STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	22CI	A. BUILDING: _____ B. WING _____	05/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRENADA REHABILITATION AND HEALTHCARE CEN	1966 HILL DRIVE GRENADA, MS 38901

(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) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) conducted an annual re-certification survey at the facility from 4/30/2023 to 5/15/2023. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements and cited M190, M500, M815 and M1570 related to the annual survey.The SA re-entered the facility on 5/15/23 for a Complaint Investigation (CI) MS # 21504 related to neglect, pressure sores and staffing and determined the facility was in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements related to CI MS # 21504. The census at the time of the survey was 84 and the facility is licensed for 95 beds.	M 000		
M 190	45.2.33 Restraint Restraint. The term "restraint" shall include any means, physical or chemical, which is intentionally used to restrict the freedom of movement of a person. This Statute is not met as evidenced by: Based on observation, staff, resident interview and resident representative interview, record review and facility policy review the facility failed to ensure a resident was assessed for the need of physical restraint as evidenced by no restraint assessment completed prior to applying a lap tray for one (1) of 18 residents reviewed. Resident #45 Findings Include Record review of the facility policy titled, "Physical Restraints and Involuntary Seclusion" with a	M 190	M 190 Restraints 1. Root Cause Analysis was conducted by the Interdisciplinary Team and based on findings Resident #45 received gradual reduction of restraint on 5-3-2023 and 5-10-2023 the gradual reduction was successful and new physician's orders discontinuing resident's lap tray was obtained. 2. Quality reviews of current Residents' care plans and physicians' orders were	6/15/23

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M 190	Continued From page 1 revision date of 10/08/20 revealed under "Policy ...#1. Restraints will not be used unless the facility's Interdisciplinary Team has completed an assessment and evaluation to identify causative medical or environmental factors and considered less restrictive alternatives (except in an emergency). #3 The patient/resident will have the right to refuse or accept the use of restraints. In order for the patient/resident to make an informed choice about the use of restraints, the potential outcomes of restraint use will be explained to the patient/resident. This includes but is not limited to: A. Potential negative outcomes of incontinence, B. Decreased ROM, and ability to ambulate, C. Reduced social contact and D. Possible symptoms of depression. An observation on 4/30/23 at 4:08 PM revealed Resident #45 was self-propelling her wheelchair with a lap tray attached. An observation and interview on 5/1/23 at 9:15 AM revealed Resident #45 was self-propelling her wheelchair with a lap tray attached. An interview at this time with the resident revealed she did not like the lap tray, did not want it and cannot remove it herself. An interview on 5/1/23 at 3:00 PM with the Director of Nurses (DON) revealed that Resident #45 had several falls, and one was with a major injury, so they had a meeting with corporate and therapy and decided that a lap tray was the next step in keeping her in her wheelchair. She revealed the resident should have had an assessment regarding the restraint, but she could not find it or the consent form. An interview on 5/1/23 at 3:15 PM with the Corporate Clinical Nurse confirmed they had a	M 190	conducted on 5-10-2023, by the Director of Nursing (DON), Minimum Data Set Nurse (MDS), and Regional Director of Clinical Services (RDCS) to ensure compliance with protecting and promoting the rights of the residents regarding restraint physicians' orders. One resident out of eighty-four had the potential to be affected. 3. On 5-15-2023 the Staff Development Nurse (SDC) initiated in-service for the following Departments: Administration, Nursing, Therapy, Social Services, Activities, Maintenance, Dietary and Environmental Services on Resident's Rights/Exercise of Rights and Restraints policy and procedures. New hires' training and education will be conducted in orientation. 4. Restraint Physician Orders will be monitored starting 5-15-2023 by the Minimum Data Set Nurse (MDS), Director of Nursing (DON) or Unit Manager; 3 x weekly for 4 weeks, then 2 x weekly for 4 weeks, then 1 time a week for 4 weeks, to ensure compliance with protecting and promoting the rights of the residents regarding restraints physicians' orders. Findings will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee monthly starting 6-15-2023, times three months. 5. Completion date is set as 6-15-2023.	

