STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255327	A. BUILDING _____ B. WING _____	01/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTHA COKER GREEN HOUSE HOME	2041 GRAND AVE YAZOO CITY, MS 39194

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification along with a complaint, CI MS #16545 from 1/28/20 to 1/30/20. During the survey, the SA determined that the facility was not in compliance with the requirements of participation for Medicare and Medicaid. The SA substantiated CI MS #16545 for Quality of Care with no citations related to the complaint. The SA cited F550, F656, F657, F679, F812 and F880 during the survey. At the time of the survey, the facility held a license for 60 beds and the census was 60 residents.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F 550		3/28/20

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

Electronically Signed | 03/03/2020

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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F 550	Continued From page 1 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, facility policy review, and staff interview, the facility failed to preserve a resident's dignity by failing to provide meals to all residents at a table at the same time for one (1) of two (2) resident dinning observations, Resident #25. Findings include: Review of the facility's "Resident Rights" policy, dated November 2017, revealed the resident has a right to be treated with respect and dignity. Record review of physician's orders dated 11/26/19, revealed an order for Regular diet, regular texture, and thin liquids. The comprehensive care plan problem for nutritional risk and risk for dehydration includes interventions for Regular Diet with regular texture and thin liquids and honor food preferences within	F 550	1. The Shahbaz staff (certified nurse assistants) involved were immediately in-serviced on the proper procedures for maintaining elder (resident) dignity during mealtimes by the Registered Nurse Supervisors on 1/28/2020. The seating arrangement at the table of the affected elder was changed by the Shahbaz staff on 1/28/2020 to ensure that all elders can eat at the same time. 2. The facility has determined that all elders requiring feeding assistance at mealtimes have the potential to be affected. "Shahbaz and licensed nurses were in-serviced by the Registered Nurse Supervisors, Director of Nursing, and Shahbaz Coach on the proper procedures for assisting residents with meals to ensure elder dignity is maintained during	

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F 550	Continued From page 2 diet regimen. Review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/28/2019, indicated a Brief Interview for Mental Status (BIMS) was coded as 99. The MDS section G0110H1, eating self-performance was coded as 3 which is extensive assistance and section G0110H2, eating support provided was coded as 2, which indicated, one person physical assist. An observation of the dinner meal on 1/28/2020 from 11:30 AM until 12:30 PM, revealed the residents were all seated at the table by 11:30 AM. The first plate was delivered to the table at 11:40 AM. Certified Nursing Aide (CNA) #8 started assisting Resident #25 at 12:13 PM. Resident #25 sat at the table for 43 minutes and was not served her meal for 33 minutes. An interview with CNA #7 on 1/28/2020 at 1:48 PM, revealed "If they don't like something, we will fix them soup and a sandwich. We have one that just wants soup, crackers, and ice cream every day. We give them whatever they want." An interview with CNA #8 on 1/28/2020 at 2:00 PM, revealed "We take turns feeding Resident #25. She stated Resident #25 is not always last but, "the table is so crowded we have to wait until some of them finish to feed her." An interview with the Director of Nursing (DON) on 1/28/20 at 3:50 PM, revealed "Ideally we want everyone eating at the same time and if we need to rearrange the setting to accomplish that, we can." A review of the facility's Face Sheet revealed, the facility admitted Resident #25 on 8/20/19, with	F 550	mealtimes. This was completed by 2/28/2020. A meal observation checklist was created on 2/5/2020 by the Registered Dietician for the clinical support team to guide meal observations to ensure resident rights and dignity are maintained at each meal. Any corrective actions needed will be addressed with the staff immediately and recorded on meal observation checklist as they occur. 3. The clinical support team conducted meal observations of staff during mealtimes daily from 1/31/2020 thru 2/14/2020, three times per week for two weeks from 2/16/2020 thru 2/29/2020 to ensure staff were promoting and maintaining resident dignity during mealtimes in accordance with our facility□'s practice guidelines and regulatory requirements. Meals will be observed two times per week for four weeks by clinical support team members from 3/1/2020 thru 3/28/2020 to ensure staff are promoting and maintaining resident dignity during mealtimes in accordance with our facility□'s practice guidelines and regulatory requirements. 4. Observation reports and will be reviewed by the Risk beginning Management/Quality Assurance Committee monthly starting 3/12/2020 until such time consistent substantial compliance has been achieved as determined by the committee. The Administrator will review the results of observation reports starting 1/29/2020 and address any corrective actions with	

