STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255192	A. BUILDING _____ B. WING _____	02/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE COUNTY SENIOR CARE	2124 OLD HWY 61 SOUTH PORT GIBSON, MS 39150

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F 000	INITIAL COMMENTS An annual survey was conducted at Claiborne County Senior Care February 25, 2019 to February 28, 2019. The annual survey revealed that the facility was not in substantial compliance with Medicare/Medicaid requirements of participation, and cited F759, F805, F812, and F880. Resident Census at the time of survey was 72 and the facility held a license for 75 beds.	F 000		
F 759 SS=E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, it was determined the facility failed to administer medications according to the physician's orders for one (1) resident, Resident #30, of nine (9) residents observed during medication administration. These were two (2) nurses observed for medication administration. This resulted in a medication error rate of 33%. Findings include: On 2/27/19 at 11:02 AM, during medication administration observation, License Practical Nurse (LPN) #1 was observed to administer the following five (5) medications out of the time range to Resident #30: - Atorvastatin calcium (lipid lowering agent) 80	F 759	1. Resident #30 was immediately checked 2/27/2019 for any side effects related to late administration of medications. Physician was called and informed of late medication administration by Director of Nursing (DON) on 02/27/2019. He stated to observe resident for any untoward effects for one day. Resident was observed by DON for any problems related to late administration (e.g., seizures) none were noted. Licensed Practical Nurse (LPN) #1 was in serviced by DON regarding Five Rights of Medication Pass, with emphasis on time of administration, on 2/27/2019. 2. Residents who receive scheduled	4/28/19

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

Electronically Signed | 04/19/2019

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 759	Continued From page 1 milligram (mg) one (1) tablet, - Prednisone (steroid) 40 mg one (1) tablet - Cipro (antibiotic) 500 mg one(1) tablet - Eliquis 5 mg (anticoagulant) one (1) tablet - Metoprolol 50 mg one (1) tablet The medications were crushed in a separate bag and then placed in separate containers for administration via feeding tube. LPN #1 was observed checking the placement of the feed tube. LPN #1 flushed with five (5) ml of water between each medication administered. LPN#1 flushed with 30 milliliters (ml) water before and after completion of medication pass. The nurse was observed picking up the medication containers and the water container and carried them out of the resident room. LPN #1 then threw the containers into the waste disposal. A review of the resident's 2/27/19 Medication Administration Audit Report revealed the resident was to receive the following medications at 8:00 AM: - MiraLAX Powder 3350 17 grams daily - Pantoprazole Sodium 40 mg daily - Eliquis 5 mg one(1) tablet twice a day - Systene gel one (1) drop in both eyes twice a day - Metoprolol 50 mg one(1) tablet twice a day - Atrovastatin Calcium 80 mg one (1) tablet daily - MagOx 400 mg one(1) tablet two (2) times a day - Keppra Solution 100 mg/milliliter(ml) give 15 ml every 12 hours - Prostate Sugar Free 30 ml three (3) times a day - Vitamin C 500 mg one(1) tablet three (3)	F 759	medications have the potential to be affected by the practice of giving medications out of the scheduled time frame. 3. Nursing staff was in serviced by DON regarding Five Rights of Medication Pass, with emphasis, on time 4/10/2019 (time allows for medication to be given 60 minutes before or after scheduled time). In-service is scheduled with Pharmacist 4/25/2019 regarding medication pass, with emphasis on time and appropriate cleaning and disinfecting of glucometer. Medication pass will be observed by DON two times a week for four weeks, then monthly to ensure compliance. All new hires will be in-serviced by Staff Development Nurse. 4. Results of monitoring of medication pass with be given to Quality Assurance (QA) committee by DON. The QA Committee will monitor and make recommendations as needed for sustained compliance.	

