STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255279	A. BUILDING _____ B. WING _____	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SARDIS COMMUNITY NH	613 EAST LEE STREET SARDIS, MS 38666

(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 6/6/23 through 6/8/23. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F580, F604, F658, F755,and F880. The facility held a license for 60 beds, with a census of 59.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the	F 580		7/17/23

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

Electronically Signed | 06/19/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 580	Continued From page 1 physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff interview, record review and facility policy review, the facility failed to notify the physician of the failure to obtain a medication for one (1) of 16 medications reviewed. Resident #18. Findings include: Review of the facility policy titled "Drug Administration and Documentation", latest revision date 04/21, revealed, "...If a dose of regularly scheduled medication is refused, held or for some reason not given for more than 2 doses in a row, notify the physician..."	F 580	Director of Nurses (DON) obtained Clopidogrel 75 mg as ordered from back-up Pharmacy at 8:45am on 6/7/23. Licensed Practical Nurse (LPN) #2 administered medication to resident #18 as ordered by the physician. Registered Nurse (RN)#2 notified the physician on 6/7/23 that his orders had not been followed and obtained new orders for resident #18. Resident's vital signs were obtained by LPN #2 on 6/7/23 with no negative findings. A Quality Improvement(QI) meeting was held with all department heads and Medical	

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F 580	Continued From page 2 During medication administration observation for Resident #18 with Licensed Practical Nurse (LPN) #2 on 6/7/23 at 7:45 AM, she revealed she was unable to give Resident #18 the Clopidogrel 75 milligram (mg) as ordered, revealing the medication had not been delivered from the pharmacy. LPN #2 stated the Plavix was ordered on 6/2/23 after the resident returned from a physician visit. Record review of the Physician Consultation Report dated 6/2/23, revealed, "Findings: Mixed disease in the RLE (right lower extremity). PAD (Peripheral Arterial Disease) and Chronic Venous Insufficiency with nonhealing ulcer of RT (right) foot ... New Orders: Start Plavix Daily ... A review of the Physician's Orders for Resident #18 revealed Clopidogrel 75 mg tablet give one tablet daily at 8:00 AM with an order date of 6/2/23. During an interview with the Director of Nursing (DON) on 6/07/23 at 8:00 AM, she revealed she was unaware Resident #18 did not have his Clopidogrel. The DON revealed the resident has poor circulation and confirmed by not receiving the Plavix as ordered placed Resident #18 at risk for further circulation concerns and possible blood clots. In an interview with the DON and LPN #2 on 6/07/23 at 8:20 AM, LPN #2 confirmed she had not notified anyone of needing the Clopidogrel. On 6/07/23 at 3:10 PM, during a phone interview with LPN #3 confirmed the Clopidogrel was not in the facility the 6/3/23 or 6/4/23 when she worked.	F 580	Director on 6/8/23. All residents have the potential to be affected by this deficient practice. An in-serviced was completed by RN #2 for all nursing staff on policy labeled "Drug Administration and Medication" on 6/14/23. All resident physician orders were checked against resident medicine cards to ensure accuracy by the DON and LPN's assigned to the 2 medicine carts on 6/14/2023. Any and all discrepancies found were immediately corrected. At this time all physician orders and medicine cards are 100 % accurate. DON will audit new physician orders and that medications were received and given as ordered 5 times a week for the next 4 weeks, starting 6/15/23 ending on 7/15/23 and then monthly for the next 3 months and then quarterly. The Administrator and DON will also present findings of audits in the Quarterly QI meeting on 7/17/23 and then quarterly at each QI meeting until substantial compliance is achieved. If any negative findings occur with current plan of correction, the QI committee will revise the plan of correction until compliance is obtained.	

