STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255260	A. BUILDING _____ B. WING _____	06/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLTOP MANOR HEALTH AND REHABILITATION CENTER	101 KIRKLAND STREET UNION, MS 39365

(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 Survey Agency (SA) conducted an annual recertification survey at the facility from 05/30/17 to 06/01/17. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements for participation. The SA cited the regulatory deficiencies F332 and F441. At the time of survey, the census was 57 and the facility held a license for 60 beds.	F 000		
F 332 SS=D	483.45(f)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE (f) Medication Errors. The facility must ensure that its- (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 rate of less than five (5) percent (%), as evidenced by two (2) medication errors in 25 medication administrations observed. This affected Resident #14, as evidenced by medication was administered at the wrong time.. Findings Include: Review of facility's "6.0 General Dose Preparation and Medication Administration" policy, revised 1/1/13, revealed that policy sets forth the procedures relating to general dose preparation and medication administration, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident.	F 332	1. On 5/31/17 at 11:35 am Licensed Practical Nurse (LPN)#1 notified Resident #14's physician that 2 medications were given at the wrong time. Resident #14's physician gave a telephone order to LPN#1 to check Blood Sugar as needed, Resident #14 was assessed by the DON on 5/31/17 at 11:35am with no adverse findings noted. Medication Error Report was completed and reviewed by the Quality Assurance and Performance Improvement (QAPI) committee. A one on one in-service including General Dose Preparation and Medication Administration was also completed with LPN#1 on 5/31/17 by the Director of Nurses (DON).	7/6/17

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

Electronically Signed | 07/07/2017

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F 332	Continued From page 1 Review of the facility's "6.2 Medication Administration Times" policy, revealed that the facility should commence medication administration within 60 minutes before the designated times of administration and should be completed by 60 minutes after the designated time of administration. The facility should administer medications ordered before meals approximately 30 minutes before meal time and should administer medications to be given after meals no later than 30 minutes after a meal has been ended. Resident #14: Record review of Physicians orders for May 2017, for Resident #14, revealed the following two (2) orders: 1) Calcium Acetate 667 Milligram (mg) capsules, take two (2) capsules three (3) times daily with meals (Scheduled dose times 07:30 AM,11:30 AM and 5:30 PM). 2) Glemeride 4 mg tablet , take one (1) tablet by mouth before breakfast (Schedule dose time is 07:30 AM). During medication administration on 05/31/17 at 9:17 AM, Licensed Practical Nurse (LPN) #1 was observed administering Calcium Acetate 667 mg capsules, two (2) capsules and one (1) Glemeride 4 mg tablet to Resident #14. During an interview on 05/31/17 at 09:20 AM, immediately after she gave the medication to Resident #14, LPN #1 confirmed that she was supposed to give the medications Calcium Acetate and Glemeride at 07:30 AM, because one (1) was supposed to be given with meals and one (1) was supposed to be given before. LPN #1	F 332	2. Residents of the facility that receive medication have the potential to be affected by this practice. 3. In-services were completed by the DON on 7/6/17 with all Licensed Nurses on the policy "General Dose Preparation and Medication Administration" to stress that medications are given at the correct time. No licensed nurse was allowed to work prior to receiving the in-service. A copy of the in-service and sign in page is included for review. 4. The DON, Assistant Director of Nurses (ADON), or Unit Manager (UM) to conduct observations of Medication Pass 3 times a week for 2 weeks, 2 times a week for 2 weeks, weekly for 4 weeks, and ongoing monthly with findings reported to the QAPI committee monthly, QAPI monitoring schedule modified based on findings. Completed observations are attached for review.	

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F 332	Continued From page 2 said she didn't get her medication cart out until 08:00 AM. LPN #1 said this has happened many times with these two (2) medications. She stated that the medications should be administered in the morning by the night shift. LPN #1 said she has mentioned this to the night nurses but not to the Director of Nursing (DON). During an interview on 05/31/17 at 11:06 AM, the DON confirmed that the two (2) medications, Calcium Acetate and Glemeride were given late to Resident #14 and should be given as ordered, with and before meals. The DON said that the nurses have things to do when they first arrive on shift such as: get a report from the off going nurses, count the medications in the medication carts, and get the vital signs from the Certified Nursing Assistance(CNA)'s. The DON said she would probably get the night shift nurses to administer the "before meals "and "with meals" medication. The facility admitted Resident #14 on 07/22/15, with diagnosis including Type Two Diabetes Mellitus and Chronic Kidney Disease. Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/16/17, revealed Resident #14 had a Brief Interview for Mental Status (BIMS) score of 15.	F 332		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (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		7/6/17

