STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A190	A. BUILDING _____ B. WING _____	09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TALLAHATCHIE GENERAL HOSP ECF	201 SOUTH MARKET ST/P. O. BOX 230 CHARLESTON, MS 38921

(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 CI MS #16016 The State Agency (SA) conducted an annual recertification along with a complaint, MS #16016 from 09/16/19 to 09/19/19. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid and cited F658, F693, and F880. The SA did not substantiate MS #16016 for lack of Registered Nurse coverage, with no citations related to the complaint. The census was 92 and the facility has a license for 98 beds.	F 000		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility policy review, the facility failed to administer medications via Percutaneous Endoscopic Gastrostomy (PEG) tube in a manner to prevent potential risks for two (2) of two (2) PEG tube administrations observed, out of 12 residents with feeding tubes, Resident #45 and Resident #70. Findings include: Review of "Fundamentals of Nursing", Potter and Perry: Ninth Edition, page 635, revealed special consideration is needed when administering medications to patients with enteral or small-bore	F 658	1. Residents #45 and #70 were assessed by licensed nursing personnel on 9/18/19 which was the date of findings by state agency staff. Both Resident #45 and Resident #70 were found to have patent Percutaneous Endoscopic Gastrostomy (PEG) with no adverse reactions noted. All residents with Percutaneous Endoscopic Gastrostomy (PEG) tubes may be affected. All residents in-house have been reviewed for appropriate peg tube assessment, and orders have been made as needed. Immediate actions were taken for all	10/6/19

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

Electronically Signed | 10/04/2019

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F 658	Continued From page 1 feeding tubes. Failing to follow current evidenced-based recommendations from the American Society for Parental and Enteral Nutrition (ASPEN) can result in tube obstruction, reduced medication effectiveness, and increased risk of medication toxicity. When administering more than one (1) medication at a time, give each separately and flush between medications with 15 to 30 milliliters (mL) of water. Review of the facility policy titled, "Gastric Tube Medication Administration", effective 2001, revised 9/08, revealed it is the policy to flush the tubing with the amount of water ordered before administering the medication and flush the tubing after administering medication with the amount of water ordered. On 09/17/19 at 08:20 AM, Licensed Practical Nurse (LPN) #1 administered five (5) medications to Resident #70 via Percutaneous Endoscopic Gastrostomy (PEG) tube. LPN #1 did not flush between each medication when administered. Interview with LPN #1, on 9/18/19 at 11:45 AM, confirmed that she did not flush between each medication because the policy had changed. She stated they flushed before and after the medications, but not between the medications. She stated she thought there should be a flush between each medication, because that's what she was taught in school. On 09/17/19 at 8:35 AM, LPN 2 administered seven (7) medications to Resident #45 via PEG tube. LPN #2 failed to flush between each medication when administered.	F 658	residents with Percutaneous Endoscopic Gastrostomy (PEG) tubes at Tallahatchie General Hospital Extended Care Facility (TGH ECF). 2. All residents who reside in TGH ECF with a Percutaneous Endoscopic Gastrostomy (PEG) tube have the potential to be affected by the same alleged deficient practice. 3. TGH ECF Facility Percutaneous Endoscopic Gastrostomy (PEG) Gastric Tube Medication Administration Policy was updated on 10/1/19 by the Director of Nursing, Administrator, Staff Development Registered Nurse, Quality Assurance Registered Nurse and Interdisciplinary Team to meet recommendations based on Fundaments of Nursing, Potter and Perry, Ninth edition, which is consistent with the current evidence-based recommendations from the American Society for Parental and Enteral Nutrition (ASPEN). The facility policy now utilizes the following: " Flush tubing with 15 milliliters (ml) of water (or prescribed amount) before and after administering each individual medication unless otherwise ordered by the Medical Doctor (MD). " After verifying new orders with primary MD, all Percutaneous Endoscopic Gastrostomy (PEG) tube orders were changed on MAR as of 10/1/19 to reflect this change in policy. " All licensed nursing staff were educated on the updated facility policy regarding administering medications via Percutaneous Endoscopic Gastrostomy (PEG) tube by Director of Nursing	

