STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40CH	A. BUILDING: _____ B. WING _____	01/05/2023

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M 000	Initial Comments The State Agency (SA) determined during an annual recertification survey, conducted from Jan 3, 2022 to Jan 5, 2022. The SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm Mississippi regulations.Deficiencies were cited at M 500, M 610, M 615 and M 815. The facility had a census of 88 during the survey and is certified for 99 beds.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his	M 500		2/9/23

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M 500	Continued From page 1	M 500		

medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action;

4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record;

5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal;

6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the

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M 500	Continued From page 2	M 500		

facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law;

7. is free from mental and physical abuse;
8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint;
9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract;

10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs;

11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care;

12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail

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M 500	Continued From page 3 unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level II Based on resident/resident representative and staff interviews, facility policy review, and record review the facility failed to resolve a grievance related to transportation to the dialysis center for	M 500	The facility Plan of Correction is as follows: 1. Resident #25 began wheelchair accessible van transport to Dialysis appointments on 01/05/2023. In-service with all nursing staff on the facility's Policy	

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M 500	Continued From page 4 one (1) of three (3) dialysis residents reviewed. Resident #25. Findings include: Review of the facility policy, titled, "Resident and Family Grievances /Complaints", undated, revealed it is the policy of this facility to support each resident's and family member's right to voice grievances without discrimination, reprisal or fear of discrimination or reprisal. Review of the facility policy titled, "Dialysis Policy", dated 3/21/2022 revealed "....Procedure, the facility will arrange for the residents to receive proper transportation per van or transport service..." An interview, on 01/03/23 at 11:30 AM, with Resident #25 revealed they (the staff) push her in the wheelchair to dialysis. She stated that the van can be outside the facility, and they will push her to dialysis even if it is raining. She stated that she gets wet even with an umbrella. An interview, on 1/4/23 at 5:10 PM, with Director of Nursing (DON) and the Administrator (ADM) revealed that Resident #25's husband had spoken to both of them concerning taking Resident #25 to dialysis in a wheelchair when the weather is bad and rainy. She stated that he felt they needed to build a pavilion over the walkway to the dialysis unit. The DON stated that they use the van if the weather is bad, but when questioned by the State Agency (SA) the DON admitted that they do push the residents in their wheelchairs to dialysis using an umbrella if it is raining. She stated that Resident #25's husband had called her and requested that his wife go by van if the weather is bad. The DON stated that	M 500	and Procedure for transport via van of Residents for Dialysis appointments on 01/11/23. 2. All residents have the potential to be affected. 3. On 01/05/2023 the facility administrator requested permission from the resident council to attend and participate in the council meeting on 01/26/2023. The residents granted the administrator and the Director of Nursing (DON) request to attend. On 01/26/2023, in the resident council meeting, the residents were educated on the grievance process how to report concerns and to report any unresolved concerns to the administrator. The Administrator conducted the resident council meeting as an education for the Activities Director (AD) as well as residents on how to document, report, handle and follow-up to ensure grievances are reported, handled and are resolved to the residents satisfaction. The AD is to discuss in resident council any unresolved grievances from the previous meeting and report them to the Administrator within 24 hours. The grievance forms have been made available to all residents by placing forms in a reachable location for all residents. The forms are located at each nursing unit on counter clearly marked as Grievance Forms and are within easy reach of the residents. Any staff may complete an individual grievance form for a resident, to be given to the Administrator within 24 hours. The Administrator will meet with the appropriate department to determine a resolution. The resolution will be discussed with the resident and the	

