MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	71IH	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TISHOMINGO COMM LIVING CENTER	1410 WEST QUITMAN STREET IUKA, MS 38852

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M 000	Initial Comments The State Agency (SA) conducted an annual recertification survey and complaint investigations for CI MS #21345, CI MS #21398, and CI MS #21656 from 5/15/23 through 5/18/23. The SA extended the survey and entered the facility again on 05/31/23 and exited on 06/01/23. The SA found the facility to not be in compliance regarding CI MS #21656 related to the death of a resident. The facility was not in compliance with the requirements of participation in Medicare and Medicaid. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid Services and cited F578, F583 F644, F656, F 695, F801, and F812. The SA investigated CI MS #21345 for Respect/Resident Rights and did not cite deficiencies related to this allegation. The SA investigated CI MS #21398 for Physical Environment and did not cite any deficiencies related to this allegation. During the survey, the SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which began on 5/15/23, when the facility failed to accurately transcribe physician's orders, reconcile, and verify physician's orders resulting in the omission of an insulin order and develop a comprehensive care plan regarding the care needed for the diagnosis of diabetes for Resident #1. Resident #1's physician ordered long-acting insulin was not administered for five days following admission on 5/15/23 at approximately 4:49 PM and the resident had to be transferred to the Emergency Room on 5/20/23 at 5:10 AM, which revealed a blood sugar of 764 at 5:38 AM and resulted in death of the resident at 6:35 AM with a diagnosis of diabetic ketoacidosis (DKA).	M 000		

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M 000	Continued From page 1 The facility's failure to accurately transcribe physicians orders, reconcile and verify physicians orders to prevent Diabetic Ketoacidosis as a result of the omission of an insulin order and failure to develop and implement a comprehensive care plan regarding the care needed for the diagnosis of diabetes the facility placed Resident #1 and other residents with significant medication orders at risk of developing a situation that was likely to cause serious injury, harm, impairment, or death. The SA notified the facility's Administrator of the IJ and SQC on 5/31/23 at 5:00 PM and provided the Administrator with the IJ templates. The State Agency (SA) called Immediate Jeopardy (IJ) on 05/31/23 at 5:00 PM and provided the facility with the IJ templates. Immediate Jeopardy was cited at: 42 CFR 483.21 (a) Baseline Care Plan (F655) at a scope and severity (S/S) of J; 42 CFR 483.21 (b)(3) Professional Standards (F658) at a S/S of J; 42 CFR 483.70 (i)(1)(ii) Medical Record Accurately documented (F842) at a S/S of J Immediate Jeopardy and Substandard Quality of Care (SQC) was cited at: 42 CFR 483.25 Quality of Care (F684) at a S/S of J; 42 CFR 483.45(f)(2) Free of Significant Medication Error (F760) at a S/S of J The facility submitted an acceptable Removal Plan on 05/31/23 and the IJ was removed on 05/31/23. The SA validated the Removal Plan on 06/01/23 and determined the IJ was removed on 05/31/23.	M 000		

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M 000	Continued From page 2 The facility was licensed for 73 beds and the census at the time of the survey was 67. The State Agency (SA) conducted an annual recertification survey and complaint investigations for CI MS #21345, CI MS #21398, and CI MS #21656 from 5/15/23 through 5/18/23. The SA extended the survey and entered the facility again on 05/31/23 and exited on 06/01/23. The SA found the facility to not be in compliance regarding CI MS #21656 related to the death of a resident. The facility was not in compliance with	M 000		

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M 000	Continued From page 3	M 000		

the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirments at M and cited M175, M460, M500, M655 and M815. The SA investigated CI MS #21345 for Respect/Resident Rights and did not cite deficiencies related to this allegation. The SA investigated CI MS #21398 for Physical Environment and did not cite any deficiencies related to this allegation.

During the survey, the SA identified an Immediate Jeopardy (IJ) which began on 5/15/23, when the facility failed to accurately transcribe physician's orders, reconcile, and verify physician's orders resulting in the omission of an insulin order and develop a comprehensive care plan regarding the care needed for the diagnosis of diabetes for Resident #1. Resident #1's physician ordered long-acting insulin was not administered for five days following admission on 5/15/23 at approximately 4:49 PM and the resident had to be transferred to the Emergency Room on 5/20/23 at 5:10 AM, which revealed a blood sugar of 764 at 5:38 AM and resulted in death of the resident at 6:35 AM with a diagnosis of diabetic ketoacidosis (DKA).

The facility's failure to accurately transcribe physicians orders, reconcile and verify physicians orders to prevent Diabetic Ketoacidosis as a result of the omission of an insulin order and failure to develop and implement a comprehensive care plan regarding the care needed for the diagnosis of diabetes the facility placed Resident #1 and other residents with significant medication orders at risk of developing a situation that was likely to cause serious injury, harm, impairment, or death.