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F 759	Continued From page 2 times a day - Prednisone 40 mg one (1) tablet daily - Tylenol with Codeine #3 300-30 mg one(1) tablet daily - Cipro 500 mg one (1) capsule twice a day - An additional review of the resident's Medication Administration Audit Report revealed the resident did not receive the following six (6) medications during the 11:02 AM medication pass, which were scheduled to be given at 8:00 a.m.: - Magnesium Oxide (mineral) 400 mg one (1) tablet - Keppra Solution (anti-convulsant) 100 mg/milliliter (15 ml every 12 hours) - Tylenol with Codeine #3 (narcotic) 300-30 mg - Miralax Powder (laxative) 17 grams - Pantoprazole sodium (antacid) 40 mg - Systane gel 0.4-0.3% (dry eyes) one (1) drop to both eyes - These medications were later charted as being given at 1:327 PM., four (4) hours after the 8:00 AM scheduled time. In an interview conducted on 2/27/19 at 11:02 AM., LPN #1 stated she was running late giving her medications because it had been a long time since she had administered medications to the residents. She also reported that she was having difficulty with her computer. The computer was locking her out of the system and she was unclear of why this was occurring. The Administrator was working on her computer to solve the issue. In an interview with the Director of Nursing on 2/28/19 at 4:45 PM, the DON said that all medications had been administered to Resident	F 759		

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F 759	Continued From page 3 #30, but they had been given late according to her report from LPN #1 and her audit report. The DON said she was sorry that this had occurred. The Medical Director was unavailable for an interview regarding the late administration of this resident's medications During the Medication Administration observations, 33 medications were observed being administered with 11 total medications errors. The facility's medication error rate was 33 percent.	F 759		
F 805 SS=F	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility recipes, it was determined the facility failed to follow the puree recipes for fried chicken and broccoli menus. This had the potential to affect six (6) of six (6) residents receiving pureed diets. Findings include: Review of the facility's document titled, "Recipe Report Pureed Fried Chicken", with a copyright date of 1999 to 2019, revealed the recipe was designed for 10 residents receiving a pureed diet. The recipe called for eight (8) pieces of chicken rolled in seasoned flour and fried. Remove the required number of portions and place in the	F 805	1. Six residents that had the potential to be affected were interviewed. No residents served a pureed diet had any signs and symptoms of aspiration related to pureed consistency 2/28/2019 and were assessed by Director of Nursing (DON). Dietary Cook (DC) # 7 was in-serviced on preparation and preparation of pureed diet by Dietary Manager (DM) on 2/28/2019. 2. All six residents on a pureed diet had a potential to be affected by deficient practices. No other residents had a potential to be affected by this deficient	4/28/19

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F 805	Continued From page 4 processor bowl. Process for 30 to 45 seconds or until the mixture is smooth. Check for texture and consistency; add hot liquid, if needed, to make the consistency of pudding or mashed potatoes. Food thickener should not be needed. If liquid is added, continue the process for one (1) minute longer or until smooth Review of the facility document titled, "Recipe Report for Pureed Broccoli", with a copyright date of 1999 to 2019, revealed the resident was designed for 10 residents. The recipe called for two and half (2 ½) pounds (lbs.) of frozen broccoli florets to be placed in the steamer with seasoning of margarine and salt for five (5) to 10 minutes, or until tender. Then removed the required number of portions from the amount prepared and place in the food processor bowl. Process for 30 to 45 seconds or until mixture is smooth. Check for texture and consistency; add thickener if needed, to make consistency of mashed potatoes. On 2/27/19 at 9:43 AM, observation of the pureed meal preparation for fried chicken revealed Dietary Cook (DC) #7 placed six (6) fried boneless chicken breasts in the Robot Coupe and poured a small amount (no measurement used) of whole milk in the mixer and proceeded to puree the mixture for two (2) to three (3) minutes. During this process, the Cook added a small amount of milk four (4) additional times without measurement. DC #7 was asked what consistency she was looking for in the pureed mixture. DC #7 responded she was not sure what the surveyor meant by consistency. After giving the Cook an example of consistency (i.e. pudding or mashed potatoes), the Cook responded the consistency, "Should be able to fill scoop #10". When finished pureeing, the mixture had a	F 805	practice, as all other residents were on a non-pureed diet. 3. DM will observe Dietary Cooks five days a week for four weeks and monthly to ensure appropriate consistency of pureed foods and recipes are being followed, as of 2/28/2019. DM will ensure that pureed foods are being prepared in a consistency that is appropriate for each Resident s ability to chew and swallow. All pureed foods will be blended to a consistency that holds its shape such as mashed potatoes or pudding. DC # 7 and Dietary Cooks will be in-serviced monthly via video presentation of pureed food consistency by DM beginning 2/28/2019. All newly hired Dietary Employees will be in-serviced by DM. In-service to dietary staff on Policy # FP.6 Standardized Recipes and MS.16 Preparation and Preparation of Pureed Diet was conducted by Registered Dietitian on 4/17/2019. 4. Results of daily monitoring of recipes prepared will be done through observation, with an emphasis on following standardized recipes, correct use of recipe weight, measurements, consistency of pureed food, and yields discussed with DC # 7 and all Dietary Cooks. DM will forward all notes and recommendations to Quality Assurance (QA) committee. QA committee will monitor and make recommendations as needed for sustained compliance.	

