STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255270	A. BUILDING _____ B. WING _____	06/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PONTOTOC HEALTH & REHAB CENTER	278 WEST EIGHTH STREET PONTOTOC, MS 38863

(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 6/13/18 to 6/15/18. During the survey the SA determined the facility was not in compliance with the Medicare and Medicaid Requirements for Participation. The SA cited a regulatory deficiency at F759. The census at the time of the survey was 56, and the facility was certified for 60 beds.	F 000		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview, the facility failed to provide Resident #13's fingernail care for one (1) of 19 residents reviewed for Activities of Daily Living (ADL) care. Findings include: An observation, on 06/13/18 at 12:59 PM, revealed a brown colored material under Resident #13's fingernails on both hands. An observation, on 06/14/18 at 8:35 AM, revealed Resident #13's fingernails continued to be dirty with a brownish material under the nails. An observation and interview with the Director of Nurses (DON) regarding Resident #13's fingernails, on 06/14/18 at 2:00 PM, the DON confirmed Resident #13's fingernails were dirty,	F 677	1) On 6/14/18 the Director of Nursing (DON)assessed Resident #13's fingernails and found they needed cleaning and filing. On 6/14/18 DON cleaned and filed the fingernails of Resident #13. There were no negative outcomes. 2) All Residents which require staff to clean the fingernails have the potential to be affected by this deficient practice. 3) On 6/14/18 the DON completed a 100% audit of all residents to observe fingernails for cleanliness and condition of fingernails. Four (4) out of 56 residents observed were in need of fingernails being trimmed and/or cleaned. Fingernails were trimmed and/or cleaned at time of	7/29/18

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

Electronically Signed | 07/26/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255270	A. BUILDING _____ B. WING _____	06/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PONTOTOC HEALTH & REHAB CENTER	278 WEST EIGHTH STREET PONTOTOC, MS 38863

(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 677	Continued From page 1 and needed to be cleaned and trimmed. Review of Resident #13's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 4/16/18, revealed a Basic Interview for Mental Status (BIMS) score was 00, which indicated severe cognitive impairment. Further review of the MDS revealed Resident #13 required extensive assistance with two person physical assist with bed mobility, was totally dependent on staff with one person physical assist with dressing, and extensive assistance with one person physical assist with toilet use and personal hygiene. The MDS also revealed Resident #13 was admitted by the facility on 10/19/15.	F 677	observation by Director of Nursing. On 6/19/18 the Staff Development Nurse began an in-service regarding the facility policy "Fingernail and Toenail Care" for all Nursing Staff to include Registered Nurses (RN), Licensed Practical Nurses (LPN) and Certified Nursing Assistants (CNA) The Daily Worksheet for CNA's was updated by Director of Nursing on 6/18/18 to include the designated Residents for CNA's to complete fingernail Care for, to include cleaning, cutting and filing of fingernails. The Treatment Records were updated by the Treatment Nurse on 6/17/18 to include the designated Residents for the RN to complete Fingernail Care,to include cutting and filing. On 6/27/18 Nursing Staff, to include RN's and LPN's began observations of all Residents fingernails for cleanliness and condition of fingernails. Any Resident identified to need the fingernails cleaned or filed had the fingernails cleaned and/or filed. The observations are documented on the "Fingernail Check for Cleanliness and Condition of Nails" form. This process is to be conducted Monday through Friday for four weeks, then if no concerns are identified, the process is to be conducted two times a week for two weeks, then random observations monthly for cleanliness and condition of nails. 4)The results of the observations will be reviewed at the Daily Stand Up Meeting Monday through Friday with the results being taken to the monthly Quality Assurance Performance Improvement	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255270	A. BUILDING _____ B. WING _____	06/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PONTOTOC HEALTH & REHAB CENTER	278 WEST EIGHTH STREET PONTOTOC, MS 38863

(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 677	Continued From page 2	F 677	Meeting by Quality Assurance Nurse for review and recommendations.	
F 759 SS=D	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, staff interview, record review, and facility policy review, the facility failed to maintain a medication error rate less than five percent (5%) as evidenced by failure to flush between medications administered through a Percutaneous Endoscopic Gastrostomy (PEG) tube for four (4) of 35 medication administration opportunities observed. Findings include:. Review of the facility's policy titled, "Medication Administration", with a revision date of 6/15/18, revealed medications administered through a PEG tube should be administered individually, flushing with 5 cc (cubic centimeter) after each medicaiton. On 6/14/18 at 4:28 PM, an observation of Resident #25's medication administration revealed Licensed Practical Nurse (LPN) #1 administered four (4) medications via the resident's PEG tube. LPN #1 crushed an Eliquis five (5) milligram (mg.) tablet, and Lopressor 25 mg., one half (1/2) tablet, and poured each medication into separate medication cups. LPN	F 759	1) On 6/14/18 at 5:20 PM LPN#1 observed resident up in wheelchair at nurse's station with no acute distress noted, no negative outcomes. On 6/15/18 the Director of Nursing (DON)obtained an order from Nurse Practitioner and revised the Physician Orders for Resident #25 to include, "Flush with 5 (five) cc (cubic centimeters) water between each medication". 2) All Residents receiving medication via the Percutaneous Endoscopic Gastrostomy Tube (PEG), have the potential to be affected by the deficient practice. On 6/14/18 Resident #25 was the only resident receiving medication via the Percutaneous Endoscopic Gastrostomy Tube (PEG). 3) On 6/18/18 Licensed Practical Nurse (LPN) #1 (one) was in-serviced by the DON on the facility policy "Medication Administration" with a revision date of 6/15/18 which included on Page 5 of 5: "Flush prior to administering medication(s.	7/29/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255270	A. BUILDING _____ B. WING _____	06/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PONTOTOC HEALTH & REHAB CENTER	278 WEST EIGHTH STREET PONTOTOC, MS 38863

