STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255344	A. BUILDING _____ B. WING _____	04/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUITMAN COUNTY HEALTH & REHAB LLC	350 GETWELL DRIVE MARKS, MS 38646

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Management Solutions, LLC on behalf of Mississippi State Department of Health, at the facility from 4/2/19 to 4/4/19. During the survey, the facility was found not to be in substantial compliance with the requirements of participation for Medicare and Medicaid. The facility was cited regulatory deficiencies at F689, F758, F761, F838, and F880. The census at the time of the survey was 47, and the facility was certified for 60 beds.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to properly assess the use of lap belts as a potential accident hazard for two (2) of 18 residents reviewed, Residents #33 and #42. Findings include: Review of the facility's "Hazardous Areas, Devices and Equipment" policy, revised 07/2017, indicated, "...Any element of the resident environment that has the potential to cause injury	F 689	1) On 04-18-2019, the Minimum Data Set Coordinator completed the "Fall Assessment" on resident #33 and #42. Both Residents reviewed for lap belt use being potential contributing factor of fall. Residents # 33 and # 42 lap belts were not found to be a contributing factor. On 04-8-19, the Minimum Date Set Coordinator completed a "Physical Restraint Elimination Assessment" on Residents #33 and #42. Residents #33 and #42 current lap belts ordered were	5/17/19

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

Electronically Signed | 05/17/2019

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F 689	Continued From page 1 and that is accessible to a vulnerable resident is considered hazardous...Data from Accident and Incident Reports will be used as part of the hazard's assessment and analysis, including trends in accident types, areas in the facility, associations with particular staff or shifts and equipment used...". The facility's "Falls and Fall Risk, Managing" policy, with a revision date of December, 2007, indicated, "...Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling... If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant...". Review of the facility's policy for Restraints, revised April 2017, revealed restraints shall be used in such a way as not to cause physical injury to the resident and to insure the least possible discomfort to the resident. A resident placed in a restraint will be observed every 30 minutes by nursing personnel and an account of the resident's condition shall be recorded in the resident's medical record. Restrained individuals shall be reviewed regularly, (at least quarterly) to determine whether they are candidates for restraint reduction, less restrictive methods of restraints, or total restraint elimination. The facility did not assess the use of lap belts as a possible contributing factor for falls experienced by Resident #33 and Resident #42, nor did the facility consistently refer the residents to therapy for screening as directed by facility policy	F 689	determined to be the least restrictive option at this time with the benefits out weighing the risk. 2)On 04-08-2019, the Minimum Data Set Coordinator assessed 100% of residents for restraint use being a contributing factor of falls. Four (4) of the forty-three (43) residents have the potential to be affected by this deficient practice. On 04-08-2019, the Minimum Data Set Coordinator completed a "Fall Assessment" to include review of restraints as contributing factors for falls. No restraint use noted as a contributing factor for falls per Minimum Data Set Coordinator on 04-08-2019. 3) On 04-08-2019, the Nurse Consultant conducted a 1:1 in-service with the Minimum Data Set Coordinator on assessment of residents with falls to include restraint as a potential contributing factor. On 05-15-2019, the Minimum Data Set Coordinator initialted an in-service for all nursing staff on completing the fall assessment and restraint assessment with all falls. On 5/10/19, the Quality Assurance Committee reviewed the policy and procedures for "Hazardous Areas, Devices and Equipment" and "Falls and fall risk managing, with no recommended changes to the policy at this time. In attendance at the meeting were the Administrator, Acting Director of Nursing,Minimum Data Set Coordinator, Infection Control Nurse, Human Resources Director, Maintenance Supervisor, and Medical Director. 4) The Minimum Data Set Coordinator will monitor all resident with falls each week X 12 weeks during the "High Risk Fall"	

