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	255284	A. BUILDING _____ B. WING _____	07/02/2019

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HERITAGE HOUSE NURSING CENTER	3103 WISCONSIN AVENUE VICKSBURG, MS 39180

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F 000	INITIAL COMMENTS The State Survey Agency (SA) conducted an annual recertification survey along with a complaint survey for CI MS #15795, at the facility from 06/30/19 to 07/02/19. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements for participation and cited F554 and F880. The SA did substantiate CI MS #15795 for quality of care, with no citations related to the complaint. The facility was certified for 60 beds, and had a census of 52 at the time of the survey entrance.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility policy review, the facility failed to assess a resident for self-administration of medication. The resident was observed administering her own medications that were left in a cup at the bedside. This affected one (1) of 52 residents observed on initial tour, Resident #32. Findings include: Review of the facility's "Self-Administration of Medication" policy, Resident Care Manual LA & MS, Section S-Z, Pharmacy Manual, Section II, Latest Revision: 11/17, revealed: A resident will be allowed to self-administer medication only if:	F 554	F554 Resident Self-Admin Meds Clinically Appropriate Facility failed to assess a Resident #32 for self administration of medication. 1. Director of Nursing was notified on 6/30/2019 of the deficient practice by Licensed Practical Nurse #3 and immediately assigned Resident #32 to be evaluated by a licensed nurse with no adverse effects noted. Licensed Practical Nurse #3 was provided individual education on 7/1/2019 by Staff Development Nurse regarding direct	7/29/19

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

Electronically Signed | 07/25/2019

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.

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F 554	Continued From page 1 a) the attending physician writes or gives a verbal order that the resident may keep a medication at bedside for the purpose of self-administration, and b) the resident has been determined by the interdisciplinary care team to be cognitively, physically, and visually able to self-administer medications, therefore clinically appropriate, and is routinely monitored as to whether the resident continues to be capable and/or still taking medications as ordered. Review of Resident #32's physician's orders, dated July 2019, revealed no order for self-administration of medications. An observation in Resident #32's room, on 06/30/19 at 9:45 AM, revealed a medication cup, with seven (7) pills of various types inside the cup, on top of the over bed table, which was positioned across the bed in front of Resident #32. A four (4) ounce plastic cup of water was next to the medication cup. Resident #32 was in bed with the head of bed raised at approximately 30 degrees. Her eyes were initially closed until approached by the surveyor. When asked about the medications on the over bed table, Resident #32 stated they always leave them. Resident #32 swallowed the medication with the water from the plastic cup and said she had just got there today. An interview with Licensed Practical Nurse (LPN) #3, on 6/30/19 at 9:50 AM, confirmed that she had left the pills on Resident #32's over bed table. She stated she brought the medications in about 8:30 or 9:00 AM. She stated, "I always watch her". An interview with LPN #4/Assessment Nurse, at 10:03 AM on 06/30/19, revealed she reviewed	F 554	observation medication administration. 2. All fifty-eight (58) of fifty-eight (58) residents that receive medication administration by facility staff have the potential to be affected by this deficient practice. 3. Licensed nurses in-servicing initiated by Staff Development Nurse on 7/1/2019 regarding self administration of medications and medication administration guidelines. Upon hire, all licensed nursing staff will receive a skills competency evaluation by the Staff Development Nurse on medication administration. Actively employed licensed nursing staff will receive skill competency evaluations annually and as needed by the Staff Development Nurse or Director of Nursing. 4. Director of Nursing, Staff Development Nurse, or Pharmacy Consultant will monitor medication administration practices by licensed nurses on various shifts beginning on 7/25/2019 at least three (3) times weekly for four (4) weeks, then one (1) time weekly for four (4) weeks. Director of Nursing or Staff Development Nurse will report any recurring problem to the monthly Quality Assessment and Improvement Committee. Administrator and Director of Nursing will take necessary corrective action such as:	

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F 554	Continued From page 2 Resident #32's chart and care plans and stated the resident was not assessed to be able to self-administer her medications. LPN #4 stated "No ma'am, not that I know of, no", regarding self-administration of the medications. On 06/30/19 at 2:57 PM, an interview with LPN #3, confirmed the medications in the cup on the Resident #32's table was seven (7) tablets, which included one Multivitamin tablet, one Protonix DR 40 milligram (mg) tablet, one Aspirin (ASA) 325 mg tablet, one Klor Con (potassium) tablet, Metoprolol 25 mg one half tablet, one Colestipol HCL 1 gram (GM) tablet, and one Citalopram HBR 10 mg tablet. On 07/01/19 at 3:25 PM, an interview with the Director of Nursing (DON) revealed, "She is not assessed to be able to self-administer her meds. No, she should never have left the meds at the bedside. Her Brief Interview for Mental Status (BIMS) score is not high enough to even be considered for self administration of meds". Review of In-service Training, dated 08/08/18, instructed by the DON, revealed, "Title and Detailed Content of Inservice: Medication Administration Guidelines - see attached policy *Emphasis on medication administration times, administering correct dose as ordered, crush meds guidelines, revealed that LPN #1 attended the in-service on 08/10/18. Review of the Face Sheet for Resident #32 revealed the facility admitted the resident, on 05/06/19, with a diagnosis of Unspecified Dementia without Behavioral Disturbance. Review of the Minimum Data Set (MDS)	F 554	Individual inservices, re-inservice, or disciplinary action up to and including termination of employees, and initiate Quality Assurance and Performance Improvement (QAPI) if warranted. QAPI Committee will make recommendations or changes as needed.	

