STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255111	A. BUILDING _____ B. WING _____	03/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST POINT COMMUNITY LIVING CENTER	1122 N ESHMAN AVENUE WEST POINT, MS 39773

(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 A Recertification survey was conducted by Healthcare Management Solutions, LLC on behalf of the Mississippi State Department of Health from 03/18/19 - 03/21/19. The facility was found not to be in substantial compliance with Medicare and Medicaid requirements for participation. Deficiencies were cited at F687 and F924. The census at the time of survey was 64 and the facility held a license for 100 beds.	F 000		
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy on "Foot Care," the facility failed to provide needed nail care for one (1) of four (4) diabetic residents, Resident #49. As a result of this deficient practice, Resident #49's toenails were discolored and thickened with jagged ridges and cracks across the surfaces. This deficient practice had the	F 687	1. Resident #49 toenails were trimmed with foot care by the Director of Nursing on March 20, 2019. 2. The facility recognizes that all residents with diabetes and peripheral Vascular Disease have the potential to be affected by this alleged deficient practice. All	4/30/19

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F 687	Continued From page 1 potential to promote fungal infections of the toenails. Findings include: The facility's policy on "Foot Care," dated 08/25/14, documented the following procedures: "6. Examine feet carefully for evidence of any discoloration, breaks in skin integrity, irritation or edema. 7. Toenails are to be clipped and filed smoothly. NOTE: THE PODIATRIST OR NURSE IS TO CLIP NAILS FOR ALL DIABETIC RESIDENTS AND RESIDENTS WITH PERIPHERAL VASCULAR DISEASES." Observation on 03/18/19 at 11:41 AM, revealed Resident #49 sat in her room in a Geri-chair. Her uncovered feet rested on the floor in front of the Geri-chair. Her toenails on both feet were discolored and thickened, with jagged ridges and cracks across the surfaces of the toenails. During an interview on 03/20/19 at 10:11 AM, Licensed Practical Nurse (LPN) #1, assigned to Resident #49, reported she had not seen Resident #49's toe nails, but would check them and provide additional information. LPN #1 provided no additional information during the survey. During an interview on 03/21/19 at 9:04 AM, the Director of Nursing (DON) agreed to check Resident #49's toenails and provide additional information. During a follow up interview on 03/21/19 at 10:16 AM, the DON stated she checked Resident #49's toenails and determined they needed care. She stated the LPN who completed the weekly body	F 687	residents toenails and feet were observed, including 20 Diabetics for any needed care with no concerns. Observations were initiated on March 25, 2019 completed on April 5, 2019 by the Director of Nursing. 3.Licensed nurses staff was inserviced on the residents nail/foot care when performing body audits and appointments for podiatrist as needed. Inservice was initiated on March 20, 2019 and completed on April 26, 2019. Inservice was performed by Director of Nursing and Assistant Director of Nursing. The careplan was updated on April 24, 2019 to include routine assessment of nail care by the Director of Nursing. 4. Registered Nurse Supervisor, Director of Nursing, and/or Assistant Director of Nursing will check five residents with diagnosis of diabeted and/or peripheral Vascular Disease three times a week for four weeks. The Corrective action will be monitored and evaluated by the Qualtity Assurance Performance Improvment Committee on a quarterly basis and more often if necessary. If any revisions to the plan of correction are needed the revisions will be developed and approved by the Quality Assurance commitee. Quality Assurance Tools will be reviewed quarterly with recommendations and/or corrective actions given as necessary to ensure the plan of correction is achieved and sustained.	