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F 580	Continued From page 3 She confirmed she did not notify the pharmacy or the physician. LPN #3 confirmed she should have contacted the resident's physician and the pharmacy of these concerns. An interview with Registered Nurse (RN) #1 on 6/08/23 at 8:15 AM, confirmed if a nurse is unable to get a medication the physician needs to be notified. During an interview with the Administrator on 6/08/23 at 8:28 AM, she revealed the nurses did not give the Clopidogrel as ordered and failed to notify the pharmacy of the medication order and did not notify the physician of not having the medication to be administered. Record review of the Admission Record revealed that the facility admitted Resident #18 to the facility on 8/03/15 with diagnoses of Atrial Fibrillation, Heart Failure, and Atherosclerotic Heart Disease of Coronary Arteries.	F 580		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property,	F 604		7/17/23

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F 604	Continued From page 4	F 604		

and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.

§483.12(a) The facility must-

§483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.
This REQUIREMENT is not met as evidenced by:
Based on observation, resident and family interview, staff interview, record review, and facility policy review the facility failed to ensure residents were free from restraints for one (1) of 59 residents reviewed. Resident #42

Findings Include:

Record Review of the facility policy titled, "Restraints and Safety Devices", with a revision date of 10/22, revealed, "It is the philosophy of this facility that a resident has the right to be free from any physical or chemical restraints ..."

An observation on 6/6/23 at 9:15 AM, revealed Resident #42 was in the bed laying on a winged mattress with full siderails in the upright position on both sides of the bed.

During an interview with Resident #42 on 6/6/23

Resident #42 was given an new bed and a new mattress at 5:15 p.m. on 6/7/2023 after resident told the Administrator that she was ok with her switching them out. The Director of Nurses (DON) assisted the Administrator in changing out the bed and mattress for resident #42. Resident #42 stated that she was comfortable and happy with the new bed and mattress. The Administrator and the maintenance director checked every bed in the facility for the 54" side rails and removed them.

All residents have the potential to be affected by this deficient practice.

An in-service on the facility Restraint Policy was conducted by Staff Development Registered Nurse with all facility staff on 6/9/2023. All staff

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F 604	Continued From page 5 at 9:16 AM, she shook her head no when asked if she knew why she was on the winged mattress and had full siderails up on either side of the bed. A record review of Resident #42's Physician Orders , dated June 2023 revealed that she did not have an order for a winged mattress or full side rails. A record review of Resident #42's Nurse Data Collection and Screening, completed on 5/17/23, revealed that she did not have a bed rail or a restraint in use. A record review of Resident #42's medical record revealed she did not have a consent or assessment for the use of the winged mattress or full siderails. An observation of Resident #42 on 6/7/23 at 4:00 PM, revealed she was in bed laying on a winged mattress with full siderails in the upright position on both sides of the bed. During an interview on 6/7/23 at 4:02 PM, with Resident #42's Resident Representative (RR), she stated she did not know anything about the winged mattress or full side rails and stated that Resident #42 did not like the mattress. During an interview with Resident #42 on 6/7/23 at 4:04 PM, she shook her head no when asked if she liked the winged mattress. Resident #42 shook her head yes when asked if the mattress was uncomfortable. During an interview with Licensed Practical Nurse (LPN) #1 on 6/7/23 at 4:20 PM, she stated that winged mattresses are used to prevent residents	F 604	in-serviced voiced understanding of facility restraint policy. Residents will be monitored by DON/Administrator (ADM) weekly times 3 months to ensure compliance with F604. Weekly rounds will be completed by DON/ADM and an audit will be completed on each resident to ensure that every resident residing in the facility is free of chemical and/or physical restraints beginning on 6/15/2023. DON and the Administrator will report findings of audit to daily department head meeting once a week for 4 weeks beginning 6/15/23, then monthly for the next 3 months and then at the quarterly QI meeting to be held on 7/17/23 and then every quarter thereafter until substantial compliance is obtained. If concerns are identified with the current corrective action plan, the Quality Improvement Committee will revise the plan of correction until compliance is obtained.	

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F 604	Continued From page 6	F 604		

from falling out of bed. She stated that they only used one-half (1/2) side rails in the facility for bed mobility. She stated that if a resident had a winged mattress or full side rails, then they would not have a Physician's order for them. The order would not show up on the electronic Medication Administration Record (eMAR). She stated she would know if a resident was supposed to have a winged mattress or full side rails because she would be told in report. LPN #1 stated that she was familiar with Resident #42 and the resident did not have a winged mattress or full side rails.

