STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255097	A. BUILDING _____ B. WING _____	07/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE CENTER OF ABERDEEN	505 JACKSON ST ABERDEEN, MS 39730

(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 an annual recertification, along with a complaint, MS #15972, from 7/9/19 to 7/11/19. During the survey, the SA determined the the facility was not in compliance with the requirements of participation for Medicare and Medicaid. The SA cited F693 during the survey. The SA did not substantiate MS #15972 for neglect and cited no deficiencies. At the time of survey, the census was 100 and the facility held a license for 120 beds.	F 000		
F 693 SS=D	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 and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.	F 693		7/23/19

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

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F 693	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility policy review, the facility failed to ensure proper placement of the Percutaneous Endoscopic Gastrostomy (PEG) tube, prior to administration of medications via PEG tube for one (1) of one (1) resident observed during medication pass, Resident #19. The facility had a total of eight (8) residents identified with a PEG tube. Findings include: Review of the facility's "Administering Medications Through Nasogastric or Gastrostomy Tube" policy, dated 03/18, revealed, Procedures: 6. Verify proper tube placement by aspirating gastrointestinal contents. On 7/10/19, during the 8:00 AM medication pass, an observation of Licensed Practical Nurse (LPN) #1, revealed she administered medications via a PEG tube to Resident #19 and failed to check for placement of the feeding tube prior to administering the medications. On 7/10/19 at 8:40 AM, during an interview with LPN #1, she stated, "I just messed that all up because I didn't check placement before I gave the meds." The nurse verified placement after administration of medications by aspirating stomach contents. On 7/10/19 at 12:10 PM, an interview with LPN #1, revealed, she should have checked placement by aspirating stomach contents prior to administering the medications to ensure the tube was properly placed.	F 693	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceeding and submit these responses pursuant to our regulatory obligations. 1. Licensed Nurse #1 was immediately in-serviced on July 10, 2019 by the Director of Nursing with return demonstration of verifying the Percutaneous Endoscopic Gastrostomy(PEG)tube placement prior to giving flushes or administering medications. Resident #19 was assessed by Director of Nursing on 7/10/19 through 7/12/19 with no adverse outcomes. 2. The facility has determined that eight residents with PEG tubes have the potential to be affected by this deficient practice. 3. Licensed Nurses were in-serviced by the Director of Nursing with return demonstration on the facility's Administering Medication Through Gastrostomy Tube policy, starting on July 10, 2019 with completion date on July 23, 2019. A validation checklist was completed for each nurse to determine nurse was performing the procedure correctly,completed on July 23, 2019. No deficient practice was identified. 4. The Director of Nursing or Staff	

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F 693	Continued From page 2 On 7/10/19 at 12:18 PM, an interview with the Director of Nursing (DON), revealed, the nurse should have checked placement prior to giving medications. The DON stated the facility policy requires stomach contents be aspirated. On 7/10/19 at 12:26 PM, an interview with the DON, revealed, the Staff Educator is responsible for staff education, but she was out of the facility at this time. The DON stated LPN #1 attended in-service education on 4/10/2019, provided by the Pharmacy Consultant, that discussed medication administration via a PEG tube and checking placement. Review of the Pharmacy in-service sign in sheet, titled, "Med Pass Points", dated 4/10/19, revealed, LPN #1 was in attendance. The topic "Peg Tube Administration" was covered and specifically addressed: "Always check placement of the tube."	F 693	Development will complete random PEG Tube Validation Checklists of nurses for six consecutive weeks beginning July 24, 2019 to ensure nurses are performing the procedure in accordance with our facility's policy on Administering Medications Through Gastrostomy Tube. Nurse competency validation checklist will be done annually and upon hire. Findings will be reported to the Quality Assurance and Improvement Committee by the Director of Nursing for three months for review. Committee will make recommendations or revisions to ensure continued compliance.	

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	255097	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/11/2019**

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CARE CENTER OF ABERDEEN	**505 JACKSON ST** **ABERDEEN, MS 39730**

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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 374 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observations and testing, the facility failed to properly maintain door openings in smoke barrier walls as per NFPA 19.3.7.8. This deficiency practice affected two (2) of six (6) smoke compartments and 14 of 99 residents in the facility on the day of survey. Findings Include: On July 11, 201 at 10:20 AM, observation revealed to smoke barrier doors near Room 101	K 374	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceeding and submit these responses pursuant to our regulatory obligations. 1. Smoke barrier doors near room 101 were adjusted per outside vendor on 7/11/19 and secure closure was achieved	7/23/19

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K 374	Continued From page 1 of the facility did not fully close upon activation of the fire alarm system. These smoke barrier doors were incapable of resisting the passage of smoke throughout the facility.	K 374	on 7/11/19. All six smoke barrier doors were then inspected to ensure proper closure of the doors by outside vendor on 7/11/19. 2. the facility determined that there were 14 residents with potential to be affected by this deficient practice. 3. Administrator in-serviced maintenance on importance of closure and inspection of smoke barrier doors per regulation of smoke compartments on 7/11/19. 4. Maintenance Supervisor will inspect closure of all smoke compartment doors and report any problems identified to the Administrator weekly. Problems identified will be corrected immediately and brought to the Quality Assurance and Improvement Committee for review to ensure continued compliance.	

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E 000	Initial Comments EMERGENCY PREPAREDNESS Survey conducted on 07/11/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were cited.	E 000		

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