STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255342	A. BUILDING _____ B. WING _____	03/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MS CARE CENTER OF RALEIGH	309 MAGNOLIA DR/HIGHWAY 35 SOUTH RALEIGH, MS 39153

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey, at the facility, from 03/03/2020 to 03/06/2020. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid. The SA cited the regulatory deficiency at F812. At the time of the survey, the facility had a census of 110, and held a license for 116 beds.	F 000		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review it was determined the facility failed to serve food in a safe and sanitary condition to	F 812	1. (a) The Administrator had a one on one conference with Dietary Manager on the overall operation and management of	4/10/20

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

Electronically Signed | 04/24/2020

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F 812	Continued From page 1 prevent the possible spread of infection and contamination, during one (1) of two (2) kitchen observation. The identified concerns placed all residents receiving food/nourishment from the kitchen at risk for foodborne illnesses. Findings include: A review of the facility's "Food Service Operational Standards For Purchasing, Cooking and Storage" policy, undated, revealed: "This facility 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." Avoid overloading cooking surfaces. Wash, rinse, and sanitize all equipment and utensils before and after each use. Review of the facility's "Hand Washing Policy," undated, revealed, handwashing would be done by all staff throughout their shift, and to reduce the transmission of organisms from resident to resident, and from the staff to the resident. A review of the facility's "Cleaning and Sanitizing Equipment" policy, undated, revealed: "All equipment is kept clean and food contact surfaces are cleaned and sanitized. Remove food and soil from under and around the equipment. Remove detachable parts and manually wash, rinse, and sanitize or run through dish machine. Allow to air dry. Wash and rinse fixed food contact surfaces, then wipe or spray with a chemical sanitizing solution." Review of the facility's training record, titled "Safety and Dietary Procedures", dated	F 812	her Dietary Department and her responsibilities to ensure all job duties of her employees are carried out on a daily basis according to the State and Federal Regulations on March 5, 2020. (b) The oven was cleaned on March 4, 2020. (c) The frequency of cleaning the oven has been changed from monthly to weekly on March 8, 2020. 2. All residents have the potential to be affected by the deficient practice of preparing, distributing and serving food in accordance with professional standards for food service safety. 3. (a) An in-service was conducted for all Dietary employees by the Quality Assurance Nurse on March 12, 2020 on Employee Sanitation Practices, Cleaning and Sanitizing Equipment, Production Storage and Dispensing of Ice, Proper Hand Hygiene and Avoiding Cross Contamination within the department. (b) An in-service was also conducted by Registered Dietitian on March 19, 2020 on Hand Washing Importance and Technique. (c) The Registered Dietitian will make Sanitation Rounds monthly of the dietary department and document negative findings in her report. 4. (a) The Quality Assurance nurse will audit the Dietary Department staff for proper employee hand washing, donning of gloves, use of hair nets, proper handling of ice, cleaning of equipment,	

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F 812	Continued From page 2 02/26/2020, revealed the dietary staff was in-serviced on Food Storage, Food Preparation, Food Service/Sanitation, Safety, Food Temperature and other Safety Measures, which included cross contamination, handwashing, cleaning surfaces and proper refrigeration of leftovers. A review of the facility's "Employee Sanitation Practices" policy, undated, revealed, gloves are worn to protect food by creating a barrier between the hands and food. Gloves should be changed as soon as they become soiled or torn and before beginning a different task. An observation, during the initial tour of the kitchen, on 03/03/2020 at 9:15 AM, revealed the conventional oven was dirty with build-up of food on the inside walls of the oven. The aluminum foil, in the bottom of the oven, was dirty with food build up. The two (2) small ovens had food build up on the inside walls and on the aluminum foil in the bottom of the ovens. The door of the oven had food build up on it as well. During an interview, on 03/03/2020 at 9:35 AM, the Dietary Manager (DM) stated that all the ovens were dirty. The DM stated she had a schedule for when the ovens are supposed to be cleaned, and they were apparently not cleaned according to the schedule. The DM stated the food build-up on the ovens looked to be from several days of cooking. A review of the "Cleaning Schedule #1", dated February 2020-March 01, 2020, revealed the small ovens were initialed as being last cleaned on February 27, 2020. The large oven was initialed as being last cleaned on February 29,	F 812	and observing for cross contamination. The audits begin on March 11, 2020 and will be done two times weekly for four weeks, then one time weekly for two weeks and two times monthly for two months. (b) Audit report findings will be given to the Administrator after each audit is completed for immediate follow-up on any negative findings. (c) The Quality Assurance nurse will report her audit findings to the Quality Assurance Performance Improvement Committee quarterly for review and to make recommendation and/or changes as needed to ensure continued compliance.	