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M 500	Continued From page 5 she guessed they could try to schedule the van to be available on dialysis days. The DON stated they have at times shared vans with the senior care facility next door. She stated they do not have a transport service in this city. The DON stated that she referred Resident #25's husband to the Administrator. The ADM confirmed that they probably need to have them (the residents) in a van if the weather is bad. He confirmed that he was sure the residents had probably gotten wet when it was raining outside. He confirmed the residents could get sick due to the exposure. He stated that he had spoken with Resident #25's husband one or two times concerning this issue. The ADM and the DON confirmed this would be considered a verbal grievance. The Administrator stated that he did not have a written record of his conversation with Resident #25's husband. He stated that it had been about two (2) weeks since he talked to the resident's husband and confirmed this issue would be considered an unresolved grievance. The ADM confirmed that their dialysis policy revealed that residents will receive proper transportation per facility van or transport service, but it does not mention anything about wheelchairs. A telephone interview on 01/05/23 at 10:25 AM, with Resident # 25's Resident Representative/husband revealed that he was concerned about his wife being pushed in her wheelchair to the dialysis center when the weather is bad outside. He stated that Resident #25 told him she gets wet going over there when it is raining. She complained about getting cold and her nose getting stopped up. She told him that many times the bus is there, but they won't use it. He stated that he had talked to the Director and the Administrator concerning this. He stated that he suggested that they get together with	M 500	resident will sign when resolution is satisfied as met. Beginning 01/11/2023 and on 01/23/2023 facility staff has been in-serviced by Staff Development Nurse on documenting and handling resident grievances. Resident Grievance forms have been placed on each unit and have been placed in a easily accessible site for residents. 4. Administrator will monitor through resident interviews, at least three (3) interviews weekly x three (3) weeks beginning on 01/16/2023-02/06/2023, then monthly through resident council to ensure that grievances are resolved. Administrator will report findings to the Quality Assurance Performance Improvement (QAPI) committee for review on 02/15/23, for revisions or resolutions to the plan.	

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M 500	Continued From page 6 dialysis and possibly build a covered shed between the two buildings. He stated the Administrator said that he had not thought of that. He stated that he had not heard anything back from the administration and he felt like there could be a danger to his wife especially if it was wet or icy and the nurse aide slipped down. During an observation, on 01/05/23 at 11:14 AM, the Maintenance staff measured the distance down the walkway from the front of the facility to the front of the dialysis building and the distance was 328 feet (109.3 yards). Review of the Order Summary Report for Resident #25 revealed an order dated 9/13/22 for dialysis 3 times a week on Tuesday, Thursday, and Saturday for hemodialysis. Record review of the Admission Record for Resident #25 revealed she was admitted to the facility on 8/31/2022 with diagnoses of End stage Renal Disease, Dependence on Renal Dialysis, Hemiplegia and Hemiparesis following Cerebral Infarction, Diabetes Type 2, and anxiety disorder. Review of Section C of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/2/22 revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated Resident #25 was cognitively intact.	M 500		
M 610	45.21.2 Activities of daily living Activities of daily living. Each resident shall receive assistance as needed with activities of daily living to maintain the highest practicable well being. These shall include, but not be limited to:	M 610		2/9/23

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M 610	Continued From page 7 1. Bath, dressing and grooming; 2. Transfer and ambulate; 3. Good nutrition, personal and oral hygiene; and 4. Toileting. This Statute is not met as evidenced by: Level II Based on observations, staff interview, record review and facility policy review, the facility failed to ensure residents who were dependent on staff for nail care received those services as evidenced by long, jagged nails on two (2) of nineteen residents reviewed. Resident #11 and Resident #61. Findings include: Review of the facility policy titled, "Fingernails/Toenails, Care of" with a revision date of 03/21/22 revealed "Policy ...The purposes of this policy is to clean the nail bed, to keep nails trimmed, and to prevent infections...Procedure ...6. Nail care includes daily cleaning and regular trimming; 7. Proper nail care can aid in the prevention of skin problems around the nail bed 8. Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin". Resident #11 An observation on 01/03/23 at 11:40 AM, revealed Resident #11 sitting up in his wheelchair in his room. This observation revealed the resident is non-verbal but acknowledged when he was spoken to and held up his right hand and	M 610	The facility plan of correction is as follows: 1. Resident #11 and #61 had nails trimmed and filed on 1/6/22. All residents nails were inspected and trimmed/filed as needed by 1/12/22. Licensed Practical Nurse #2 had a one on one in-serviced on the correct policy and procedure for nail management of all residents. Nail care for resident #11 was provided by Licensed Practical Nurse #2. 2. All residents have the potential to be affected. 3. The Staff Development Nurse in-serviced nursing staff 01/11/2023 on Policy and Procedure for trimming/filing nails as needed. 4. The Director of Nursing (DON), RN Supervisor or Staff Development Nurse will observe nails for six (6)) resident twice weekly beginning 01/09/23-02/09/23, then continue monitoring x 3 months to ensure that nails are clean and trimmed. The DON will report findings to the Quality Assurance Performance Improvement committee on 02/08/23 then monthly 03/09/23-05/09/23 for review, revision and resolution to the plan.	