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F 554	Continued From page 3 Admission assessment, with an Assessment Reference Date (ARD) of 06/14/19, revealed in Section C, the resident had a Brief Interview for Mental Status score of 9, which indicated moderately impaired cognitive skills for daily decision making.	F 554		
F 880 SS=E	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	F 880		7/29/19

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F 880	Continued From page 4 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. 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, and record review, the facility failed to provide care in a manner to prevent the	F 880	F880 Infection Prevention and Control Facility failed to provide care in a manner	

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F 880	Continued From page 5 possible spread of infection as evidenced by the nurse's hair becoming contaminated by making contact with the floor and then the medication cart drawer and top; failed to properly clean a feeding syringe, and perform hand hygiene for two (2) of five (5) residents observed for medication administration, Resident #5 and Resident #30. The facility also failed to properly label a feeding syringe and formula bag for one (1) of four (4) residents receiving enteral feedings, Resident #20. Findings include: Record review of the facility's policy titled, "General Infection Prevention and Control Nursing Policies", dated 06/14, revealed it is the policy of this facility that all nursing activities will be performed in a manner to minimize the potential for infection in residents, staff, and visitors. Review of the facility's policy titled, "Gastrostomy/Nasogastric Tube", Nursing Procedures Section III - G-M, latest revision: 12/18, revealed: Label formula container with resident's name, room, date, starting time, rate at milliliters (ML)/hour and initials of licensed staff preparing formula. All ancillary feeding supplies should also be changed at least every 24 hours or as recommended by the manufacturer. (Flushing syringes, indwelling tube plugs and other multi-use supplies). Formula container and tubing should be used for no longer than 48 hours or per manufacturers' recommendations. Review of the label from the Generica Medical 60 cubic centimeter (cc) Piston Irrigation Syringe with ENFit revealed: Suggested Procedure: 7.	F 880	to prevent the possible spread of infection as evidenced by the nurse s hair becoming contaminated by making contact with the floor and then the medication cart drawer and top; failed to properly clean a feeding syringe, and perform hand hygiene for two (2) of five (5) residents observed for medication administration, resident #5 and resident #30. The facility also failed to properly label a feeding syringe and formula bag for one (1) of four (4) residents receiving enteral feedings, Resident #20. 1. Director of Nursing was notified of the deficient practice by the surveyor on 7/1/2019 and immediately provided individual education regarding management of long hair with Licensed Practical Nurse (LPN) #1 and assured compliance with all licensed nursing staff on duty. Director of Nursing also provided individual education on 7/1/2019 to LPN #2 and LPN #3 regarding infection control practices to include handwashing during medication administration, and tube feeding formula/syringe requirements. The nocturnal licensed nurse who was responsible for the deficient practice of not labeling the tube feeding syringe on 6/30/2019 was also provided individual education by the Staff Development Nurse on 7/2/2019. 2. All fifty-eight (58) of fifty-eight (58) residents that receive direct care by facility staff have the potential to be affected by this deficient practice.	

