STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255304	A. BUILDING _____ B. WING _____	12/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NICHOLS CENTER	1308 HIGHWAY 51 NORTH MADISON, MS 39110

(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 conducted an annual recertification survey along with a complaint, CI MS #00016357 from 12/2/19 to 12/4/19. The SA substantiated CI MS #00016357 for misappropriation of property with no citations related to the complaint. During the survey, the SA determined the facility was not in compliance with the requirements of participation for Medicare and Medicaid. The SA cited F656, F657, F658 and F812. The census at the time of the survey was 55, and the facility was licensed for 60 beds.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).	F 656		1/4/20

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

Electronically Signed | 12/23/2019

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 656	Continued From page 1 (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on facility policy review, staff interview, and record review, the facility failed to develop a comprehensive care plan related to medications for two (2) of 18 care plans reviewed, Resident #24 and Resident #11. Findings include: Review of the facility's "Care Plans" policy, not dated, revealed each resident will have a plan of care to identify problems, needs and strengths that will identify how the interdisciplinary team will provide care. Responsibility: All members of the interdisciplinary team. Monitored by the MDS (Minimum Data Set) and Director of Nurses. Procedures included: The care plan will be reviewed and revised at quarterly intervals in	F 656	Tag F 656 1. Immediate action taken for the residents identified in the survey as resident #11, and resident # 24 was to review their care plans by the MDS Coordinator on 12/4/19 and to update them at that time. Resident's # 11's care plan was updated to include the cardiovascular diagnoses and related medications. Resident # 24's care plan was updated to include Eliquis and the interventions related to the anticoagulant medication. 2. The facility determined that all residents have the potential to be affected by this practice. 3. Actions taken/systems put into place	

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F 656	Continued From page 2 conjunction with the completion of MDS assessments (quarterly, significant change, annual) and with changes in resident's condition as needed. Upon a change in condition, the care plan will be updated or an initial care plan will be initiated. Resident #11 Review of Resident #11's diagnoses included Primary Pulmonary Hypertension, Essential Hypertension, Chronic Systolic Heart Failure, and Chronic Atrial Fibrillation. Review of the physician's orders revealed an order, dated 11/19/19, for Warfarin 3 Milligrams (mg) on Monday, Wednesday, Friday, Saturday and Sunday due to Atrial Fibrillation; and, Warfarin 2 mg on Tuesday and Thursday due to Atrial Fibrillation. An order, dated 9/26/17, for Nifedipine ER (Extended Release) 30 mg take 2 tablets daily for Hypertension. An order, dated 2/19/19, for Furosemide 20 mg daily for Heart Failure. An order, dated 9/26/17, for Lisinopril 10 mg twice daily due to Hypertension, and an order, dated 9/26/17, for Sildenafil 20 mg 3 times daily due to Hypertension. Review of the comprehensive care plan for Resident #11 revealed no care plan was developed for the cardiovascular diagnoses or medications. On 12/03/19 at 12:31 PM, an interview with Registered Nurse (RN) #1/Minimum Data Set (MDS) Coordinator confirmed there was no care plan developed for Resident #11 related to cardiovascular diagnoses or medications. RN #1 revealed she does not know why there was not a	F 656	to reduce the risk of future occurrence The nursing staff began conducting a 100 % audit of all resident care plans on 12/5/19 and is to be completed by January 4, 2020, to ensure that all medications and diagnosis are care planned. The process is overseen by the Director of Nursing. The MDS Coordinator will print and review new orders for residents each day to ensure that all of the new orders are care planned to include diagnosis and medications pertinent to the resident's care. This review and updating started on 12/5/19 and will continue going forward each day. 4. How the corrective actions will be monitored to ensure the practice will not reoccur: The Administrator, and or Director of Nursing, will conduct a sample of 10 resident's care plans per week, beginning 12-26-19, to review to assure that all care plans are updated according to the plan. Any variance to the plan will be addressed immediately in QAPI.	

