MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	42PM	A. BUILDING: _____ B. WING _____	03/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW NURSING & REHABILITATION CEI	1600 WEST CLAIBORNE AVENUE EXTENDED GREENWOOD, MS 38930

(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) COMPLETE DATE
M 000	Initial Comments A Recertification Survey was conducted by Healthcare Management Solutions (HMS), LLC from 3/25/19 through 3/28/19, on behalf of the Mississippi State Department of Health. During the recertification survey, it was determined that the facility is not in compliance with the Minimum Standards of Operation for Institutions for the Aged or Infirm, state licensure requirements at M500, M610 and M640. Census at the time of survey was 64, and the facility held a license for 80 beds.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his	M 500		5/3/19

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M 500	Continued From page 1 medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal;	M 500		

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M 500	Continued From page 2 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other	M 500		

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M 500	Continued From page 3 residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level II Based on review of the facility's policy,	M 500	Resident #39 and #22 were assessed by the Director of Nursing on 03/26/19 in their wheelchairs, it was determined that	

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M 500	Continued From page 4 observations, interviews, and record reviews, the facility failed to ensure two (2) of two (2) sampled residents, Residents (R) #39 and R #65, out of a total sample of 22 residents, were free of physical restraints. Specifically, the residents had lap belts in place, which neither resident could remove on demand. There was no documented evidence the facility assessed the residents, or the use of the lap belts, prior to use of the restraints. Findings include: Review of the facility's policy titled, "Use of Restraints," revised April 2017, revealed restraints would only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully. Continued review of the policy revealed restraints would only be used to treat the resident's medical symptom(s) and never for discipline, staff convenience, or for the prevention of falls. Further review of the policy revealed physical restraints were defined as any manual method, physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body. The policy revealed placing a resident in a chair that prevents the resident from rising, was a practice that inappropriately utilized equipment to prevent resident mobility and was considered a restraint, which would not be permitted. Continued review of the policy revealed prior to placing a resident in restraints, there would be a pre-restraining assessment and review to determine the need for restraints, which would determine possible underlying causes of the problematic medical symptom and, to determine if there were less restrictive interventions that could have improved the	M 500	neither resident required lap belts for safety or restraint and they were utilized because lap belts were a standard accessory on their particular model of wheelchair. The lap belts that were attached to Resident #39's and Resident #22's wheelchairs were immediately released and subsequently removed by the Maintenance Supervisor on 03/26/19. No resident suffered adverse effects from this deficient practice. The two residents in wheelchairs with attached seat belts had the potential to suffer adverse effects from this deficient practice. All new wheelchairs that have safety belts attached will have the safety belts removed until the resident is assessed for the need of a safety belt. Nursing staff was in serviced on 03/26/19 by the Director of Nursing on the use of restraints per facility policy to include a resident's right to be free of unnecessary restraints. A 100% audit of residents with lap belts was conducted by the Director of Nursing on 03/26/19, to ensure the resident can release the lap belt on request or it will be considered a restraint and will be coded as such and will ensure those residents were assessed prior to the use of the belts and other interventions had been attempted prior to use. Three wheelchairs were found to have safety lap belts attached to the wheelchairs during the 100% audit. One of the three requires the seat belt as a restraint. The other safety belts were removed by the Maintenance Director on 03/26/2019. The Assistant Director of Nursing will monitor	