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M 610	Continued From page 8	M 610		

showed his thumb nail and used his other fingers on his right hand to rub his long, uncut thumb nail. The observation revealed the resident then held up his left thumb and showed his left thumb nail was long, uncut and the resident's right ring finger and little fingernails on both hands were long, uncut, and jagged.

An observation on 01/04/23 at 11:00 AM, revealed Resident #11 lying in bed with nails long, uncut, and jagged to hands bilaterally.

An observation and interview on 01/04/23 at 11:10 AM, with Licensed Practical Nurse (LPN) #2 revealed it is the responsibility of the 3 PM-11 PM shift Certified Nursing Assistants (CNAs) to do the nail care. LPN #2 confirmed that the resident's nails were long and jagged and needed to be trimmed and filed. She revealed the purpose for keeping the resident's nails trimmed were to prevent injury and a skin tear.

Record review of Resident #11's Admission Record revealed the resident was admitted to the facility on 06/09/05 with medical diagnoses that included Hemiplegia and Hemiparesis following Cerebral infarction affecting left non-dominant side.

Record review of Resident #11's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) dated 11/28/22, revealed in Section C a Brief Interview for Mental Status (BIMS) with no score which indicates the resident is severely cognitively impaired and in Section G revealed the resident is totally dependent on staff for personal hygiene.

Resident #61

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M 610	Continued From page 9 An observation on 01/03/23 at 12:50 PM, revealed Resident #61 lying in bed with hands drawn inward bilaterally with long, uncut, fingernails. An observation on 01/04/23 at 8:53 AM, revealed Resident #61 lying in bed with hands in splints and long, uncut, fingernails. An interview and observation on 01/04/23 at 11:05 AM, with CNA #3 revealed it is the responsibility of the 3 PM-11 PM shift CNAs to complete nail care. She confirmed that Resident #61's nails were too long and needed to be trimmed and stated that she started working on the north end hallway yesterday and noticed that her nails were long and uncut, but she did not trim them or say anything to Resident #61's nurse. An observation and interview on 01/04/23 at 11:25 AM, with LPN #3 revealed she is Resident #61's nurse and confirmed that the resident's nails are too long and needed to be trimmed because she has bilateral hand contractures, and the nails could dig into her skin and cause an injury. Record review of Resident #61's Admission Record revealed the resident was admitted to the facility on 03/17/21 with medical diagnoses that included Need for assistance with personal care. Record review of Resident #61's Minimum Data Set with an Assessment Reference Date (ARD) of 10/13/22 revealed in Section G that the resident is totally dependent on staff for personal hygiene and bathing and in Section C revealed a BIMS score of 05, which indicates the resident is severely cognitively impaired.	M 610		

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M 610	Continued From page 10 An interview on 01/04/23 at 11:45 AM, with the Director of Nurses (DON) confirmed that it is the responsibility of the 3 PM-11 PM shift CNAs to do nail care unless the resident is a diabetic or they are having a challenge and if they are then they are to notify their nurse. She revealed that completed nail care is not documented anywhere but is expected to be done with baths and the trimming should be addressed at least once per week. She revealed the reason that nails need to be trimmed is to prevent injury and infection.	M 610		
M 615	45.21.3 Pressure sores Pressure sores. Residents with a pressure sore shall receive necessary treatment and service to promote healing and prevent the development of new pressure sores. Residents without pressure sores will not develop pressure sores unless the residents' clinical condition indicates they were unavoidable. This Statute is not met as evidenced by: Level III Based on observation, staff interview, record review and facility policy review, the facility failed to perform physician ordered weekly body audits as evidenced by two (2) high risk residents developing an avoidable facility acquired pressure ulcer for two (2) of 10 residents with pressure ulcers reviewed. Resident #32 and Resident #67. Findings include: Record review of the facility policy titled, " Instructions For Pressure Wound Documentation and Photographing Procedure for Wounds Via PCC (Point Click Care) Skin/Wound APP with a	M 615	The facility plan of correction is as follows: 1. Resident #32 had body audit done on 1/4/22 then weekly. Resident #67 had body audit done 01/08/22 then weekly. 2. All residents have the potential to be affected. 3. The Director of Nursing in-serviced the licensed nurses 01/11/2023 on policy and procedure for completing body audits weekly. Body audits are being done weekly per the assigned nurses. The Director of Nursing (DON), Staff Development Nurse or Wound Care Nurse will review nine (9) records twice weekly 01/09/23 - 02/08/23 then monthly	2/9/23