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M 190	Continued From page 2	M 190		

meeting with therapy and decided that Resident #45 needed a lap tray to keep her from falling, because she had fallen so much and had some injuries. She revealed the facility did not have an assessment form that would have been completed for the restraint. She revealed the resident should have had a consent form on her record, but we cannot find it.

An interview 5/1/23 at 3:38 PM with the Assistant Director of Nurses (ADON) revealed she went to medical records and found Resident #45's consent for the restraint that was signed by the resident's representative on 4/10/23.

An interview on 5/2/23 at 12:15 PM with the Corporate Clinical Nurse confirmed that the facility policy read that an assessment was needed for a restraint but revealed she is unaware of an assessment form. She confirmed that Resident #45 did not have a restraint assessment completed prior to the lap tray being attached to the resident's wheelchair as a restraint.

An interview on 5/2/23 at 4:21 PM with Resident #45's representative revealed he was aware that his sister had a lap tray on her wheelchair now and he knew she did not like it. He revealed the facility did not ask for his consent prior to applying the lap tray, he was notified by the facility after the lap tray was applied, he did not get educated on the risk of the lap tray and he did not have to sign anything giving consent.

An interview on 5/3/23 at 9:50 AM with the ADON revealed that Resident #45's representative had given consent for the lap tray verbally over the phone but admitted that consent was not obtained prior to applying the lap tray. She

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M 190	Continued From page 3 revealed the consent for the resident's lap tray should have been obtained prior to applying it because it was not an emergency. Observation and interview on 5/15/23 at 11:30 AM with Resident #45 revealed she was up in a wheelchair with a high back in her room. Resident has a soft pink helmet on her head. She does not have a lap tray or seat belt on. Her speech can be difficult to understand but she is able to say "yeah", "no" and complete simple sentences. When asked if she knew there would be a lap tray used before the staff used one on her wheelchair, she stated "yeah". When asked why she didn't want the lap tray on her wheelchair, she stated "couldn't move like I wanted". State Agency (SA) asked if the facility staff had explained to her that she could be harmed/hurt if she falls out of the wheelchair, she stated "yes". It is noted that she does display the jerking, sudden movements from her extremities that accompany Huntington's disease. Interview with the Director of Nurses on 5/15/23 at 11:45 AM revealed that the consent for the lap tray was verbally over the phone due to the RP living 3.5 hours away. She stated that Resident #45 had a fall this morning, but had no injuries from this fall. She said that Resident #45 is glad she doesn't have to use the lap tray anymore. The RP is aware the lap tray has been discontinued (dc'd). Care plan meeting with the RP are done over the phone due to the distance of his home to the facility. The DON explained the risks of falls and possible injury have been explained to both the RP and resident by the DON and the clinical nurse consultant. The DON confirmed the lap tray was discontinued on 5/11/23.	M 190		

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M 190	Continued From page 4 Record review of Resident #45's physician's orders revealed an order dated 4/10/23- Apply lap tray when up in wheelchair, check every 30 minutes and release every 2 hours for toileting and repositioning every shift for involuntary movement of trunk and extremities related to Huntington's Disease. Record review of Resident #45's care plans revealed the resident had a care plan created on 4/22/20 and revised on 4/11/23 that read; I am going to fall; I prefer to keep my independence with making coffee from sink. I do not want to have a special cup to prevent spills. She is at high risk for falls with a goal of; I will be free of major injury related to falls through the review date and interventions that include 4/10/23 Restraint would be appropriate at this time due to continuous decline in condition resulting in involuntary movement of trunk and extremities. (Resident #45's proper name) is no longer able to safely maintain position in wheelchair, lap tray applied to wheelchair, staff to check restraint placement every 30 minutes and remove for repositioning and toileting every 2 hours. Record review of Resident #45's record revealed there was no documentation of an assessment for the use of the lap tray or whether the resident could release the lap tray. Record review of Resident #45's Face Sheet revealed the resident was admitted to the facility on 11/01/19 with medical diagnoses that included Huntington's Disease. Record review of Resident #45 Minimum Data Set (MDS) an Assessment Reference Date (ARD) of 2/6/23 revealed in Section C a Brief Interview for Mental Status (BIMS) of 14, which	M 190		

