STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255307	A. BUILDING _____ B. WING _____	02/13/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted a recertification survey from 2/10/19 through 2/13/19. During the survey the SA determined the facility was not in compliance with the Medicare and Medicaid Requirements for Participation. The SA cited deficiencies at F623, F625, F644 and F880. The census at the time of entrance was 132. The facility is licensed for 150 beds.	F 000		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable	F 623		3/12/19

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

Electronically Signed | 03/08/2019

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 623	Continued From page 1 before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with	F 623		

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F 623	Continued From page 2 developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review the facility failed to notify the Responsible Party (RP) of Resident #2's transfer to the hospital, for one (1) of five (5) residents reviewed for hospitalization, Resident #2. Findings include:	F 623	F623 1. Registered Nurse #2 documented in nurses notes on 2/21/19 the events on 1/28/19 for Resident #2's appointment at wound care and transfer from wound care to the hospital for evaluation and	

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F 623	Continued From page 3 Record review of the facility's "Notification To Responsible Party" policy, revised 1/12/05, revealed the Responsible Party (RP) will be notified for all Resident's MD appointments, tests, outside therapy, admissions, and/or discharges to any outside facility. Notify family member and/or Responsible Party when any of the following occurs: Admit and/or discharge to any outside facility (Hospital, Senior Care Unit, etc.) Record review revealed the facility transferred Resident #2 to the hospital on 01/28/19. Resident #2 left on 1/28/19 to an appointment with the wound clinic and was transferred from the wound clinic to the Emergency Room (ER) due to low blood pressure. Resident #2 returned to the facility on 2/5/19. On 02/11/19 at 2:15 PM, an interview with the Director of Nursing (DON) and the Administrator revealed they were unaware of the regulation that the facility should send a hand written note to the RP of the transfer and the reason why they were transferred. The DON revealed they call the RP when a resident is transferred to the hospital, but do not send a letter. Record review of the nurses notes do not reveal the RP was notified of the transfer for Resident #2 on 1/28/19. The surveyor attempted to call the RP (daughter) but there was no answer and the number did not have a voice mail message available. On 2/12/19 at 9:18 AM, interview with the Director of Social Services revealed a bed hold policy/notification is not sent to the RP or the hospital at the time of transfer to the hospital.	F 623	notification of resident representative on 1/29/19. The administrator mailed a Bed Hold/Transfer Notice to Resident Representative for Resident #2 on 2/28/19 2. The facility has determined that all residents who are transferred to an outside certified facility, including hospital, have the potential of improper notification of transfer. 3. The Director of Nursing Services revised and renamed Notification to Responsible Party policy to Notification to Resident Representative. The policy revision included notification of resident representative of transfer to any outside facility (such as hospital or senior care facility) and to provide bed hold notice to the resident and/or resident representative upon transfer to another facility. An In-service education was initiated by the Director of Nursing Service on 2/26/19 for all Registered Nurses and Licensed Practical Nurses on policy revision including notifying resident representative of transfer and bed hold notice upon transfer or therapeutic leave. Registered Nurses and Licensed Practical Nurses not in-serviced on 2/26/19 will not be allowed to work until they have been in-serviced.	

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F 623	Continued From page 4 Record review of Resident #2's nurse's notes revealed on 1/28/19 at 1:07 PM, the resident went on Leave of Absence (LOA) for an appointment via (Ambulance service) to the Wound Care Center. On 1/28/19 at 10:32 PM, a Nurse's note revealed the nurse called the hospital to check on the resident and was told she was still in the back awaiting lab results. On 1/28/19 at 10:30 PM, a nurse's note revealed the nurse called the hospital to get an update on the resident's status and was informed that her nurse did not have any information and she would call when the ER Nurse gets an update. The next nurse's note was on 2/5/19, when the resident returned to the facility from the hospital stay. There is not documentation the RP was notified of the transfer by phone or written notice.	F 623	Newly hired Registered Nurses and Licensed Practical Nurses hired on or after 2/26/19 will be checked off on orientation checklist for Notification of Resident Representative. Inservice education conducted by Administrator on 2/26/19 with Social Services staff on written Transfer/Bed Hold Notice policy and Bed Hold/Transfer Notice form. 4. Quality Assurance Committee reviewed possible corrective action on 2/21/19. Beginning 3/1/19 the Director of Nursing Services will conduct a weekly record audit for 12 weeks of all residents who have been transferred to an outside certified facility, including hospital, to ensure resident representative was notified and documentation in medical record of notification. Any non compliance will be addressed immediately. Beginning 3/1/19 the administrator will conduct a weekly record audit for 12 weeks to ensure medical record includes documentation that written notification of transfer/bed hold notice was provided to resident/resident representative upon transfer to an outside certified facility, including hospital, of if they go on therapeutic leave. Any non compliance will be addressed immediately.	