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F 656	Continued From page 3 care plan, she thought there had been one developed. RN #1 revealed there should be a care plan developed for any medications and diagnosis. Resident #24 Review of the comprehensive care plan for Resident #24 revealed no care plan developed for the medication Eliquis and its potential side effects. Review of Resident #24's physician's orders revealed an order, dated 1/19/19, for Eliquis 2.5 mg tablet take one tablet by mouth twice daily for Paroxysmal Atrial Fibrillation. On 12/04/19 at 12:31 PM, an interview with Registered Nurse (RN) #1/ Minimum Data Set (MDS) Coordinator confirmed there was no care plan developed for Resident #24 related to Eliquis or interventions related to the anticoagulant medication. RN #1 revealed she does not know why there was not a care plan, she thought there had been one developed. RN #1 revealed there should be a care plan developed for any anticoagulants.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician.	F 657		1/4/20

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F 657	Continued From page 4 (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on facility policy review, record review and staff interview, the facility failed to revise a care plan for nutrition for one (1) of 18 residents reviewed, Resident #9. Findings include: Review of the facility's "Care Plans" policy, not dated, revealed each resident will have a plan of care to identify problems, needs and strengths that will identify how the interdisciplinary team will provide care. Responsibility: All members of the interdisciplinary team. Monitored by the MDS (Minimum Data Set) and Director of Nurses. Procedures included: The care plan will be reviewed and revised at quarterly intervals in conjunction with the completion of MDS assessments (quarterly, significant change,	F 657	Tag F657 1. Immediate action taken for the residents identified in the survey as resident #9, was to review their care plans by the MDS Coordinator on 12/4/19 and to update it at that time. Resident's # 9's care plan was updated to include the mechanical soft diet. 2 The facility determined that all residents have the potential to be affected by this practice. 3 Actions taken/systems put into place to reduce the risk of future occurrence The MDS coordinator began conducting a 100 % audit of all resident care plans on 12/5/19 and is to be completed by January 8, 2020. Going forward, the MDS Coordinator will print and review new	

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F 657	Continued From page 5 annual) and with changes in resident's condition as needed. Upon a change in condition, the care plan will be updated or an initial care plan will be initiated. Resident #9 Review of the December 2019 physician's orders revealed an order, dated 11/22/19, for a Mechanical Soft Diet. Review of the care plan, with a start date of 6/12/19, revealed, "Problem, Inadequate nutritional intake: Protein Calorie Malnutrition, PEG (Percutaneous Endoscopic Gastrostomy) tube for nutrition, at risk for alteration in nutrition status, at risk for alteration in hydration status, resident is nothing by mouth (NPO) and receives nutrition by Percutaneous Gastrostomy Tube (PEG) tube only, at risk for aspiration, Category: Nutrition." The Mechanical Soft Diet was not care planned for Resident #9. Interview on 12/03/19, at 11:36 AM, with Registered Nurse #1 (RN)/Minimum Data Set (MDS) Coordinator, revealed RN#1 confirmed the Mechanical Soft Diet was not care planned and stated it should have been care planned. She stated the purpose of a care plan would be to describe how the resident should be cared for. RN #1 stated that care plans should be updated quarterly, yearly and with changes. She revealed that when the new order is taken, the care plan should be updated soon after. She confirmed it is the policy of the facility to update the care plan with changes and the policy was not followed. Review of the Face Sheet revealed Resident #9 was admitted by the facility, on 5/30/19, with	F 657	orders for residents each day to ensure that any diet order or change in diet order is care planned for each resident's diet. 4. How the corrective actions will be monitored to ensure the practice will not reoccur: The Administrator, and or Director of Nursing, will conduct a sample of 10 resident's care plans per week, beginning 12-26-19, to review to assure that all care plans are updated according to the plan. Any variance to the plan will be addressed immediately in QAPI.	

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F 657	Continued From page 6 diagnoses which included Aftercare Following Joint Replacement Surgery, Gastrostomy Status, Dysphagia, and Dementia in Other Diseases.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, record review, facility policy review, manufacturer's recommendation, and review of the Mississippi Nursing Practice Law, the facility failed to administer a metered dose inhaler per manufacturers recommendations for one (1) of five (5) residents observed for medication administration, Resident #2. Findings include: Review of the Mississippi Nursing Practice Law, with an effective date of July 1, 2010, revealed on pages three (3) and four (4) of 26: 73-15-5 Definitions. (2) The practice of nursing by a registered nurse means the performance for compensation of services which requires substantial knowledge of biological, physical, behavioral, psychological, and sociological sciences, and of nursing theory as the basis for assessment, diagnosis, planning intervention, and evaluation in the promotion, maintenance of health; management of individual's responses, to illness, injury or infirmity; the restoration of optimum function; or the achievement of a	F 658	Tag F658 1. Immediate action taken for the resident identified in the survey and identified as resident #2, Resident was assessed by the Director of Nurses on 12/3/19 to assure no untoward side effects of failing to wait a minute between inhaler doses was noted. The physician was notified by the Director of Nurses regarding the medication error involving the inhaler. The resident, who has a BIMS of 15, stated that she had been on this medication for a long time and had not known the correct way to take the med. 1:1 education was provided by the Director of Nurses on 12/3/19 to the nurse delivering the med in error. The resident was taught correct process in which to administer the med as well. 2. Identification of other residents having the potential to be affected was accomplished by the Director of Nurses obtaining a list of all residents who were receiving multiple doses of inhalers. Four residents were identified using multi-dose	1/4/20