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M 190	Continued From page 5 indicates the resident is cognitively intact. Level II Based on observation, staff, resident interview and resident representative interview, record review and facility policy review the facility failed to ensure a resident was assessed for the need of physical restraint as evidenced by no restraint assessment completed prior to applying a lap tray for one (1) of 18 residents reviewed. Resident #45 Findings Include Record review of the facility policy titled, "Physical Restraints and Involuntary Seclusion" with a revision date of 10/08/20 revealed under "Policy ...#1. Restraints will not be used unless the facility's Interdisciplinary Team has completed an assessment and evaluation to identify causative medical or environmental factors and considered less restrictive alternatives (except in an emergency). #3 The patient/resident will have the right to refuse or accept the use of restraints. In order for the patient/resident to make an informed choice about the use of restraints, the potential outcomes of restraint use will be explained to the patient/resident. This includes but is not limited to: A. Potential negative outcomes of incontinence, B. Decreased ROM, and ability to ambulate, C. Reduced social contact and D. Possible symptoms of depression.	M 190		

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M 190	Continued From page 6 An observation on 4/30/23 at 4:08 PM revealed Resident #45 was self-propelling her wheelchair with a lap tray attached. An observation and interview on 5/1/23 at 9:15 AM revealed Resident #45 was self-propelling her wheelchair with a lap tray attached. An interview at this time with the resident revealed she did not like the lap tray, did not want it and cannot remove it herself. An interview on 5/1/23 at 3:00 PM with the Director of Nurses (DON) revealed that Resident #45 had several falls, and one was with a major injury, so they had a meeting with corporate and therapy and decided that a lap tray was the next step in keeping her in her wheelchair. She revealed the resident should have had an assessment regarding the restraint, but she could not find it or the consent form. An interview on 5/1/23 at 3:15 PM with the Corporate Clinical Nurse confirmed they had a meeting with therapy and decided that Resident #45 needed a lap tray to keep her from falling, because she had fallen so much and had some injuries. She revealed the facility did not have an assessment form that would have been completed for the restraint. She revealed the resident should have had a consent form on her record, but we cannot find it. An interview 5/1/23 at 3:38 PM with the Assistant Director of Nurses (ADON) revealed she went to medical records and found Resident #45's consent for the restraint that was signed by the resident's representative on 4/10/23. An interview on 5/2/23 at 12:15 PM with the	M 190		

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M 190	Continued From page 7 Corporate Clinical Nurse confirmed that the facility policy read that an assessment was needed for a restraint but revealed she is unaware of an assessment form. She confirmed that Resident #45 did not have a restraint assessment completed prior to the lap tray being attached to the resident's wheelchair as a restraint. An interview on 5/2/23 at 4:21 PM with Resident #45's representative revealed he was aware that his sister had a lap tray on her wheelchair now and he knew she did not like it. He revealed the facility did not ask for his consent prior to applying the lap tray, he was notified by the facility after the lap tray was applied, he did not get educated on the risk of the lap tray and he did not have to sign anything giving consent. An interview on 5/3/23 at 9:50 AM with the ADON revealed that Resident #45's representative had given consent for the lap tray verbally over the phone but admitted that consent was not obtained prior to applying the lap tray. She revealed the consent for the resident's lap tray should have been obtained prior to applying it because it was not an emergency. Observation and interview on 5/15/23 at 11:30 AM with Resident #45 revealed she was up in a wheelchair with a high back in her room. Resident has a soft pink helmet on her head. She does not have a lap tray or seat belt on. Her speech can be difficult to understand but she is able to say "yeah", "no" and complete simple sentences. When asked if she knew there would be a lap tray used before the staff used one on her wheelchair, she stated "yeah". When asked why she didn't want the lap tray on her wheelchair, she stated "couldn't move like I wanted". State	M 190		