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F 623	Continued From page 5	F 623	Quality Assurance Committee reviewed Plan of Correction 3/6/19 The Director of Nursing Services and administrator will present finding of audits to the Quality Assurance Performance Committee quarterly at a minimum or as often as needed for further review/recommendation or corrective action.	
F 625 SS=F	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the	F 625		3/12/19

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F 625	Continued From page 6 resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to notify the Responsible Party (RP) of bed hold for five (5) of five (5) residents reviewed for hospitalization; Resident #2, Resident #16, Resident #55, Resident #126, and Resident #130. Findings include: Record review of the facility's "Notification To Responsible Party" policy, with a revised date of 1/12/05, revealed the RP will be notified for all Resident's MD appointments, tests, outside therapy, admissions, and/or discharges to any outside facility. Notify family member and/or RP when any of the following occurs: Admit and/or discharge to any outside facility (Hospital, Senior Care Unit, etc.) Resident #55 Record review revealed Resident #55 was transferred to the Wound Care Center on 9/19/18, and sent to hospital from there with Bradycardia. The physician and RP were notified of the transfer. Resident returned with a new Percutaneous Endoscopic Gastrostomy (PEG) tube. There was no written bed hold notice provided/documented. Resident #2 Record review revealed Resident left on 1/28/19, to an appointment with the wound clinic, and was transferred from the wound clinic to the ER due to	F 625	F625 1. Resident Representative for Resident #2 was mailed a Bed Hold Notice on 2/28/19 by the administrator. Resident Representative for Resident #16 was mailed a Bed Hold Notice on 2/28/19 by the administrator. Resident Representative for resident #55 was mailed a Bed Hold Notice on 2/28/19 by the administrator. Resident Representative for Resident #126 was mailed a Bed Hold Notice on 2/28/19 by the administrator. Resident #130 expired on 11/20/18. Bed Hold Notice no longer applicable. 2. The facility has determined that all residents that are transferred to another certified facility, including hospital, or go on therapeutic leave have the potential of improper notification of bed hold policy. 3. Inservice education conducted by Administrator on 2/26/19 with Social	

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F 625	Continued From page 7 low blood pressure. Resident #2 returned to the facility on 2/5/19. There was no documentation that the RP was provided written notice of the transfer. Record review of the nurse's notes do not reveal the RP being notified of the transfer. The surveyor attempted to call the RP (daughter), but there was no answer and the number did not have a voice mail message available. Record review of Resident #2's nurse's notes revealed on 1/28/19 at 1:07 PM, the resident went for an appointment via the ambulance service, to the Wound Care Center. The nurse's note, dated 2/5/19, revealed the resident returned to the facility from the hospital stay. There is not documentation of the Responsible Party being notified of the transfer by phone or written notice of a bed hold. Resident #16 Record review revealed Resident #16 was transferred to the hospital on 12/24/18, for evaluation of shortness of breath per ambulance. The resident's RP was notified of status and the transfer to hospital. No written notice of bed hold was found in chart. Resident #126 Record review revealed Resident #126 was hospitalized 01/03/2019 through 01/17/2019, for Geri-Psych evaluation and treatment. The RP was notified of transfer and condition. Care plan in place with interventions to prevent transfer. No notification of a written bed hold policy was provided. Resident #130	F 625	Services staff on written Transfer/Bed Hold Notice policy and Bed Hold/Transfer Notice form. The Director of Nursing Services revised and renamed Notification to Responsible Party policy to Notification to Resident Representative. The policy revision included notification of resident representative of transfer to any outside facility (such as hospital or senior care facility) and to provide bed hold notice to the resident and/or resident representative upon transfer to an outside facility. An In-service education was initiated by the Director of Nursing Service on 2/26/19 for all Registered Nurses and Licensed Practical Nurses on policy revision including notifying resident representative of transfer and bed hold notice upon transfer or therapeutic leave. Registered Nurses and Licensed Practical Nurses will not be allowed to work until they have been in-serviced. Newly hired Registered Nurses and Licensed Practical Nurses hired on or after 2/26/19 will be checked off on orientation checklist for Notification of Resident Representative. 4. Quality Assurance Committee reviewed possible corrective action on 2/21/19. Beginning 3/1/19 the administrator will conduct a weekly record audit for 12 weeks to ensure medical record includes documentation that written notification of	