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F 805	Continued From page 5 smooth runny appearance with no shape. The Dietary Cook placed the mixture in a steel container in the warming oven. The Dietary Cook said the mixture was enough for six (6) residents. The Dietary Cook then prepared to puree the broccoli. The Dietary Cook drained water from a pot of cooked broccoli and then placed broccoli florets (without measurement) into the Robot Coupe and proceeded to puree the vegetable. The Dietary Cook, when asked how much broccoli was used, responded it was "one (1) chunk". She did not know exactly how many ounces the "one (1) chunk" was. The Cook pureed the mixture for approximately 60 seconds and then stirred the mixture with a spatula. The Cook did not add anything else to the mixture. The mixture was pureed again for 40 seconds and then was poured into a metal container and placed in the oven. The mixture lacked the consistency of pudding or mashed potatoes. An interview was conducted with Dietary Cook #7 on 2/27/19 at 10:23 AM. DC #7 admitted that she did not add the milk to the puree fried chicken and was not aware the recipe required (called for) hot liquid to be added, not cold milk. The Cook also stated that she does not always measure the amount of food item, that she usually guesses on what the amount should be. The Dietary Cook further stated that she prepared enough for the six (6) residents on pureed diets. However, if the residents requested additional servings, that she would have to prepare more of the pureed items, causing a delay in the resident receiving their food requests in a timely manner. During an interview with the Dietary Manager	F 805		

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F 805	Continued From page 6 (DM) on 2/27/19 at 10:40 AM, the procedure the Dietary Cook used to puree the fried chicken and broccoli was described. The DM stated the Cook should have followed the recipes to ensure the pureed items were prepared to the proper consistency, palatability, and serving size. The Cook stated the pureed items should have consistency of mashed potatoes or pudding. The DM agreed the Dietary Cook should follow the recipe for the pureed fried chicken and pureed broccoli. The DM confirmed currently there were six (6) residents in the facility on a pureed diet.	F 805		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the kitchen	F 812	F812 - Freezer Door	4/28/19

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F 812	Continued From page 7 was maintained in a sanitary manner. Inspection tour of the facility revealed excessive buildup of frost and ice in the facility freezer, crusty residue on the dish storage cart, and residents' water pitcher with water inside the inner container. This created the potential for the spread of food borne illness to 73 of 75 residents who received their meals prepared in the kitchen. Findings include: The initial kitchen inspection was conducted with Dietary Cook (DC) #6, on 2/25/19 at 9:30 AM, with the following concerns identified: The walk-in freezer had an outside temperature (temp) of minus one (1) degree and inside temp of minus 10 degrees, with a heavy buildup of frost and ice along the doorway of freezer, ceiling, packages of food, and around the fans in the room. Icicles were forming from the ceiling of the freezer, frost starting to form on the floor, and food frozen solid. DC #6 stated this problem has existed for several months. DC #6 stated they had the "Trouble Shooter" company to evaluate the problem two (2)times and explained a new strip was needed along the edge of the doorway for the door to close properly. DC #6 stated the staff must scrape the frost/ice from the doorway to allow the door to close properly. Tour of the kitchen on 2/27/19 8:45 AM, revealed the following concerns: Four (4) of eight (8) residents' water pitchers were observed with water droplets trapped inside pitcher container. Interview with Dietary Cook #6 revealed the water pitchers were supposed to be completely dry and this was not sanitary. DC #6	F 812	1. Freezer temperature was immediately checked on 2/25/2019 by Dietary Manager (DM) with result of -4 degrees. Temperature was within the required normal range. 2. All Residents foods stored in freezer have a potential to be affected by damaged freezer door (failure to close properly). All residents had the potential to be affected by this deficient practice. 3. DM will continue to monitor temperature and ice build-up twice a day for maintenance of temperature and prevention of ice build-up. Dietary staff in-serviced 2/28/2019 & 3/7/2019 by DM on preventing and monitoring abnormal temperatures (walk-in freezer) and ice build-up on walk-in freezer door. The DM began to monitor temperatures and ice build-up twice a day on 2/25/2019. Temperatures are to be recorded daily and within compliance range of -10 degrees by day cook, evening cook, and DM. A new walk-in freezer door was ordered on 4/17/2019 and will arrive for installation on or before 5/17/2019 through Troubleshooters, Inc. RD conducted in-service on 4/17/2019 for all Dietary staff regarding freezer temperatures and removal of ice build-up on freezer door. All newly hired Dietary Employees will be in-serviced by DM. 4. Results of daily /monthly freezer temperatures will be given to Quality Assurance (QA) Committee monthly by DM. Dietary Manager and Dietary Cooks	