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M 615	Continued From page 11 revision date of 09/07/22" revealed "...8. Review body audits daily to ensure they are completed as scheduled. This can be completed as you review your dashboard daily". Resident #32 An observation on 1/3/23 at 11:05 AM, revealed Resident #32 lying in bed, Heel protectors to bilateral feet. An interview on 1/4/23 at 11:00 AM, with the Treatment Nurse confirmed that Resident #32 had a facility-acquired pressure ulcer to her left heel that was discovered on 12/9/22. She confirmed that it was a suspected deep-tissue injury. The Treatment Nurse revealed she had already done the treatment for today but did show the pressure ulcer to the SA. SA observed a dry, blackened area with no opened areas to left heel. An interview on 1/4/23 at 12:25 PM, with Licensed Practical Nurse (LPN) #1 confirmed that weekly body audits are to be completed on all residents. She revealed that the body audit for Resident #32 was to be completed by the day shift nurse. She confirmed that there were no body audits completed for Resident #32 since 9/5/22 and Resident #32 has a deep tissue injury to her left foot. An interview on 1/04/23 at 2:50 PM, with Certified Nurse Assistant (CNA) #1 revealed that she has been assigned Resident #32. She stated "if we notice any skin issues with our residents, we are to notify the nurse. When I put her back in bed today, I put her heel protectors on, but I don't think she has any sores on her feet." An interview on 1/4/23 at 3:17 PM, with the	M 615	03/09/23-05/09/23 x 3 months to ensure body audits are being completed as ordered. 4. All residents had body audits completed by 1/12/22 and will have body audits done weekly. The Director of Nursing will bring findings to Quality Assurance Performance Improvement committee on 02/08/23 then monthly 03/09/23-05/09/23 for review x 3 months, revisions and resolutions to the plan, and evaluation of the plan as a sustainable solution.	

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Director of Nurses (DON) confirmed that each resident is to have a weekly body audit and that Resident #32 had not had a body audit since 9/5/22. The DON confirmed the suspected deep tissue injury was facility acquired and if the weekly body audits were being completed as they should have been, this wound could have possibly been prevented.

An interview on 1/5/23 at 03:40 PM, with Registered Nurse (RN) #1 revealed the resident had a stroke in 2019 and was readmitted to the facility. She revealed that the Skin at Risk score was 14, and the resident was at high risk for skin breakdown. Registered Nurse #1 confirmed the only order in place at that time was for the resident to be turned every two hours.

A record review of the last weekly body audit completed dated 9/5/2022 revealed there were no skin issues or wounds present. Preventative interventions ...Turn every two hours.

A record review of the Skin & Wound Evaluation effective date 12/9/22 revealed the type of wound was Pressure, the stage was Deep Tissue Injury: Persistent nonblanchable deep red, maroon or purple discoloration. Location, Left Heel. In-house acquired. Wound measurements Area 11.8 centimeters (cm), Length 4.3 cm, Width 3.7 cm.

A record review of Resident #32's Admission Record revealed the resident was readmitted to the facility on 10/29/19 with diagnoses of Cerebral infarction, Hemiplegia, and Hemiparesis affecting left non-dominant side, Type 2 Diabetes Mellitus and Hypertensive heart disease.