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F 550	Continued From page 3 diagnosis of Chronic Obstructive Pulmonary Disease (COPD).	F 550	the clinical support team. 5. Corrective action completion date: 3/28/2020.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for	F 656		3/28/20

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F 656	Continued From page 4 future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and facility policy review, the facility failed to implement an activity care plan, for one (1) of 18 resident care plans reviewed, Resident #5. Findings include: Review of the facility's "Activity" policy, dated 11/28/17, revealed it is the policy of this facility to provide an ongoing program to support residents in their choice of activities based on their comprehensive assessment, care plan, and preferences of each resident. Facility sponsored group, individual, and independent activities will be designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, as well as, encourage both independence and interaction within the community. Review of the facility's "Comprehensive Care Plans" policy, dated November 2017, indicated, "It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet the resident's	F 656	1. The care plan of affected elder #5 was updated after the elder was interviewed to confirm activity preferences. The activity interview and care plan update were completed on 3/2/2020. 2. The facility has determined that all elders have the potential to be affected. 3. All clinical support team members responsible for writing care plans were educated on the facility□s policy and procedure for developing Comprehensive Care Plans on 2/4/2020 by the Director of Nursing. All elder□s will be interviewed by 3/4/2020 for activity preferences. All activity care plans will be reviewed/updated by 3/14/2020 to ensure accuracy regarding the elder□s status and preferences. The Activity Director will educate Shahbaz staff about the elder□s preferences related to activities and will monitor weekly activity calendars to ensure elder□s preferences are represented by 3/28/2020. 4. Beginning 2/4/2020, the care plans will be reviewed and discussed in accordance with the care plan review schedule by the Minimum Data Set Coordinator(s)and the interdisciplinary team. All care plans will	

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F 656	Continued From page 5 medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment." Record review of the care plan with a Problem and/or Need indicated, "Resident #5 has a need for continuing group activity contact. She currently enjoys card games, playing Bingo, and watching game shows on television, and listening to music." The care plan interventions include "Ensure that a variety of cards and other games are available at all times for leisure and group activities", and "Engage resident in group activities". During an observation of the Hearth Area in House #5 on 1/28/20, from 10:00 AM to 11:20 AM, neither Morning Stretch nor Bingo occurred as indicated by the Activity Calendar. Review of the Activity Calendar posted at the kitchen counter revealed Morning Stretch was scheduled at 10:00 AM, and Bingo was scheduled for 10:30 AM. On 01/30/20 1:58 PM, an interview with the Director of Nursing (DON) revealed she could not say whether or not Resident #5's care plan was followed but there is no documentation of any Activities performed for the month of January (2020) in House #5. Review of the facility's Face Sheet revealed the facility admitted Resident #5 on 9/19/16. Resident #5's current diagnoses included but not limited to Gastro-esophageal Reflux, Vitamin D Deficiency, and Arthropathy. Review of Resident #5's Quarterly Minimum Data	F 656	be updated as indicated with significant changes and quarterly/annuals assessments, this will be an ongoing evaluation by the Director of Nursing and the Interdisciplinary Team. Also beginning 2/4/2020, The Director of Nursing and assigned Registered Nurses will complete audits of all care plans to be completed by 3/14/2020 to ensure each care plan is reviewed/updated and accurate. Results will be reviewed by the Risk Management/Quality Assurance Committee and Medical Director monthly until such time consistent substantial compliance has been achieved as determined by the committee beginning 3/12/2020. "Corrective action completion date: 3/28/2020.	