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F 812	Continued From page 8 removed the water pitchers from the tray. A Two (2) tier cart that contained two (2) trays of dishes including 38 plates, 53 bowls, and 27 saucers for the lunch meal service, had beige crusty-type flakes on the cart and among the dishes. An interview with DC #6, during this observation, revealed the staff should ensure the cart is clean by wiping it off before putting trays of clean dishes on the cart. The walk-in freezer outside temperature showed a minus four (4) degrees and frost forming on the bottom portion of the door. There was a sign posted on the freezer door instructing the staff to be sure the door was completely closed. Frost and ice had formed on the doorway, walls, and around fans of the freezer motor; and small icicles were forming on the ceiling. The Dietary Manager (DM) had just finished scraping ice and frost from the edges of the freezer door. The DM stated the problem had existed for several weeks now. The DM stated the Maintenance Supervisor was unable to fix the problem and they had to call in an outside contractor, "The Trouble Shooters", twice to address the problem. The DM thought the door needed to replace. The DM stated that the Administrator had the paper work and was addressing problem. The DM also stated the staff usually scraped the frost/ice from the doorway every other day to ensure the door closed properly. The DM acknowledged that frost was now forming on the bottom door leading to the refrigerator portion. A wall vent with heavy brown grease buildup was observed. The DM stated the maintenance department was responsible for cleaning. The DM was unable to provide cleaning log for the	F 812	will monitor temperatures daily until new door is installed. QA committee will monitor for sustained compliance. F812 Two- tier cart 1. All dishes, trays and cart were immediately washed, cleaned and sanitized by Dietary Employee (DE) #6. DE #6 immediately in-serviced by Dietary Manager (DM) on 2/27/2019 cleaning and sanitizing equipment. 2. All residents had the potential to be affected by a lack of cleanliness. No residents were affected due to lack of cleanliness of dishes on storage cart (dishes were scheduled to be use for lunch meal service only). 3. Register Dietitian (RD) conducted in-service on 4/17/2019 for all Dietary staff regarding Policy # SI.34, Cleaning and Sanitizing Equipment, and Policy # SI.8, Machine Ware Washing. DM will monitor daily lunch cart daily for cleanliness of cart, trays, and dishes beginning 2/28/2019 for four weeks, then monthly to ensure compliance. All newly hired Dietary Employees will be in-serviced by DM. 4. Results of daily monitoring of cleanliness of two-tier cart and dishes and trays will be reported by the DM to the Quality Assurance (QA) Committee monthly for recommendations or changes as needed to ensure compliance. F812 Water Pitchers	