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F 658	Continued From page 7 dignified death. Nursing practice includes, but is not limited to, administration, teaching, counseling, delegation, and supervision of nursing, and execution of the medical regimen, including the administration of medications, and treatments prescribed by any licensed or legally authorized physician, or dentist. (5) The practice of nursing by a licensed practical nurse means the performance for compensation of services requiring basic knowledge of the biological, physical, behavioral, psychological, and sociological sciences, and of nursing procedures which do not require the substantial skill, judgement, and knowledge required of a registered nurse. These services are performed under the direction of a registered nurse, or a licensed physician, or licensed dentist, and utilize standardized procedures in the observation, and care of the ill, injured, and infirm; in the maintenance of health; in action to safeguard life and health; and in the administration of medications, and treatments prescribed by any licensed physician, or licensed dentist authorized by state law to prescribe. Review of the facility's "Oral Inhalation Administration" policy, not dated, revealed the policy is to allow for correct administration of oral inhalers to residents and for instruction in proper technique for those residents able to administer the medication to themselves. The procedure instructions guide staff to instruct the resident to breath out through their mouth, inhale slowly over three (3) to five (5) seconds as they depress the canister to release the medication, to hold their breath for 10 seconds and then to exhale slowly. Instructions include if there are repeat doses the resident is to breathe normally for one (1) minute, wait one (1) to two (2) minutes and repeat the	F 658	inhaler. 3. Actions taken/systems put into place to reduce the risk of future occurrence is for the Director of Nurses provided 1:1 education for the nurse that committed the medication error on 12/3/19. An in service was provide by the clinical educator on 12/6/19 for nurses regarding the proper preparation and use of inhalers. 4. How the corrective actions will be monitored to ensure the practice will not reoccur: Director of Nursing, or the RN Supervisor or the pharmacy consultant will conduct random audits weekly for four weeks to observe nurses providing inhalers to patients. Any variance to the correct method will be addressed immediately. We will address this concern and plan of intervention in QAPI monthly.	

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F 658	Continued From page 8 steps. Review of the Advair HFA inhaler manufacture's insert revealed steps for use included breathe out through your mouth and push as much air from your lungs as you can. Put the mouthpiece in your mouth and close your lips around it. Push the top of the metal canister all the way down while you breathe in deeply and slowly through your mouth. Hold your breath for about 10 seconds, or for as long as is comfortable. Breathe out slowly as long as you can. Wait about 30 seconds and shake the inhaler well for five (5) seconds and repeat steps. On 12/03/19 at 8:50 AM, an observation during the medication pass revealed Licensed Practical Nurse (LPN) #1 handed the Advair metered dose inhaler to Resident #2. Resident #2 placed the inhaler in her mouth and pressed the top of the canister two (2) times, one right after the other, without exhaling, taking a deep breath, shaking the canister or waiting for 30 seconds. LPN #1 did not instruct Resident #2 on the proper use. Review of Resident #2's December 2019 physician's orders revealed an order, dated 11/18/19, for Advair HFA 115-21 MCG (Microgram)inhaler-2 puffs inhalation every 12 hours. On 12/03/19 at 8:50 AM, an interview with Licensed Practical Nurse, (LPN) #1 confirmed she did not instruct Resident #2 before or during the administration of the Advair inhaler. LPN #1 confirmed Resident #2 did not wait 30 seconds between puffs and did not shake the inhaler between puffs. LPN #1 confirmed the Advair insert revealed in the steps for how to use the	F 658		

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F 658	Continued From page 9 inhaler to breathe out, place inhaler in your mouth, dispense medication and inhale, hold your breath 10 seconds, wait 30 seconds, shake canister for five (5) seconds and repeat steps. LPN #1 revealed that by not waiting 30 seconds and following the instructions the resident would not get the most effect of the medication in her lungs and it may not help her breathing as much as it should. On 12/03/19 at 9:00 AM, an interview with Resident #2 confirmed she did not know she should wait 30 seconds between the 2 puffs of her Advair and had not been waiting. Resident #2 revealed no one had told her to wait between puffs, but she is glad she now knows because she wants her medicine to work the best it can. Record review of Resident #2's Face Sheet revealed the diagnosis of Asthma.	F 658		
F 812 SS=E	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.	F 812		1/4/20