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F 687	Continued From page 2 audits failed to look at and assess Resident #49's toenails. The DON stated the facility had no policy on body audits and tracking or trending of diabetic residents' toenails, but she expected the assigned nurse to assess each diabetic residents' toenails for needed care on a weekly basis. She added that a call would be placed to the physician to get an order for Podiatry care. The DON stated that in response to this situation, the facility drafted a performance improvement plan to assure such failures did not reoccur. Review of Resident #49's quarterly Minimum Data Set (MDS), with an Assessment Reference Date of 01/09/19, indicated the resident had an active diagnosis of Diabetes Mellitus. Review of Resident #49's "Care Plan," revised on 01/08/19, revealed it did not include interventions for the routine assessment of Resident #49's toenails.	F 687		
F 924 SS=D	Corridors have Firmly Secured Handrails CFR(s): 483.90(i)(3) §483.90(i)(3) Equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the facility's "Emergency Evacuation" policy, and review of the facility's posted fire evacuation plan, the facility failed to ensure handrails were installed on both sides of a section of a corridor leading to an approved emergency exit, for one (1) of 12 approved exits. This deficient practice had the potential to affect any resident, visitor, or staff that would use the corridor in the event of an emergency evacuation of the facility. Findings include:	F 924	1. Maintenance Director gathered quotes to order handrails. Quote was received by (Name of Construction of Company) on April 23, 2019. 2. Residents that access the hallways have the potential to affected by the alleged deficient practice. There were no residents affected. 3. Handrails were ordered on April 23, 2019 by Administrator. Handrails will be	4/30/19

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F 924	Continued From page 3 Review of the facility's undated policy and procedure titled, "Emergency Evacuation," revealed the policy included the facility's "Evacuation Plan" (a facility map that includes directional arrows to guide persons in the direction of the nearest emergency exit according to their location in the facility). Review of the "Evacuation Plan" on the wall at the nurses' station indicated the corridor, identified as the "Laundry Hall," and the exit door at the end of the corridor, as one (1) of the facility's approved evacuation routes in the event of an emergency. Observation on 03/20/19 at 3:30 PM, revealed the "Laundry Hall" corridor, which had no resident rooms, lacked handrails on both sides of the corridor for over 54 feet to the exit door. During an interview at this same time, the Administrator stated, "No one lives in the area, but if someone were close, they would use that exit [to evacuate the facility]."	F 924	added to the hallway upon arrival. 4.Maintenance Director will make facility rounds on handrails weekly for six weeks. Rounds for handrails were initiated on April 29, 2019 by Administrator. The Corrective action will be monitored and evaluated by the Quality Assurance Performance Inprovement Committee on a quarterly basis and more often if necessary. If any revisions to the plan of correction are needed the revisions will be developed and approved by the Quality Assurance commitee. Quality Assurance Tools will be reviewed quarterly with recommendations and/or corrective actions given as necessary to ensure the plan of correction is achieved and sustained.	

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	255111	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/21/2019**

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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		

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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.

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E 000	Initial Comments Initial certification survey conducted 4/21/19 revealed the above facility does not meet all applicable Federal, State and local Emergency Preparedness requirements. Deficeincies were identified.	E 000		
E 015 SS=E	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures.	E 015		4/30/19

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E 015	Continued From page 1 (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to maintain and update the emergency preparedness (EP) policies and procedures per requirements of 42 CFR §483.73(b) (1). Findings Include: On March 21, 2019 at 10:45 AM, the facility failed to provide updated policies and procedures containing amount of water supply in the facility. Documentation review revealed the EP policies and procedures stated the facility shall have reserve water for emergencies, but observation and interviews revealed that the reserve water wasn't located in the facility or on site on the day of survey.	E 015	1. Maintenance Supervisor will transport Emergency water from climate control storage to West Point Community Living Center by April 30, 2019. 2. All residents and staff have the potential to be affected by the alleged deficient practice. 3. Water will be on site at West Point Community Living Center according to the count established by the Emergency Operations plan for the facility. 4.Maintenance Supervisor inserviced by the Administrator on ensuring water is on site acccording to Emergency Operations	

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E 015	Continued From page 2 The finding was acknowledged by the Administrator and Maintenance Supervisor verified this observation during the exit interview on 2/21/19.	E 015	plan on April 26, 2019. Maintenance Director will check emergency water once a month for 3 months to ensure water is matching the current count established by the Emergency Operations Plan for the facility.The Corrective action will be monitored and evaluated by the QAPI Committee on a quarterly basis and more often if necessary. If any revisions to the plan of correction are needed the revisions will be developed and approved by the QA commitee. Quality Assurance Tools will be reviewed quarterly with recommendations and/or corrective actions given as necessary to ensure the plan of correction is achieved and sustained.	