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F 812	Continued From page 9 vent. During an interview on 2/27/19 3:30 PM, the Administrator acknowledged problems with the facility's freezer. The Administrator stated the "Trouble Shooters" consultants had evaluated the problems twice and identified the building's "settling" has caused the problems with the freezer door and the age of the freezer was a problem also. The Administrator stated the freezer door needed to be replaced as well as the refrigerator door. The Administrator provided a copy of a capital equipment request. The Administrator also stated the request had been submitted to the Corporate office and was awaiting the approval.	F 812	1. All water pitchers with trapped water droplets inside of pitcher insulation were immediately discarded by Dietary Manager (DM). Dietary Employee (DE) # 6 immediately in-serviced by DM on 2/27/2019 regarding discarding water pitchers that had trapped water droplets inside and to replace with new water pitchers that do not have the potential for trapped water droplets inside insulation of water pitchers. In-service held on 2/28/2019 by Dietary manager (DM) on Food contact surface (water pitchers) are to be washed, rinsed, sanitized and air dried after each wash. 2. All residents had the potential to be affected by unsafe sanitation practices but none were affected. Residents and staff interviewed did not reveal any complaints regarding the water trapped within the insulation of the pitchers by Director of Nursing (DON) and DM on 2/28/2019. 3. DM and day shift Dishwasher Aide will check the water pitchers three (3) days a week beginning 2/28/2019 then monthly to ensure compliance and observe for any visible signs of water droplets trapped inside water pitcher liner. Any detection will be reported immediately to Administrator. All newly hired Dietary Employee will be in-serviced by DM. Registered Dietitian (RD) conducted in-service on 4/17/2019 for all Dietary staff regarding Policy #SI.8, Machine Ware Washing.	

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F 812	Continued From page 10	F 812	4. Results of monitoring trapped water droplets inside of water pitcher s insulation will be given to Quality Assurance (QA) committee by Dietary Manager monthly. The QA committee will monitor and make recommendations or changes as needed to ensure sustained compliance. F 812 Kitchen Wall Vent Rack 1. The grease build-up on kitchen wall vent rack was immediately removed by Maintenance Personnel, washed, and cleaned. 2. All Residents had the potential to be affected by unsafe sanitation practices. 3. DM will monitor kitchen wall vent weekly and monthly to ensure no build-up of grease occurs beginning 2/28/2019. Kitchen wall vent will be cleaned by Maintenance Supervisor every Wednesday, beginning 2/28/2019. All newly hired Dietary Employees will be in-serviced by DM on Policy # SI.34, Cleaning and Sanitizing Equipment/ non-contact food surfaces. Register Dietitian (RD) conducted in-service on 4/17/2019 for all Dietary staff regarding Policy # SI.34, Cleaning and Sanitizing Equipment/ non- contact food surfaces. 4. Results will be reported monthly by the DM to the Quality Assurance (QA) Committee for recommendations or changes as needed to ensure sustained compliance.	

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	255192	A. BUILDING _____ B. WING _____	02/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE COUNTY SENIOR CARE	2124 OLD HWY 61 SOUTH PORT GIBSON, MS 39150

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F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		4/28/19

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	255192	A. BUILDING _____ B. WING _____	02/28/2019

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F 880	Continued From page 12 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policy, it was determined the facility failed to ensure the staff followed policy and procedures for disinfecting glucometers before and after each resident use for two (2) of six (6) glucometers observed for cleaning. This had the potential to spread blood-borne pathogens to residents who received Acu-checks. The facility also failed to ensure that one (1) of three (3) residents, Resident #30, received wound care and dressing changes, utilizing	F 880	F880 Glucometers 1. The fifteen residents that received finger stick blood sugar checks that shift by Licensed Practical Nurse (LPN) #1 and LPN #2 were immediately identified and assessed by Director of Nursing (DON) for any signs or symptoms of infection on 2/27/2019. The physician was notified by the DON of improper cleaning and disinfecting of glucometers possibly	

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	255192	A. BUILDING _____ B. WING _____	02/28/2019

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CLAIBORNE COUNTY SENIOR CARE	2124 OLD HWY 61 SOUTH PORT GIBSON, MS 39150