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F 812	Continued From page 10 §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, staff interview, record review and facility policy review, the facility failed to follow proper sanitation and food storage to prevent the likelihood of food borne illness for one (1) of two (2) dietary tours. Findings include: Review of the facility's "Storage of Refrigerated Food" policy, originated 9/04, revealed: "Policy: The facility ensures the quality and safety of refrigerated foods through accepted storage practices. Procedure: 3. Food taken out of original containers is put in a clean sanitized container with a tight fitting lid. No food is left uncovered. 4. All non-hazardous, opened foods are labeled with name of food and date stored. 5. All hazardous foods are labeled with the name of food and date to be discarded or the date stored. Cooked foods should not be held longer than 48 hours." Review of the facility's "Storage of Canned and Dry Food" policy, originated 9/04, revealed: "Procedure: 6. Opened products are stored in tightly covered containers. Zip lock bags may be used. 7. Opened packages are labeled with name of product and date opened." Review of the facility's "Employee Sanitation Practices" policy, dated 9/04, revealed: Policy: Food service employees shall follow sanitary practices to prevent the spread of foodborne	F 812	Tag F812 1. Immediate action taken for the identified problem during the survey: On 12/2/19, the Administrator immediately discarded items that were either improperly stored, not labeled or not dated. The microwave was cleaned on 12/2/19 by dietary personnel. On 12/2/19, the administrator in-serviced the dietary personnel regarding the proper technique for sanitary practices during meal prep and service which included proper thermometer use and sanitation with alcohol prep between food items. Additionally, he addressed prevention of the potential for cross contamination by changing gloves between tasks. The in service included instruction that clean cloths must be held in a bucket of sanitizer solution between uses. Monitoring of the residents for upset stomach issues was accomplished by the medical staff and no symptoms of food borne illness were identified. The food served on 2 December 2019 that was Black-eyed Peas, Buttered Carrots and Country Fried Steak. 2. Identification of other residents having the potential to be affected because of the nature of the violation, all residents receiving food from the kitchen had the	

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F 812	Continued From page 11 illness and reduce those practices which result in food contamination and compromised food safety. Procedure:. 2. b. Gloves are worn to protect food by creating a barrier between the hand and food but should be used only when doing one task. c. Gloves should be changed: i. As soon as they become soiled or torn, ii. Before beginning a different task." On 12/02/19 10:10 AM, an observation during the dietary tour with Dietary Staff #2/Cook, revealed the microwave oven's entire inside was splattered with a cream color dried matter. In the refrigerator there was an open package of 160 slices of Yellow Pasteurized Processed American Cheese slices with approximately one half (1/2) of the 160 slices present and open to air. A fourth of a head of iceberg lettuce was wrapped in plastic wrap with no label or date. Green Onions, approximately 8 in. x 12 in. x 2 in. were wrapped in original packaging and clear plastic wrap with an 11/6/19 date. The green onions were turning brown and mushy/slimy. There was one half of a meat and cheese sandwich on wheat bread wrapped in plastic wrap that was not labeled or dated. A gallon zip lock bag 1/4 full of what appeared to be red peppers or pimento type food was not labeled or dated. In the freezer, a 6"x 6" plastic container with a lid contained what appeared to be green beans not labeled or dated. A full gallon zip lock bag of frozen macaroni type material was not labeled or dated. In the pantry, a 50 pound (lb) paper bag of sugar was open with a date of 11/30/19 and loosely rolled down from the top. It contained approximately six (6) inches depth of sugar in the bottom of the bag. A 50 lb. paper bag of Buttermilk Biscuit Mix with a date of 4/24/19, was open and loosely rolled down from the top. It contained approximately 8 inch depth	F 812	potential to be affected. However none were found to have been impacted based on the monitoring of the residents identified in bullet 1 3. Actions taken/systems put into place to reduce the risk of future occurrence: In-service training was performed with half of the staff on 12-19-2019 by the Registered Dietician covering the identified deficiencies including sanitation, proper storage and labeling of food items for refrigeration and storage. Another in-service was held on 12-23-2019 for the remaining dietary staff covering the same subject. 1 to 1 instruction will continue by the dietary supervisor daily initially and then weekly after two weeks. A new food processor was purchased 12/20/19 and has not yet arrived for the purpose of preparing mechanically altered food. Additional, larger, containers were purchased for the proper storage of bulk dry goods on 12/2619 and arrived on 12/27/19. 4. How the corrective actions will be monitored to ensure the practice will not reoccur: 1 to 1 instruction daily for two weeks began 12-9-2019 through 12-22-2019 for each shift. The instruction included proper labeling of stored items, proper thermometer use, changing of gloves when needed, cloths in sanitizing solution and proper cleaning and sanitizing kitchen equipment. A daily check sheet was developed by the dietary supervisor who observes that the correct procedures are properly performed or	

