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	255175	A. BUILDING _____ B. WING _____	09/12/2019

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DIVERSICARE OF BROOKHAVEN	519 BROOKMAN DRIVE BROOKHAVEN, MS 39601

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey from 9/9/19 through 9/12/19. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements of participation. The SA cited the regulatory deficiencies F 641, F 728, and F 880. At the time of the survey, the census was 53 and the facility held a license for 58 beds.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to accurately code the Minimum Data Set (MDS) for falls for one (1) of two (2) residents reviewed for falls, Resident #36 And, failed to accurately code the MDS for discharge for one (1) of three (3) resident MDSs reviewed for discharge, Resident #56. Findings include: Review of a statement, provided by the facility, revealed the facility follows the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) manual and the State of Mississippi Division of Medicaid Case Mix Index, Meyers and Stauffers. The CMS RAI Version 3.0 Manual dated October 2018, page 1-7 revealed, the RAI process require that the	F 641	1. Modification on 9/11/2019 of Minimum Data Set (MDS) identified on Resident #56 to correctly code to accurate discharge destination completed by Registered Nurse Assessment Coordinator (RNAC). 100% audit conducted on 9/12/2019 of discharge assessments completed in last 90 days for identification of any errors in coding discharge destination. No other inaccuracy in discharge destination identified in audit. 2. All Residents being discharged are at risk for the deficient practice. 3. RNAC to have second person (Director of Nursing(DNS) or partner RNAC) to review coding of discharge destination on	10/18/19

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

Electronically Signed | 10/04/2019

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F 641	Continued From page 1 assessment accurately reflects the resident's status. According to Page J-32 of CMS Resident Assessment Instrument (RAI) Version 3.0 Manuel, "It is important to ensure the accuracy of the level of injury resulting from a fall. Since injuries can present themselves later than the time of the fall, the assessor may need to look beyond the Assessment Reference Date (ARD) to obtain the accurate information for the complete picture of the fall that occurs in the look back of the MDS." Resident #56 Review of Resident #56's MDS with an Assessment Reference Date (ARD) of 8/15/19, revealed the assessment was coded as a planned Discharge-Return Not Anticipated, with the discharge status to an acute hospital. Review of Resident #56's physician orders, dated 8/14/19, revealed an order to discharge the resident home on 8/15/19 with medications. Review of the Physician Discharge Summary indicated, Resident #56 was admitted on 7/19/19, and discharged on 8/15/19, home with her son. Review of the General Progress Note dated 8/15/19, and timed for 1:44 PM, indicated Resident #56 was discharged home. On 9/12/19 at 8:32 AM, an interview with the Director of Nurses (DON) revealed she would expect the MDS to be completed precisely according to the resident. On 9/12/19 at 9:05 AM, an interview with Registered Nurse (RN) #2 revealed the Discharge MDS should have been coded as a discharge to the community. She also stated the facility uses the RAI Manual and the Case Mix Guidelines to code the MDS.	F 641	all discharge assessments prior to completion and submission of the record. Education provided to RNAC for coding discharge destinations on MDS per Reimbursement Specialist on 9/11/2019. 4. DNS/RNAC/Assistance Director of Nursing (ADNS) will monitor 100% of discharge assessments weekly for four weeks, then monthly for two months to identify any inaccuracy in discharge destination coding, beginning 9/16/2019. Findings of this audit will be reviewed in Quality Assurance and Performance Improvement (QAPI) where extensions to plan will be made based on center compliance. 1. Modification on 9/10/2019 MDS identified on Resident #36 to correctly code fall that occurred completed by RNAC. 100% audit completed on 9/11/2019 of current Residents to determine any falls that occurred in the past 90 days by review of Risk Management Tracking and progress notes in Point Click Care (PCC) by RNAC. Compared findings of audit to MDS coding. No additional discrepancies were found and no other modifications required. 2. All Residents with history of falls are at risk for the deficient practice. 3. Education to RNAC provided on 9/12/2019 to review progress notes and Risk Management Tracking in PCC to determine if falls have occurred during assessment period. Education provided	