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F 658	Continued From page 2 Interview with LPN #2 on 9/18/19 at 1:35 PM, revealed she thought she had flushed between some of the medications she had administered through Resident #45's PEG tube, but realized she didn't. She stated she did flush the tube before giving the medications and after they were all given. Interview with the Director of Nursing (DON) on 9/18/19 at 9:45 AM, revealed that Standards of Practice are to flush with water between medications. She stated that's why the nurses set up and give each medication individually, flushing before and after the medication. The DON confirmed the policy does not instruct to give water between each medication. On 09/18/19 at 3:30 PM, an interview with the Administrator revealed they had discussed the issue about PEG tube medications and she stated their policy was not correct.	F 658	Services, Quality Assurance Registered Nurse, Staff Development Registered Nurse, Registered Charge Nurse, Minimum Data Set Registered Nurse on 10/1/19, 10/2/19, 10/3/19, 10/4/19, & 10/6/19. " All licensed nursing staff were observed and checked off on properly administering Percutaneous Endoscopic Gastrostomy (PEG) tube medications per the new facility policy on 10/1/19, 10/2/19, 10/3/19, 10/4/19, & 10/6/19. " In the future, all licensed nursing staff will be educated on the Percutaneous Endoscopic Gastrostomy (PEG) tube policy and checked off on properly administering Percutaneous Endoscopic Gastrostomy (PEG) tube medications per the facility policy during new hire orientation. 4. The facility will monitor its performance to make sure that solutions are sustained and correction is achieved as follows: " Director of Nurses, Quality Assurance Registered Nurse, Staff Development Registered Nurse, Registered Charge Nurse, Minimum Data Set Registered Nurse will monitor Percutaneous Endoscopic Gastrostomy (PEG)tube feedings at random three (3) times weekly x two (2) weeks beginning week of 10/7/19. " Director of Nurses, Quality Assurance Registered Nurse, Staff Development Registered Nurse, Registered Charge Nurse, Minimum Data Set Registered Nurse will then monitor Percutaneous Endoscopic Gastrostomy (PEG) tube	

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F 658	Continued From page 3	F 658	feedings at random 2 times weekly x four (4) weeks. " Director of Nurses, Quality Assurance Registered Nurse, Staff Development Registered Nurse, Registered Charge Nurse, Minimum Data Set Registered Nurse will then monitor Percutaneous Endoscopic Gastrostomy (PEG) tube feedings at random one (1) time weekly x six (6) weeks. " The results of these audits will be presented in the facility s monthly Quality Assurance Meetings for 3 months or until 100% compliance is achieved. The Quality Assurance Committee will make recommendations and or changes as needed.	
F 693 SS=E	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills	F 693		10/6/19

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F 693	Continued From page 4 and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility policy review, the facility failed to ensure appropriate procedures to prevent complications while administering medications via Percutaneous Endoscopic Gastrostomy (PEG) tube. This is evidenced by the failure to flush between each medication administered via PEG tube for two (2) of two (2) PEG tube administrations observed out of 12 residents with PEG tubes, Resident #45 and Resident #70. Findings include: Review of the facility policy titled, "Gastric Tube Medication Administration", effective 2001, revised 9/08, revealed it is the policy to flush the tubing with the amount of water ordered before administering the medication and flush the tubing after administering medication with the amount of water ordered. Review of "Fundamentals of Nursing", Potter and Perry: Ninth Edition, page 635, revealed when administering more than one (1) medication at a time, give each separately and flush between medications with 15 to 30 milliliters (mL) of water to prevent complications such as tube obstruction, reduced medication effectiveness, and increased risk of medication toxicity. Resident #70 On 09/17/19 at 8:20 AM, Licensed Practical Nurse (LPN) #1 administered five (5) medications	F 693	1. Residents #45 and #70 were assessed by licensed nursing personnel on 9/18/19 which was the date of findings by state agency staff. Both Resident #45 and Resident #70 were found to have patent Percutaneous Endoscopic Gastrostomy (PEG) with no adverse reactions noted. All residents with Percutaneous Endoscopic Gastrostomy (PEG) tubes may be affected. All residents in-house have been reviewed for appropriate peg tube assessment, and orders have been made as needed. Immediate actions were taken for all residents with Percutaneous Endoscopic Gastrostomy (PEG) tubes at Tallahatchie General Hospital Extended Care Facility (TGH ECF). 2. All residents who reside in TGH ECF with a Percutaneous Endoscopic Gastrostomy (PEG) tube have the potential to be affected by the same alleged deficient practice. 3. TGH ECF Facility Percutaneous Endoscopic Gastrostomy (PEG) Gastric Tube Medication Administration Policy was updated on 10/1/19 by the Director of Nursing, Administrator, Staff Development Registered Nurse, Quality Assurance Registered Nurse and Interdisciplinary Team to meet recommendations based on Fundaments of Nursing, Potter and Perry, Ninth edition, which is consistent	