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F 656	Continued From page 6 Set (MDS) with an Assessment Reference Date (ARD) of 10/14/19, revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognitive skills for daily decision making.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff	F 657	1. On 2/4/2020 Resident #19'□s care	3/28/20

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F 657	Continued From page 7 interview, record review, and facility policy review, the facility failed to revise Resident #19's activity care plan for one (1) of 18 care plans reviewed. Findings include: Review of the facility's "Comprehensive Care Plans" policy, dated November 2017, indicated, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet the resident's medical, nursing, mental and psychosocial needs that are identified in the resident's Comprehensive Assessment. The Policy Explanation and Compliance Guidelines revealed, the comprehensive care plan will be reviewed and revised by the interdisciplinary team. Review of Resident #19's care plan revealed, she has been spending most of her time in bed due to recent decline in health. Resident #19 enjoys some activities such as; and there were no activities listed after this statement. The goal and target date of 12/12/19 revealed, Resident #19 will enjoy one on one activities of choice and show a physical sign of enjoyment following at least one activity. The care plan approaches included, place activity calendar in a room where it is easily accessible, encourage to attend activities, cue to activity, time and place as needed, assist to activity as needed, provide in room activities of resident choice such as card games, provide equipment and supplies for activity." On 01/28/2020 at 10:52 AM, during initial tour,	F 657	plan was reviewed and updated to reflect her current status by the Registered Nurse Supervisor. 2. This facility determined all elders are at risk for this deficient practice. 3. All Registered Nurses responsible for care plans were in-serviced on 2/4/2020 by the director of nursing on reviewing/updating care plans. All clinical support team members responsible for care planning were in-serviced on 3/2/2020 on reviewing/updating care plans with new orders, status changes, quarterly, and with significant changes. All care plans will be reviewed and updated by 3/14/2020 by the responsible member of the clinical support team or assigned registered nurse supervisor. The care plans will be updated weekly beginning 3/2/2020 with new orders and status changes by the responsible member of the clinical support team. The care plans will be reviewed/updated quarterly and with significant changes to accurately reflect the resident□s status. This will be ongoing. 4. The clinical support team will discuss all elders with a significant change at stand-up daily, Monday through Friday starting 3/2/2020. Each member responsible for care plans will review/update the care plan to reflect the elder□s current status beginning 3/2/2020. The Registered Nurse Supervisor or assigned clinical support team member will educate front line staff on the elder□s current status and change in care as they occur starting 3/2/2020. Starting 2/29/2020, the Activity Director	

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F 657	Continued From page 8 Resident #19 was observed lying in her bed, facing the window. The window blinds were closed, and the lights were off. Resident #19 had her eyes open and was looking at the closed window. On 01/28/2020 at 2:50 PM, Resident #19 was observed lying in her bed, facing the door, with her eyes closed. The window blinds remained closed, and the lights are off in her room. On 01/29/2020 at 9:15 AM, Resident #19 was observed lying in her bed. The window blinds remained closed and the lights were on in her room. Resident #19 had her eyes opened and responded to her name being called with a smile. On 01/29/2020 at 4:05 PM, Resident #19 was observed lying in her bed facing the window with the blinds closed, the lights off, and she was looking at the window. On 01/29/2020 at 10:50 AM, during an interview with the Director of Nursing (DON), regarding activities for Resident #19, she indicated, "She is hospice, and they come several times a week, and her daughter is here all the time. There is not an individual activity log for one activity for her." Review of resident #19's chart revealed diagnoses of Alzheimer's disease, Blindness - Left Eye, Low Vision - Right Eye, Dementia with Lewy Body, Major Depressive Disorder and Anxiety. Resident #19's Significant Change in Condition Status (SCSA) with an Assessment Reference Date (ARD) of 11/7/19 revealed a Brief Interview for Mental Status (BIMS) score was 6, indicating she was severely cognitively impaired.	F 657	will interview the elder and determine if the activity preferences have changed or need to be updated. The Activity Director will educate Shahbaz staff for the changed activity preferences and monitor the activity calendar and logs two times per week to ensure elder□s preferences are being met. If no problems occur, the monitoring will be decreased to monthly for April forward. Results will be reviewed by the Risk Management/Quality Assurance Committee and Medical Director monthly until such time consistent substantial compliance has been achieved as determined by the committee beginning 3/12/2020. Corrective action completion date: 3/28/2020.	