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F 641	Continued From page 2 A review of the facility's Face Sheet revealed, the facility admitted Resident #56 on 7/19/19, with a diagnosis of Cerebral Infarction. Resident #36 A Review of Resident #36's MDS, with an ARD of 8/20/19, Section J1800, revealed "No" was marked regarding if there where any falls since admission/entry or Reentry or Prior Assessment. "No" was marked to the question, "Has the resident had any falls since admission/entry or reentry or the prior assessment, which is more recent?" Record review revealed Resident #36 had an accidental fall from the wheelchair on 5/28/19 and was transferred to the local hospital Emergency Department and returned to the facility on 5/28/19. Record review of the Facility Incident Report, dated 05/28/2019, revealed Resident #36 had an unwitnessed fall from the chair to the floor. On 09/11/19 on 11:47 AM, an Interview with Registered Nurse #2/MDS Coordinator, revealed Resident #36's MDS was coded incorrectly on 08/20/2019 for Section J1800, falls. RN #2 stated Resident #36 did have a fall, and it should have been coded on the MDS.	F 641	for coding falls on MDS per Resident Assessment Instrument (RAI) Guidelines per Clinical Reimbursement Specialist on 9/12/2019. Interdisciplinary Team (IDT) will review Risk Management Tracking in PCC in Daily Clinical Start up. 4.DNS, RNAC, and ADNS will monitor 100% of assessments completed each week for four weeks, the monthly for two months to identify any inaccuracy in fall coding, beginning on 9/16/2019. Any variance will be corrected immediately and addressed in QAPI.	
F 728 SS=D	Facility Hiring and Use of Nurse Aide CFR(s): 483.35(d)(1)-(3) §483.35(d) Requirement for facility hiring and use of nurse aides- §483.35(d)(1) General rule. A facility must not use any individual working in the facility as a nurse aide for more than 4	F 728		10/18/19

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F 728	Continued From page 3 months, on a full-time basis, unless- (i) That individual is competent to provide nursing and nursing related services; and (ii)(A) That individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §483.151 through §483.154; or (B) That individual has been deemed or determined competent as provided in §483.150(a) and (b). §483.35(d)(2) Non-permanent employees. A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (d)(1)(i) and (ii) of this section. §483.35(d)(3) Minimum Competency A facility must not use any individual who has worked less than 4 months as a nurse aide in that facility unless the individual- (i) Is a full-time employee in a State-approved training and competency evaluation program; (ii) Has demonstrated competence through satisfactory participation in a State-approved nurse aide training and competency evaluation program or competency evaluation program; or (iii) Has been deemed or determined competent as provided in §483.150(a) and (b). This REQUIREMENT is not met as evidenced by: Based on staff interviews, record reviews, and facility statement, the facility failed to ensure Nurse Aides (NA) in Training completed the examination within 120 days for three (3) of 43 nurse aides employed.	F 728	1. Nursing Aide #1, Nursing Aide #2, and Nursing Aide #3 were removed from working schedule on 9/10/2019 until certification has been obtained and are registered in Pearson Vue database.100% audit conducted on 9/12/2019 on all	

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F 728	Continued From page 4 Findings include: A review of a statement, signed by the Director of Nursing, not dated, revealed the facility follows Mississippi State regulations for the employment of nursing aides. A review of the Mississippi Nurse Aide Candidate Handbook, dated July 2018, revealed the nurse aide must take and pass both parts of the National Nurse Aide Assessment Program (NNAAP) Examination and be certified within four (4) months (120 days) from the hire date. A review of the Certified Nurse Aide (CNA) certifications list revealed NA #1, NA #2, and NA #3 did not have any certifications listed. All three (3) aides were listed as Nurse Aides in Training on the list of employees provided by the facility. Review of the work schedule and documentation for NA #1, revealed the NA was hired 3/28/19. There was no documentation that NA #1 was certified. NA #1 completed the Mississippi State Nurse Aid Training Program on 11/21/18. The NA was scheduled and worked last on Sunday, 9/8/19. Review of the work schedule and documentation for NA #2, revealed she was hired 3/21/19. She completed the Mississippi State Nurse Aid Training Program on the 9/19/18. There was no documentation that NA #2 had been certified. NA #2 last worked Thursday, 9/5/19, Friday, 9/6/19, and Monday, 9/9/19. Review of NA #3's personnel file and schedule revealed the last scheduled work day was 7/3/19, with a hire date of 1/28/19. There was no	F 728	current Nursing Aide employees to verify certification obtained within 120 days after employment with any such employee found and removed from the working schedule per Director of Nursing (DNS) and Assistant Director of Nursing (ADNS). No other employees were removed from the schedule. 2. All Residents in the center are at risk for the deficient practice. 3. Education/In-service on Mississippi State Regulations of the Employment of Nursing Aides provided to DNS and ADNS to monitor for certification completion within 120 days of employment per Director of Clinical Operations on 9/12/2019. All new potential hires will have completed certification prior to the hiring process. 4. DNS and ADNS will monitor all new potential Nursing Aides applicants for completion of certification prior to employment offer beginning 9/12/2019. This will discussed and documented in monthly Quality Assurance and Performance Improvement (QAPI) for three months. Any variance to procedure will be corrected immediately and addressed by DNS.	