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M 190	Continued From page 8 Agency (SA) asked if the facility staff had explained to her that she could be harmed/hurt if she falls out of the wheelchair, she stated "yes". It is noted that she does display the jerking, sudden movements from her extremities that accompany Huntington's disease. Interview with the Director of Nurses on 5/15/23 at 11:45 AM revealed that the consent for the lap tray was verbally over the phone due to the RP living 3.5 hours away. She stated that Resident #45 had a fall this morning, but had no injuries from this fall. She said that Resident #45 is glad she doesn't have to use the lap tray anymore. The Resident Representative (RR) is aware the lap tray has been discontinued (dc'd). Care plan meeting with the RR are done over the phone due to the distance of his home to the facility. The DON explained the risks of falls and possible injury have been explained to both the RR and resident by the DON and the clinical nurse consultant. The DON confirmed the lap tray was discontinued on 5/11/23. Record review of Resident #45's physician's orders revealed an order dated 4/10/23- Apply lap tray when up in wheelchair, check every 30 minutes and release every 2 hours for toileting and repositioning every shift for involuntary movement of trunk and extremities related to Huntington's Disease. Record review of Resident #45's care plans revealed the resident had a care plan created on 4/22/20 and revised on 4/11/23 that read; I am going to fall; I prefer to keep my independence with making coffee from sink. I do not want to have a special cup to prevent spills. She is at high risk for falls with a goal of; I will be free of major injury related to falls through the review date and	M 190		

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M 190	Continued From page 9 interventions that include 4/10/23 Restraint would be appropriate at this time due to continuous decline in condition resulting in involuntary movement of trunk and extremities. (Resident #45's proper name) is no longer able to safely maintain position in wheelchair, lap tray applied to wheelchair, staff to check restraint placement every 30 minutes and remove for repositioning and toileting every 2 hours. Record review of Resident #45's record revealed there was no documentation of an assessment for the use of the lap tray or whether the resident could release the lap tray. Record review of Resident #45's Face Sheet revealed the resident was admitted to the facility on 11/01/19 with medical diagnoses that included Huntington's Disease. Record review of Resident #45 Minimum Data Set (MDS) an Assessment Reference Date (ARD) of 2/6/23 revealed in Section C a Brief Interview for Mental Status (BIMS) of 14, which indicates the resident is cognitively intact.	M 190		
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	M 500		6/15/23

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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 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

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M 500	Continued From page 11 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 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;	M 500		

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M 500	Continued From page 12 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 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	M 500		

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M 500	Continued From page 13 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 staff and resident interview, record review and facility policy review the facility failed to review and gain consent on a cognitively intact residents Advanced Directives (Resident # 52) and failed to obtain a physician's order and formulate a Do Not Resuscitate (DNR) status in the medical record (Resident #181) for two (2) of 29 resident's advance directives reviewed. Resident # 52 and #181 Findings Include: An interview on 5/1/23 at 3:15 PM, with the Administrator revealed the facility did not have a policy related to the process for ensuring the appropriate code status for DNR for residents. Resident # 52 An interview on 5/1/23 at 4:10 PM, with Resident #52 revealed no one from the facility had talked to him about his wishes regarding wanting CPR (cardio pulmonary resuscitation) or not. An interview on 5/1/23 at 4:20 PM, with the Corporate Clinical Nurse revealed that if a resident is admitted and is not cognitively able to	M 500	M 500 Residents' Rights 1. Root Cause Analysis was conducted by the Interdisciplinary Team and based on findings; the Social Services Director met with Resident #52 on 5-3-2023 and reviewed his Advanced Directives with no negative findings nor updates, the Medical Records Nurse obtained the signed Advanced Directive physician order for Resident# 181 on 5-1-2023 and uploaded it into the Electric Health Record. 2. Quality reviews of current Residents' Advanced Directives were conducted on 5 -11-2023 by the Medical Records Nurse to ensure compliance with request/refuse/discontinue treatment; formulate Advanced Directives. Two residents out of eighty-four had the potential to be affected. 3. On 5-15-2023 the Staff Development Nurse (SDC) initiated an all Nursing in-service on request/refuse/discontinue treatment; formulate Advanced Directives policy and procedures. New hires' training and education will be conducted in orientation.	