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F 679	Continued From page 9	F 679		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, record review and facility policy review the facility failed to provide activities on a scheduled basis for one (1) of 16 residents observed for activities, Resident #5. Findings include: Record review of the facility's "Activities" policy, dated 11/28/2017, revealed, "Policy: It is the policy of this facility to provide an ongoing program to support residents in their choice of activities based on their comprehensive assessment, care plan, and preferences of each resident. Facility sponsored group and individual activities and independent activities will be designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, as well as, encourage both independence and interaction within the community." During observation of the common area in House	F 679	1. Bingo was offered as an activity on 1/31/2020, 2/1/2020 and 2/4/2020 and elder #5 participated. Elder #5 did participate in activities and the activities were documented on the activity log in February 2020. The care plan of affected elder #5 was updated after the elder was interviewed to confirm activity preferences. The activity interview and care plan update were completed on 3/2/2020. 2. The facility has determined that all residents have the potential to be affected. 3. A new Activities Director started on 1/30/2020. The new activity director was in-serviced by the administrator and human resources director on 1/30/2020 as to the facility and its policies and procedures. The Activity director took supplies to the houses for weekend activities on 1/31/2020. On 2/1/2020 the Shahbaz (certified nurse assistant) were	3/28/20

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F 679	Continued From page 10 #5 on 1/28/20, from 10:00 until 11:20 AM, neither Morning Stretch nor Bingo occurred per review of the Activity Calendar. On 01/28/20 at 11:20 AM, an observation in the Common Room revealed, Bingo did not occur at 10:30 AM. On 01/28/20, at 10:28 AM, during an interview with Resident #5 in the common area, she stated she loved it at the facility but there are no activities. She stated she loves Bingo and they stopped it a good while ago. The House Coordinator for House #5 on January 1 through February 29, 2020, Shahbaz #1 was listed for Activities per schedule posted on bulletin board next to the kitchen. On 01/29/20, at 3:45 PM, in an interview with Resident #5 in the common room, she stated that she enjoyed Bingo yesterday and that it was the first time they played in a long time. When asked if they had any activities this morning she stated, "no, just sat here and looked at this TV." She stated that she had hoped to play Bingo again this morning and that she would love to play more often stating, "I love Bingo". On 01/28/20, at 3:29 PM, during an interview with, Shahbaz #1, she stated, "everyone is responsible for activities, I work the evening shift, no other, they just put you down as house coordinator for certain things. They have an activities person at the office that brings the stuff down for activities, they really want you to do them, but they bring what they want you to do". On 01/29/20, at 3:15 PM, during an interview with	F 679	in-serviced by the administrator and shahbaz coach on activity expectations. The Activity Director and all Shahbaz were in-serviced on 2/3/2020 by a consultant activity director on engaging the elders, providing two daily activities based on elder preference, logging activities, activity codes, activity participation reports, weekly interviews on elder preferences, and logging any activities provided by volunteers/others. The activity director was also in-serviced on Minimum Data Set, Section F by the consultant on 2/03/2020. The Activity Director was in-serviced by the consultant activity director on 2/10/2020 on the It□s Never 2 Late (IN2L) computer system provided for the elders with games and links to social media,care planning. The consultant futher reviewed information from education received on 2/3/2020. The activity supplies in each Green House were inventoried to ensure adequate supplies available in each home on 2/10/2020 4. The Activities Director monitored the activity participation log three times per week for three weeks from 2/3/2020 thru 2/21/2020. The activity participation logs will be reviewed two times per week from this point forward. The Activities Director monitored activities five times per week from 2/10/2020 thru 2/28/2020. The activities will be monitored two times per week from this point forward. The Activities Director and assigned Licensed Practical Nurse started interviewing elders on 2/20/2020 to ensure personalized and meaningful	