During an interview with the Minimum Data Set (MDS) Nurse on 6/7/23 at 4:30 PM, she stated that if a resident had a winged mattress or full side rails, then they would have a physician's order, assessment, and care plan. She stated that Resident # 42 did not have a winged mattress, full side rails, physician's orders for a winged mattress and side rails, or a care plan for a winged mattress and side rails. She stated when she did the Admission MDS she would have seen it and questioned it. The MDS Nurse stated that Resident # 42 moved rooms and if she now has a winged mattress and full side rails it is likely because that was the bed in the room when she moved into it.

During an interview on 6/7/23 at 4:42 PM, with the Director of Nursing (DON) she stated that if a resident had a winged mattress or full side rails they should have a physician's order, assessment, and care plan; and that it would show up on the eMAR for the staff to know that the resident was supposed to have it.

During an observation and interview with the DON on 6/7/23 at 4:45 PM, she verified that

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F 604	Continued From page 7 Resident #42 did have a winged mattress and full side rails on her bed and that she should not have them. The DON stated that these items were a restraint and if the resident attempted to get out of bed with them in place she could fall and injure herself. During an interview with the Administrator on 6/8/23 at 8:15 AM, she verified that the side rails on Resident #42's bed were 54 inches long. Record review of the Face Sheet revealed that the facility admitted Resident #42 to the facility on 5/10/23 with a diagnosis of Cerebral Infarction. Record review of the MDS Section C with an Assessment Reference Date (ARD) date of 5/17/23, revealed that Resident #42 had a Brief Interview for Mental Status (BIMS) score of seven (7) which indicated that she was moderately cognitively impaired.	F 604		
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, record review, and facility policy review the facility failed to assure that services were being provided according to accepted standards of clinical practice as evidenced by Clopidogrel (Plavix) signed off as administered on the medication record for Resident #18 by staff on four (4)	F 658	Director of Nurses (DON) obtained Clopidogrel 75 mg as ordered from the back-up Pharmacy at 8:45am on 6/7/23. Licensed Practical Nurse (LPN) #2 administered medication to resident #18 as ordered by the physician. Registered Nurse (RN)#2 notified the physician on	7/17/23

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F 658	Continued From page 8 consecutive days when the medication had not been dispensed by a pharmacy for one (1) of 16 medications reviewed. Findings include: A review of the facility policy titled, "Administration of Medications," revised 10/17, Purpose: "To administer medications in accordance with best practice." During medication administration observation for Resident #18 with Licensed Practical Nurse (LPN) #2 on 6/7/23 at 7:45 AM, she revealed she was unable to give Resident #18 the Clopidogrel 75 milligram (mg) as ordered, revealing the medication had not been delivered from the pharmacy. LPN #2 stated the Plavix was ordered on 6/2/23 after returning from a physicians visit. A review of the Physician's Orders for Resident #18 revealed Clopidogrel 75 mg tablet give one tablet daily at 8:00 AM with an order date of 6/2/23. A review of the Physician Consultation Report dated 6/2/23, revealed under New Orders: Start Plavix Daily ... A review of the Electronic Medication Administration Record (e-MAR) for June 2023, revealed Clopidogrel 75 mg tablet daily at 8:00 AM was signed off as administered by LPN #3 on June 3rd and 4th and by LPN #2 on June 5th and 6th. An interview with the Director of Nursing (DON) on 6/07/23 at 8:00 AM, she revealed she was unaware Resident #18 did not have his	F 658	6/7/23 that his orders had not been followed and obtained new orders for resident #18. Resident's vital signs were obtained by LPN #2 on 6/7/23 with no negative findings. A Quality Improvement (QI) meeting was held with all department heads and Medical Director on 6/8/23. All residents have the potential to be affected by this deficient practice. In-services were completed by RN #2 for all nursing staff on policy labeled " Administration of Medications" and "Care Plan Process Policy" on 6/9/23. All resident physician orders were checked against resident medicine cards to ensure accuracy by the DON and LPN's assigned to the 2 medicine carts on 6/14/2023. At this time all physician orders, medicine cards and care plans are 100 % accurate. DON will audit new physician orders and that medications were received and given as ordered 5 times a week for the next 4 weeks and that they are updated on the care plans, starting on 6/15/23 ending on 7/15/23 and then monthly for the next 3 months and then quarterly at the QI meetings until substantial compliance is achieved. The first QI meeting is scheduled to be held on 7/17/23. If any negative findings occur with current plan of correction, the QI committee will revise the plan of correction until substantial compliance is obtained.	