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F 693	Continued From page 5 to Resident #70 via PEG. LPN #1 did not flush between each medication when administered. On 09/18/19 at 11:45 AM, an interview with LPN #1 revealed she did not flush between each medication when administering by PEG because they had had a big discussion about this a while ago and the policy was changed. She stated they flush before and after meds (medications) but not between each one . LPN #1 stated she thought she should flush between each one because that was what she was taught in school and that is how she did it when she worked at another facility. Resident #45 On 09/17/19 at 08:35 AM, Licensed Practical Nurse (LPN) #2 administered seven (7) medications to Resident #45 via PEG tube. LPN #2 failed to flush between each medication when administered. On 09/18/19 at 1:35 PM, an interview with LPN #2 revealed she thought she flushed between some of them, but realized she didn't. She stated she did flush before giving the medications and after they were all given. On 09/18/19 at 09:45 AM, an interview with the Director of Nursing (DON) revealed that Standards of Practice are to flush with water between medications. She stated they should give each medication separately and add water if needed. The DON confirmed the policy does not instruct to give water in between each medication. She stated this is on her, not the nurses and they will look at the policy. On 09/18/19 at 3:30 PM, an interview with the	F 693	with the current evidence-based recommendations from the American Society for Parental and Enteral Nutrition (ASPEN). The facility policy now utilizes the following: " Flush tubing with 15 milliliters (ml) of water (or prescribed amount) before and after administering each individual medication unless otherwise ordered by the Medical Doctor (MD). " After verifying new orders with primary MD, all Percutaneous Endoscopic Gastrostomy (PEG) tube orders were changed on MAR as of 10/1/19 to reflect this change in policy. " All licensed nursing staff were educated on the updated facility policy regarding administering medications via Percutaneous Endoscopic Gastrostomy (PEG) tube by Director of Nursing Services, Quality Assurance Registered Nurse, Staff Development Registered Nurse, Registered Charge Nurse, Minimum Data Set Registered Nurse on 10/1/19, 10/2/19, 10/3/19, 10/4/19, & 10/6/19. " All licensed nursing staff were observed and checked off on properly administering Percutaneous Endoscopic Gastrostomy (PEG) tube medications per the new facility policy on 10/1/19, 10/2/19, 10/3/19, 10/4/19, & 10/6/19. " In the future, all licensed nursing staff will be educated on the Percutaneous Endoscopic Gastrostomy (PEG) tube policy and checked off on properly administering Percutaneous Endoscopic Gastrostomy (PEG) tube medications per the facility policy during new hire	

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F 693	Continued From page 6 Administrator revealed they had discussed the issue about PEG tube medications and their policy was not correct.	F 693	orientation. 4. The facility will monitor its performance to make sure that solutions are sustained and correction is achieved as follows: " Director of Nurses, Quality Assurance Registered Nurse, Staff Development Registered Nurse, Registered Charge Nurse, Minimum Data Set Registered Nurse will monitor Percutaneous Endoscopic Gastrostomy (PEG)tube feedings at random three (3) times weekly x two (2) weeks beginning week of 10/7/19. " Director of Nurses, Quality Assurance Registered Nurse, Staff Development Registered Nurse, Registered Charge Nurse, Minimum Data Set Registered Nurse will then monitor Percutaneous Endoscopic Gastrostomy (PEG) tube feedings at random 2 times weekly x four (4) weeks. " Director of Nurses, Quality Assurance Registered Nurse, Staff Development Registered Nurse, Registered Charge Nurse, Minimum Data Set Registered Nurse will then monitor Percutaneous Endoscopic Gastrostomy (PEG) tube feedings at random one (1) time weekly x six (6) weeks. " The results of these audits will be presented in the facility s monthly Quality Assurance Meetings for 3 months or until 100% compliance is achieved. The Quality Assurance Committee will make recommendations and or changes as needed.	
F 880	Infection Prevention & Control	F 880		10/6/19