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M 500	Continued From page 14 sign their own admission paperwork and then becomes cognitive at a later date, they do not redo or go over the resident's advance directive. An interview on 5/1/23 at 4:30 PM, with Social Services revealed she was unaware that if a resident was not cognitive on admission but became cognitive during their stay at the facility then the resident's advance directive needed to be reviewed and resigned. An interview on 5/3/23 at 09:30 AM, with Social Services revealed that Resident #52 could understand you when you spoke with him and make his wishes known. She confirmed that the resident had never attended a care plan meeting and no follow up was documented regarding speaking with the resident to verify he agreed with the plan of care that was decided upon. Record review revealed Resident #52 had an Advance Directive signed by the resident's representative on admission 08/27/20 and a code status change on 01/28/21. Record review of Resident #52's history of Minimum Data Sets with Brief Interviews for Mental Status (BIMS) scores revealed a BIMS score on the Admission MDS dated 9/3/20 of 7 which indicated severely impaired cognitive status. The MDS dated 11/30/20 revealed a BIMS score of 11 which indicated that the resident had moderately impaired cognitive skills. The MDS dated 3/13/23 revealed a BIMS score of 11. Record review of Resident #52's Admission Record revealed he was admitted to the facility on 08/28/20 with medical diagnoses that included Cerebral Infarction Unspecified.	M 500	4. Advanced Directives will be monitored starting 5-15-2023 by the Medical Records Nurse, Director of Nursing (DON) or Unit Manager; 3 x weekly for 4 weeks, then 2 x weekly for 4 weeks, then 1 time a week for 4 weeks, to ensure compliance. Findings will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee monthly starting 6-15-2023, times three months. 5. Completion date is set as 6-15-2023.	

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M 500	Continued From page 15 Resident #181 Record review of "CONSENT FOR CARDIOPULMONARY RESUSCITATION (CPR) form, for Resident #181, signed by her Resident Representative on 4/20/23, revealed " ... This statement will remain in effect as long as the resident remain a resident of this facility ... 'x' Decline CPR' I understand that CPR constitutes an extraordinary measure and SHOULD NOT be performed. ... Date 4/20/23." Record review of the "Order Summary Report," for Resident #181, revealed she did not have a Do Not Resuscitate (DNR) order in the Electronic Health Record (EHR). Record review of the "Admission Record" for Resident #181 revealed an admission date of 04/24/2023. An interview on 5/1/23 at 02:45 PM, with Medical Records confirmed there was not a DNR order in the EHR for Resident #181. She noted old DNR orders are used for residents who readmit to the nursing facility in less than 30 days of discharge and a new order for DNR did not have to be obtained from the physician. She confirmed that Resident #181 was discharged from the nursing facility and readmitted on 04/24/2023 and confirmed that the physician's order for DNR from the previous admission, for Resident #181, was being used for the readmission. An observation and interview on 5/1/23 at 03:00 PM, with the Director of Nursing (DON), confirmed Resident #181 was recently readmitted to the nursing facility. After being completely discharged from the nursing facility, there was a new "Consent For Cardiopulmonary	M 500		

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M 500	Continued From page 16 Resuscitation" form for the code status request of DNR signed by the Resident Representative. There was not a new code status order obtained related to the new admission to the nursing facility. She revealed she was not aware she needed to have a new physician's order for DNR upon readmission if the resident was not out of the nursing facility for more than 30 days and confirmed that the resident/family choice for plan of care related to Advance Directives was not being honored. She revealed Resident #181 needed to have a signed physician's order in the Electronic Health Record for DNR to ensure Resident #181's choice was honored for her Advanced Directive and to ensure the appropriate level of care was rendered in case of a medical emergency for Resident #181. An interview on 5/1/23 at 03:15 PM, with the Administrator, revealed the nursing facility did not have a policy related to the process of ensuring the appropriate code status of DNR, for residents, was completed in the EHR. He confirmed the nursing staff should have obtained a signed DNR order for Resident #181 from her admitting physician and confirmed the nursing facility was not honoring the choice of DNR for Resident #181.	M 500		
M 815	45.29.1 Safe Food Handling Procedures 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	M 815	M 815 Safe Food Handling Procedures	6/15/23