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F 689	Continued From page 2 following a fall. Resident #33 Review of the clinical record revealed the physician ordered the use of a self-releasing seat belt for Resident #33 on 08/16/16. A "Fall Assessment", dated 03/21/18, identified Resident #33 as a high fall risk. Specifically, this document noted the resident had a history of falls and a diagnosis of Dementia. The assessment indicated the resident would lean forward, was confused and had poor comprehension. A "Fall Assessment" was completed on 06/09/18 and 09/05/18, and noted the same information. Review of the "Departmental Notes", dated 11/13/18, revealed Resident #33 was found seated in her wheelchair with her seat belt on and located behind another resident who was in a wheelchair. The entry noted Resident #33 was found with her wheelchair flipped forward and was caught by the back of the other resident's wheelchair. The seat belt had to be released by staff after this incident. There were no injuries sustained by Resident #33. A "Resident Incident Report", dated 11/13/18, noted the above information. There was no information in this document that indicated the facility assessed whether the self-releasing belt was a potential accident hazard, or if the lap belt remained the best option for the resident. The report did document this was an unwitnessed event. The quarterly "Minimum Data Set (MDS)", with an Assessment Reference Date (ARD) of 02/20/19, noted Resident #33 was unable to complete the	F 689	meeting for completion of the Fall Assessment to ensure restraints are assessed as a potential contributing factor of the fall. Results will be logged on a "Fall\Restraint Evaluation Log" beginning 05-16-2019 "High Risk Fall" meeting. Any issue noted will be corrected immediately and The Quality Assurance Nurse report quarterly to the Quality Assurance Committee, to determine if changes need to be made.	

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F 689	Continued From page 3 Brief Interview for Mental Status (BIMS) evaluation due to the resident being rarely/never understood. The resident was assessed by staff to be moderately cognitively impaired. Resident #33 required the assistance of two staff members for bed mobility and transfers. The resident used a trunk restraint daily while out of bed. A care plan, dated as initiated 02/26/19, identified Resident #33 required assistance with activities of daily living. One of the approaches identified was to check the self-releasing seat belt every two hours and to release and exercise the resident. Another care plan issue, dated as initiated 02/26/19, noted Resident #33 was at risk for falls. An approach identified a self-releasing seat belt would be attached to the wheelchair due to decreased safety awareness. Another approach identified Resident #33 should be screened per PT (Physical Therapy) and OT (Occupational Therapy) after falls and PRN (as needed). There was no evidence to show that this seat belt device was assessed as a potential accident hazard. On 04/02/19 at 10:31 AM, Resident #33 was observed in a wheelchair with a self-releasing lap belt secured about her waist. An interview was attempted with Resident #33. The resident could not be understood at this time. In an interview, on 04/03/19 at 12:02 PM, the acting Director of Nursing (DON) stated therapy staff were to screen for the use of lap belts and make recommendations. Review of the "Face Sheet" revealed Resident #33 was admitted to the facility, on 08/03/16, with diagnoses of unspecified Dementia with	F 689		

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F 689	Continued From page 4 behavioral disturbance and muscle weakness. Resident #42 Review of the Physician Orders, dated 06/26/17, revealed an alarmed self-releasing seat belt for Resident #42 was ordered due to a decrease in safety awareness and Alzheimer's disease. The "Departmental Notes", dated 02/10/19, noted Resident #42's alarm from her self-releasing lap belt was heard. The staff member found the resident at the foot of her bed on the floor. She sustained no injuries. A referral was made, on 02/10/19, to therapy to evaluate Resident #42 from her recent fall. There was no mention of the self-releasing lap belt and whether this might be considered a risk for harm for the resident or not. The evaluation did not state if the lap belt was still considered the best option for safety for the resident or not. The quarterly MDS assessment, with an ARD of 02/27/19, noted Resident #42 was unable to complete the BIMS evaluation due to the resident being rarely/never understood. Staff assessed the resident was moderately cognitively impaired. The resident required limited assistance of two staff members for bed mobility and extensive assistance for transfers of two staff members. The resident used a trunk restraint daily while out of bed. A Care Plan, dated as initiated on 03/05/19, identified Resident #42 was considered high risk for falls. Identified approaches included the resident was to have an alarmed self-releasing seat belt due to decreased safety awareness and	F 689		

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F 689	Continued From page 5	F 689		

Alzheimer's disease. There was no mention the resident had the behavior of attempting to stand by herself while in the wheelchair.

Review of the "Departmental Notes", dated 03/16/19, revealed Resident #42 had an unwitnessed fall. Resident #42 was found on the ground, scooting towards her bed from the bathroom, and her shirt was covered with urine. The resident sustained no injuries. There was no evidence the resident was referred to the therapy department for screening after her 03/16/19 fall.