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F 880	Continued From page 6 Must be changed every 24 hours. Review of the facility's policy titled, "Infection Prevention and Control Employee Health Policy", dated 06/14, revealed all personnel must maintain a high degree of personal cleanliness and must practice hand hygiene before and after having contact with residents, before and after using the restroom, and when otherwise indicated in the daily execution of their duties. Review of the facility's policy titled, "Administering Medications through Nasogastric or Gastrostomy Tube", dated 03/18, instructed nursing to wash hands properly and to clean and store syringe per facility policy. Resident #5 An observation, on 06/ 30/19 at 4:00 PM, revealed Licensed Practical Nurse (LPN) #1 prepared medication pass for Resident #5 by removing wipes out of the bottom drawer of her medication cart. As she was squatting down and reaching into the bottom drawer, her hair, which was in long braids, were resting and sweeping on the floor and in the bottom drawer of the med cart. As LPN #1 continued to prepare for the medication administration for Resident #5, she opened the top drawer to retrieve alcohol wipes and her hair was resting on the top drawer and on the top of the cart. LPN #1 entered Resident #5's room, and when she performed the finger stick, her hair rubbed against the bed and the resident. During an interview, on 07/1/19 at 10:25 AM, the Director of Nursing (DON) revealed the facility did not have a policy related to the length of hair, or	F 880	3. Staff Development Coordinator initiated inservice for remaining nursing staff on 7/2/2019 regarding infection control practices to prevent cross contamination which included management of long hair and handwashing. Inservice also initiated for licensed nursing staff on 7/1/2019 by Staff Development Coordinator regarding proper labeling and management of tube feeding formula and syringe. Upon hire, annually, and as needed, all nursing staff will receive orientation training by the Staff Development Nurse or Director of Nursing regarding infection control practices. Upon hire, annually, and as needed, licensed nursing staff will receive a skills competency evaluation by the Staff Development Nurse on medication administration to include gastrostomy tube procedures. Actively employed licensed nursing staff will have skills competency evaluations annually and as needed by the Staff Development Nurse or Director of Nursing. 4. Director of Nursing, Staff Development Nurse, or pharmacy consultant will monitor tube feeding practices by licensed nurses on various shifts beginning 7/25/2019 at least three (3) times weekly for four (4) weeks, then one (1) time weekly for four (4) weeks. Administrator or Director of Nursing will monitor nursing staff for proper management of hair on various shifts at least three (3) times weekly for four (4) weeks, then one (1) time weekly for four (4) weeks.	

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F 880	Continued From page 7 the need to have long hair pulled back in order to prevent the potential spread of infection. The DON confirmed the nurse's hair resting on the floor, sweeping across the front of the medication cart, in the drawers, and on items in the resident's room, could result in the spread of infection. The DON revealed the nurses should have their hair pulled back. On 7/1/19 at 3:20 PM, an interview with LPN #1 confirmed she was aware her braids did touch the floor, medication drawers, top of medication cart and items in the resident's room. LPN #1 confirmed that her hair could cause a spread of infection to the residents. LPN #1 revealed she pulled her hair back on 07/01/19, because she realized the issue of her hair being a possible cause of infection from the day before. Resident #30 On 06/30/19 at 8:30 AM, an observation of LPN #2 revealed she did not perform any type of hand hygiene prior to medication preparation for Resident #30, during administration of the medication, or after exiting the room and preparing for another resident's medication pass. LPN #2 did not wear gloves while preparing the meds, and placed her bare finger into the pouches, used for crushing medications, and the plastic medication cup. LPN #2 administered medications through the 60 cubic centimeter (CC) syringe and when finished, she separated the syringe, placed the syringe in the plastic bag without washing, rinsing or drying, and hung the bag on the enteral feeding pole at Resident #30's bedside. On 07/01/19 at 10:25 AM, an interview with the	F 880	Director of Nursing or Staff Development Nurse will report any recurring problem to the monthly Quality Assessment and Improvement Committee. Administrator and Director of Nursing will take necessary corrective action such as: Individual inservices, re-inservice, or disciplinary action up to and including termination of employees, and initiate Quality Assurance and Performance Improvement (QAPI) if warranted. QAPI Committee will make recommendations or changes as needed.	

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F 880	Continued From page 8 DON confirmed LPN #2 should have cleaned and dried the syringe used to administer the medications to Resident #30. The DON confirmed that during medication administration, LPN #2 should have washed her hands or used a sanitizer before entering the resident's room, and before exiting the room. The DON confirmed LPN #2 should not put her bare fingers into the medication cups or the plastic bags used to crush medications. The DON confirmed that by not washing her hands during medication pass, placing her fingers in the medication cup, and not cleaning the syringe, could cause the potential spread of infection. The DON revealed the facility provided training to nursing on medication administration and infection control. On 07/01/19 at 2:00 PM, an interview with LPN #2 confirmed she did not wash her hands or use an antibacterial sanitizer on her hands prior to preparing the medications, administering the medications, and before preparing medications for the next resident. LPN #2 revealed she usually does not wash her hands during medication administration, and only washes her hands when she leaves a resident's room. LPN #2 confirmed she may have put her fingers into the medication cup and the plastic bag for crushing medications, but does not remember for sure. LPN #2 revealed she has not been instructed or trained to rinse or dry the syringe after use for medication administration. LPN #2 confirmed that by not washing her hands, cleaning the syringe, and placing her fingers in the medication cup and plastic bag, could cause the spread of infection. LPN #2 revealed the Pharmacy Consultant observed her pass medications about a month ago, but did not watch her administer medications through a feeding	F 880		