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	255304	A. BUILDING _____ B. WING _____	12/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NICHOLS CENTER	1308 HIGHWAY 51 NORTH MADISON, MS 39110

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F 812	Continued From page 12 of mix in the bottom of the bag. One half package of Dry Fruit Punch mix was wrapped in plastic wrap and stored in the original box. No open date was on the plastic wrap. Punch mix crystals were falling out of the plastic wrap into the box. An interview with Dietary Staff #2 at this time revealed that all food should be labeled and dated after opening and wrapped tightly. She stated that she would throw it away. She stated that workers on the other shift probably did not label the food. During an observation of the tray line temperatures and interview, on 12/2/19, at 11:15 AM, revealed Dietary Staff #2 wiped the thermometer probe with gloved fingers between each food tempted. She stated, "I thought it was ok, it's all going to the same place". She took several pieces of Country Fried Steak from the large steam pan and placed it in a smaller steam pan. She tore the steak up with her fingers to make the chopped steak. She then wiped her gloves with a dish cloth that was lying on the counter of the steam table and spooned Black Eyed Peas, Carrots, and Corn Bread into smaller steam pans to make pureed foods. She stated, "It's the dish cloth I clean with". She took the foods and the dish cloth over to the preparation table by the blender and proceeded to make the pureed food. She then wiped the counter with the same dish cloth. In an interview and observation, on 12/02/19, at 10:45 AM, with the Administrator, he confirmed the cheese was not wrapped, the lettuce, sandwich, red peppers/pimento type food in the refrigerator and the frozen macaroni type food, and green beans were not labeled and dated. He confirmed the sugar and biscuit mix were not sealed properly and the Fruit Punch dry mix was	F 812	makes correction on the spot. Disciplinary actions for those that refuse to comply will be initiated. Beyond that spot checks through the week and monitoring of proper practices weekly will continue using a weekly check list developed. Monthly the QAA will review the documents from the dietary department and view the practices. This will continue for at least three months (1—4-2020)	

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	255304	A. BUILDING _____ B. WING _____	12/04/2019

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F 812	Continued From page 13	F 812		

not labeled, dated, and sealed properly. He stated the cheese could become spoiled and molded, the green onions should be thrown away due to the brown, mushy appearance, and that all foods not labeled and stored properly should be discarded due to the risk of food borne illness. He stated, "If its not labeled, we don't know what it is and it should not be used.". He confirmed that the microwave "needs attention".

An interview, on 12/4/19 at 10:00 AM, with the Dietary Staff #1/Dietary Manager, he stated that dry foods should be stored in a sealed container because something might get in it if the bag was folded over. He stated that all foods that have been opened or refrigerated should be labeled and dated. He stated "Residents could get sick if you serve something out of date". In regards to the tray line temps and dish cloth, he stated that "It could contaminate things and make residents sick. You are supposed to throw gloves away and wash hands. You must change gloves between different tasks. Meats should be put in the chopper, not torn by hand".

Review of an In-Service Form, Subject: Infection Control. How to decrease bacteria growth in food to reduce the likelihood of food borne illness in the residents eating food prepared by dietary, presented by the Registered Dietitian, on 10/29/19, revealed that Dietary Staff #2 attended. Contents of the in-service include, "According to the FDA (Food and Drug Administration), cloths used for wiping counters and other surfaces shall be: 1) Held between uses in a chemical sanitizer solution.. All items stored in refrigerators must be covered, labeled, and dated with an open/expiration date."

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	255304	A. BUILDING **02 - THE NICHOLS CENTER** B. WING _____	**12/06/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NICHOLS CENTER	**1308 HIGHWAY 51 NORTH MADISON, MS 39110**

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K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility meets the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). There were no LSC deficiencies cited during this survey.	K 000		

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

Electronically Signed | 12/21/2019

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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E 000	Initial Comments ********** Survey conducted on 12/06/19 revealed the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were cited.	E 000		

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

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