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	255327	A. BUILDING _____ B. WING _____	01/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTHA COKER GREEN HOUSE HOME	2041 GRAND AVE YAZOO CITY, MS 39194

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F 679	Continued From page 11 the Administrator in the kitchen area of House #5, she was looking for the Activity Log, but it was not in the book and staff did not know where it was for January. She confirmed that there was no Activity Log in the book for January for House #5. She stated, "Bingo is big in this house, they love it here." In an interview on 01/30/20, at 1:10 PM, the Administrator stated, "If it wasn't documented, it wasn't done", and that there was no Activity Log for the month of January for House #5. Record review of the facility's Face Sheet revealed, the facility admitted Resident #5 on 9/19/16 with diagnoses of Gastro-esophageal Reflux Disease, Vitamin D Deficiency, and Arthropathy. Record review of Resident #5's Quarterly Minimum Data Set with an Assessment Reference Date of 10/14/19, revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognitive skills for daily decision making.	F 679	activities are provided for each elder. The interviews will be completed by 3/4/2020. The care plans will be updated by assigned members of the clinical support team by 3/14/2020. The Activities Director will educate Shahbaz staff for elder□s preferences related to activities and will monitor weekly activity calendars to ensure elder□s preferences are met. This will be completed by 3/28/2020. Findings will be discussed with the Resident Council beginning 2/27/2020 and at then monthly Quality Assurance meeting (starting 3/12/2020) until such time as consistent satisfaction is reported by the Resident Council. "Corrective action completion date: 3/28/2020.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable	F 812		3/28/20

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F 812	Continued From page 12 safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility policy review, the facility failed to discard expired food, and label and date opened food items for four (4) of six (6) kitchens observed. Findings include: Review of the facility's "Food and Supply Storage Procedures" policy, dated 6/09, revealed all food, non-food items and supplies used in food preparation shall be stored in such a manner as to maintain the safety and wholesomeness of the food for human consumption. Most products contain an expiration date. The words "sell-by" or "use-by" should precede the date. The "sell-by" date is the last date that food can be sold. Do not sell products in retail areas or place on patient trays and/or resident plates past the date on the product. Cover, label, and date unused portions and open packages. Date and rotate items, first in, first out (FIFO). Discard food past the use-by date. House #1 On 1/28/20 at 10:45 AM, the initial tour of the kitchen in House #1 revealed, the refrigerator in the pantry behind the kitchen had four (4) bottles of eight (8) ounces banana nut flavor shake with an expiration date of August 1, 2019. An Observation of the refrigerator in the pantry	F 812	1. On 1/28/2020 all expired or not labeled(dated) foods were removed and destroyed by assigned clinical support team members. On 1/28/2020 the registered dietician went through each kitchen to ensure no items were missed during the initial clean up by the clinical support team. 2. This facility has determined that all elders are risk for this deficient practice. 3. All foods will be labeled/dated before or as they are delivered to each house by the staff member delivering the food as of 1/31/2020. All Shahbaz (certified nurse assistants) were in-serviced on 1/31/2020 by the Registered Dietician on the plan of correction for labeling and dating food. On 2/4/2020 the Regional Director of Nutrition met with the Registered Dietician to inservice on storage and labeling of food items. 4. Beginning 2/3/2020 The Registered Dietician, Systems Executive Chef, Dining Director, Certified Dietary Manager, Executive Chef, and the District Manager will provide weekly audits of the houses for eight weeks to ensure no unlabeled or expired foods are on the premises. Beginning 3/13/2020, the auditing reports	