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F 441	Continued From page 3 (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 4 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, record review, and facility policy review, the facility failed to perform incontinence care in a manner to prevent cross contamination for one (1) of four (4) incontinent care observations; Resident #4, and failed to wash hands between residents while performing glucose finger-sticks for two (2) of six (6) residents observed during medication pass; Resident #1 and Unsampled Resident A. Findings include: A review of the facility's "Standard Precautions" policy, dated of 11/30/14, reads "Standard precautions are designed to reduce the risk of transmission of microorganisms from both recognized and unrecognized sources of infection in health care facilities. Change gloves between	F 441	1. On 5/31/17 Certified Nursing Assistant (CNA)#1 and CNA#2 were in-serviced by the DON on Standard Precautions, Incontinent Care, and Hand Washing Technique. On 5/31/17 LPN#2 was in-serviced by the DON on Blood Glucose Monitoring, Standard Precautions, and Hand Washing Technique. 2. On 6/17/17 the DON completed a quality review of current residents requiring incontinent care for CNAs following proper incontinent care technique to include following standard precautions and proper hand washing technique. On 6/17/17 the DON completed a review of current residents for Licensed Nurses following infection	

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F 441	Continued From page 5 tasks and procedures on the same resident after contact with material that may contain a high concentration of microorganisms. Remove gloves promptly after use; before touching non-contaminated items and environmental surfaces and before going to another resident." A review of the facility's "Blood Glucose Monitoring" policy, dated of 11/30/14, reads "Wash hands, put on gloves, wipe site with alcohol swab and allow to dry, pierce the site with lancet or bloodletting device, transfer drop of blood to reagent strip, apply pressure to puncture site, discard test strip and other materials per standard precautions, and wash hands." Resident #4: Observation on 5/31/17 at 4:00 PM, revealed Certified Nursing Assistant (CNA) #1 failed to change gloves while performing incontinent care and after performing incontinent care on Resident #4. CNA #1 placed soiled linens into the soiled linen bag then removed clean linens from the clean linen bag while wearing the same soiled gloves after incontinent care. CNA #2 was present. Interview on 5/31/17 at 4:15 PM, with CNA #1, revealed her stating, "I remembered what I did wrong when I was doing incontinent care, but I can't remember now." CNA #1 also stated, "Oh, I removed the dirty pad and should have changed my gloves before putting the clean one (referring to the pad) on. I know that I didn't change my gloves at all when I was doing incontinent care and that could cause bacteria or a bladder infection." Interview on 05/31/17 at 4:30 PM, with CNA #2,	F 441	control technique with bold glucose monitoring to include following standard precautions and proper hand washing technique. Follow up based on findings of review. 3. In-services were completed by the DON on 7/6/17 with Licensed Nurses to include the following Blood Glucose Monitoring, Standard Precautions, and Hand Washing Technique. In-services were completed by the DON on 7/6/17 with CNAs to include the following Standard Precautions, Incontinent Care, and Hand Washing Technique. A copy of the in-services and sign in pages are included for review. 4. The DON, ADON, or UM to conduct observation of Blood Glucose Monitoring, adherence to standard precautions, hand washing, and incontinent care 3 times a week for 2 weeks, 2 times a week for 2 weeks, weekly for 4 weeks, and ongoing monthly with findings reported to the QAPI committee monthly, QAPI monitoring schedule modified based on findings. Completed observation are attached for review.	

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F 441	Continued From page 6	F 441		

revealed she observed CNA#1 failing to change her gloves and by not changing her gloves could cause an infection.

Interview on 06/01/17 at 9:25 AM, with Registered Nurse (RN) #1, revealed she teaches the CNAs to wash their hands before and after wearing gloves, when the gloves becomes soiled, and when going from dirty to clean. RN #1 stated, "They have had in-services. I tell them they need to change their gloves after a resident, before they apply clean items on residents. They should not keep the same gloves on during the entire incontinent care process. This could cause the resident to get an infection from cross contamination."

A review of the Face Sheet revealed the facility admitted Resident #4 on 05/13/16, with diagnoses that included Heart Failure and Chronic Obstructive Pulmonary Disease.

A review of Resident #4's quarterly Minimum Data Set (MDS), with an Assessment Reference Date of 05/12/17, revealed a Brief Interview of Mental Status (BIMS) score of 2, which indicated severe cognitive impairment.

Resident #1 and Unsampled Resident #A:
Licensed Practical Nurse (LPN) #2 was observed Administering medications and performing a Finger-stick Glucose Test on 05/31/17 between 4:30 PM and 4:41 PM. . LPN #2 was observed at 4:30 PM in Resident #1's room administering the medication Insulin, removing gloves and exiting room without washing her hands. LPN #2 was then observed on 05/31/17 at 4:41 PM, entering

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F 441	Continued From page 7 Un-sampled Resident A's room to perform a Finger-stick Glucose Test. She donned gloves but did not wash her hands before entering the room or after exiting the room. During an interview on 05/31/17 at 4:45 PM, LPN #2 confirmed she did not wash her hands before or after entering the two(2) rooms. LPN #2 admitted to being nervous and knew that she should have washed her hands. She revealed failure to wash hands could cause the spread of infections. The facility admitted Resident #1 on 09/30/14, with a diagnosis including Type Two Diabetes Mellitus. The Facility admitted Un-sampled Resident #A on 4/26/16, with a diagnosis including Type two Diabetes Mellitus.	F 441		

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	255260	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**05/31/2017**

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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.