In an interview, on 04/03/19 at 12:51 PM, Licensed Practical Nurse (LPN) #66 stated Resident #42 would attempt to stand up on her own from her wheelchair. LPN #66 confirmed the resident used a self-releasing lap belt.

In an interview on, 04/03/19 at 1:59 PM, Certified Nursing Assistant (CNA) #22 confirmed Resident #42 would attempt to stand when sitting in her wheelchair even with her lap belt attached. CNA #22 stated she reminds the resident to sit back down.

In an interview, on 04/03/19 at 2:54 PM, the MDS Coordinator stated Resident #42 was at high risk for falls. She said the resident had a history of releasing the lap belt and standing unassisted.

A telephone interview was conducted with the Director of Rehabilitation (DR) on 04/04/19 at 9:15 AM. The DR said Resident #42 was safer with a lap belt on than without. The DR confirmed the resident was considered high risk for falls. The DR said if a resident had a fall, therapy would assess them to see if they need therapy or not. The DR was unable to explain why this had not

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F 689	Continued From page 6 occurred for Resident #42. Review of the "Face Sheet" revealed Resident #42 was admitted to the facility, on 11/11/16, with diagnoses of repeated falls and Alzheimer's disease.	F 689		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a	F 758		5/17/19

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F 758	Continued From page 7 diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review, the facility failed to ensure that two (2) of five (5) residents reviewed for unnecessary medications had adequate indications for use of an antipsychotic medication, Seroquel. Neither resident received a gradual dose reduction (GDR), nor did the physician provide a clinical rationale for the continued use of the medication for Resident #17 and Resident #32. Findings include: Review of the facility's "Antipsychotic Medication Use" policy, dated as revised December 2016, noted "Antipsychotic medications will be prescribed at the lowest possible dosage for the shortest period of time and are subject to gradual dose reduction and re-review...residents will only receive antipsychotic medications when necessary to treat specific conditions for which	F 758	1) On 04-19-2019, Resident # 17 received physician order for Gradual Dose Reduction of Seroquel to 12.5 milligrams(mg) every hour sleep(hs). On 04-11-19, Resident # 17 had order written for gradual dose reduction of Wellbutrin medication to 150 mg by mouth daily. On 04-11-2019, Resident # 32 received order to discontinue Seroquel medication. 2) On 04-09-2019, the Pharmacy Consultant conducted 100% audit of all Resident's medications. Fourteen (14) residents have the potential to be affected by this deficient practice. Four (4) of the fourteen (14) residents were recommended for gradual dose reductions by Pharmacy Consultants. On 04-09-2019, the recommendations were sent to the Medical Director. The Medical Director agreed to all four (4)	

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F 758	Continued From page 8 they are indicated and effective...The attending physician will identify, evaluate and document, with input from other disciplines and consultants as needed, symptoms that may warrant the use of antipsychotic medications...Residents who are admitted from the community or transferred from a hospital and who are already receiving antipsychotic medications will be evaluated for the appropriateness and indications for use...or re-evaluate the use of the antipsychotic medication at the time of admission and/or within two weeks (at the initial MDS assessment) to consider whether or not the medication can be reduced, tapered, or discontinued. Based on assessing the resident's symptoms and overall situation, the physician will determine whether to continue, adjust, or stop existing antipsychotic medication. Diagnosis of a specific condition for which antipsychotic medications are necessary to treat will be based on a comprehensive assessment of the resident...or clearly documenting (based on assessing the situation) why the benefits of the medication outweigh the risks or suspected or confirmed adverse consequences." Review of the Food and Drug Administration Medication Guide revealed, "...SEROQUEL may cause serious side effects, including: 1. risk of death in the elderly with dementia. Medicines like SEROQUEL can increase the risk of death in elderly people who have memory loss (dementia). SEROQUEL is not for treating psychosis in the elderly with dementia." The facility failed to ensure Resident #17 and Resident #32 received Seroquel (an antipsychotic medication) at the lowest possible dosage for the shortest period by failing to attempt GDRs and	F 758	recommendations and physicians orders were completed on 4/11/2019. 3)On 05-10-2019, the Quality Assurance committee reviewed the policy and procedure "Antipsychotic Medication Use" with no recommended revisions to the policy at this time. The Quality Assurance committee discussed need for physician to provide a clinical rationale for gradual dose reductions recommendations does not agree. In attendance at the Quality Assurance committee meeting were: Administrator, acting Director of Nursing, Minimum Data Set Coordinator, Quality Assurance Nurse, Social Services Director, Human Resources Director, Maintenance Supervisor,and Housekeeping Supervisor. On 05-16-2019, the Quality Assurance Nurse in-serviced all nurses on the importance of completion of behavior flow sheets to include current behaviors, interactions, and outcomes on every shift, the purpose being to get pertinent information to the Physician. 4) The facility will begin an "Antipsychotic Committee", to include Administrator, Director of Nursing, Minimum Data Set Coordinator, Quality Assurance Nurse, And Infection Control Nurse. This committee will meet monthly beginning 05-27-2019, to review all residents receiving Antipsychotic medications, Residents with changes in behaviors, and Resident's last documented gradual dose reduction. The Quality Assurance Nurse will report the finding of the committee to the Quality Assurance Committee.	