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F 812	Continued From page 3 2020. During an observation, on 03/04/2020 at 10:56 AM, Dietary Worker #2 knocked a piece of white sandwich bread, that was in a paper sleeve, off of a serving cart onto the floor. Dietary Worker #2 picked the sleeve with the piece of bread in it, up off the floor, and placed it back on top of the cart with the other pieces of sandwich bread in sleeves. The sleeve with the piece of bread that had fallen to the floor, was taken off of the cart; however, the other sleeves of bread were served to the residents. Dietary Worker #2 did not remove her gloves or wash her hands after picking the sleeve of bread off the floor and placing it back onto the cart. Dietary Worker #2 went back to the food serving line, wearing the same gloves that she used to pick the bread up off the floor. During an observation, on 03/04/2020 at 11:02 AM, the Dietary Manager (DM) was assisting Dietary Worker #3 in calibrating the thermometer to check food temperatures. The DM, without wearing gloves, picked up the foam cup that was being used for calibration, went to the ice maker and dipped the foam cup into the ice machine to obtain more ice. During an interview on, 03/04/2020 at 11:04 AM, the DM stated that she used the foam cup to obtain ice from the ice machine, instead of using the scoop. The DM stated she shouldn't have done it, and that it was contamination. The DM revealed they did not discard the ice from the ice machine, nor did they clean the ice machine. During an interview, on 03/04/2020 at 11:06 AM, Dietary Worker #2 confirmed she picked up the	F 812		

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F 812	Continued From page 4 paper sleeve containing the piece of sandwich bread, from the floor and placed it back on top of the cart with the other sleeves of bread. Dietary Worker #2 stated she was not supposed to do that. Dietary Worker #2 stated she should have thrown it away. Dietary Worker #2 revealed she threw the sleeve of bread away, but it was after she had sat it on the other sleeves of bread, on the cart. Dietary Worker #2 stated they still served the other sleeves of bread to the residents for lunch, and they should have thrown it away. On 03/04/2020 at 11:29 AM, during an interview, the Dietary Manager (DM) stated that she saw Dietary Worker #2 drop the sleeve, with the piece of bread in it, pick it up, and put it on top of the cart with the other sleeves containing the bread. The DM confirmed she saw Dietary Worker #2 throw away the sleeve of bread that had fallen on the floor, but it was after she had placed the contaminated bread back on the cart. The DM stated she told Dietary Worker #2 not to put it back on the cart, but she did it anyway. The DM stated what Dietary Worker #2 had done was contamination. She stated that Dietary Worker #2 should have discarded the whole cart of bread, after she laid the contaminated bread back onto the cart. During an interview, on 03/04/2020 at 1:25 PM, the DM stated that it was ultimately her responsibility to make sure the equipment was cleaned as scheduled. The DM stated that it was also her responsibility to make sure that the contaminated food was not served. On 03/06/2020 at 9:14 AM, during an interview, with the DM, revealed she saw Dietary Worker #2 go back to the serving line, without washing her	F 812		

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F 812	Continued From page 5 hands and changing gloves, after picking the bread up off of the floor. During an interview, on 03/06/2020 at 11:47 AM, the Administrator stated that she considered it an infection control issue, with the staff not following the cleaning schedule for cleaning the oven and back splash on the oven. The Administrator stated the Dietary Manager getting the ice from the ice machine without gloves on, and without using the scoop, was an infection control issue. She stated that the Dietary Manager not washing her hands and changing gloves, after picking the bread up off the floor, and before returning to the serving line, was an infection control issue. The Administrator stated Dietary Worker #2 should not have placed the bread back on the cart. She stated the tray of bread, on the cart, should have been discarded since it was contaminated, and fresh bread should have been brought out to be served. The Administrator stated Dietary Worker #2 contaminated the other bread on the serving cart, when she placed the bread that was picked up off of the floor, back onto the serving cart. A review of the facility's training record, dated 02/26/2020, revealed the Dietary Manager and Dietary Worker #2 were in-serviced on Food Safety and Dietary Procedures.	F 812		

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	255342	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/05/2020**

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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 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and	K 918		4/10/20

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Electronically Signed | 05/21/2020

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K 918	Continued From page 1 separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on document review, the facility failed to properly test the emergency generator as per NFPA 110 section 8.4.1. The deficient practice affected the entire facility on day of survey. Findings include: During document review on 3/5/2020 at 10:35 AM, the documentation revealed the generator was load tested for 10 minutes monthly load tests for the year of 2019 and 1st quarter of 2020. The generator shall test run for 30 minutes during a monthly load test.	K 918	1. Administrator met with Maintenance staff to discuss generator full load test. Full load test must be for 30 minutes during a monthly load test. 2. All residents have the potential to be affected by deficient practice. 3. Maintenance staff will test run the generator for 30 minutes during a monthly load test. Q. A. Nurse will monitor full monthly test load of the generator for 4 months. Documentation of the full load will be documented on the Generator Test Log. Log will indicate the start time of the test and the time the test was completed. 4. Maintenance Director will present copies of the Generator Test Log to the Safety Committee monthly and the QAPI Committee quarterly to ensure continued compliance.	

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E 000	Initial Comments ********** Survey conducted on 03/05/20 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were cited.	E 000		

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