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F 812	Continued From page 13 revealed a five (5) pound container of sour cream with an expiration date of 1/24/20, a 5-pound container of cottage cheese with an expiration date of 12/16/19, and a six (6) pound container of mustard with an expiration date of 9/3/19. On 1/28/20 at 11: 15 AM an interview with Shahbaz #6 confirmed four (4) banana nut shakes had an expiration date of 8/1/19, the sour cream had an expiration date of 1/24/20, the container of cottage cheese had an expiration date of 12/16/19, and the container of mustard had an expiration date of 9/3/19. Shahbaz #6 confirmed all of the expired food should be thrown away. Shahbaz #6 revealed, anyone getting into the refrigerator should check for expired items and discard them if they are expired. On 01/28/20 at 2:20 PM an interview with the Licensed Dietician (LD) confirmed the Shahbaz were responsible for checking all food items in the pantry, freezer, and the refrigerator for expiration dates and throw them away if they were expired. The LD confirmed if the residents ate some expired food it could make them sick. House #5: On 01/28/20, at 2:36 PM, in House #5, the following pantry items were observed to be expired: Two (2) 15.25-ounce (oz) cans of black beans with an expiration date of 8/22/19. One (1) box of buttermilk biscuit Mix 5 lb. with an expiration date of September 27, 2019. One (1) partially used open box of devil's food cake mix with a best if used by date of January 16, 2020. One (1) 20 oz. opened loaf of 100% whole wheat	F 812	will be reviewed by the Risk Management/Quality Assurance Committee monthly until such time consistent substantial compliance has been achieved as determined by the committee. Corrective action completion date: 3/28/2020.	

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F 812	Continued From page 14 bread with a best by date of January 18, 2020, with 17 slices in the bag. One (1) 20 oz. opened loaf of 100% whole wheat bread with best by date of January 25, 2020 with 22 slices in the bag. The following items were open and unlabeled and/or dated: One (1) - 2.7 oz plastic jar of chocolate sprinkles 1/2 full. One (1) - 9 oz. box of mashed potatoes was opened approximately 2 inches on edge of the top lid and not sealed. On 01/28/20, at 3:02 PM, an observation of the kitchen refrigerator revealed a five (5) pound (lb.) bag of mozzarella shredded cheese opened and the bag was not labeled or dated. It contained about three (3) inches of cheese in depth in the bottom of the bag. A three inch by six inch slice of corn bread was loosely wrapped in crumpled aluminum foil with no label or date. One small 4 oz. bowl of ravioli labeled good thru 1/26/20, covered in clear plastic was in the refrigerator. An observation of a kitchen cabinet revealed three (3) large tea bags in a torn zip lock gallon bag with no date on the bag. Shahbaz #1 put them in a new zip lock bag and replaced the bag in the cabinet. She said, "I'm pretty sure they will be used tomorrow". On 01/28/20, at 3:06 PM, during an interview with Shahbaz #1, she stated, "It's not labeled so I'll throw it out". Shahbaz #1 stated, our policy is to date and label, we really don't have to label things that have an expiration date on it like bread or salt, coffee or tea. We have a certain amount of days things can be open, so you have to label them, so you know when to throw them out. We	F 812		

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F 812	Continued From page 15	F 812		

have three (3) days. We have a guide that lets us know the shelf life of products.

On 01/29/20, at 12:07 PM, during an interview with Administrator, she stated the Shahbaz are responsible for making sure food is labeled, dated, or discarded when expired. No food should be served after the expiration date or use by date.

House #2:

On 01/28/2020 at 10:45 AM, during initial tour, the following items were noted in House #2:
In the Dry Food Pantry:
One (1) bag of hamburger buns - open with no dated label.
One (1) loaf of bread - open with no dated label.
One (1) - large gallon of oil - open with no dated label.
One (1) - large bottle of white vinegar - open with no dated label.
One (1) - loaf of unopened bread on the floor behind the door of the pantry.

In the kitchen refrigerator:
Multiple pieces of stacked, sliced cheese - open, partially wrapped in plastic wrap, edges of cheese were dried and hard, no dated label.
One (1) - container of blueberries - partially used with no dated label.

House #3:

In the Dry Food Pantry:
Multiple individual coffee bags in a gallon plastic bag - open with no dated label.
Two (2)- gallon bags of macaroni pasta - open with no dated label.