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F 880	Continued From page 9 tube. Record review of the Annual Nurse Skills Competency Evaluation, dated 06/11/19, and signed by LPN #2, revealed she was trained in Gastrostomy tube care and infection control/hand hygiene. Resident #20 On 06/30/19 at 11:50 AM, an observation revealed a bag containing a 60 cubic centimeter (cc) syringe was hanging from the Intravenous (IV) pole in Resident #20's room. This bag was not labeled or dated. A bag of Isosource HN enteral formula, with less than 100 milliliter (ml) left in the bag, was hanging and infusing per the resident's gastrostomy tube at 58 milliliters/hour via a feeding pump. This bag was not labeled with the Resident #20's name, room number, infusion rate, starting time, staff initials, or date. At 11:53 AM on 06/30/19, further observation revealed Licensed Practical Nurse (LPN) #3 entered Resident #20's room with a new bag of Isosource. During an interview at this time with LPN #3, she confirmed the Isosource which was infusing was not labeled, and the syringe bag was not dated. She dated the bag that held the syringe with the current date and left it hanging from the pole. She replaced the enteral formula bag. On 06/30/19 at 11:53 AM, an interview with Registered Nurse #1/Supervisor, who was present in the room, confirmed the Isosource enteral formula bag was not labeled with the resident's name, room number, date, starting time, infusion rate, or staff initials. She stated	F 880		

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F 880	Continued From page 10 that the bag should be labeled when hung, and that there was no way to know when it was started. She stated, "There's so much turn over on night shift, I don't know". Review of the Physician Orders for the month of June 2019, revealed the resident had an order for "Isosource HN at 58 cc/hour per Percutaneous Gastrostomy Tube continuously. On 07/01/19 at 3:22 PM, an interview with the Director of Nursing (DON) confirmed the enteral formula bag should have been labeled and dated. She stated the rate should be documented on the label, with an initial. The DON stated that the syringe bag should be dated and initialed, and the syringe should be changed every 24 hours on the night shift. She stated the facility's policy was not followed. The DON stated that LPN #3 should have discarded the syringe because there was no date on it, and she should have replaced it with a new syringe and dated it with the current date. She stated, you don't know how long it was hanging there. That would be an infection control problem. She should have got a new syringe. She also stated that possible consequence of not labeling enteral formula container when it was hung could result in it hanging longer than the recommended time, which is 48 hours. Review of the Face Sheet for Resident #20 revealed she was admitted by the facility, on 01/29/09, with the medical diagnosis of Hemiplegia following Unspecified Cerebrovascular Accident affecting Left Non-dominant Side.	F 880		

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F 000	INITIAL COMMENTS The State Survey Agency (SA) conducted an annual recertification survey along with a complaint survey for CI MS #15795, at the facility from 06/30/19 to 07/02/19. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements for participation and cited F554 and F880. The SA did substantiate CI MS #15795 for quality of care, with no citations related to the complaint. The facility was certified for 60 beds, and had a census of 52 at the time of the survey entrance.	F 000		

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

Electronically Signed — 07/25/2019

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
	255284	A. BUILDING **01 - 0101** B. WING _____	**06/30/2019**

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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 919 SS=D	Electrical Equipment - Other CFR(s): NFPA 101 Electrical Equipment - Other List in the REMARKS section any NFPA 99 Chapter 10, Electrical Equipment, requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 10 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to properly protect electrical junction boxes as per NFPA 70 section 314.28 C. This deficiency affected one (1) of five (5) smoke compartments and 12 of the 52 residents in the facility on the day of survey. Findings include: On June 30, 2019 at 12:15 PM, observation revealed uncovered electrical junction boxes above the ceiling near Room 113 and inside the Kitchen HVAC Closet of the facility.	K 919	K919 Electrical Equipment - Other Facility failed to properly protect electrical junction boxes as per NFPA 70 section 314.28 C. 1. Maintenance Director contacted the Heating Ventilation Air Conditioning (HVAC) contractor, Temperature Control Specialist, on 7/2/2019 and retained a work order to complete the repairs. (Exhibit #15) All uncovered junction boxes have been repaired as of 7/25/2019. (Exhibit #17) 2. All fifty-eight (58) of fifty-eight (58) residents residing in the facility have the potential to be affected by uncovered	7/29/19

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K 919	Continued From page 1	K 919	junction boxes. 3. Maintenance Director s weekly checklist will include monitoring of junction box coverage during weekly checks and following any repairs or additions. (Exhibit #16) 4. Maintenance Director or Administrator will monitor junction box coverage at least one (1) time weekly indefinitely. (Exhibit #16). Maintenance Director will report any recurring problem to the monthly Quality Assessment and Improvement Committee. Administrator will take necessary corrective action to maintenance contractors such as: Individual inservices, re-inservice, or termination of contract, and initiate Quality Assurance and Performance Improvement (QAPI) if warranted.	

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E 000	*Initial Comments* Survey conducted on 06/30/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were cited.	E 000		

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