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	255182	A. BUILDING _____ B. WING _____	10/19/2017

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F 000	INITIAL COMMENTS CI #CI4814 and #CI4817 The State Agency (SA) conducted an annual survey along with a complaint investigation (CI #CI4814 and #CI4817) from 10/16/17 to 10/19/17. The result of the complaint investigation was unsubstantiated with no deficiencies cited related to the complaints. During the annual recertification survey from 10/16/17 to 10/19/17, the SA determined the facility was not in compliance with Medicare and Medicaid requirements for participation. The SA cited the regulatory deficiency F225, F441, and F526 for the recertification survey. The census at time of survey was 89 with a license for 105.	F 000		
F 225 SS=E	INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS CFR(s): 483.12(a)(3)(4)(c)(1)-(4) 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his	F 225		11/16/17

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

Electronically Signed | 11/07/2017

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 225	Continued From page 1 or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.	F 225		

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F 225	Continued From page 2 (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, facility policy review, and staff interviews the facility failed to implement the established methods for the screening of new employee hires for one (1) of six (6) new hire employee files reviewed. Findings include: Review of the facility policy titled "Policy: Preventing Abuse", not dated, revealed that background checks will be completed for all persons seeking employment with the facility. The facility policy revealed that the screening process consist of criminal background checks through the police department, personal character references, employment reference checks through prior employment, and credential checks for Certified Nursing Assistants (CNA) and nurses. Review of the facility personnel file for CNA #1, revealed that the employee was hired on 08/14/17. The personnel file revealed no documentation of previous employer reference checks. There was a letter from the Mississippi State Department of Health (MSDH) dated October 7, 2016, as relating to the Federal Bureau of Investigation (FBI) fingerprint checks. The letter cleared the employee to work within a licensed childcare facility. The letter did not	F 225	* CNA #1 did not work in the facility at any time once the discrepancy was noted. ** All residents have the potential to be affected by this same deficient practice. All hire packets were reviewed. There were two other discrepancies which have been corrected. *** Human Resources (HR) will verify all employee references. HR will only accept background letters from the State Department of Health Criminal History Record Check Division that state "this agency found no violations that prevent (name) from working with patients, residents or clients being served by a licensed hospital, nursing home, personal care home, home health agency or hospice". Administrator in-serviced HR personnel on the importance of correct background checks and validating reference checks. **** Quality Assurance (QA)will monitor five new hire files per month (if applicable) for a period of six months to ensure new hire policy has been followed. They will bring their findings to the monthly QA Committee meeting.	

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F 225	Continued From page 3 mention any clearance to work within a licensed Long Term Care (LTC) nursing facility. The review of the personnel file for CNA #1 also revealed that CNA #1's employment was terminated with the facility on 09/11/17. During an interview, on 10/17/17 at 1:55 PM, the Nursing Facility Administrator (NFA) confirmed that the new hire screening procedure for CNA #1 was incomplete. The NFA stated that when the new hire screening error was discovered, an attempt was made to correct the employee file. However, the employee left the facility resulting in his termination before the new hire screening error could be corrected. During an interview, on 10/18/2017 at 10:20 AM, the Human Resource Director (HRD) confirmed that she had not followed the correct procedure for the new hire screening process for CNA #1. The HRD stated that she had not made any references checks to CNA #1's previous employers. The HRD stated that when CNA #1 presented the letter from MSDH to her at the time of hire, it looked legitimate. The HRD stated that she did not notice any of the discrepancies on the letter. The HRD also stated that she thought that if CNA #1 was clear to work with children that he would be clear to work with the elderly.	F 225		
F 441 SS=E	INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.80(a)(1)(2)(4)(e)(f) (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 441		11/16/17

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F 441	Continued From page 4 (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 (facility assessment implementation is Phase 2); (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	F 441		

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F 441	Continued From page 5 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. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (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, facility policy review, and record review the facility failed to ensure the possible spread of infection for one (1) of three (3) observations related to cleaning the Glucometer, Resident #12, and one (1) of two (2) observations of eye drop administration, Un-Sampled Resident #A. Findings include: A facility policy titled "Glucometer Disinfection Policy", not dated, reads in order to avoid potential cross contamination, the Glucometer should be properly disinfected before use, during use and after use. An in-service meeting, dated 9/7/17, for survey ready, revealed Licensed Practical Nurse #1	F 441	* LPN#1 cleaned glucometer after use on Resident #12. Eye drops for Un-sampled Resident #A were discarded and new ones were ordered. Both residents were put on monitoring for signs and symptoms of infection for 72 hours. ** All residents who need blood sugar levels checked or need eye drops applied are at risk by this same deficient practice. *** An in-service has been conducted by the Director of Nursing (DON)on the proper cleaning procedure for glucometer use. This in-service was started on 10/20/17 and continued until 11/07/17. All nurses have been in-serviced. An in-service has been conducted by	

