in the dietary office and she would make sure the DM knew where to locate it. The facility failed to meet the requirements of the emergency menu that would provide adequate nourishment as required by their policy.	F 803		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255096	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/15/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISVILLE HEALTHCARE LLC	**543 EAST MAIN STREET/PO BOX 542** **LOUISVILLE, MS 39339**

(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 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility meets the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). There were no LSC deficiencies cited during this survey.	K 000		

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

Electronically Signed | 06/19/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255096	A. BUILDING _____ B. WING _____	05/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISVILLE HEALTHCARE LLC	543 EAST MAIN STREET/PO BOX 542 LOUISVILLE, MS 39339

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E 000	Initial Comments * EMERGENCY PREPAREDNESS * Survey conducted on 5/15/19 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

Electronically Signed | 06/19/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.