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 _____	04/04/2019

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
F 000	INITIAL COMMENTS The State Survey Agency (SA) conducted an annual recertification survey at the facility from 4/2/19 to 4/4/19. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements for participation. The SA cited the regulatory deficiency F880. At the time of survey, the census was 51, and the facility held a license for 60 beds.	F 000		
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. §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;	F 880		4/25/19

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

Electronically Signed | 04/25/2019

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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 _____ B. WING _____	04/04/2019

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
F 880	Continued From page 1 §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 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.	F 880		

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	255327	A. BUILDING _____ B. WING _____	04/04/2019

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
F 880	Continued From page 2 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, facility policy review, Assure Prism Multi Blood Glucose Monitoring System Reference Manual review, Super Sani Disinfectant Cloth Label review, and record review, the facility failed to disinfect the multi use glucometer in a manner to prevent the potential spread of infection for three (3) of four (4) glucometer cleaning prior to a finger stick. Resident #18, #39 and #41 Findings include: Record review of the facility's policy titled, "Glucometer Disinfection" undated, revealed the purpose of this procedure is to provide guidelines for the disinfection of capillary-blood sampling devices to prevent transmission of blood borne diseases to residents and employees. Disinfection is a process that eliminates many and all pathogenic microorganisms, except bacterial spores, on inanimate objects. Policy Explanation and Compliance Guidelines: 3. The glucometer should be disinfected with a wipe pre-saturated with an EPA (Environmental Protection Agency) registered healthcare disinfectant that is effective against HIV (Human Immunodeficiency Viruses), Hepatitis C and Hepatitis B virus. 5. Procedure: J. Using first wipe, clean first to remove heavy soil, blood, and/or other contaminants left on the surface of the glucometer. K. After cleaning, use second wipe to disinfect the glucometer thoroughly with the disinfectant wipe, following the manufacturer's instructions. L. Use third wipe to wrap the glucometer to disinfect for two (2) minutes.	F 880	• Licensed Practical Nurse (LPN) #1 and Licensed Practical Nurse (LPN) #2 were immediately in-serviced by the Director of Clinical Support, Registered Nurse on 4/3/2019 and by the Director of Nursing on 4/4/2019 on the proper procedures for glucometer cleaning and disinfecting. • The facility has determined that all residents requiring finger stick glucose monitoring, 21 of 60 potential residents, have the potential to be affected. • All nursing staff have been in-serviced on the facility's Glucometer Disinfection policy and procedure by the Director of Nursing or assigned Registered Nurse supervisor starting 4/3/2019 thru 4/25/19. In-service training includes written instructions on the expected procedure and observation of each nurse performing the cleaning and disinfection of a glucometer. A validation checklist is used to ensure the correct procedure is followed by each nurse. Instructions for the procedure has been posted in each nursing station. • The Director of Nursing or assigned Registered Nurse supervisor, will complete validation check-offs with all licensed nursing staff. All full-time med pass nurses were in-serviced and completed validation check offs from 4/3/2019 thru 4/12/2019. Five validation check-offs will be completed per week for four weeks, starting 4/14/2019 thru	

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 _____	04/04/2019

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 880	Continued From page 3 Record review of the Assure Prism Multi Blood Glucose Monitoring System, Quality Assurance and Quality Control (QA/QC) Reference Manual, no date, revealed: Page 16. The disinfection procedure was needed to prevent the transmission of blood borne pathogens. A variety of the most commonly used EPA-registered wipes have been tested and approved for cleaning and disinfecting the Assure Prism Multi Blood Glucose Monitoring System. The disinfectant wipes listed below have been shown to be safe for use with this meter. Please read the manufacturer's instructions before using their wipes on the meter. (The list included the Professional Disposables International (PDI) Super Sani-Cloth Germicidal Disposable Wipe). Page 17. Disinfecting (The meter should be cleaned prior to disinfection.) Step 5. Open the towelette container and pull out 1 (one) towelette and close the lid. Step 6. Wipe the entire surface of the meter 3 (three) times horizontally and 3 (three) times vertically to remove blood-borne pathogens. Step 7. Dispose of the used towelette in a trash bin. Step 8. Allow exteriors to remain wet for the appropriate contact time and then wipe the meter using a dry cloth. (The contact time for the Super Sani-Cloth Germicidal Disposable Wipe is 2 (two) minutes per the included Disinfectant Brand Name and Contact Time chart listed under Step 8.) Record review of the Super Sani-Cloth container label directions for disinfecting revealed: Unfold a clean wipe and thoroughly wet surface. Allow treated surface to remain wet for a full 2 minutes. Let air dry. On 4/3/19 at 11:00 AM, an observation revealed Licensed Practical Nurse (LPN) #1 wiped the	F 880	5/11/2019. Five check-offs per month will be completed for three months, starting 5/12/2019 thru 8/14/2019. Annually and on hire every licensed nurse will receive training and perform a validation check-off for the cleaning and disinfection of the glucometer to ensure nurses are performing the procedure in accordance with our facility's policy and procedure for glucometer disinfection. Validation checklist will be reviewed by the Risk Management/Quality Assurance Committee monthly and make recommendations as needed until such time consistent substantial compliance has been achieved as determined by the committee.	