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F 758	Continued From page 9 failing to clearly identify the indications for continued use of the medication. The physician failed to assess the residents and provide a medical rationale regarding the continued use of the Seroquel. Resident #17 A physician's order, dated 05/03/18, ordered Seroquel 50 milligrams (mg) be administered to Resident #17 at 9:00 PM daily. A review of Resident #17's "Behavior/Intervention Monthly Flow Record", from 10/01/18 through 03/30/19, revealed staff monitored for aggressive behaviors, hallucinations, delusions, and psychosis related to the use of Seroquel. None of the behaviors were noted for this period. The electronic Medication Administration Records (MARs) were reviewed from 10/01/18 through 03/30/19. Each month indicated the Seroquel was ordered to treat Resident #17's psychosis. A physician's note, dated 11/15/18, indicated Resident #17's behaviors were "well controlled on current medications of Seroquel 50 mg to be administered at 9:00 PM daily, Wellbutrin [an antidepressant] 200 mg daily, and Aricept [to treat mild to moderate dementia] 10 mg daily." The Physician's Note continued by stating the resident had a history of Dementia and alcohol abuse. Resident #17's quarterly "Minimum Data Set (MDS)", with an Assessment Reference Date (ARD) of 01/15/19, indicated the resident had a Brief Interview for Mental Status (BIMS) score of six out of 15 which indicated moderately impaired cognition. Resident #17 had diagnoses of Psychotic disorder other than Schizophrenia,	F 758		

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F 758	Continued From page 10 Depression (other than Bipolar disorder) and Dementia. Resident #17 did not experience delusions or hallucinations, and was not a danger to self or to others. A care plan, dated as initiated 01/22/19, identified Resident #17 was taking Seroquel for psychosis with behaviors with auditory and visual hallucinations. Review of the Psychologist's "Physician Notes", dated 01/30/19, identified a one on one session was held with Resident #17. It was noted the resident had "no current issues". Review of the Psychologist's "Physician Notes", dated 02/20/19, identified a one on one session was held with Resident #17. It was noted the resident had no suicidal or homicidal ideations and the resident was not plagued with perceptual disturbances. Review of the Psychologist's "Physician Notes", dated 03/20/19, identified a one on one session was held with Resident #17. It was noted the resident had no suicidal or homicidal ideations. The "Departmental Notes", from 10/02/18 to 04/03/19, revealed Resident #17 exhibited no behaviors such as aggression to self or to others, delusions, or hallucinations. In an interview, on 04/04/19 at 9:55 AM, Certified Nursing Assistant (CNA) #12 stated Resident #17 did not yell out constantly, but would yell during showers. CNA #12 stated the resident did not make up stories that were not true, and did not see things that were not there. She said she had worked with the resident for the past two years.	F 758		