A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of

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10/6/22 revealed Resident #32 had a Brief Interview for Mental Status (BIMS) score of 8, which indicated the resident was moderately impaired.

Resident #67

An observation on 01/03/23 at 11:52 AM, revealed Resident #67 sitting up in her reclining wheelchair in the day room.

An observation on 01/04/23 at 4:02 PM, with the Treatment Nurse revealed a Stage 3 pressure ulcer to Resident #67's left heel with scar tissue and no drainage noted.

An interview on 01/04/23 at 3:33 PM, with Licensed Practical Nurse (LPN) #3 confirmed that the LPN's are assigned the weekly body audits on the residents. She revealed it is triggered on the Electronic Treatment Administration Record (ETAR) and there is also an electronic form that has to be completed. She does not recall whether she ever was assigned Resident #67, but when she does a body audit, she takes the resident's clothes off and checks from head to toe for any skin issues.

An interview on 01/04/23 at 4:15 PM, with the Treatment Nurse confirmed that Resident #67 currently has a facility acquired Stage 3 pressure ulcer to her left heel that was discovered on 07/22/22 as a Stage 2. She revealed that it is the responsibility of the LPN on the hall to do the resident's body audit's weekly. She stated the only preventative measure the resident had in place prior to the development of this pressure ulcer was turning and repositioning every two hours. She reported that in hindsight preventative measures being put into place prior to the

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development of this pressure ulcer might have prevented the development of it. She revealed that if the body audits would have been done weekly like they are supposed to then the pressure ulcer could have been discovered at an earlier stage.

An interview on 01/04/23 at 4:30 PM, with the DON confirmed that Resident #67 has a facility acquired pressure ulcer to her left heel and a right leg amputation. She revealed that weekly body audits are supposed to be performed by the LPN's assigned to that resident. She revealed that this resident was in the hospital from around the first of May and returned to the facility on 6/3/22. She revealed that the re-admission body audit did not show any issues with the resident's left foot or heel. She confirmed the resident did not get a weekly body audit after her re-admission to the facility on 6/3/22 but received one on 7/22/22 and that was when the pressure ulcer to her left heel was discovered. She confirmed that the resident did not have any preventative measures in place besides being turned or repositioned every two hours prior to the development of the pressure ulcer. She revealed that the resident only had one foot and should have had preventative measures in place to protect the left foot prior to the development of the current pressure ulcer. She confirmed that if the resident would have had her weekly body audits, then the pressure ulcer might have been discovered earlier.

An interview on 01/05/23 at 2:30 PM, with LPN #2 confirmed that weekly body audits are supposed to be completed on all residents to make sure they have no skin issues and different nurses, and different shifts are assigned the body audits. She revealed that the body audits are

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documented as complete on the ETAR and a form titled "Weekly Body Audit" is completed on the computer and would be under "miscellaneous" on the resident's electronic record. During this interview, LPN #2 reviewed Resident #67's "miscellaneous" section in the resident's electronic record and confirmed that no weekly body audits were documented on Resident #67 from 6/4/22 until 7/21/22. She revealed she has no idea why this resident would not have had a weekly body audit completed, but should have.

An interview on 01/05/23 at 5:00 PM, with the Treatment Nurse revealed she had not been made aware of the MDS skin assessments that indicated that Resident #67 was at high risk for pressure ulcers.

Record review of Resident #67's Admission Record revealed the resident was admitted to the facility on 02/11/22 with medical diagnoses that included Type II Diabetes and Acquired absence of the right leg below the knee.

Record review of Resident #67's Order Summary Report revealed the following orders:
02/11/22 Weekly body audits per assigned nurse on Fridays, in the morning every Friday. This review revealed there were no pressure ulcer preventative orders noted.