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 _____	04/04/2019

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
F 880	Continued From page 4 Assure Prism Multi Glucometer, prior to Resident #30's finger stick glucose, with the Super Sani - Cloth for approximately five (5) seconds, and then placed the glucometer on a Kleenex to air dry. LPN #1 performed the finger stick glucose on Resident #30, and then returned to the medication cart and wiped the contaminated glucometer with the Super Sani - Cloth for approximately 10 seconds and placed the glucometer on a Kleenex to air dry. On 4/3/19 at 11:15 AM, an observation revealed LPN #1 cleaned the Assure Prism Multi Glucometer before she performed a finger stick glucose on Resident #18. LPN #1 cleaned the glucometer with the Super Sani - Cloth by wiping the glucometer for approximately 10 seconds. LPN #1 performed the finger stick glucose on Resident #18, and then returned to the medication cart and wiped the glucometer with the Super Sani - Cloth for approximately 10 seconds, and then placed the glucometer on a Kleenex. On 4/3/19 at 11:20 AM, an interview with LPN #1 revealed she usually cleaned the glucometer about 15 seconds, and then places it on the Kleenex to air dry until it appears dry, a few minutes, time differs. LPN #1 stated she cleaned the glucometer 15 seconds before performing the finger sticks on Resident #18 and Resident #30. On 4/3/19 at 3:28 PM, an observation revealed LPN #2 cleaned the Assure Prism Multi Glucometer by wiping the glucometer with the Super Sani - Cloth for approximately 30 seconds, and then placed the glucometer on a clean Kleenex. LPN #2 then performed the finger stick on Resident #41, and then returned to the	F 880		

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	255327	A. BUILDING _____ B. WING _____	04/04/2019

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
F 880	Continued From page 5 medication cart. LPN #2 then wiped the glucometer with the Super Sani - Cloth for approximately 30 seconds before she placed the glucometer on a Kleenex. On 4/3/19 at 3:35 PM, an interview with LPN #2 confirmed she wiped the glucometer for 30 seconds prior to performing the finger stick on Resident #41. LPN #2 read the Super Sani - Cloth label directions at this time, and confirmed disinfecting required the surface of the object being disinfected stay wet for 2 (two) minutes, and she did not keep the glucometer wet for 2 (two) minutes. LPN #2 stated not keeping the glucometer wet for two (2) minutes could cause the spread of infection to other residents. On 4/3/19 at 3:55 PM, an interview with the Director of Nursing (DON) revealed she was not aware the directions for disinfecting the glucometer with the Super Sani-Cloth wipes required the glucometer to stay wet for two (2) minutes. On 4/4/19 at 8:30 AM, an interview with LPN #1 confirmed she kept the glucometer wet for approximately 15 seconds when she performed the finger sticks on Residents #18 and #30 and did not know she should keep the glucometer wet for 2 (two) minutes. LPN #1 revealed since she did not keep the glucometer wet for two (2) minutes it could cause the spread of an infection to other residents.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255327	A. BUILDING **G6 - MARTHA COKER - GREENHOUSE UNIT 06** B. WING _____	**04/03/2019**

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 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 | 04/16/2019

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
	255327	A. BUILDING **G5 - MARTHA COKER - GREENHOUSE UNIT 05** B. WING _____	**04/03/2019**

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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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		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) 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 _____	**04/03/2019**

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 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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	255327	A. BUILDING **G1 - MARTHA COKER - GREENHOUSE UNIT 01** B. WING _____	**04/03/2019**

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 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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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 _____	**04/03/2019**

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 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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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 _____	**04/03/2019**

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 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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	255327	A. BUILDING _____ B. WING _____	04/03/2019

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
E 000	Initial Comments *EMERGENCY PREPAREDNESS* Survey conducted on 4/3/19 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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