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F 758	Continued From page 11 In an interview, on 04/04/19 at 10:00 AM, Licensed Practical Nurse (LPN) #64 said that she has worked with Resident #17 since August 2018. LPN #64 said the resident did not yell out constantly, did not hit out, did not make up stories, did not see things that were not there, and no one was afraid of the resident. Both the Administrator and the acting Director of Nursing (DON) were interviewed on 04/04/19 at 11:10 AM. The Administrator said Resident #17 was not a threat to others, and generally there were no concerns with Resident #17's behaviors. In an interview, conducted by telephone on 04/04/19 at 1:09 PM, the Medical Director (MD) stated residents are prescribed an antipsychotic who have mental health disorders, and residents who lash out and can hurt themselves or others. He said that he relies on what the nurses tell him when he makes his routine visits, since the staff know about the resident. The MD said they could do better on the residents who have no behaviors and looking at a GDR. He was unable to explain why a GDR had not been attempted for Resident #17 in the 11 months since the Seroquel was initiated despite an absence of behaviors or indicators for the continued use of the medication. Review of the "Face Sheet" revealed Resident #17 was admitted by the facility, on 06/07/17, with a diagnosis of unspecified Dementia with behavioral disturbances. Resident #32 The "Pharmacist Consultation Report Clinical Comments and Suggestions", dated 10/04/18,	F 758		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUITMAN COUNTY HEALTH & REHAB LLC	350 GETWELL DRIVE MARKS, MS 38646

(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 758	Continued From page 12 indicated, "Seroquel 25 mg q (every) HS (hour of sleep) for dementia. Consider reducing to Seroquel 12.5 mg q HS." The physician responded by marking the box that indicated no action was necessary at the time, and direction that the resident was to continue the same dose. Review of the quarterly MDS with an ARD of 12/05/18; the 30-day MDS with an ARD of 01/27/19; and the 14-day MDS with an ARD of 02/18/19 all revealed Resident #32 exhibited no behaviors, hallucinations or delusions during the look-back periods. A "Physician's Progress Note", dated 02/13/19 at 8:50 AM, indicated the resident expressed feelings of sadness, but denied experiencing any crying spells. It was noted that the resident napped "frequently". A review of the February 2019 "Behavior/Intervention Monthly Flow Record" revealed Resident #32 had cried on five nights. The staff noted they responded each time by providing redirection and one on one. There were no outcomes documented. A review of the March 2019 "Behavior/Intervention Monthly Flow Record" revealed on 13 nights the resident had experienced "disordered thinking", although this was not clearly defined. The staff documented they responded each time by providing redirection and one on one. A "Physician's Progress Note," dated 03/27/19 at 10:10 AM, revealed the resident had "regressed overall and was sleeping excessively".	F 758		

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F 758	Continued From page 13 In an interview, on 04/03/19 at 1:39 PM, the acting DON was asked to review the October 2018 pharmacy consultant's report. She said she would speak to the physician about trying a GDR for Resident #32 as no clinical rationale for the refusal to a dose reduction had been provided. In an interview, on 04/04/19 at 9:10 AM, Registered Nurse (RN) #68 stated she had spoken to the physician about the lack of a GDR since the resident's admission in October 2017. RN #68 said the physician told her to write the order to decrease the Seroquel, and to monitor the resident. In an interview, on 04/04/19 at 10:25 AM, the acting DON explained Resident #32 used to call out or cry but that Resident #32 was "quieter now". The acting DON further explained Resident #32 used to talk loudly at night which was disruptive to Resident #32's roommate. In an interview, on 04/04/19 at 10:30 AM, CNA #71 said she had provided care for Resident #32 on day shift for the previous six months. CNA #71 said the resident had always complained of care, and being moved around. CNA #71 said Resident #32 would lightly slap the staff's hands when she didn't want something done. On 04/04/19 at 12:50 PM, the Pharmacy Consultant was interviewed by telephone regarding antipsychotic medications and the physician's response to GDR requests. The Pharmacist stated he reviewed progress notes and physician's orders. The pharmacist said he had made appropriate recommendations regarding the continued use of Seroquel for Resident #32, however that was all he could do.	F 758		

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F 758	Continued From page 14 In a telephone interview, on 04/04/19 at 1:09 PM, the Physician was unable to explain why no GDR had been attempted for Resident #32. Review of the admission physician's orders, dated 10/09/17, revealed Resident #32 was admitted by the facility with diagnoses that included Depression, Type II Diabetes Mellitus, and Dementia. These orders also indicated Resident #32 was admitted with an order for Seroquel 25 mg one tablet by mouth at bedtime for delusions.	F 758		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit	F 761		5/17/19