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F 880 SS=D	Continued From page 7 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	F 880		

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F 880	Continued From page 8 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. §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 prevent the spread of infection by contaminating gloves and wound during care for one (1) of two (2) wound care observations, Resident #51. Findings include: Review of the facility policy titled, "Infection Control", revealed the staff will protect	F 880	1. Licensed Practical Nurse #3 was in-serviced on proper infection control practices during wound care on 9/25/19 by the Infection Control Nurse. Resident #51 s wound was assessed by the Wound Care Registered Nurse on 9/21/19 with no signs and symptoms of infection noted. 2. The facility has determined that all residents have the potential to be affected	

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F 880	Continued From page 9 themselves from infection and simultaneously protect the resident form exposure to additional infectious agents by being knowledgeable regarding diseases and modes of transmission. Review of the facility policy titled, "Pressure Ulcer Treatment", effective 4/2010, revealed to position the resident and place a towel next to the resident (under) the wound to serve as a barrier to protect the bed linen and other body sites. On 09/18/19 at 11:20 AM, during an observation of pressure ulcer care, performed by Licensed Practical Nurse (LPN) #3, with the assistance of Registered Nurse (RN) #2, Resident #51 was turned to his right side. His brief was undone and slightly pulled away from his buttocks, but then moved back towards his body touching the wound area. LPN #3 did not place the brief in a manner so that it would not contaminate the wound. LPN #3 placed his gloved hand inside the slightly open brief. The back side of his gloved hand touched the brief while cleaning the wound and while applying the dressing. On 9/18/19 at 11:45 AM, an interview with LPN #3 confirmed he should have positioned the brief away from the wound better to prevent it from touching the wound area and contaminating the wound and gloves. On 09/19/19 at 10:44 AM, an interview with the Director of Nursing (DON) confirmed she felt LPN #3 had contaminated the wound and his gloves by not removing the resident's brief before wound care. On 09/19/19 at 10:46 AM, an interview with RN #1 revealed she had just checked LPN #3 off on	F 880	by the deficient practice of failing to prevent the possible spread of infection. 3. All licensed nurses were in- serviced on the facility s Wound Care/Dressing Change Policy which was revised on 10/01/19 by the Interdisciplinary team, Director of Nurses, Administrator, Staff Educator Registered Nurse and Quality Assurance Registered Nurse. All licensed nurses were in serviced and demonstrated competency of proper infection control practices during wound care by return demonstration(s) on 10/1/19, 10/2/19, 10/3/19, 10/4/19, and 10/6/19. In-services and competency check-offs were conducted by the Staff Educator Nurse, Infection Control Nurse, Director of Nurses &/or Registered nurse Minimum Data Set Coordinator. 4. Beginning 10/2/19, the Director of Nurses, Infection Control Registered Nurse, Staff Educator Registered Nurse or Registered nurse Minimum Data Set Coordinator will perform random observations of infection control practices during wound care twice weekly times two weeks then weekly times four weeks then monthly times two months. All findings will be reported to the Quality Assurance Committee monthly for evaluation of effectiveness and compliance. The Quality Assurance Committee will make recommendations and/or changes as needed.	

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F 880	Continued From page 10 wound care about two (2) weeks ago. She stated he had no problems during the check off. She stated LPN #3 knew that would contaminant the wound. On 09/19/19 at 10:50 AM, an interview with RN #2 revealed she started to tell LPN #3 to remove the brief, but she thought she could only assist him with holding the resident over. She confirmed the wound was contaminated by the brief and his gloves touching the brief contaminated them.	F 880		

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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 | 10/04/2019

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A190	A. BUILDING **02 - TALLAHATCHIE GENERAL HOSPITAL ECF** B. WING _____	**09/19/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TALLAHATCHIE GENERAL HOSP ECF	**201 SOUTH MARKET ST/P. O. BOX 230 CHARLESTON, MS 38921**

(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
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A190	A. BUILDING _____ B. WING _____	09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TALLAHATCHIE GENERAL HOSP ECF	201 SOUTH MARKET ST/P. O. BOX 230 CHARLESTON, MS 38921

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E 000	Initial Comments *EMERGENCY PREPAREDNESS* Survey conducted on 09/19/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were cited.	E 000		

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

Electronically Signed | 10/04/2019

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.