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F 728	Continued From page 5 documentation of a Certificate of Training or certification. During an interview on 09/10/19 at 3:05 PM, Registered Nurse (RN) #1/Staff Development (SD) stated the NAs in Training would work until they passed both tests. RN #1 stated that NA #3 had passed one (1) of the tests, but not both. She stated that NA #3 had not worked in almost 90 days. RN #1 said she believed the facility policy was they could work for a year without being certified. During an interview on 09/11/19 at 11:01 AM, RN #1/SD said the two (2) NA in Training that were on the schedule, NA #1 and NA #2, were sent home and told they could no longer work as of yesterday (9/10/19), until they passed the test. RN #1 said she did not have access to examination results in the facility. During an interview on 09/11/19 at 1:42 PM, the Director of Nursing (DON) said she was aware the three (3) NA were working in the facility as NAs in Training, but did not know that the aides had 120 days to pass the CNA certification from the hire date, to continue working; providing resident care.	F 728		
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		10/18/19

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F 880	Continued From page 6 §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	F 880		

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F 880	Continued From page 7 disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §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, staff interview, record review, and facility policy review, the facility failed to prevent the possible spread of infection during medication administration for two (2) of 12 resident medication observations, Resident #23 and Resident #43; and the facility failed to clean the glucometer properly for one (1) of two (2) acu-checks observed, Resident #155. Findings Include: A review of a document on letterhead, provided by the facility, titled "Medication administration Policy", revealed, "Medication Administration is followed per standards of nursing practice". A review of facility policy titled "Handwashing/Hand Hygiene", revealed, "This	F 880	1. Resident #23 and Resident #43 were assessed on 9/10/2019 by Director of Nursing (DNS). There were no negative findings for this Resident. 2. All Residents in the center are at risk for the deficient practice. 3. Direct training/In-service with return demonstration observed per Assistant Director of Nursing (ADNS) on 9/12/2019 on Licensed Practical Nurse #1 on administering medications, ensuring LPN #1 washed her hands before, during, and after medication administration. LPN #1 had direct in-service on 9/12/2019 regarding use of a barrier for medications/cup prior to taking down the hall. Training/In-service and observation	

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F 880	Continued From page 8 center considers hand hygiene the primary means to prevent the spread of infection. Use alcohol based hand rub or alternatively soap and water before and after direct contact with residents and before preparing or handling medications". A review of facility policy titled "Policies and Practices-Infection Control", dated November 1, 2017, revealed, "This center's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections. The objectives of our infection control policies and practices are to maintain a safe, sanitary, and comfortable environment for team members, residents, volunteers, visitors, and the general public". A review of a document, provided by the facility's Staff Development Nurse, and titled "Medication Administration Competency Checklist", an excerpt pulled from Perry & Potter, Clinical Nursing Skills & Techniques 8th Edition, revealed nurses are checked off to perform hand hygiene before preparing medication. Res #23 An observation on 9/10/19 at 08:45 AM, revealed LPN #1 began to pull Resident #23's medication. LPN #1 reached into her pocket and pulled medication cart keys out and unlocked the cart. LPN #1 placed a medication cup using her bare hands on top of the medication cart, without a barrier, and began to put medications into the cup. LPN #1 stated she didn't have B12 medication for Resident #23, so she picked up	F 880	by return demonstration of licensed nurses performing medications administration, not limited to proper hand hygiene, initiated on 9/16/2019 and to be completed by 10/16/2019. Competency evaluations will be completed at the time of hire and yearly thereafter by ADNS or licensed nurse. Infection Control in Relias Learning completed by all licensed nurses. 4. DNS and ADNS will perform audits of licensed nurses performing medication administration, not limited to hand hygiene, for five times weekly for one week, three times weekly for two weeks, then weekly for five weeks to assure medication administration is performed with proper technique and in accordance of Infection Control and Medication Administration policies and guidelines. All variances to procedure will be immediately corrected and addressed in Quality Assurance and Performance Improvement (QAPI) by DNS. 1. Resident #155 was assessed on 9/10/2019 by DNS. There were no negative findings for this Resident. 2. All Diabetic Residents are at risk for the deficient practice. 3. Direct training/in-service of cleaning/disinfecting glucometer per manufacturer guidelines with return demonstration observed by ADNS on 9/13/2019 of Registered Nurse #3	