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F 761	Continued From page 15 package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the facility failed to dispose of loose medications in the medication cart drawers; dispose of expired vials of insulin in medication carts; and dispose of one opened and undated vial of insulin and one expired vial of Tuberculin serum in the medication refrigerator according to the facility's policies. The expired and undated insulins had the potential to affect three (3) of 10 residents, Residents #14, #23, and #41, who received insulin injections; the expired Tuberculin serum had the potential to affect staff and 47 residents who may have required a tuberculin test; and the loose medications had the potential to affect the 47 of 47 residents who received medications. Findings include: Review of the facility's "Medication Carts" policy, dated 07/30/18, indicated, "Before end of each shift the med cart is to be wiped with disinfectant wipe, all liquid medication bottles should be cleaned with disinfectant wipe and any loose pills in the med cart are to be discarded in the sharps container." The facility's policy for expired vials of medications indicated, "To minimize contamination, facility staff should date the label of any multi-use vial when the vial is first accessed and access the vial in a dedicated medication preparation area: If a multi-dose vial has been opened or accessed (e.g.,	F 761	1) On 04-03-2019, expired medications for Resident #14, #41, and #23 were removed from medication cart by acting Director of Nursing. On 04-03-2019, acting Director of Nursing removed open/undated medication vial and expired Tuberculin vial from Med Room refrigerator. 2) All forty-seven (47) residents receiving medications have the potential to be affected by this deficient practice. On 05-03-2019, the acting Director of Nursing conducted an 100% audit of all multi-dose vials for expiration and proper labeling. No other vials were noted to improper labeling or expired. 3) Beginning 05-05-2019, acting Director of Nursing conducted and in-service on medication cart policy with emphasis on proper cleaning of the cart, checking for loose pills, and expired medications every shift. On 5/10/19, the Quality Assurance Committee reviewed the policy for "Medication Carts" and medication labeling with no recommended changes at this time. In attendance at the Quality Assurance meeting were: Administrator, acting Director of Nursing, Minimum Data Set Coordinator, Infection Control Nurse, Social Work Director, Human Resources Director, Medical Director,Maintenance Supervisor, and Housekeeping Supervisor. 4) Beginning 05--22-2019 The Director of	

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F 761	Continued From page 16 needle-punctured), the vial should be dated and discarded within 28 days...". One (1) of the two (2) medication carts utilized contained loose pills in one of the drawers. The medication cart also contained four vials of expired insulins prescribed for three different residents. The refrigerator in the medication room used for storing medications contained an opened and undated vial of insulin and an expired, used vial of Tuberculin used for residents and staff. 1. On 04/03/19 at 8:50 AM, Licensed Practical Nurse (LPN) #66 was observed passing medications from a medication cart. Observation of one of the drawers revealed six unidentified pills of different shapes and colors lying loose on the bottom of the drawer. On 04/03/19 at 9:00 AM, LPN #66 was asked who was responsible for cleaning out the medication carts. LPN #66 stated the night nurse should have cleaned out the cart before her shift ended last night. LPN #66 stated the pills should not be lying loose in the cart. On 04/03/19 at 9:05 AM, the acting Director of Nursing (DON) was asked who was responsible for making sure there were no loose pills in the medication carts. The DON said every shift should clean the carts at the end of their shifts. The DON said there should be no loose pills in the medication carts. 2. On 04/03/19 at 8:50 AM, LPN #66 was observed passing medications from one (1) of the two (2) medication carts being utilized.	F 761	Nursing will audit medication carts and medication room each week day for two (2) weeks, then weekly for two (2) weeks to ensure medication carts are maintained according to policy. Results of the audit will be recorded on the Cart Maintenance Log. Any issue found will be corrected immediately and reported to the Quality Assurance Committee at the quarterly meeting by the Quality Assurance Nurse.	