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M 815	Continued From page 17 Based on observations, staff interviews and facility policy review, the facility failed to properly label and store food items in a cooler in the kitchen according to professional standards for food service safety, failed to properly label food items stored in the resident nourishment refrigerators, failed to maintain a temperature log for the resident nourishment refrigerators, and failed to maintain a cleaning schedule for the resident nourishment refrigerators located on A-Hall and C-Hall nursing units of the nursing facility for one (1) of two (2) tours. Findings include: Review of the facility policy titled, "Receiving," with a revised date of 9/2017, revealed "Policy Statement: Safe food handling procedures for time and temperature control will be practiced in the transportation, delivery, and subsequent storage of all food items. Procedures ... 6. All food items will be stored in a manner hat ensure appropriate and timely utilization based on the principles of "first in - first out" (FIFO) inventory management." Review attempted for facility policy for resident nourishment refrigerators revealed the nursing facility did not have a policy. The Administrator provided a letter on the nursing facility's letterhead that revealed "the facility does not have a policy on Resident Nourishment Refrigerators in regard to cleaning schedules and general maintenance." An observation during the initial kitchen tour on 4/30/23 at 03:47 PM, revealed a cooler with food items stored that were not disposed of by the date indicated on the containers. The observation	M 815	1. Root Cause Analysis was conducted by the Interdisciplinary Team and based on findings on 4-30-2023, the Dietary Director disposed of all expired food items including brown gravy, beef base, ham, egg salad, V8 juice, tomato soup, and sliced bologna. On 5-3-2023 the Maintenance Director removed the nourishment refrigerators from A, B, and C Hall Nursing units. Residents' nourishment items will now be stored in Dietary and available upon request. On 5-3-2022, quality review observations were conducted by the Administrator to ensure Nourishment Refrigerators and expired food were disposed of and the facility was in compliance. No deficient areas were noted. 2. Eighty-four residents have the potential to be affected. 3. On 4-30-2023, the Dietary Director initiated an all Dietary staff in-service on labeling/dating food items and disposing of expired food policy and procedures. New hires' training and education will be conducted in orientation. 4. On 5-15-2023, the Administrator and or Dietary Director will conduct Quality Review Observations ensuring that food items are properly dated/labeled and expired foods are disposed 3 times a week for 4 weeks, then 2 times a week for 4 weeks, and then 1 time a week for 4 weeks to ensure compliance with food procurement, storing, and serving sanitary. Findings will be reported to the	

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M 815	Continued From page 18 revealed an opened and partially used white plastic container of pimento cheese with a Date Prepared/Opened of 4/19/23 and no Use By Date was indicated; revealed a clear plastic storage container of leftover brown gravy with a Shelf Life date of 4/22/23; revealed an unopened white plastic container of beef base with a Shelf Life date of 2/26/23, revealed an opened and partially used white plastic container of beef base with a Shelf Life date of 2/26/23; revealed a clear plastic zip lock bag that contained a leftover portion of a ham with a date of 4/16/23; revealed a clear plastic storage container of leftover egg salad with a Shelf Life date of 4/21/23; revealed a clear plastic pitcher of V8 vegetable juice drink with a Date Prepared/Opened of 4/20/23; revealed a clear plastic storage container of leftover tomato soup with a Date Prepared/Opened date of 4/18/23; and revealed a clear plastic zip lock bag that contained sliced bologna with a Date Prepared/Opened of 4/19/23. An observation and interview on 4/30/23 at 03:52 PM, with the Dietary Aide was observed to remove the items from the cooler, revealed the stored food items were expired, and should be thrown away after being in the cooler for six (6) days. She noted she was responsible to store leftovers and unused portions of food items in the cooler on her shift and was supposed to watch the dates to throw the leftovers and unused food items away by the expiration dates. She noted if any of the food items had been fed to a resident, the resident could have possibly gotten sick. An interview on 5/2/23 at 11:30 AM with the Dietary Manager revealed all other food items listed should have been discarded after 7 days of the date on the containers. She revealed she usually checked the coolers for expired food each	M 815	Quality Assurance and Performance Improvement (QAPI) Committee monthly starting 6-15-2023, times three months. 5. Completion Date 6-15-2023.	

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M 815	Continued From page 19	M 815		

week but did not check this cooler before she left on Friday, 4/28/23. She confirmed that if a resident had been served the expired food items there was the possibility of them getting a food borne illness.

An interview on 5/2/23 at 12:00 PM with the Administrator, he confirmed the items should have been labeled properly for storage and to enable the dietary staff to discard the food items by the expiration date of 7 days. He also confirmed that if a resident had been served the expired food items there was the possibility of them getting a food borne illness.