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M 500	Continued From page 5 symptoms. The policy also revealed restraints would only be used upon the written order of a physician and after obtaining consent from the resident and/or representative. Resident #39 Observation on 03/25/19 at 1:55 PM, revealed R #39 sitting in front of the "B Wing" nurses' station, in his wheelchair, with a lap belt fastened. During observation on 03/26/19 at 3:15 PM, in the dining room, Certified Nursing Assistant (CNA) #18 prompted R #39 to unbuckle his seat belt; however, the resident did not attempt to unbuckle it. Review of Resident #39's medical record revealed the "Physician Orders" dated March 2019, revealed no order for the use of a wheelchair with a lap belt. There was no assessment or consent for the lap belt for Resident #39. Review of R #39's Quarterly "Minimum Data Set (MDS)," with an Assessment Review Date (ARD) of 02/11/19, revealed a Brief Interview for Mental Status (BIMS) was not conducted, due to the resident was rarely/never understood. The facility assessed the resident to have severe cognitive impairment. The MDS specified the resident had no range of motion impairment to his lower extremities. The MDS did not specify the use of a trunk restraint. Interview, on 03/26/19 at 3:10 PM, with CNA #18, revealed she was assigned and familiar with R #39. She stated the resident had to keep his seat belt on to keep him from falling out of his wheelchair. The CNA stated she put the resident's seat belt on him at all times while he	M 500	the residents with lap belts three times per week for eight weeks starting 03/26/19, to ensure the lap belts are being used as ordered and if not ordered as restraints the resident can release the belt on request. Any new wheelchair purchase or obtained by the facility will be assessed for safety lap belts, and the lap belt will be removed prior to use if not required. Beginning 03/26/19, the Care Plan Coordinator will monitor all residents with lap belts weekly for eight weeks to ensure ongoing compliance and restraints will be reviewed per the Minimum Data Set schedule for quarterly resident assessments in the Restraint Reduction Committee for continued compliance. Adverse findings will be forwarded to the Quality Assurance Committee by the Care Plan Coordinator during the monthly Quality Assurance meeting. The Quality Assurance Committee will then determine appropriate actions to be taken to include but not limited to re-education and discipline of the responsible staff.	

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M 500	Continued From page 6 was in his wheelchair, because if not, he would lean forward and fall out of it. The CNA further stated she had worked at the facility since July of 2018, and he had always had his seat belt on since she started. An interview on 03/26/19 at 3:17 PM, with Licensed Practical Nurse (LPN) #2, revealed R #39 did not have a physician's order for a seat belt; however, the CNAs may not always fasten the seat belt, but just when the resident was in an agitated mood, and for his safety. Continued interview revealed it was the LPN's expectation the CNAs would buckle the seat belt when the resident became agitated. Review of R #39's "Face Sheet," revealed the facility admitted the resident on 12/13/16, with diagnoses which included Metabolic Encephalopathy, Disease of Spinal Cord, Unspecified Lack of Coordination, Abnormalities of Gait and Mobility and Abnormal Posture. Resident #65 Observation and interview on 03/26/19 at 1:50 PM, with CNA #27, revealed R #65 had a lap belt fastened while she was in her wheelchair. During the observation, the CNA prompted the resident to take her seat belt off; however, the resident was not able to unfasten the seat belt. Interview with the CNA confirmed the resident was not able to release the seat belt. Review of R #65's "Face Sheet," revealed the facility admitted the resident on 05/09/01, with diagnoses which included Schizophrenia, Brief Psychotic Disorder, Lack of Coordination, and history of falling. Review of "Physician Orders" dated March 2019,	M 500		

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M 500	Continued From page 7 revealed no order for the use of a wheelchair with a lap belt. Review of the medical record also revealed no assessment for the seat belt. Review of R #65's Quarterly "MDS", with an ARD of 03/11/19, specified a BIMS was not conducted due to the resident was rarely/never understood; however, the facility assessed the resident to have severe cognitive impairment. The "MDS" specified the resident had upper and lower extremity range of motion impairments to one side. The "MDS" did not specify the resident had a trunk restraint. Interview on 03/26/19 at 1:56 PM, with CNA #19, revealed she was assigned to R #65 and was familiar with the resident. She revealed she had never seen the resident release the seat belt. The CNA stated she fastened the resident's seat belt today because if not, the resident would tip over out of her wheelchair. Interview on 03/26/19 at 2:05 PM, with LPN #11, revealed she was assigned and familiar with R #65. Continued interview revealed the purpose of the seat belt for R #65 was to keep the resident from moving and falling out of her wheelchair. Further interview with the LPN revealed she could not locate an order for the seat belt. Interview on 03/26/19 at 2:41 PM, with the Director of Nursing (DON), revealed there was no physician order for either R #39 or R #65 to have a seat belt fastened while in their wheelchairs. She stated the seat belts should not have been put on the residents. Interview on 03/28/19 at 12:23 PM, with the Medical Director, revealed it was his expectation the facility would contact him for an order for the	M 500		