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F 658	Continued From page 9	F 658		

Clopidogrel and confirmed the Resident has poor circulation and not receiving the Clopidogrel as ordered placed Resident #18 at risk for further circulation concerns and possible blood clots.

An interview with the DON and LPN #2 on 6/07/23 at 8:20 AM, the State Agency (SA) presented the e-MAR record to LPN #2 and asked if she administered the Clopidogrel to Resident #18 on June 5th and 6th as it was signed off as administered. LPN #2 revealed to the SA and DON she did not give the Clopidogrel stating "I guess I was just clicking the e-MAR." LPN #2 confirmed she should not have signed the medication as given.

A phone interview with LPN #3 on 6/07/23 at 3:10 PM, she revealed she did not administer the Clopidogrel 75 mg because she questioned where the order came from. SA questioned LPN #3 as to why the medication record had her initials as Plavix being administered. LPN #3 revealed she should not have signed the Clopidogrel as given stating "I must have been clicking the computer screen to fast." LPN #3 confirmed the medication was not in the facility and she should not have signed the Clopidogrel off because it was not given.

An interview with the Minimum Data Set Nurse (MDS) on 6/07/23 at 1:30 PM, she revealed she called and spoke with a pharmacist at the pharmacy and the pharmacist revealed there was no record of an order for Clopidogrel for Resident #18 until the DON called this morning on 6/7/23.

An interview with the Administrator on 6/08/23 at 8:28 AM, she revealed the nurses did not give the Clopidogrel as ordered. The Administrator

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F 658	Continued From page 10 confirmed LPN #2 and LPN #3 did not follow the standards of practice for medication administration when they signed off medications as given when the medication was not delivered until 6/7/23. Record review of the Admission Record revealed that the facility admitted Resident #18 to the facility on 8/03/15 with diagnoses of Atrial Fibrillation, Heart Failure, and Atherosclerotic Heart Disease of Coronary Arteries. Record review of the MDS with an Assessment Reference Date (ARD) of 3/16/23 with a Brief Interview of Mental Status (BIMS) score of 15 which indicates Resident #18 is cognitively intact.	F 658		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-	F 755		7/17/23

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F 755	Continued From page 11 §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review the facility failed to meet the pharmaceutical needs of a resident when staff failed to obtain and provide the medication Clopidogrel for Resident #18 for one (1) of 16 medications reviewed. Findings include: A review of the facility policy titled, "Physician Orders," revised 1/23, revealed "It is the policy of the facility that all physician's orders will be implemented timely and carried out in a professional manner ... An order for medication or supplies shall be placed to the pharmacy or appropriate supplier." ... A medication administration observation for Resident #18 with Licensed Practical Nurse (LPN) #2 on 6/7/23 at 7:45 AM, revealed she was unable to give Resident #18 the Clopidogrel 75 milligram (mg) as ordered. She revealed the medication had not been delivered from the pharmacy. LPN #2 stated the Clopidogrel was ordered on 6/2/23 after the resident returned from	F 755	Director of Nurses (DON) obtained Clopidogrel 75 mg as ordered from Davis Pharmacy at 8:45am on 6/7/23. Licensed Practical Nurse (LPN) #2 administered medication to resident #18 as ordered by the physician. Registered Nurse (RN)#2 notified the physician on 6/7/23 that his orders had not been followed and obtained new orders for resident #18. Resident's vital signs were obtained by LPN #2 on 6/7/23 with no negative findings. A Quality Improvement (QI) meeting was held with all department heads and Medical Director on 6/8/23. All residents have the potential to be affected by this deficient practice. In-serviced was completed by RN #2 for all nursing staff on policy's labeled "Physician Orders", "Standards for Pharmacy Suppliers" and "Pharmacist Services Policy" on 6/9/23. All nursing staff voiced understanding of these 3 facility policies. Starting 6/9/23 All	