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F 880	Continued From page 13 appropriate clean technique. Findings include: Glucometers: Review of the facility policy titled, "Infection Prevention and Control Program", dated 8/2017, indicated it was the policy of this facility to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infection. The policy documented: 8. Equipment Protocol: a. All reusable items and equipment requiring special cleaning, disinfection, or sterilization shall be cleaned in accordance with our current procedure governing the cleaning and sterilization of soiled or contaminated equipment. Review of the manufacturer's undated recommendations titled, "Cleaning and Disinfection Procedures" documented cleaning and disinfecting the FORA GD 20 blood glucose meter. To clean the glucometer use a lint free cloth damped with soapy water or isopropyl (70% to 80%) to clean the outside of the blood glucose meter. To disinfect the blood glucometer, the manufacturer recommended the use of Super Sani-Cloth Germicical Wipes or Sani-Cloth Bleach Germicidal Disposables. The manufacturer's recommendations also included that it was crucial that the FORA GD20 meter was completely dry before testing a resident's blood glucose level and to follow the disinfectant product label instructions to ensure proper drying times. A review of the label for the use of the Super Sani-Cloth Germicidal Disposable Wipes revealed the following: if present, remove heavy	F 880	affecting the residents that received blood sugar checks that day (2/27/2019). Physician informed facility to notify him if any of the residents exhibited any signs or symptoms of infection. 2. All residents that received finger stick blood sugar PRN (as needed) or scheduled were at risk of infection from improper cleaning of glucometers. All fifteen of the residents identified that received a finger stick blood sugar check that shift were identified and assessed for any signs of infection by DON with no negative findings. 3. DON will monitor nursing staff beginning 2/28/2019 for appropriate cleaning and disinfecting of glucometers three times a week for four weeks, then weekly for two weeks and monthly thereafter. LPN #1 and LPN #2 were in-serviced regarding proper cleaning and disinfecting of glucometers on 2/27/2019 by DON. Representative from glucometer company conducted in-service on proper cleaning and disinfecting of glucometers for nursing staff on 3/26/2019. Pharmacist is scheduled for in-service on 4/25/2019 regarding proper disinfecting and cleaning of glucometers. 4. Results of monitoring of the cleaning and disinfection of glucometers will be forwarded to the Quality Assurance (QA) Committee by the DON monthly. The QA Committee will make recommendations as needed.	

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F 880	Continued From page 14 soil loads prior to disinfecting. Unfold a clean wipe and thoroughly treat the surface. Allow surface to remain treated for two (2) minutes and let air dry Review of the facility policy titled, "Glucometer Disinfection", dated 2/10/2018, indicated the purpose of this procedure is to provide guidelines for the disinfection of capillary-blood sampling devices to prevent transmission of blood borne diseases to residents and employees. 1. The facility will ensure blood glucometers will be cleaned and disinfected after each use and according to manufacturer's instructions for multi-resident use. 3. The glucometers should be disinfected with a wipe pre-saturated with an Environmental Protection Agency (EPA) registered healthcare disinfectant that is effective against HIV, Hepatitis C and Hepatitis B virus . 4. Glucometers should be cleaned and disinfected after each use and according to manufacturer's instructions, regardless of whether they are intended for single resident or multiple resident use. 5. Procedure included: i. Retrieve two (2) disinfectant wipes from container. j. Using first wipe, clean first to remove heavy soil, blood and/ or other contaminants left on the surface of the glucometer. k. After cleaning, use the second wipe to disinfect the glucometer thoroughly with the disinfectant wipe, following by wrapping the machine with the disinfecting wipe and leaving wrapped no less than two (2) full minutes. l. Discard disinfectant wipe in waste receptacle. m. Perform hand hygiene.	F 880	F880 Wound Care 1. Resident #30 s wound was immediately checked by Director of Nursing (DON) for any signs or symptoms of infection when informed of deficient practice on 2/27/2019. The Physician was informed by the DON on 2/27/2019 of the lack of proper procedure for clean wound dressing change. Physician asked to be informed of any changes in resident condition over the next 24 hours. There were no changes in the Resident #30 s wound when checked by DON the next day. Wound Care Nurse was in-serviced by DON on 2/27/2019 regarding the appropriate number of employees needed to safely complete wound care using infection control technique. 2. The four residents with wounds had the potential to be affected by the practice of not having the appropriate number of assistants needed to safely and effectively use infection control techniques. All four residents were assessed by DON on 2/27/2019 with no negative effects. None of the wounds showed evidence of infection in wounds. 3. In-service was held for nursing staff 3/26/2019 by DON on using the appropriate number of staff needed to perform wound care using infection control techniques. In-service for nursing staff scheduled with Pharmacist on 4/25/2019 regarding infection control related to wound care. New staff will be in-serviced upon hire by Staff	