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M 500	Continued From page 8 use of a lap belt. Interview on 03/28/19 at 12:49 PM, with the Administrator revealed it was her expectation the staff would not have fastened the lap belts, because there was no physician's order or assessments. She revealed it was important residents were not in restraints that were not ordered for their overall safety.	M 500		
M 610	45.21.2 Activities of daily living Activities of daily living. Each resident shall receive assistance as needed with activities of daily living to maintain the highest practicable well being. These shall include, but not be limited to: 1. Bath, dressing and grooming; 2. Transfer and ambulate; 3. Good nutrition, personal and oral hygiene; and 4. Toileting. This Statute is not met as evidenced by: Level II Based on record review, resident and staff interviews, and review of the facility's policy, the facility failed to implement a physician's order for one (1) resident, Resident (R) #40, to provide Restorative services to help prevent decline, out of a survey sample of 22 residents. Findings Included: Review of the facility's policy titled, "Activities of Daily Living (ADLs), Supporting" revised 03/18	M 610	Resident #40 is on Restorative caseload and is provided Restorative services by their assigned Certified Nursing Assistant when the lead Restorative Certified Nursing Assistant is not available. Resident # 40 was assessed by the Therapy Department on January 30, 2019 and referred for the Restorative program. A physician's order was obtained for the resident to begin Restorative care and Restorative care was started by the Restorative Certified Nursing Assistant on February 1, 2019.	5/3/19

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M 610	Continued From page 9 indicated, " . . . Residents will [sic] provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). . . Residents will be provided with care, treatment, and services to ensure that their activities of daily living (ADLs) do not diminish unless the circumstances of their clinical condition(s) demonstrate that diminishing ADLs are unavoidable. . . Appropriate care and services will be provided for residents who are unable to care out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with. . . Hygiene. . . Mobility (transfer and ambulation, including walking). . . Elimination (toileting). . . " Review of R #40's "physician order" dated 01/30/19, indicated to ambulate 60 to 150 feet with a rolling walker and gait belt six (6) times a week. In addition, the physician ordered to provide R #40 with therapeutic exercises which included three (3) repetitions of 20 leg kicks, knee rails, and hip abductions six (6) times a week. This care was to be provided by Restorative. Review of R #40's care plan, dated as initiated 08/23/18, identified R #40 had an ADL deficit. There was a hand-written note under "Approaches", without a date of the revision, which indicated to ambulate the resident 60 to 150 feet, with a rolling walker and gait belt six (6) times a week. The care plan directed the Restorative Certified Nursing Assistant (RCNA) to provide this care. The hand-written note indicated the resident was to receive therapeutic exercises, three repetitions of 20 leg kicks, knee raises, and hip abductions six (6) times a week. R #40's quarterly "Minimum Data Set (MDS)" with	M 610	No resident suffered any adverse effects from this deficient practice. A the time of survey there were three residents on Restorative caseload that had the potential to suffer adverse effects from this deficient practice. The Lead Restorative Certified Nursing Assistant and the floor Certified Nursing Assistants were in-serviced by the Therapy Department Manager on following physician's orders and care plans that relate to providing Restorative care to residents on 04/01/19-04/03/19. including activities of daily living such as hygiene, mobility, elimination, dining and communication. A 100% audit was done by the Restorative Nurse on 03/28/2019, with orders for Restorative Service to ensure the services were being provided. No other issues were identified during the audit. The Restorative Nurse will monitor documentation five days a week for eight weeks beginning 05/01/2019, to ensure resident's with Restorative orders are receiving services as ordered The Assistant Director of Nursing will monitor Restorative documentation and the provision of Restorative services two times a week for eight weeks, then the Minimum Data Set Coordinator will review Restorative documentation quarterly per the Minimum Data Set quarterly schedule to ensure on-going compliance. Monitoring will begin 05/01/19. Any adverse findings will be forwarded to the Quality Assurance Committee by the Director of Nursing/Assistant Director of Nursing	

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M 610	Continued From page 10 an Assessment Reference Date (ARD) of 02/14/19, indicated R #40's Brief Mental Interview for Mental Status (BIMS) score indicated R #40's cognition was intact. Review of R #40's "Face Sheet" indicated the facility admitted R #40 on 08/23/18, with a diagnosis of Cerebral Vascular Accident. A document titled, "Therapy to Restorative Form" noted a referral for R #40 to receive restorative nursing services. The date of the signature from the therapist was dated 01/30/19, and signed by RCNA #14. A document titled, "RET (restorative)" for the month of 02/2019, identified R #40 was to be ambulated 60 to 150 feet six (6) times a week with a rolling walker and a gait belt. The treatment was signed off for 02/01/19, 02/04/9 through 02/08/19, 02/11/19 through 02/15/19, 02/18/19 through 02/22/19, and 02/25/19 through 02/28/19. The signed off dates were the same for therapeutic exercises. A document titled "RET" for the month of 03/2019, identified R #40 was to be ambulated 60 to 150 feet six (6) times a week with a rolling walker and a gait belt. The treatment was signed off on 03/04/19, and below the initials were "150." The sign off sheet noted initials on 03/05/19 through 03/08/19, 03/11/19 through 15/19, 03/18/19 through 03/22/19, and from 03/25/19 through 03/28/19. The signed off dates were the same for therapeutic exercises. The Restorative Director (RD) was interviewed on 03/27/19 at 8:36 AM. The RD stated that there was only one (1) fulltime RCNA. The RD stated that all CNAs were able to provide residents with	M 610	during the monthly Quality Assurance Meeting. The Quality Assurance Committee will determine appropriate action to be taken to include but not limited to re-education and disciplinary action for the responsible staff.	