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F 880	Continued From page 9 the uncovered medication cup, containing medication, and sat the cup on multiple surfaces, without a barrier, while searching for medication. LPN #1 entered Resident #23's room and pulled the privacy curtain with her hand and administered the four (4) medications. LPN #1 exited the room, threw garbage in the garbage can, by lifting the lid of the can with her hand. LPN #1 charted the medications as given on the computer. LPN #1 failed to wash or sanitize her hands before, during or after the medication administration. A review of facility document titled "Licensed Nurse Core Clinical Competency-Skill: Medication Administration" dated 4/16/19, revealed LPN #1 was trained in Implementation of Prepared Medications including, but not limited to, Hand Hygiene. An interview on 09/10/19 at 11:05 AM, with LPN #1, revealed, "I was just a nervous wreck. I don't remember not washing my hands because I usually wash my hands or sanitize my hands a lot. I thought I used hand sanitizer, but I guess I didn't. I was just so frustrated because I didn't have my medications on the cart. I really didn't know what to do". Res #43 An observation on 09/10/19 at 8:03 AM, revealed LPN #1 coming from another resident's room prior to going to her medication cart to pull medications for Resident #43. LPN #1 began to pull medications for Resident #43, without washing or sanitizing her hands. LPN #1 lifted the lid on the garbage can with her bare hands and put trash into the garbage and continued to pull pills, without washing or sanitizing her hands.	F 880	cleaning/disinfecting a glucometer before and after Resident using a Sani-cloth/wipe as a cleaning agent, then using a second Sani-cloth/wipe to wrap around the meter and allowed to remain wet for full two minutes, removed from wipe and allowed to air dry on a clean surface/barrier, then stored away. Training/In-service and observation by return demonstration of licensed nurses performing proper cleaning/disinfecting of glucometer initiated on 9/16/2019 and to be completed by 10/16/2019. Competency evaluations will be completed at the time of hire and yearly thereafter by ADNS or licensed nurse. ADNS will monitor the completion of competency evaluations. 4. DNS and ADNS will perform audits of licensed nurses performing glucometer cleaning/disinfecting for five times weekly for one week, three times weekly for two weeks, then weekly for five weeks to assure glucometer cleaning/disinfecting are performed in accordance to policy and guidelines. All variances to procedure will be immediately corrected and addressed in QAPI by DNS.	

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F 880	Continued From page 10 LPN #1 pulled medications, lifted the garbage can lid with her bare hands, placed the pill cup on medication cart and counter surfaces without a barrier, and did not wash or sanitize hands before, during or after administering medication. LPN #1 went back to the cart, turned on the computer, and charted the medications administered. LPN #1 did not wash or sanitize her hands, but rather moved on to pull another residents medication. An interview on 09/10/19 at 2:55 PM, with the Director of Nursing (DON), revealed that It is an infection control issue with LPN #1 not washing or sanitizing her hands before, during or after resident care, as well as taking the cup of pills down the hall with them not covered, and LPN #1 should have used a barrier for the pills (cup). An interview on 09/11/19 at 4:16 PM, with RN #4/ Infection Control Nurse, revealed, "LPN #1 not washing her hands is an infection control issue. She should have washed her hands before, during and after resident care and before pulling medications". An interview on 09/11/19 at 4:30 PM with RN #1/Staff Development Nurse, revealed that LPN #1 not performing hand hygiene before, during and after resident care is an infection control issue, as well as LPN # carrying the pills uncovered down the hall is considered an infection control issue. RN #1 stated that they teach the employees to perform hand hygiene before, during and after care. Res #155 A review of a document, provided by the facility on facility letter head, revealed Glucometer	F 880		