An observation and interview with the Director of Nursing (DON), on 5/3/23 at 10:30 AM, confirmed the resident nourishment refrigerators' freezers on the A Hall and the B Hall nursing units had a thick layer of ice. The buildup of ice in the freezer protruded outward causing the A-Hall refrigerator's door not to close and seal. The DON observed and revealed that the thermometer in the refrigerator on the A Hall nursing unit registered 60 degrees for the internal temperature. The A Hall refrigerator was observed to have two (2) unlabeled clear plastic zip lock bags of cut up cantaloupe, a small bottle of milk, and a clear plastic storage container, of outside food, that was not properly labeled. The B Hall Refrigerator was observed to have a thick layer of ice in the freezer section of the resident nourishment refrigerator and had 1 quarter sized and 2 nickel sized brown spots of a thick appearing liquid substance on the bottom floor of the refrigerator. DON confirmed there was a temperature log that indicated the refrigerator was last inspected and cleaned on 11/5/22 and had been inspected and cleaned 9/1-6/2022. She confirmed the resident nourishment refrigerators

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M 815	Continued From page 20	M 815		

had not been inspected and cleaned regularly on the A-Hall and B-Hall nursing units. She confirmed that both resident nourishment refrigerators needed to be cleaned, should have been kept clean, and the temperatures should have been monitored on a regular schedule, and confirmed the food items in the refrigerator should have been labeled properly to avoid the possibility of food borne illnesses for residents and to allow food items to be discarded in a timely manner. She revealed the unlabeled food items in the refrigerator and the refrigerators not being cleaned regularly have the possibility to cause a resident the possibility of food borne illnesses.

Record review of the nursing facility's dietary manager and the dietary department staff in-services revealed "Associate In-Service Record ... (Dietary Manager's Name Removed) ... 4/24/23 ... Topic: Labeling, Dating, and Expired Foods Procedures: Once a product is opened, it must be dated, and if necessary, labeled. ... There cannot be any expired food in the kitchen. As an Account Manager, it is your responsibility that all food items are in date. All food items must be checked during your daily morning walk through. If a food item has expired, throw it away. Every food item, in your kitchen must be seen and touched daily to ensure it has not expired/fallen out of date." Associate In-Service Record ... 4/19/23 ... Topic: Labeling and Dating Procedures and Expired Food Items: Once a product is opened, it must be dated, and if necessary, labeled. "

Record review of the log for the B-Hall resident nourishment refrigerator revealed "REFRIGERATOR-NON-Medication TEMPERATURE no greater than 38 degrees;

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M 815	Continued From page 21 Monitored for temperature and appropriate contents. The refrigerator should be clean. ... MONTH Nov 22; DAILY INSPECTION 11/5/22; DAILY TEMP 36 degrees; REFRIGERATOR CLEANED? (check mark) ... MONTH 09/22; DAILY INSPECTION 9/1, 9/2, 9/3, 9/4, 9/5, 9/6; REFRIGERATOR CLEANED? (check mark for all dates noted)."	M 815		
M1570	48.58.1 Infection Control The following infection control standards shall be met: 1. The facility must maintain and document an effective infection control program that protects patients, families, visitors, and facility personnel by preventing and controlling infections and communicable diseases. 2. The facility must have an active surveillance program that includes specific measures for prevention, early detection, control, education, and investigation of infections and communicable diseases in the facility. There must be a mechanism to evaluate the effectiveness of the program(s) and take corrective action when necessary. The program must include implementation of nationally recognized systems of infection control guidelines to avoid sources and transmission of infections and communicable diseases. 3. The facility must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions. This Statute is not met as evidenced by:	M1570		6/15/23