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F 812	Continued From page 16 Three (3) - gallon bags of white rice - open with no dated label. One (1) - gallon bag of spaghetti pasta- open with no dated label. One (1)- bag of corn chips - open with no dated label. In the pantry refrigerator: Two (2) - boxes of strawberries - partially used, with mold on them, juice from strawberries leaked out on the door shelf - open and no dated label. Two (2) - boxes of blueberries - open with no dated label Three (3) - heads of lettuce in a large clear bag - open with no dated label. One (1) - head of cabbage in a plastic grocery bag - open with no dated label. In the kitchen refrigerator: One (1) - bottle of grape jelly - open with no dated label. In the Kitchen freezer: One (1) - gallon of vanilla ice cream - open with no dated label. One (1) - box of popsicles - open with no dated label.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		3/28/20

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F 880	Continued From page 17 §483.80(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: §483.80(a)(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; §483.80(a)(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 must prohibit employees with a communicable disease or infected skin lesions from direct	F 880		

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F 880	Continued From page 18 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. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(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, facility policy review and staff interview the facility failed to prevent the possible spread of infection during medication pass for one (1) of three (3) medication administration observation. Findings include: Review of the facility's "Standard Precautions Infection Control" policy, dated 11/2018, did not address using a barrier for items taken into an elder's room during medication pass. On 01/29/20, at 08:59 AM, during an observation of medication pass, Licensed Practical Nurse #1 (LPN), placed eye drops and nasal spray bottle for Resident # 10 on the window ledge of the resident's room without a barrier. The eye drop box fell on floor. LPN #1 picked up the box after med pass was completed and placed the eye	F 880	1. Licensed Nurse #1 was instructed 0n 1/30/2020 on the use of a barrier during administration of medications or treatments. Licensed Nurse #1 was further educated by the director of nursing that if a medication or package is dropped or placed on any surface without a barrier it must be cleaned and disinfected immediately before returning it to the medication cart on 1/30/2020. On 1/30/2020 the medication cart and its contents were cleaned and disinfected by the assigned Medical Records Licensed Nurse. 2. The facility has determined that all residents receiving medications or treatments are at risk for this deficient practice. 3. All Licensed Nursing staff were in-serviced by the Director of Nursing on	

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F 880	Continued From page 19 drop bottle into the box. She then walked to the sink in the resident's bathroom and placed the eye drop box and nasal spray bottle on the counter next to the sink while she washed her hands. She then took the items and replaced them in the medication cart. In an interview on 01/30/20, at 08:48 AM, the Director of Nursing (DON) stated that the LPN, "should have used barrier and if the box was dropped it should have been cleaned before placed back in the cart. This would be an infection control issue and we will go wipe the entire cart down". 01/30/20 10:53 AM In an interview with Registered Nurse #1(RN), Clinical Coordinator-Infection Preventionist, she stated, "Any time staff take anything in a room it should be on a barrier. That is part of the infection control policy but they don't have one specific to med pass".	F 880	the facility□s expectation of medication pass infection control safety on 1/31/2020. Medication pass observations were started on 1/31/2020 by the Director of Nursing and continued weekly by the Director of Nursing and Registered Nurse Supervisors. A medication pass observation list was created on 2/4/2020 by the Director of Nursing to promote a consistent method to observe each medication pass and education with each observation. Any negative finding with the medication pass observation will be corrected immediately and documented on the observation checklist for review purposes. 4. The Director of Nursing and Registered Nurse supervisors will complete Medication pass observations four times per week starting 2/3/2020 through 2/28/2020 and two times per week starting 3/1/2020 through 3/28/2020. Medication pass checklist results will be reviewed by the Risk Management/Quality Assurance Committee and Medical Director monthly until such time consistent substantial compliance has been achieved as determined by the committee beginning 3/12/2020. "Corrective action completion date: 3/28/2020.	