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(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 880	Continued From page 11 cleaning is done according to manufacturer's guidelines. A review of a booklet, provided by the facility, titled "Assure Platinum QA/QC Reference Manual", revealed Sani-cloth Germicidal Disposable wipes are one of the agents approved for cleaning the Assure Platinum Glucometer. Record review of booklet titled "Assure Platinum User Manuel", the type of glucometer used by the facility, revealed, "Cleaning and disinfecting can be completed by using a commercially available EPA registered disinfectant detergent or germicide wipe. To use a wipe, remove from container and follow product label instructions to disinfect the meter". A review of the Sani-cloth Germicidal Disposable wipe label revealed, "To Disinfect or Deodorize: To disinfect nonfood contact surfaces unfold and clean and thoroughly wet surface. Allow treated surface to remain wet for a full two minutes let dry. For blood: all blood and body fluids must be thoroughly cleaned from surfaces and objects before disinfection by the germicidal wipe. Open, unfold and use first germicidal wipe to remove heavy soil. Contact time: use second germicidal wipe to thoroughly wet surface Allow to remain wet for two (2) minutes. Let air dry. A review of a training document provided by the facility titled "Glucometer Cleaning/Disinfecting Process" revealed, "Cleaning: the glucometer must be cleaned and wiped with Sani-cloth/wipe as a cleaning agent first. This will clean the meter but not disinfect to prevent the spread of infection. Disinfect: Gather a second Sani-cloth/wipe around the meter and allow the	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255175	A. BUILDING _____ B. WING _____	09/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF BROOKHAVEN	519 BROOKMAN DRIVE BROOKHAVEN, MS 39601

(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 880	Continued From page 12 whole glucometer to remain wet for 2 minutes. This may take more than one cloth/wipe to keep the glucometer wet for two (2) minutes (this information is on the wipe packet/box under the disinfect instructions). Once the glucometer has been wet for 2 minutes, unwrap the glucometer and allow the glucometer to air dry". An observation on 09/10/19 at 11:05 AM, revealed RN #3 failed to clean the glucometer for the appropriate amount of time suggested by the manufacturer prior to performing an acu-check on Resident #155. RN #3 wiped the glucometer with a Sani-cloth/wipe for approximately 11 seconds, and placed it onto a Kleenex. RN #3 stated "the first wipe is to clean and the second wipe is to disinfect". RN picked the glucometer back up from the Kleenex and wiped the glucometer the second time with a different Sani-cloth/wipe for approximately 10 seconds. RN #3 stated she was going to allow the glucometer to dry for four (4) minutes. RN #3 allowed the glucometer to dry for approximately three (3) minutes. RN #3 performed the acu-check. RN #3 laid the glucometer on a Kleenex on the medication cart. RN #3 sanitized her hands, gloved, used a Sani-wipe to wipe the glucometer for approximately 30 seconds and then laid the glucometer back onto the dirty Kleenex that was lying on the medication cart. RN #3 stated "I'm going to let it dry and then I'll put it back in the drawer. The RN didn't use the glucometer on any other resident. A review of facility document titled "Licensed Nurse Core Clinical Competency-Skill: Assure Platinum Blood Glucose Monitoring System", dated 5/10/19, revealed RN #3 was competent to perform each task including, but not limited to,	F 880		

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	255175	A. BUILDING _____ B. WING _____	09/12/2019

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DIVERSICARE OF BROOKHAVEN	519 BROOKMAN DRIVE BROOKHAVEN, MS 39601

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F 880	Continued From page 13 the cleaning/disinfecting of the Glucometer correctly. An interview on 09/10/19 at 2:55 PM, with the Director of Nursing (DON), revealed that it is an infection control issue with RN #3 not cleaning the glucometer for the manufacturer's recommended time. An interview via telephone on 09/11/19 at 10:34 AM, with RN #3, revealed, "I honestly did not know about the glucometer having to be kept wet for two (2) minutes until they told me about it yesterday. To be honest, I have never read on the back of the Sani-cloth wipes. I was doing what I had been told. I learned something new yesterday and I will read on the container from now on". An interview on 09/11/19 at 4:16 PM, with RN #4, Infection Control Nurse, stated that they have to go by the manufacturers recommendations to clean the glucometer. "We have to do what is in black and white. RN #3 did not follow the process as stated by the facility". An interview on 09/11/19 at 4:30 PM, with RN #1/Staff Development Nurse, verified the training document used in Clinical Education for staff does say to keep the glucometer wet for two (2) minutes. RN #1 stated "we teach to clean the glucometer for two (2) minutes. RN #3 did not follow the guidelines for cleaning the glucometer and is considered an Infection Control issue".	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255175	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/09/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF BROOKHAVEN	**519 BROOKMAN DRIVE** **BROOKHAVEN, MS 39601**

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K 000	INITIAL COMMENTS The facility meets the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). There were no LSC deficiencies cited during this survey.	K 000		

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

Electronically Signed | 10/04/2019

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255175	A. BUILDING _____ B. WING _____	09/09/2019

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E 000	Initial Comments ********** Survey conducted on 09/09/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were cited.	E 000		

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

Electronically Signed | 10/04/2019

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