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F 880	Continued From page 15 During the medication administration pass observation on 2/27/19 at 8:05 AM, License Practical Nurse (LPN) #1 was observed cleaning/disinfecting a blood glucose meter in the following manner: LPN #1 picked up the blood glucose meter from the medication cart located on Hall C. She took one (1) wipe from a container labeled PDI Santi-Hands. Using the Santi-Hands cloth, LPN#1 wiped off the blood glucose meter on the front side and then turned it over and wiped off the back side. LPN #1 then placed the blood glucose meter in the top drawer of the medication cart on Hall C and threw away the PDI Santi-Hands cloth in the waste dispenser. LPN #1 took another PDI Santi- Hands cloth from the container on medication cart Hall C and wiped off her hands. On 2/27/19 at 11:57 AM, LPN #2 was observed cleaning and disinfection a blood glucose meter on the medication cart located on Hall A in the following manner: LPN #2 took one (1) cloth from a blue top container labeled Clorox Healthcare Bleach Germicidal Wipes. LPN#2 then took the germicidal wipe and wiped down the front side of the blood glucose meter and then turned it over and wiped down the back side. LPN #2 then took a clean paper towel and wrapped the blood glucose meter in the towel. LPN #2 then placed the wrapped blood glucose meter in the medication cart's top drawer. LPN #2 then threw the germicidal wipe in the waste dispenser and used another germicidal wipe to clean her hands. Review of the facility sanitization policy revealed that the PDI Santi Wipe were recommended for an antiseptic for handwashing to decrease	F 880	Development Nurse. Beginning 2/28/2019, DON will monitor wound care by nursing staff two times a week for four weeks, one time a week for two weeks, and monthly thereafter. 4. Results of monthly monitoring will be forwarded to the Quality Assurance (QA) Committee monthly by the DON. The QA Committee will review and make recommendations or changes as needed to ensure sustained compliance.	

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F 880	Continued From page 16 bacteria on the skin. On 2/27 19 at 1:53 PM, an interview was conducted with LPN #2 at the nurse's station. LPN #2 reported she had been trained by several different nurses. LPN #2 said she was told to wipe the blood glucose meter down with a bleach wipe and then place the blood glucose meter in a paper towel. In an interview, on 2/27/19 at 1:58 PM, at the nurse's station, LPN #1 said she was taught to wipe the blood glucose meter down before putting in back in the medication cart. LPN #1 stated she did not recall any wait time for drying. An interview was conducted with RN Charge Nurse #3 (RN) at the nurses' station on 2/27/19 at 2:23 PM. RN #3 reported she did not remember the procedure for cleaning and disinfection the blood glucose meters. She stated it had been a long time since she had attended an in-service for cleaning and disinfecting blood glucose meters. An interview was conducted on 2/27/19 at 2:27 PM with LPN #4. The LPN said she would clean her glucose meter before and after using it. She said that she would let it air dry about three (3) minutes and that she used the purple Super Cloths to clean the glucose meter. LPN #4 said she had been in-serviced last year. An interview was conducted on 2/27/19 at 4:00 PM, with the Staff Development Coordinator (SDC), in her office. The SDC reported that the staff should know the procedure for cleaning and disinfection the facility blood glucose meters. She said the Director of Nursing (DON) had conducted the last in-service on 1/24/19. The	F 880		

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	255192	A. BUILDING _____ B. WING _____	02/28/2019

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CLAIBORNE COUNTY SENIOR CARE	2124 OLD HWY 61 SOUTH PORT GIBSON, MS 39150