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	255279	A. BUILDING _____ B. WING _____	06/08/2023

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F 755	Continued From page 12 an outside appointment. She confirmed she faxed the order to the pharmacy that day. LPN #2 also revealed when she came back to work on Monday 6/5/23 the medication was not in the facility, so she notified pharmacy again on 6/5/23 and 6/6/23 and the physician of not having the medication to administer. A review of the Physician's Orders for Resident #18, revealed Clopidogrel 75 mg tablet give one tablet daily at 8:00 AM with an order date of 6/2/23. A review of the Physician Consultation Report dated 6/2/23, revealed under New Orders: Start Plavix Daily ... During an interview with the Director of Nursing (DON) on 6/07/23 at 8:00 AM, she revealed she was unaware Resident #18 did not have his Clopidogrel. A review of the emergency drug kit with the DON revealed there is no Clopidogrel on the formulary list. The DON placed a call to pharmacy to have the medication sent from back-up pharmacy. The DON revealed the resident has poor circulation and confirmed by not receiving the Plavix as ordered placed Resident #18 at risk for further circulation concerns and possible blood clots. In an interview with the DON and LPN #2 on 6/07/23 at 8:20 AM, revealed the DON asked LPN #2 "Who did you report to that Resident #18 needed Clopidogrel and if you notified the pharmacy who did you speak with." LPN #2 confirmed she had not notified anyone of needing the Clopidogrel. Record review of the Electronic Medication	F 755	nursing staff will order medications from Pharmacy and wait for a fax confirmation sheet and/or call them to ensure they received the order. If Pharmacy is unable to fill that prescription they will call the back-up pharmacy and notify the facility that they have called it into the back-up Pharmacy to ensure that the medication is received by the facility and administered to the resident per the physician's order and timely. All new resident physician orders were checked against resident medicine cards to ensure accuracy by the DON and LPN's assigned to the 2 medicine carts on 6/14/2023. At this time all physician orders and medicine cards are 100 % accurate. DON will continue to audit new physician orders and that medications were received and given as ordered 5 times a week for the next 4 weeks and then monthly for the next 3 months, starting 6/14/23 and ending on 9/14/2023 then quarterly at the QI meetings. The Administrator and DON will report findings from the audits regarding F755 in the Daily Department Head meeting beginning 6/14/2023, for 4 weeks. The Administrator and DON will also present findings of audits in the Quarterly QI meetings, the first one to be held on 7/17/23 until substantial compliance is achieved. If any negative findings occur with current plan of correction, the QI committee will revise the plan of correction until substantial compliance is obtained.	

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F 755	Continued From page 13	F 755		

Administration Record (EMAR) revealed an order dated 6/2/23 "Clopidogrel 75 mg tablet, oral 8a (AM) daily. Give 1 tab (tablet) by mouth daily." Documentation on the EMAR revealed staff initials were listed on 6/3/23 through 6/6/23 indicating the medication had been administered.

An interview with the Administrator on 6/07/23 at 1:20 PM, revealed LPN #2 failed to order the Clopidogrel when she obtained the order on 6/2/23.

During an interview with the Minimum Data Set Nurse (MDS) on 6/07/23 at 1:30 PM, revealed she called and spoke with a pharmacist at the pharmacy and the pharmacist revealed there was no record of an order for Clopidogrel for Resident #18 until the DON called this morning 6/7/23 at 8:02 AM.

During a phone interview with LPN #3 on 6/07/23 at 3:10 PM, confirmed the Clopidogrel was not in the facility the 6/3/23 or 6/4/23 when she worked. She confirmed she did not notify the pharmacy or the physician. LPN #3 confirmed she should have contacted the resident's provider and the pharmacy of these concerns.

An interview with Registered Nurse (RN) #1on 6/08/23 at 8:15 AM, revealed all new medication orders are faxed to the Pharmacy to be filled and delivered. She went on to say if orders are received after hours, the pharmacy has an on-call pharmacist, and they would notify a local pharmacy that contracts to delivery any medications needed immediately. RN #1 confirmed if a nurse is unable to get a medication the physician needs to be notified.