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M 610	Continued From page 11 restorative care and document accordingly. An interview was conducted with CNA #15 on 03/27/19 at 3:07 PM. She stated that she has not been directed to provide restorative services to R #40. She indicated that she works on the weekend and thought that the resident could walk on his own. An interview was conducted with the Restorative Nurse on 03/27/19 at 3:10 PM. The Restorative Nurse stated that R #40 frequently refused to walk. She pointed to the "RET" document for 02/2019, and confirmed the resident refused to walk according to the way it was noted on this document. The Restorative Nurse stated R #40 only walked once on 03/04/19, and had refused on the remaining dates. An interview was conducted with R #40 on 03/28/19 at 8:56 AM. R #40 indicated that staff members have not offered to walk him. The resident denied refusing to walk. An interview was conducted with RCNA #14 on 03/28/19 at 8:58 AM. RCNA #14 stated she has not offered to walk R #40, since the resident attends activities. RCNA #14 stated she was unaware there was a physician's order to walk the resident. RCNA #14 confirmed the initials on the "RET" documents were hers. She stated that when she signs off on these documents, it means she did not complete R #40's activities for restorative. She stated that she was given this direction on how to sign off on this document by a previous nurse. The Director of Nursing (DON) was interviewed on 03/28/19 at 2:49 PM. The DON stated the RCNA was pulled to work the floor four (4) times	M 610		

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	42PM	A. BUILDING: _____ B. WING _____	03/28/2019

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M 610	Continued From page 12 in the month of 02/2019, and another four (4) times in 03/2019. The DON said R #40 was compliant with care.	M 610		
M 640	45.21.8 Accidents Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies. This Statute is not met as evidenced by: Level II Based on observation, interview, review of the facility's policy, review of "Safety Data Sheets (SDS)", and review of "Material Safety Data Sheets (MSDS)," it was determined the facility failed to ensure the residents' environment remained as free of accident hazards as possible as evidenced by a storage room, which contained chemicals, was propped open. Review of the facility's list of wandering residents revealed the facility had two (2) residents that wandered randomly throughout at the facility, out of 64 residents in the facility. Neither resident was observed trying to enter into the storage area, but had the potential. Findings include: Review of the facility's policy titled, "Hazardous Areas, Devices, and Equipment," revised July 2017, revealed all hazardous areas, devices, and equipment in the facility would be identified and addressed appropriately to ensure resident safety	M 640	The door to the storage room which contained chemicals, that was propped opened was closed and secured by the Director of Nursing immediately on 03/27/19. No residents were in the area at the time the deficient practice was noted. No resident suffered adverse effects from this deficient practice. All wandering residents have the potential to be affected by this deficient practice. All doors to areas that contain hazardous or potentially harmful items will be kept closed at all times to ensure residents safety from access to hazardous materials or other potentially harmful items locked behind closed doors. Nursing staff was in-serviced on 03/27/19 by the Director of Nursing on ensuring the residents environment remains free of hazards such as unsecured chemicals by	5/3/19