Record review of Resident #67's electronic record for 06/22 and 07/22 revealed there were no Weekly Body Audits documented between 06/4/22 and 07/21/22, and from 07/25/22 to 12/7/22. This review revealed that the Left heel pressure ulcer measurements on 7/25/22 were 4.0 cm x 5.0 cm x 0.0 cm indicating it was a Stage 2 and the measurements on the Weekly

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M 615	Continued From page 16 Wound Observation Report dated 12/7/22 were 5.0 cm x 6.5 cm x 0.1 cm indicating it was a Stage 3. Record review of Resident #67's Minimum Data Set (MDS) assessments revealed an assessment on 9/8/22 that indicated the resident had a Stage 2 pressure ulcer with no measurements noted and on the 9/14/22 MDS assessment it indicated the resident had a Stage 3 with no measurements noted. Record review of Resident #67's Progress Notes revealed the resident was re-admitted to the facility on 6/3/22 after a stay in the hospital. This review revealed that the resident did not have any issues related to the left heel on re-admission. Record review of Resident #67's Weekly Body Audits (V3.1-V4) revealed an audit dated 07/22/22 that indicated the resident had a Stage II pressure ulcer to her left heel. Record review of Resident #67's Skin and Wound Evaluation (V5.0) audits included the following measurements: 07/22/22 4.0 cm x 5.0 cm x 0.0 cm no drainage Stage II. Record review of Resident #67's Minimum Data Set with an Assessment Reference Date of 10/18/22 revealed in Section C a Brief Interview for Mental Status of 05, which indicates the resident is severely cognitively impaired and Section M revealed the resident has an unhealed Stage 3 pressure ulcer.	M 615		
M 815	45.29.1 Safe Food Handling Procedures	M 815		2/9/23

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M 815	Continued From page 17 Safe Food Handling Procedures. Food shall be prepared, held, and served according to current Mississippi State Department of Health Food Code Regulations. This Statute is not met as evidenced by: Level II Based on observation, staff interview, facility policy review, and record review the facility failed to prevent the possibility of food borne illness as evidenced by improper thawing of raw chicken, improper storage of two (2) bags of opened flour, and black substance on the inner door panel of the ice machine. This had the potential to affect 77 of 88 residents who receive food or ice from the kitchen. Findings include: Record review of Facility Policy dated for 02/11/2022 titled, "Food Service Operational Standards For Purchasing, Receiving, Cooking and Storage of Food", revealed "Policy: "The facility receives, stores, prepares, distributes and serves food under sanitary conditions to prevent the spread of food borne illness and to reduce those practices that result in food contamination and compromised food safety...Procedure...3. Storage...b. Foods should be stored above the floor....d. Keep foods in leak proof, non-absorbent, sanitary wrapping...4. Thawing...b. If time and space do not allow for refrigerator thawing, thaw frozen foods under potable (drinkable), running water at a temperature of 70 degrees or lower..." Record review of Facility Policy, "Ice Machine Maintenance and Cleaning" dated 06/06/2022 revealed "Policy: The facility ice machine will be	M 815	1.) On January 6th, 2023, The Dietary Manager and Maintenance Supervisor emptied the ice machine located in the Kitchen and deep cleaned the inside holding area. An in-service was done at this time with the Administrator, Dietary Manager and Maintenance Supervisor regarding Ice Machine Cleaning Policy. On January 11th, 2023, the Dietary Manager turned on the water over the pan of frozen, raw chicken that was in sink as to completely submerge under potable water at 70 degrees or below with sufficient water pressure to remove loose food bits into the drain. All Dietary Workers were promptly in-serviced on the facility policies title Thawing Foods and Food Service Operational Standards for Purchasing, Reviewing, Cooking and Storage of Foods on January 11th, 2023. 2.) The Facility has determined that all residents who consume food and liquids by mouth have the potential to be affected. 3.) On January 25th, 2023, the Dietary Manager in-serviced all dietary staff on the facility policies titled Thawing Foods and Food Service Operational Standards for Purchasing, Reviewing, Cooking and Storage of Foods The Dietary Manager will continue to in-service all dietary staff	