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F 880	Continued From page 17 SDC said she does random inspections to monitor and ensure the staff are doing the proper procedure for cleaning and disinfecting their blood glucose meters. The SDC reported she watches the nurses as they do their Acu-checks and cleaning of their blood glucose meters. The SDC said she would be doing another in-service with the nurses on the policy of cleaning and disinfecting the facility blood glucose meters. On 2/27/19 at 4:16 PM, an interview was conducted with the DON in the facility conference room. The DON said she discusses and demonstrates the proper procedure to her nurses weekly. She stated she does random discussions and does not use a sign-in sheet. The DON said she would expect them to know how to clean and disinfect their blood glucose meter. The DON said she purchased two (2)blood glucose meters for each medication cart, so they would not have to wait while the blood glucose meter dried between cleanings. She said they were shown the facility policy and procedure on how to clean and disinfect the blood glucose meters in the last in-service. The facility provided documentation of an in-service class, conducted on the 1/24/19, for the licensed staff, which included training on disinfecting the blood glucose meters. Review of the facility's attendance sheets revealed LPN #1 and LPN #2 attended this training session. Resident #30: Review of facility undated document titled, "Clean Dressing Change", documented compliance guidelines for dressing changes included the following: #5. Set up a clean field on the overbed table with	F 880		

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F 880	Continued From page 18 needed supplies wound cleansing and dressing application .... #6. Establish area for soiled products to be placed #7. Wash hands and put on clean gloves #8. Place a barrier cloth or pad next to the resident under the wound to protect the bed linen #9. Loosen the tape and remove existing dressing ... #10. Remove gloves pulling inside out over the dressing and discard into appropriate receptacle #11. Wash hands and put on clean gloves #12. Cleanse the wound as ordered taking care not to contaminate other skin surfaces or surfaces of the wound (clean outward from the center of the wound) Pat dry with gauge. #13. Wash hands and put on clean gloves #14. Apply topical ointments or creams and dress the wound as ordered Observation on 2/25/19 at 2:29 PM, of Resident #30's wound care, revealed the following: The Wound Care Nurse had the resident position on his side. She prepared the over-bed table with two (2) plastic cups, one (1) cup contained saline soaked gauze and the other cup contained Dakin soaked gauze. The WCN removed the old undated dressing from the resident's sacral wound. The WCN discarded the old dressing in a plastic bag located at the foot of the bed. The wound was a healing stage III sacral ulcer, with pink granulating tissue, with a small dark area in the center of the wound. The WCN removed her gloves and went to wash her hands. While the nurse was washing her hands, the resident rolled onto his back. The WCN nurse returned and donned a new pair of gloves from the nightstand at the foot of the resident's bed and reposition the resident on his side. The WCN obtained a saline	F 880		

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F 880	Continued From page 19 soaked gauze and wipe from the resident's buttock cheek to the center of the sacral ulcer, thereby contaminating the wound from other skin surfaces. The WCN discarded the used gauze and with her dirty gloves, placed a clean gauze in the resident's sacral wound. The nurse left to change her gloves and the resident again rolled onto his back contaminating the clean gauze. The WCN donned clean gloves and removed contaminated gauze from wound and then packed area with Dakin's soaked gauze. The packed wound was then covered with a silicone dressing, without the LPN changing to new gloves. The silicone dressing was not thoroughly sealed and was coming loose. The nurse degloved, washed her hands, donned new gloves, and held the dressing in place for 45 seconds, until the dressing was completely sealed. During an interview with the Director of Nursing (DON) on 2/26/19 at 3:10 PM, the dressing change observed by the WCN on 2/25/19 was described to the DON. The DON stated she couldn't understand why the nurse did not have another staff member help position the resident. The DON also stated that when cleaning a wound, the nurse should wipe in a circular motion from the clean area to dirty area. The DON also stated that it appeared the WCN had contaminated the wound a couple times during the dressing change. An interview with the WCN on 2/27/19 at 4:15 PM, revealed she was aware there should have been another staff member present to help her, but it was at the end of the shift and could not find anyone. The WCN admitted that she had made some mistakes while doing the dressing changes	F 880		

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	255192	A. BUILDING _____ B. WING _____	02/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE COUNTY SENIOR CARE	2124 OLD HWY 61 SOUTH PORT GIBSON, MS 39150

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F 880	Continued From page 20 because she was nervous and did not expect to have anyone observe her that day doing a dressing change.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255192	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/26/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE COUNTY SENIOR CARE	**2124 OLD HWY 61 SOUTH** **PORT GIBSON, MS 39150**

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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 | 04/18/2019

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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E 000	Initial Comments * EMERGENCY PREPAREDNESS * Survey conducted on 2/26/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were identified.	E 000		

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