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M 640	Continued From page 13 and mitigate accident hazards to the extent possible. Continued review of the policy revealed a hazard was defined as anything in the environment that had the potential to cause injury or illness which included sharp objects that were accessible to vulnerable residents, open areas or items that should be locked when not in use, and access to toxic chemicals. Observation on 03/27/19 at 3:44 PM, on the "A Wing", revealed the central supply room door was propped open with a gallon jug containing "Classic Whirlpool Disinfectant and Cleaner." The room was unattended. Continued observation revealed a resident, who the facility identified as a resident who wanders, sitting in her wheelchair, outside the central supply room. (The resident was not attempting to enter the room). At 3:49 PM, the Director of Nursing (DON) observed the surveyor in the central supply room and inquired how the surveyor had access to the room. Observation of the central supply room revealed the room contained the following hazardous and sharp materials: one (1) gallon of "Classic Whirlpool Disinfectant and Cleaner"; seven (7) containers of "PDI Sani-Cloth Plus Germicidal Disposable Cloths" containing 65 extra-large cloths per container; eight (8) containers of "PDI Super Sani-Cloth Germicidal Wipes" containing 160 large disposable wipes per container; 20 boxes of "McKesson Alcohol Prep Pads" containing 200 prep pads per box; and 300 "McKesson Disposable Twin Blade Razors." Review of the "MSDS" for the "Classic Whirlpool Disinfectant Cleaner" revealed contact to the eyes and the skin could cause irritation. The "MSDS" revealed if swallowed, the "Whirlpool Disinfectant Cleaner" could be harmful and medical attention should be sought.	M 640	ensuring that all rooms containing potentially harmful items are locked and secured. A 100% audit was conducted by the Chief Safety Officer on 03/27/19 to ensure all doors in the facility that are required to be secure to protect the residents from possible hazards were secure. The 100% audit findings concluded all doors were secured at all times. The Maintenance Assistant will monitor all doors required to be secure to ensure they are secure five times per week for eight weeks beginning 03/27/19. The Maintenance Director will monitor the secured doors two times a week for eight weeks to ensure compliance beginning 03/27/19. The Charge Nurse will monitor all doors required to be secure to protect residents from possible hazards on their shift rounds to ensure on-going compliance. Adverse findings will be forwarded to the Quality Assurance Committee for review monthly presented by the Maintenance Director. The Quality Assurance Committee will determine appropriate action to be taken to include but not limited to re-education and disciplinary actions of responsible staff.	

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M 640	Continued From page 14 Review of the "SDS" for the "PDI Sani-Cloth Plus Germicidal Disposable Cloths" revealed it was a pesticide product registered by the United States Environmental Protection Agency. The "SDS" revealed if contact occurred to the eye, it would cause eye irritation. The "SDS" identified ingestion was unlikely if used as directed, and that first aid was not required for small amounts transferred from the hands to the mouth. Review of the "SDS" for the "Super Sani-Cloth Germicidal Wipes" revealed it was a pesticide product registered by the United States Environmental Protection Agency. The "SDS" revealed if contact occurred to the eye, it would cause eye irritation; ingestion was unlikely if used as directed; and first aid was not required for small amounts transferred from the hands to the mouth. Review of the "MSDS" for the "McKesson Alcohol Prep Pads" revealed if eye contact occurs, it would cause eye stinging. The "MSDS" revealed if ingested, vomiting should be induced, and a physician should be notified. Interview on 03/28/19 at 12:23 PM, with the Medical Director, revealed it was his expectation that whoever was responsible for making sure doors staying closed, do what they were supposed to do. Interview on 03/18/19 at 12:33 PM, with the Environmental Services Director (ESD), revealed the central supply room should not have been propped open and accessible to residents. He stated, it was important the room would not have been accessible to residents for the residents' safety.	M 640		

MSDH - Health Facilities Licensure and Certification

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M 640	Continued From page 15 Interview on 03/28/19 at 12:49 PM, with the Administrator, revealed it was her expectation the central supply room would not have been accessible to residents. The Administrator stated, it was not acceptable, and the room should have been locked at all times, due to the danger it poses to the residents. Interview on 03/28/19 at 1:18 PM, with the Assistant Director of Nursing (ADON), revealed she was the direct supervisor of the nursing staff and the Certified Nursing Assistants (CNAs). She stated it was her expectation the central supply room would not have been accessible to residents because of the potential danger of a resident getting to the chemicals. Interview on 03/28/19 at 3:08 PM, with CNA #32 revealed she was the person who propped the central supply room door open. She stated she got distracted by a co-worker asking for her assistance and forgot to remove the gallon of chemicals she used to prop the door open. She stated it was very important that she had not left the door propped open because residents pass by the room and if the door was open, a resident could get in the room and get something they were not supposed to have, putting them in harms way or danger. Interview on 03/28/19 at 3:49 PM, with the DON revealed it was important the central supply closet should not have been propped open where residents could get into the room. She stated it was important because if a resident got into the room, they could get into the hazardous chemicals in the room or even get locked in the room.	M 640		