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F 625	Continued From page 8 Record review revealed Resident #130 discharged to the hospital on 11/16/2018, related to complaint of chest pain and Shortness of Breath (SOB). The Resident and family decided to release the bed on discharge. The RP was notified per nurse's notes, of transfer and condition, but no written bed hold to the RP was provided. On 02/11/19 at 2:15 PM, an interview with the DON and the Administrator revealed they were unaware of the regulation that the facility should send a hand written note to the RP of the transfer and the reason why the Resident was transferred. The DON revealed they call the RP when a resident is transferred to the hospital, but do not send a letter. On 2/12/19 at 9:18 AM, interview with the Director of Social Services revealed a bed hold policy/notification is not sent to the RP or the hospital when the resident is transferred to the hospital. On 02/12/19 at 11:25 AM, interview with the Administrator, revealed the facility had never notified the Responsible Party in writing of the bed hold. She stated their practice has been to notify by phone only.	F 625	bed hold/transfer notice was provided to resident/resident representative upon transfer to an outside certified facility, including hospital, or upon therapeutic leave. Any non compliance will be addressed immediately. Quality Assurance Committee reviewed Plan of Correction 3/6/19 The administrator will present findings of audit to the Quality Assurance Performance Committee quarterly at a minimum or as often as needed for further review/recommendation or corrective action.	
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination	F 644		3/12/19

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F 644	Continued From page 9 includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to obtain a Level II evaluation after a new diagnosis of mental illness, for one (1) two (2) residents reviewed for Pre Admission Screening and Resident Review (PASARR), Resident #67. Findings include: Record review revealed Resident #67 was not reviewed for referral for a Level II and mental health evaluation, related to new diagnoses of Psychosis, Paranoia Aggressiveness Disorder and Anxiety Disorder. Interview on 02/11/2019 at 10:00 AM, with the Social Services Representative, confirmed that an updated PASARR had not been completed, related to new diagnoses related to mental illness, for Resident #67. The Social Services Representative stated that the purpose of an updated PASARR is to see if a resident needs additional services and to know how to care for the resident.	F 644	F644 1. Referral was made by social worker #1 for Resident #67 on 2/25/19 to the appropriate state-designated authority for Level II Preadmission Screening and Resident Reviews (PASRR)for evaluation and determination. 2. The facility has determined that all residents who have a new or possible Mental Illness (MI), Intellectual disability (ID)or related condition have the potential to be affected. Resident records for 134 residents were reviewed on 3/5/19 by LPN#2 for new diagnosis of mental illness (MI) that had not been referred to the State designated authority for a Level II evaluation and determination since last annual	

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F 644	Continued From page 10 Interview with the Director of Nursing, on 02/11/2019 at 1:05 PM, confirmed that a new evaluation was important in caring for a resident with new mental illness diagnoses. Interview on 02/11/2019 at 1:10 PM, with the Administrator, confirmed that it is Social Service's responsibility to complete the PASARR as needed, and submit them timely. The Administrator stated that responsible staff was sent to in-services on completion of the PASARR.	F 644	recertification. The record review indicated 1 resident would need a Change in Status Request form completed and submitted to the appropriate State designated authority for a Level II evaluation and determination. Social Worker #2 completed and submitted a Change in Status Request on 3/5/19. 3. An in-service education program was conducted by an independent Licensed Social Work consultant with the Administrator on 2/22/2019 on review of PASARR requirements including significant change in status requiring a Level II resident review. An in-service education was conducted by the Administrator with the Social Services Department on 2/25/2019 on "Coordination with PASARR Program" policy review and PASARR requirements including significant change in status requiring a Level II resident review. The Social Services staff will review new orders and diagnosis weekly beginning 3/4/19 at the stand up meeting to capture any new diagnosis of mental illness that will need to be referred to the State designated authority for a Level II review and determination. Social Service staff has registered to attend the scheduled Medicaid PASARR Training in 2019 on 3/21/19.	