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F 761	Continued From page 17 During the medication pass observation, four (4) opened and expired insulin vials for three (3) residents (Residents #14, #41, and #23) were observed in one the drawers of the medication cart. A vial of Lantus insulin for Resident #14 was dated as opened on 02/21/19. A vial of Humalog insulin for Resident #41 was dated as opened on 01/6/19. A vial of Lantus insulin for Resident #41 was dated as opened on 01/07/19. A vial of Novolin regular insulin for Resident #23 was dated as opened on 02/16/19. On 04/03/19 at 9:05 AM, the acting DON was asked when the insulin should be checked for an expiration date and disposed of if expired. She said the nurse normally checked the open date on the vial before they administered it. She explained if the insulin was expired (28 days after being opened) it should be disposed of and re-ordered if necessary. 3. On 04/03/19 at 9:05 AM, the Medication Room was inspected with the acting DON. In the refrigerator the following medications were observed: a vial of Levemir insulin had been opened and used but did not have a date as to when it had been opened; and an opened and used Tuberculin vial dated as opened on 02/20/19. At that time, the acting DON was asked who was responsible for putting a date on a multi-use vial of medication when they first opened it for use. The acting DON stated the nurse who initially utilized the vial was responsible for dating the multi-use vials. The acting DON was asked why the opened, expired and used Tuberculin multi-use vial remained for use in the refrigerator. The acting DON responded the nurse who normally administered the Tuberculin test had a family emergency and had to leave,	F 761		

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F 761	Continued From page 18 forgetting to dispose of the vial. The acting DON confirmed the Tuberculin vial and the Levemir insulin needed to be disposed of.	F 761		
F 838 SS=C	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and	F 838		5/17/19

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F 838	Continued From page 19 food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure Legionella (a severe form of pneumonia caught by inhaling bacteria) and other waterborne pathogens polices were incorporated into the facility assessment. This had the potential to affect all 47 residents residing in the facility. Findings include: A Standards and Certification (S&C) memorandum dated as revised 06/09/17 from the	F 838	1. On 5/14/19, the Administrator entered a contract with a water testing Lab for the purpose of testing of water for Legionella. A water sample was collected and sent to lab on 05-20-2019 according to lab policies. Results will be returned within 10-14 business days. 2) All forty-three (43) residents residing within the facility have the potential to be affected by this deficient practice. On	

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F 838	Continued From page 20 Centers of Medicare Services (CMS) stated, "...Legionella Infections: The bacterium Legionella can cause a serious type of pneumonia called LD in persons at risk. Those at risk include persons who are at least 50 years old, smokers, or those with underlying medical conditions such as chronic lung disease or immunosuppression. Outbreaks have been linked to poorly maintained water systems in buildings with large or complex water systems including hospitals and long-term care facilities. Transmission can occur via aerosols from devices such as showerheads...Facility Requirements to Prevent Legionella Infections: Facilities must develop and adhere to policies and procedures that inhibit microbial growth in building water systems that reduce the risk of growth and spread of Legionella and other opportunistic pathogens in water...This policy memorandum applies to...Long-Term Care (LTC)." Review of the facility's "Quality Assurance Performance Improvement (QAPI) Self-Assessment", dated 11/16/18, failed to identify integration of a water management program that included Legionella and other waterborne pathogens. In addition, the "Facility Assessment" failed to identify how the potential of waterborne pathogens might place current or future residents, who have respiratory diseases, at risk for the development of diseases associated with waterborne pathogens. An interview was conducted with the Administrator on 04/04/19 at 10:25 AM. The Administrator said that he did not integrate a water management program into the current facility assessment.	F 838	5/15/19, the Minimum Data Sets Coordinator assessed all cases of pneumonia as to the causative factor to determine if Legionella was the causative factor. Of the nine (9) cases over the past twelve (12)months, none were identified with Legionella as the cause. 3) On 5/10/19, the Quality Assurance Committee reviewed the policy "Infection Control Guidelines for Legionella/Legionnaires", with no recommended changes to the policy at this time. In attendance at the Quality Assurance Committee meeting were: Administrator , acting Director of Nursing, Minimum Data Set Coordinator, Quality Assurance Nurse, Social Services Director, Human Resources Director, Maintenance Supervisor, and Housekeeping Supervisor. The Quality Assurance Committee discussed that the Administrator will update the Facility Assessment with results of water testing when received. 4) The facility will test one of the environmental risk area locations annually. The Administrator or Director of Nursing will report any positive results to the Mississippi State Department of Health. The Infection Control Preventionist will report any resident with Legionella caused case of pneumonia within twenty-four (24) hours. Quarterly water testing will be required after any positive area is cleaned and cleared per Mississippi State Department of Health until testing results are negative times	