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F 755	Continued From page 14 During an interview with the Administrator on 6/08/23 at 8:28 AM, she revealed the nurses did not give the Clopidogrel as ordered and failed to notify the pharmacy of the medication order and did not notify the physician of not having the medication to be administered. The Administrator confirmed the Clopidogrel was not delivered until 6/7/23 and confirmed LPN #2 and LPN #3 should have followed up with pharmacy and notified the DON they did not have the medication. Record review of the Admission Record revealed that the facility admitted Resident #18 to the facility on 8/03/15 with diagnoses of Atrial Fibrillation, Heart Failure, and Atherosclerotic Heart Disease of Coronary Arteries. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date of 3/16/23 revealed Resident #18 had a Brief Interview of Mental Status (BIMS) score of 15 which indicates Resident #18 is cognitively intact.	F 755		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		7/17/23

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F 880	Continued From page 15 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880		

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F 880	Continued From page 16 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy review the facility failed to establish and maintain an infection prevention and control program designed to help prevent transmission of communicable diseases and infections as evidenced by failure to administer a second step Tuberculin (TB) skin test to employees prior to working in the facility for one (1) of 10 employees reviewed. Findings include : Review of the facility policy titled, " TB Testing MS", with a revision date of 7/19 revealed, "II: Employee Testing for Tuberculosis ...Baseline ...Employees with a negative tuberculin skin test and a negative symptom assessment shall have the second step of the the two-step Mantoux tuberculin skin test, administered, read, and documented in the employee's personnel record within fourteen (14) days of employment. A record review of the Maintenance Supervisor's EmployeeTuberculin TB Test Record revealed he received a step-one (1) Tuberculin purified	F 880	The Director of Nurses (DON) readministered the first step TB skin test for the maintenance director on 6/8/23 and it was read by her on 6/11/23 with no negative finding. The second step TB skin test will be administered on 6/25/23 and read on 6/28/23 by the DON. The DON then completed a 100% audit on the TB skin tests for all staff on 6/9/23. No deficiencies were identified. A Quality Improvement meeting was held on 6/8/23 with all Department Heads and the Medical Director. All staff and residents have the potential to be affected by this deficient practice. An in-service was conducted for all staff by the Staff Development Registered Nurse (RN) on 6/9/2023 on the facility policy labeled "TB Testing in MS". The DON will audit 100% of all new staff to ensure that they receive TB skin testing according to facility policy starting	

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F 880	Continued From page 17 protein derivative (PPD) skin test on 4/12/23 with a reading of 00 millimeters (mm) on 4/14/23. There is no evidence that the Maintenance Supervisor was offered or received a second step TB skin test. During an interview with Licensed Practical Nurse (LPN) Assessment Nurse on 6/8/23 at 11:45 AM, she stated that the Maintenance Supervisor did not receive a second step TB skin test. She stated that she previously administered TB skin testing but was moved into a different position. She stated now the Director of Nursing (DON) is responsible for the TB skin testing and she tries to help her. During an interview with the Administrator on 6/8/23 at 11:50 AM, she stated that she thought the LPN Assessment Nurse was responsible for administering the TB skin testing. During an interview with the DON on 6/8/23 at 12:35 PM, stated that the Staff Development Coordinator (SDC) is responsible for TB skin testing. She stated that the LPN Assessment Nurse was moved out of the SDC role, so she and the LPN Assessment Nurse have both been doing the TB Skin tests. The DON confirmed that during the time the facility was looking for a SDC there was not a consistent plan in place to ensure a TB test was not missed. She stated not doing a TB skin test on a staff or resident could cause the spread TB in the facility.	F 880	6/15/2023 for once a week for 4 weeks, then monthly for 3 months and then quarterly at the facility QI meetings. The results will be reported at the Quality Improvement committee meeting to be held on 7/17/2023 and then at every quarterly QI meeting until substantial compliance is obtained. If concerns are identified with the current corrective action plan, the Quality Improvement Committee will revise the current plan of correction until substantial compliance is obtained.	