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F 644	Continued From page 11	F 644	4. Quality Assurance Committee reviewed possible corrective action on 2/21/19. Beginning 3/8/19, Social Services will give the administrator a weekly report for 12 weeks of residents with new mental illness diagnosis and the date referral made to the State designated authority for a Level II determination. Quality Assurance Committee reviewed Plan of Correction 3/6/19 The administrator will present the weekly report from Social Services to the Quality Assurance Performance Committee quarterly at a minimum or as often as needed to review for further recommendations or additional monitoring.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		3/12/19

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	255307	A. BUILDING _____ B. WING _____	02/13/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 12 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880		

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F 880	Continued From page 13 §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, staff interview, and facility policy review, the facility failed to properly clean a blood glucose meter, per manufacture recommendations and facility policy, for one (1) of three (3) blood glucose fingerstick procedures observed. Resident #63 Findings include: Review of the facility's "Infection Control Program" policy, dated 11/19/10, revealed, "Policy: The Infection Control Program will be as follows: Designed to provide a safe, sanitary & comfortable environment. Designed to help prevent the development and transmission of disease and infection." Review of the facility's "Glucometer" policy, dated 9/17/10, revealed: "Procedure for cleaning/disinfecting Glucometer: Clean/Disinfect Glucometer before & after each use as follows: 1. Using Super Sani-Cloth Germicidal Wipe. 2. Use gloves while cleaning. 3. Place clean paper towel in drawer of med cart. 4. Wipe meter before & after each use. 5. Place clean meter on the clean paper towel.	F 880	F880 1. Licensed Practical Nurse #1 was given a 1:1 inservice on 2/27/19 by Director of Nursing Service on proper procedures for glucometer cleaning and disinfecting procedures with a return demonstration performed by LPN#1 at the end of the inservice. Return demonstration was performed successfully by LPN#1. Registered Nurse#1 was given a 1:1 in-service on 2/28/19 by Director of Nursing Service on proper procedures for glucometer cleaning and disinfecting procedures with a return demonstration performed by RN#1 at the end of the inservice. Return demonstration was performed successfully by RN#1. 2. The facility has determined that all residents requiring finger stick glucose monitoring have the potential to be	

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F 880	Continued From page 14 6. Allow meter to air dry for at least two (2) minutes after cleaning. 7. ALWAYS wear gloves while handling Sani-Cloth wipe. 8. Each medication cart has two (2) meters. 9. Dispose of Sani-Cloth wipe & gloves in trash can. 10. Wipe hands after removing gloves. Review of the Assure Prism multi Blood Glucose Monitoring System's Manufacturer's Recommendations revealed the cleaning procedure is needed to clean dirt, blood and other bodily fluids off the exterior of the meter before performing the disinfection procedure. The disinfection procedure is needed to prevent the transmission of blood-borne pathogens. A variety of the most commonly used EPA-registered wipes have been tested and approved for cleaning and disinfecting of the Assure Prism multi Blood Glucose Monitoring System. The disinfectant wipes listed below have been shown to be safe for use with this meter. Please read the manufacturer's instructions before using their wipes on the meter. Manufacturer: Professional Disposables International, Inc. (PDI) Super Sani-Cloth Germicidal Disposable Wipe. Cleaning and Disinfecting Procedures: NOTE: Do not get fluids inside the meter through the test strip port, data port or battery compartment. Never immerse the meter or hold it under running water because it will damage the meter. Two (2) disposable wipes will be needed for each cleaning and disinfecting procedure; one (1) wipe for cleaning and a second wipe for disinfecting. During an observation of a blood glucose finger stick procedure, on 02/12/19, 10:56 AM, for Resident #63, LPN #1 cleaned the glucometer	F 880	affected. 3. The Director of Nursing Services revised the Glucometer policy to include cleaning and disinfecting instructions according to manufacturer's instructions. Inservice education initiated 2/26/19 by Director of Nursing service for all Registered Nurses and Licensed Practical Nurses on Glucometer policy revisions. At the end of the In-service education each nurse performed a return demonstration of the cleaning and disinfecting procedure. A Glucometer Cleaning/Disinfecting Observation checklist was completed for each nurse to determine if the nurse was performing the procedure correctly. Corrective action was provided as needed. Registered Nurses and Licensed Practical Nurses not in-serviced on 2/26/19 will not be allowed to work until they have been inserviced which includes performing a return demonstration successfully. Newly hired Registered Nurses and Licensed Practical Nurses hired on or after 2/26/19 will be checked off on orientation checklist for Glucometer cleaning/disinfecting. 4. Quality Assurance Committee reviewed possible corrective action on 2/21/19. Beginning 3/8/19, the Unit Manager will complete six (6) random Glucometer	