(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 759	Continued From page 3 #1 added five (5) milliliters (ml) of water into each cup. LPN #1 poured up liquid Potassium 15 ml mixed in four (4) ounces of water, and liquid Colace 10 ml. LPN #1 flushed the PEG tube with 30 cubic centimeters (cc) of water, and then administered the liquid Colace, followed by the Eliquis five milligrams (5 mg.). LPN #1 did not flush with water between the Colace and the Eliquis. LPN #1 administered the liquid Potassium 15 milliliters (ml) in four (4) ounces of water, followed by the Lopressor one half (1/2) of the 25 mg. tablet. LPN #1 did not flush with water after the Eliquis, or between the Eliquis and the liquid Potassium, or between the liquid Potassium and the Lopressor. On 06/14/18 at 4:59 PM, an interview with LPN #1 confirmed she did not flush between any of the medications administered via Resident #25's PEG tube. LPN #1 revealed she knew she was supposed to flush between the medications, and she did not. LPN #1 revealed she just forgot, and has been inserviced on this. LPN #1 stated she always flushed between each medication, but she forgot today. Review of Resident #25's June 2018 Physician's Orders revealed the following medication orders: Docusate Sodium (Colace) 10 ml per PEG tube BID (twice a day), Metoprolol 25 mg. tablet, give 1/2 (one half) tablet per PEG tube BID, Potassim Chloride 10% (percent) 20 meq (milliequivalent) per 15 ml per PEG tube BID, and Eliquis 5 (five) mg. tablet, 1 (one) per PEG tube BID. On 06/15/18 at 3:40 PM, an interview with the Director of Nursing (DON) revealed the facility does all inservices with the medication nurses	F 759	Administer medications individually, flushing with 5 cc after each medication, unless order from provider has a specific flush schedule for individual resident." On 6/20/18 the Staff Development Nurse began an in-service for Registered Nurses (RN) and LPN's regarding the facility policy "Medication Administration" with a revision date of 6/15/18 which included on Page 5 of 5: "Flush prior to administering medication(s)Administer medications individually, flushing with 5 cc after each medication, unless order from provider has a specific flush schedule for individual resident." On 6/22/18 the DON, Staff Development Nurse and the Quality Assurance Performance Improvement (QAPI) Nurse began testing all Registered Nurse's and LPN's by observation and/or verbal verification of the process for the administration of medications per the PEG tube. On 6/22/18 a post test was begun with all RN's and LPN's to assure understanding of the facility policy for the flushing of the PEG tube with 5 cc of water after the administration of each medication. Random medication administration observations will be conducted by the DON, Staff Development RN or the Quality Assurance (QA) Nurse for one nurse per week on each shift for two weeks, then two nurses monthly for three months, then one nurse monthly ongoing to ensure compliance with facility guidelines for administration of medication per PEG tube. These audits will be documented on the form "Administration of Medication per PEG Tube".	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255270	A. BUILDING _____ B. WING _____	06/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PONTOTOC HEALTH & REHAB CENTER	278 WEST EIGHTH STREET PONTOTOC, MS 38863

(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 759	Continued From page 4 related to medication administration. The DON stated she was going to ask the Pharmacist to do an inservice with the nurses. She stated she was aware that there should be a flush between the medications administered through the PEG tube, and she did not cover that part of the medication through the PEG tube in any inservice. Review of the facility's Inservice Training Class Attendance Sheet revealed an inservice, dated 10/24/17, for Crushing Medications, either oral or via PEG tube, must give these medications one at a time. Review of the attached copy of Crushing Oral Medications....New Regulation from the website http://allnurses.com/geriatric-nurses-ltc/oral-crushing-oral-medications, revealed: "Crushed medications should not be combined and given all at once either orally (e.g. in pudding or similar food) or via feeding tube. LPN #1's signature was written on the attendance sheet. Review of the Face Sheet revealed Resident #25 was admitted by the facility, on 8/16/17. The Face Sheet included curent diagnoses of Cerebral Infarctoin, Gastrostomy Status, and Hypertensive Chronic Kidney Disease. Additional diagnoses included Constipation, and Hypokalemia (low potassium).	F 759	4) Results of Audits of the Administration of medication per PEG Tube will be presented at the monthly Quality Assurance Performance Improvement Committee by the Director of Nursing for review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255270	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/14/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PONTOTOC HEALTH & REHAB CENTER	**278 WEST EIGHTH STREET** **PONTOTOC, MS 38863**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility meets the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). There were no LSC deficiencies cited during this survey.	K 000		

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

Electronically Signed | 07/30/2018

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
	255270	A. BUILDING _____ B. WING _____	06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PONTOTOC HEALTH & REHAB CENTER	278 WEST EIGHTH STREET PONTOTOC, MS 38863

(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
E 000	Initial Comments Survey conducted on 6/14/18 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were identified.	E 000		

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

Electronically Signed | 07/30/2018

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.