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M1570	Continued From page 22 Level II Based on observation, staff interviews, record review and facility policy review the facility failed to prevent the possible spread of infection as evidenced by staff failed to remove gloves and perform hand hygiene after administering eye drops and prior to administering oral medication, and failed to sanitize an eye drop box before placing it in the medication cart that was sitting on a residents bedside table without a barrier for one (1) of four (4) residents reviewed during medication and treatment administration. Resident #62. Findings include: Review of the facility's policy titled, "Instillation of Eye Drops," Revised January 2014, revealed, "... Equipment and supplies... 1. Eye dropper... 4. Personal protective equipment ...Steps in the Procedure... 13. After instillation remove gloves and discard ... Wash and dry your hands thoroughly 14. Clean equipment and return to designated storage area ...." Review of the facility's policy titled, "Administering Medications," Revised April 2019 revealed, Policy Statement: Medications are to be administered in a safe and timely manner, and as prescribed...Policy Interpretation and Implementation... 25. Staff follows established facility infection control procedures (e.g., (example) handwashing, aseptic technique, gloves) for the administration of medications as applicable ..." Review of the facility's policy titled, "Cleaning and Disinfection of Resident -Care Items and Equipment," reviewed 3/2023, revealed "Policy	M1570	M 1570 Infection Control 1. Root Cause Analysis was conducted by the Interdisciplinary Team and based on findings Resident #62 was assessed by the Director of Nursing with no negative finding on 5-2-2023. On 5-2-2023 LPN#2 was in-serviced by the Director of Nursing on medication administration/infection control best practices policy and procedures to include appropriate glove usage, hand hygiene, sanitizing of equipment, and barrier usage. 2. Eighty-four residents have the potential to be affected. 3. On 5-15-2023 the Staff Development Nurse (SDC) initiated an all Nursing Staff in-service on medication administration/infection control best practices policy and procedures to include appropriate glove usage, hand hygiene, sanitizing of equipment, and barrier usage. New hires' training and education will be conducted in orientation. 4. Nursing Medication Pass will be monitored for medication administration/infection control best practices policy and procedures to include appropriate glove usage, hand hygiene, sanitizing of equipment, and barrier usage starting 5-15-2023 by the Infection Preventionist Nurse (IPN), Staff Development Coordinator (SDC), Assistant Director of Nursing (ADON) or Director of Nursing (DON); 3 x weekly for 4 weeks, then 2 x weekly for 4 weeks, then 1 time a week for 4 weeks, to ensure	

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M1570	Continued From page 23 Statement: Resident -care equipment, including reusable items... will be cleaned and disinfected according to current CDC (Center for Disease Control) recommendations for disinfection and the OSHA (Occupational Safety and Health Administration) Bloodborne Pathogen Standard ..." An observation of medication administration with Licensed Practical Nurse (LPN) #2 on 5/2/23 at 8:15 AM, revealed LPN #2 set up and administer medications for Resident #62. LPN #2 administered Refresh Tears solution one (1) drop to both eyes, placed the eye drops back in the box on the resident's bedside table without a barrier, then went on to administer oral medications to Resident #62. LPN #2 administered the oral medications with the same gloves she was wearing to administer the eye drops. LPN #2 then returned to her medication cart, put her dirty gloves in the trash and sanitized her hands. She placed the eye drop box that had been sitting on the residents bedside table with no barrier back into the medication cart without sanitizing the box. An interview on 5/2/23 at 8:20 AM, LPN #2 confirmed she did not take her gloves off or sanitize her hands after instilling the eye drops and picking up the medication cup and handing it to Resident #62. LPN #2 also confirmed she did not sanitize the eye drop box that was sitting on the resident's table before putting it back in the medication cart. She confirmed she should have done so and revealed possible concerns of not performing hand hygiene would be risk of transferring bacteria causing infections. An interview with the Infection Control (IC) nurse on 5/2/23 at 1:00 PM, she revealed staff nurses	M1570	compliance Infection Control standards. Findings will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee monthly starting 6-15-2023, times three months. 5. Completion date is set as 6-15-2023.	

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GRENADA REHABILITATION AND HEALTHCARE CEN	1966 HILL DRIVE GRENADA, MS 38901

(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) COMPLETE DATE
M1570	Continued From page 24 should perform hand hygiene after administering eye drops to reduce the spread of bacteria from one site to another and should sanitize any item that was placed on a dirty area before placing them back in the medication cart. A record review of in-services titled Safe Handling of drugs /Administration dated 1/12/23, revealed in-service topics: Administering Medications and Instillation of Eye drops with a signature for LPN #2 as attended. Record review of Resident # 62's Admission Record revealed that the facility admitted him on 2/02/22 with diagnosis which include Dry eye Syndrome, Schizophrenia and Bipolar disorder.	M1570		