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M 815	Continued From page 18 deep cleaned and sanitized once every six months and cleaned with bleach solution weekly..." On 01/03/23 at 10:35 AM, an observation during the initial kitchen tour revealed 14 raw chicken wings thawing in one side of the two (2) compartment sink. The chicken wings were submerged in a sink full of water and no water was running over the chicken to thaw it out. The observation also revealed 2 opened, twenty-five-pound bags of flour in the dry storage room. The top of each bag of flour was rolled down and was not sealed shut. One bag of flour with about five (5) pounds remaining inside, was located directly on the floor, and was not dated. The other bag of flour with approximately 20 pounds remaining, was dated, and was located on the bottom shelf about a foot off of the floor. On initial tour of the kitchen, the State Agency (SA) also observed a black substance, numerous spots about the size of a pencil eraser, scattered along the inner door panel of the ice machine and about eight (8) black spots located along the right inner gray side panel just inside the machine. On 01/03/23 at 10:40 AM, an interview with the Dietary Manager (DM) confirmed that raw chicken was not supposed to be thawed with water that was not running continuously. The DM revealed that the raw chicken was not being thawed correctly and could cause residents to get sick. The DM revealed that he had completed in-services with the employees on proper food handling, thawing, and storage of food. The DM also confirmed that the two sacks of self-rising flour should have had dates on them and should have been stored in a storage container with a lid to prevent exposure to possible contaminants.	M 815	monthly x3 months beginning in February 2023, on hire, annually and as needed on food safety policies and precautions in accordance with professional standards for food service safety. Beginning January 11th 2023, the Dietary Manager will monitor dietary staff for proper thawing procedures weekly x3 months or until consistent substantial compliance is met to ensure food safety. In addition, Beginning January 11th 2023, the Dietary Manager and Administrator will monitor the cleanliness of the ice machine and the kitchen and storage areas to ensure no items are left on the floors weekly x 3 months or until consistent substantial compliance is met to ensure food safety. The Facility has also contacted our Dietary Manager Consultant to be in the building 1 day a week for the months of January 2023 and February 2023, starting on January 10th, 2023 to mentor the Dietary Manager. 4.) Beginning January 11th 2023, the Dietary Manager and Administrator will monitor the cleanliness of the ice machine and the kitchen and storage areas to ensure no items are left on the floors weekly x 3 months or until consistent substantial compliance is met to ensure food safety. The Facility has also contacted our Dietary Manager Consultant to be in the building 1 day a week for the months of January 2023 and February 2023, starting on January 10th, 2023 to mentor the Dietary Manager. Beginning February 8th, 2023, the Dietary Manager and Administrator will bring any adverse findings to the monthly Quality	

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M 815	Continued From page 19 On 01/03/23 at 10:45 AM, an interview with the DM revealed that the black substance in the ice machine could be dirt or mold and that this could cause the residents to get sick. He also revealed that he cleaned the ice machine a week or two ago and that there was no certain person responsible for this task. The DM could not produce a cleaning schedule for the ice machine when asked for by the SA. On 01/03/23 at 10:50 AM, the SA observed the DM disposed of the bag of flour that was stored on the floor and the 14 chicken wings that were improperly thawing. On 01/05/23 at 11:00 AM, an interview with Administrator (ADM) revealed that he was the Supervisor who was directly over the DM. ADM also confirmed that the opened bags of flour could cause contamination which could make the residents sick. ADM stated that he would order a storage container with a lid to fix this issue. The ADM also confirmed that the black substance seen in the ice machine could have been mold which could cause the residents to get sick and their policy was to have the ice machine cleaned on a regular basis. On 01/05/23 at 11:40 AM, an interview with Dietary Aid #2, revealed that they received training on food handling, food thawing, and food storage when hired and that they were required to attend in-services monthly with DM. Dietary Aid #2 confirmed that the in-services were held in-person, topics were discussed verbally by DM and that the kitchen/dietary staff had to sign when completed. On 01/05/23 at 2:00 PM, an interview with Assistant Director of Nursing (ADON), revealed	M 815	Assurance Committee meeting for a period of three (3) months or until such time consistent substantial compliance has been met. Any issues found will be discussed for further recommendations and oversight.	

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M 815	Continued From page 20 that there had been no recent facility outbreaks of food borne illness and no significant stomach issues. ADON confirmed that the brown substance in the ice machine could have been mold and that this could cause sickness throughout the residents in the facility. ADON also confirmed that the chicken wings thawing in the sink without running water could cause Salmonella or other illnesses to the residents and that this was unacceptable.	M 815		