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F 838	Continued From page 21	F 838	two. The policy "Infection Control Guidelines for Legionella/Legionnaires", will be reviewed annually and as needed	
F 880 SS=C	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; §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	F 880		5/17/19

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F 880	Continued From page 22 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. 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 interview and review of the facility's infection control manual, the facility failed to: ensure that a water management program was integrated into the infection control program; and review and revise their infection control policies and procedures on an annual basis and as	F 880	1. On 5/14/19, the Administrator entered a contract with a water testing Lab for the purpose of testing of water for Legionella. A water sample was collected and sent to lab on 05-20-2019 according to lab policies. Results will be returned within	

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F 880	Continued From page 23 needed. These failures had the potential to affect 47 of 47 residents residing in the facility. Findings include: Review of the facility's "Nursing Services Policy and Procedural Manual for Long-Term Care Infection Control", dated as reviewed and adopted on 01/18/18, revealed the facility failed to identify or integrate a water management program into the infection control program. Review of the facility's "Legionella Water Management Program" policy, dated as revised 07/2017, revealed " ...The water management program includes the following elements...A detailed description of the water system in the facility...including...Receiving...Cold water distribution...heating... Hot water distribution...waste...The identification of areas in the water system that could encourage the growth and spread of Legionella or other water borne pathogens...". An interview was conducted with the Administrator on 04/01/19 at 10:25 AM. The Administrator stated a water management program was not integrated into the infection control program. In an interview, on 04/04/19 at 1:58 PM, the acting Director of Nursing (DON) explained she thought the infection control policy had not been reviewed since January 2018 because the facility had experienced a change in DONs twice since October 2018. She stated it had been difficult getting everything completed on a schedule as required but they were trying.	F 880	10-14 business days. 2) All forty-three (43) residents residing within the facility have the potential to be affected by this deficient practice. On 5/15/19, the Minimum Data Sets Coordinator assessed all cases of pneumonia as to the causative factor to determine if Legionella was the causative factor. Of the nine (9) cases over the past twelve (12)months, none were identified with Legionella as the cause. 3) On 5/10/19, the Quality Assurance Committee reviewed the policy "Infection Control Guidelines for Legionella/Legionnaires", with no recommended changes to the policy at this time. In attendance at the Quality Assurance Committee meeting were: Administrator , acting Director of Nursing, Minimum Data Set Coordinator, Quality Assurance Nurse, Social Services Director, Human Resources Director, Maintenance Supervisor, and Housekeeping Supervisor. The Quality Assurance Committee discussed that the Administrator will update the Facility Assessment with results of water testing when received. 4) The facility will test one of the environmental risk area locations annually. The Administrator or Director of Nursing will report any positive results to the Mississippi State Department of Health. The Infection Control Preventionist will report any resident with Legionella caused case of pneumonia	

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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 24	F 880	within twenty-four (24) hours. Quarterly water testing will be required after any positive area is cleaned and cleared per Mississippi State Department of Health until testing results are negative times two. The policy "Infection Control Guidelines for Legionella/Legionnaires", will be reviewed annually and as needed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255344	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/03/2019**

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QUITMAN COUNTY HEALTH & REHAB LLC	**350 GETWELL DRIVE** **MARKS, MS 38646**

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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 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to properly perform fire drills as per NFPA 19 .7.1.2. This deficiency affected all residents in the facility on the day of survey. Findings include: On April 3, 2019 at 10:20 AM, the facility could not provide documentation of a fire drill performed during the following shifts in the past year: 1. 1st shift in the 3rd quarter of 2018 2. 3rd shift of the 4th quarter of 2018	K 712	No Residents were affected by this deficiency. All Residents have the potential to by affected by this deficiency POC The maintenance supervisor was relieved of job duties and a new maintenance supervisor has been hired by the facility. New supervisor was in-services on by the Administrator and Safety Officer regarding the proper procedures and timing of fire drills, as well as insuring that all drills are signed by on duty personnel, and properly dated.	5/17/19

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

Electronically Signed | 05/17/2019

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
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K 712	Continued From page 1 3. 2nd or 3rd shift of the 1st quarter of 2019 The finding was acknowledged by the Administrator and Maintenance Supervisor verified this observation during the exit interview on April 3, 2019.	K 712	All fire drills are now up to date. The maintenance supervisor will report to QA committee on status of fire drills on a quarterly basis.	

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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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