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	255327	A. BUILDING **G1 - MARTHA COKER - GREENHOUSE UNIT 01** B. WING _____	**02/03/2020**

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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 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe	K 321		3/2/20

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

Electronically Signed | 03/03/2020

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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MARTHA COKER GREEN HOUSE HOME	**2041 GRAND AVE** **YAZOO CITY, MS 39194**

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K 321	Continued From page 1 Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to properly protect hazardous areas in accordance to NFPA 101 section 19.3.2.1. The deficient practice affected the entire facility on day of survey. Findings include: During the building inspection on 2/3/2020 at 2:40 PM, observation revealed deficiencies in the following hazardous areas of the facility: 1) 1 ft x 2 ft open penetrations in the ceiling of the Boiler Room in all six (6) Green House Homes of the facility. 2) The fire shudders were incapable of resisting the passage of smoke in Boiler Rooms of all six (6) Green House Homes	K 321	"The Boiler rooms in all six green houses were assessed by the Director of Construction Services and Property management of Methodist Senior Services and found to be working correctly and that the fire shudders were in fact capable of resisting the passage of smoke therefore they met the life safety code. "All elders have the potential to be affected if the fire shudders were not functioning properly. "The Director for Construction Services and Property Management for Methodist Senior Services reached out to the Mechanical Engineer that was responsible for helping design the Green Houses for explanation on how the boiler room fire safety was designed. He then reached out to the Deputy Bureau Director of Fire Safety and Construction Bureau of Health Facilities and Licensure and Certification for the State of Mississippi. Through email correspondence the facility was found to be in compliance with the specified Life Safety issue of concern. "The Maintenance Director for Martha Coker will assess that all fire prevention systems are functioning properly on a quarterly basis. "Completion date: 03/02/2020	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255327	A. BUILDING **02 - MARTHA COKER GREEN HOUSE HOME** B. WING _____	**02/03/2020**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTHA COKER GREEN HOUSE HOME	**2041 GRAND AVE** **YAZOO CITY, MS 39194**

(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 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 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe	K 321		3/2/20

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

Electronically Signed | 03/03/2020

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255327	A. BUILDING **02 - MARTHA COKER GREEN HOUSE HOME** B. WING _____	**02/03/2020**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTHA COKER GREEN HOUSE HOME	**2041 GRAND AVE** **YAZOO CITY, MS 39194**

(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
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255327	A. BUILDING **G3 - MARTHA COKER GREEN HOUSE HOME** B. WING _____	**02/03/2020**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTHA COKER GREEN HOUSE HOME	**2041 GRAND AVE YAZOO CITY, MS 39194**

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

Electronically Signed | 03/03/2020

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	255327	A. BUILDING **G3 - MARTHA COKER GREEN HOUSE HOME** B. WING _____	**02/03/2020**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTHA COKER GREEN HOUSE HOME	**2041 GRAND AVE** **YAZOO CITY, MS 39194**

(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
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255327	A. BUILDING **04 - MARTHA COKER GREEN HOUSE HOME** B. WING _____	**02/03/2020**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTHA COKER GREEN HOUSE HOME	**2041 GRAND AVE** **YAZOO CITY, MS 39194**

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

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	255327	A. BUILDING **04 - MARTHA COKER GREEN HOUSE HOME** B. WING _____	**02/03/2020**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTHA COKER GREEN HOUSE HOME	**2041 GRAND AVE YAZOO CITY, MS 39194**

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	255327	A. BUILDING **G5 - MARTHA COKER - GREENHOUSE UNIT 05** B. WING _____	**02/03/2020**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTHA COKER GREEN HOUSE HOME	**2041 GRAND AVE YAZOO CITY, MS 39194**

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	255327	A. BUILDING **G6 - MARTHA COKER - GREENHOUSE UNIT 06** B. WING _____	**02/03/2020**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTHA COKER GREEN HOUSE HOME	**2041 GRAND AVE YAZOO CITY, MS 39194**

(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
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	255327	A. BUILDING **G6 - MARTHA COKER - GREENHOUSE UNIT 06** B. WING _____	**02/03/2020**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	255327	A. BUILDING _____ B. WING _____	02/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTHA COKER GREEN HOUSE HOME	2041 GRAND AVE YAZOO CITY, MS 39194

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E 000	*Initial Comments* * EMERGENCY PREPAREDNESS * Survey conducted on 2/3/20 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

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