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F 441	Continued From page 6 (LPN) was in attendance. A facility policy titled, "Eye Drop Administration Policy", not dated, revealed eye drops should not be placed in your pocket or on any surface in the resident's room without a barrier. In an observation, on 10/16/17 at 3:45 PM, LPN #1 left a Personal Care Resident's (PC) room with a Glucometer and entered Resident #12's room with the same Glucometer. Observation confirmed the Glucometer was not cleaned per LPN #1, prior to checking the blood glucose on Resident #12 with the Glucometer. In an interview, on 10/16/17 at 4:35 PM, LPN #1 confirmed she had not cleaned the Glucometer between the PC resident and Resident #12's blood sugar checks. LPN #1 confirmed she was to always clean the Glucometer between residents due to infection control issues. An interview on 10/17/17 at 2:35 PM, with the Director of Nurses (DON), confirmed when a Glucometer is used, it should always be cleaned before and after use, to prevent the spread of infection. In an interview, on 10/18/17 at 3:35 PM, Registered Nurse (RN) Infection Control Nurse, confirmed Glucometers are to be cleaned in between resident use, due to potential spread of infection. Review of the facility's Face Sheet revealed the facility admitted Resident #12 on 12/27/13 with a readmission date of 7/2/15. Resident #12's diagnoses included Diabetes Mellitus and End Stage Renal Disease.	F 441	the DON on the "Eye Drop Administration Policy. This in-service was started on 10/20/17 and continued until 11/07/17. All nurses have been in-serviced. ****Quality Assurance/Staff Development will monitor one med pass per week to ensure proper procedures are being followed. This will be done for a period of six months. Their findings will be brought to the monthly QA Committee meeting.	

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F 441	Continued From page 7 Review of the Minimum Data Set (MDS), with an Assessment Reference Data(ARDS of 08/21/17, revealed Resident #12 had a Brief Interview of Mental Status (BIMS) score of 6, indicating severe cognitive status. Resident Un-Sampled #A An observation on 10/17/17 at 1:00 PM, revealed LPN #2 placed the lid (top to the eye drop bottle) and box to the eye drops on a foot stool while administering eye drops to Un-Sampled Resident #A. No barrier was placed prior to LPN #2 placing the box and top to the eye drop bottle on the foot stool. In an interview, on 10/18/17 at 11:35 AM, LPN #2, confirmed she had laid the box and lip to the eye drops on the foot stool without a barrier. LPN#2 stated that no barrier under the box and top was a break in infection control. In an interview, on 10/18/17 at 2:35 PM, the DON confirmed a barrier is us to be used at all times, when administering medication, to prevent possible spread of infection. In an interview, on 10/18/17 at 3:40 PM, the Infection Control Nurse confirmed there should always be a barrier put down prior to laying the eye drop caps or boxes on any surface in a room. Review of the facility's Face Sheet revealed the facility admitted the resident on 5/14/16. Un-Sampled Resident #A's diagnosis included Dry Eyes. Review of the MDS, with an ARD of 10/04/17,	F 441		

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F 441	Continued From page 8 revealed Un-Sampled Resident #A's BIMS score of 11, which indicated a moderately impaired cognitive status.	F 441		
F 526 SS=D	Hospice CFR(s): 483.70(o)(1)-(4) (o) Hospice services. (1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. (2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the	F 526		11/16/17

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F 526	Continued From page 9 LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.	F 526		

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F 526	Continued From page 10 (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.	F 526		

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F 526	Continued From page 11 (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. (3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the	F 526		

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F 526	Continued From page 12 medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. (4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest	F 526		

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F 526	Continued From page 13 practicable physical, mental, and psychosocial well-being, as required at §483.20. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility policy review, the facility failed to establish an interdisciplinary team member to serve as a coordinator for Hospice services for the facility. This affected two (2) of 89 residents. Findings include: The facility did not provide a policy or job description for a coordinator of Hospice care. In an interview, on 10/16/17 at 2:00 PM, the Director of Nursing (DON) said the Social Services department was responsible for coordinating care with the hospice company. In an interview, on 10/18/16 at 9:10 AM, the Social Services Representative said she was unaware of a "Hospice Coordinator" for the facility. In an interview, on 10/18/16 at 9:10 AM, the Admission Coordinator said she did not know who was designated as the coordinator for Hospice services. In an interview, on 10/19/17 at 11:30 AM, the Administrator said Social Services did the Hospice admissions and the DON had the job duties but no one had been designated with the job title. The Administrator said the DON's job description was being updated and was not current to include coordinating Hospice.	F 526	* The Director of Nursing is the person designated to coordinate with hospice. ** All hospice residents have the potential to be affected by this deficient practice. *** A new policy and job description have been written and approved by the QA Committee regarding Hospice Services. ****QA will monitor all hospice contracts to ensure all provisions have been met. QA will monitor all hospice residents once per month for a period of six months to ensure facility policy is being followed. They will bring their findings to the monthly QA Committee meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255182	A. BUILDING **01 - MAIN BUILDING 0101** B. WING _____	**10/19/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW NURSING CENTER	**16411 ROBINSON ROAD** **GULFPORT, MS 39503**

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K 000	INITIAL COMMENTS 42 CFR 438.70(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

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.