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F 880	Continued From page 15 (Assure Prism Multi Blood Glucose Meter) with PDI Sani Hands Instant hand sanitizing wipes , wiped down the meter and let dry two (2)-three (3) minutes . The Antiseptic hand sanitizer was 70% Alcohol and LPN #1 stated this was approved for use on equipment. On 02/12/19 at 2:01 PM, interview with LPN #1 revealed, "I used the wrong wipe, I was supposed to use the purple wipe". She stated she floated from hall to hall and worked wherever she was needed. She stated, "I did go back and clean the meter with the Super Sani Wipe, after I realized I had used the wrong wipe." On 02/12/19 at 1:30 PM, interview with RN #1, part-time nurse, stated, "I don't know their policy." She picked up a PPI Sani wipe container and stated, "This is what I've been using to clean it. Wipe down real good, let it sit three (3)-five (5) minutes to dry real good. I orientated one (1) time in June for one (1) day and then they gave me the keys to the cart." On 02/12/19 at 11:25 AM, interview with LPN #2, revealed she used the Super-Sani-Cloth to clean and disinfect the Glucometer. On 2/12/19 at 4:00 PM, interview with the Director of Nursing (DON) confirmed that the Glucometer should be cleaned with the Super Sani-Cloth and not the Sani Hands wipe. She stated that this is an infection control problem. 25 residents with a diagnosis of Diabetes were reviewed for blood borne infectious disease. None were noted/documented to have a blood borne infection.	F 880	Cleaning/Disinfecting observations weekly for 12 weeks while nurses perform finger stick glucose monitoring to ensure nurses are performing the glucometer cleaning and disinfecting procedure in accordance with the facility policy. Any Corrective action will be provided immediately. Quality Assurance Committee reviewed Plan of Correction 3/6/19 The Unit Manager will present findings of observations/audits to the Quality Assurance Performance Committee quarterly at a minimum or as often as needed for review/recommendations or further corrective action.	

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	255307	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/13/2019**

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K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility must meet the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA) ...	K 000		
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to meet Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection System components as required by NFPA 25, 5.2.1. The deficient practice had potential to affect the entire facility on day of survey.	K 353	1. All sprinkler heads under the exit covered porches were inspected by maintenance director and cleaning of removable debris initiated on 2/25/19. A reputable fire sprinkler company who is	3/12/19

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

Electronically Signed | 03/08/2019

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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K 353	Continued From page 1 Findings include: On 2/13/19 at 10:45 AM, observation revealed obstructed sprinkler heads under all the protecting the exit covered porches/canopies of the facility. The covered porches/canopies were made of combustible materials. The sprinkler heads were obstructed by dirt dauber nest, corrosion and miscellaneous debris which disrupt the function and activation to discharge water for fire protection. The finding was acknowledged by the Administrator and Maintenance Supervisor during the exit interview on 2/13/19.	K 353	a member of the National Fired protection Agency was contacted to replace the sprinkler heads that needed to be replaced. The new sprinkler heads were ordered 3/5/19 and will take approximately 3 weeks to make and will be installed by the fire sprinkler company as soon as they arrive. 2 All sprinkler heads have the potential to be affected by dust and debris. 3. The Administrator conducted an inservice education with the Housekeeping Director on 3/4/19 to review Sprinkler System policy and Housekeeping responsibilities. Housekeeping Director initiated an inservice education on 3/4/19 for all Housekeeping staff on cleaning sprinkler heads inside the facility and sprinkler heads at all covered porches. The Administrator initiated an Inservice education 3/4/19 for all maintenance staff on Life Safety Code deficiencies and the cleaning and inspection of sprinkler heads. 4. Quality Assurance Committee reviewed Plan of Correction 3/6/19 Housekeeping Director will perform weekly audits for 12 weeks of sprinkler	

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K 353	Continued From page 2	K 353	heads to ensure they are being cleaned and free of dust, debris and obstruction. Any corrective action will be provided immediately. Maintenance Director will conduct random monthly audits of sprinkler heads including sprinkler heads under the covered porches/canopies to be sure they are clean and free of dust, corrosion and obstruction. Any corrective action will be provided immediately. The findings of the audits/monitors will be reported to the Quality Assurance Performance Committee at least quarterly or more often as needed to assure continued performance.	

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E 000	Initial Comments * EMERGENCY PREPAREDNESS * Survey conducted on 2/13/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were identified.	E 000		

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