The SA notified the facility's Administrator of the

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M 000	Continued From page 4 IJ on 5/31/23 at 5:00 PM and provided the Administrator with the IJ templates. IJ existed at: Rule 45.25.1 Medical Records Management - M735, Level IV The facility submitted an acceptable Removal Plan on 05/31/23 and the IJ was removed on 05/31/23. The SA validated the Removal Plan on 06/01/23 and determined the IJ was removed on 05/31/23, prior to exit. Therefore, the scope and severity for Rule 45.25.1 Medical Records Management - M735 was lowered from a Level IV to a Level II, while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. The facility was licensed for 73 beds and the census at the time of the survey was 67.	M 000		
M 175	45.2.30 Qualified Dietary Manager 1. A Dietetic Technician who has successfully graduated from a Dietetic Technician program accredited by the American Dietetic Association Commission on Accreditation and Approval of Dietetic Education and earns 15 hours of continuing education units every year approved by the Dietary Manager's Association or the American Dietetic Association. 2. A person who has successfully graduated from a didactic program in Dietetics approved by the American Dietetic Association Commission on Accreditation and Approval of Dietetic Education and earns 15 hours of continuing education units every year approved by the Dietary Manager's	M 175		6/22/23

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M 175	Continued From page 5 Association or the American Dietetic Association. 3. A person who has successfully completed a Dietary Manager's Course approved by the Dietary Manager's Association and who passes the credentialing examination and earns 15 hours of continuing education units every year approved by the Dietary Manager's Association or the American Dietetic Association. 4. A person who has successfully completed a Dietary Manager's Course approved by the Dietary Manager's Association and earns 15 hours of continuing education units every year approved by the Dietary Manager's Association or the American Dietetic Association. This Statute is not met as evidenced by: Based on staff interview, record review and facility policy review the facility failed to ensure that the dietary manager had completed her required training for dietary management after one year of full-time employment for four (4) or four (4) survey days observed. Findings Include Record review of the facility policy titled, "Dietary Manager" with a revision date of 6/1/00 revealed under "Policy statement ...It is the policy of this facility that the day-to-day functions of the dietary department be under the supervision of a qualified dietary manager." An interview on 5/17/23 at 2:20 PM with the Dietary Manager (DM) and the Registered Dietician (RD) revealed that the Dietary Manager had been in that position since 5/2022 and had not completed her dietary manager certification course. The DM revealed that she was hired by	M 175	1. On 5/18/23, Dietary Manager registered and paid for a course of study in Nutrition and Foodservice Professional Training through the University of Florida. The alleged deficient practice has the potential to affect all residents. On 5/17/23, Regional Director of Operations (RDO) in-serviced Dietary Manager regarding certification and regulatory compliance. 2. All residents have the possibility of being affected by the alleged deficient practice. 3. On 5/17/23, the Regional Director of Operations and clinical educator in-serviced the Administrator and Dietary Manager on the requirement to meet the qualifications as listed in 483.60(a)(2). The dietary manager registered and paid for course of study in Nutrition and Foodservice Professional Training through	

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M 175	Continued From page 6 another administrator and when the new administrator started, they discussed the need for her to get her certification, but nothing was ever done. The RD revealed she comes to the facility two times per month. The DM revealed she had one day of training at a sister facility with the dietary manager before she started working at this facility full time. The DM revealed that she had no prior experience in a nursing facility and does not have any type of college degree. An interview on 5/17/23 at 2:40 PM with the Administrator revealed she had not been made aware when she started in August of 2022 that the Dietary Manager had not completed her dietary manager certification course and she is not sure when or how she finally discovered that. She revealed that she sent the information to their corporate office around April of this year to get approval for funding to pay for the DM to take the certification course and confirmed that the DM will start her course sometime this month. An interview on 5/18/23 at 10:30 AM with the Administrator confirmed that 12 months was too long to wait to get the DM signed up for her certification course. She revealed that she and the DM had discussed the certification course and that the DM had agreed to pay for it with her own personal credit card and get reimbursement back from the company later, but she failed to follow up with her and that was her responsibility. Record review revealed that the DM's hire date was 5/9/22.	M 175	the University of Florida. The Dietary Manager started courses on 6/12/23. 4. Starting 5/18/23, the Administrator will meet with Dietary Manager weekly to review progress toward completion of the Nutrition and Foodservice Professional Training Course until the course is completed no later than October 1, 2023. The course is preparation for the national Certifying Board for Dietary Managers Credentialing Exam. Any issues will be immediately addressed. The Administrator will report results of the audit to Quality Assurance Performance Improvement Committee (QAPI) monthly x 4 months starting 6/22/2023 and as needed for review/revision.	

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M 175	Continued From page 7 Based on staff interview, record review and facility policy review the facility failed to ensure that the Dietary Manager (DM) had completed required training for dietary management after one year of full-time employment for four (4) or four (4) survey days observed. Findings include: Record review of the facility policy "Dietary Manager" with a revision date of June 1, 2000 revealed "Policy Statement: It is the policy of this facility that the day-to-day functions of the dietary department be under the supervision of a qualified dietary manager..." An interview on 5/17/23 at 2:20 PM, with the DM and the Registered Dietician (RD) revealed that the Dietary Manager had been in that position since 5/2022 and had not completed her DM certification course. The DM revealed that she was hired by another Administrator and when the new Administrator started, they discussed the need for her to get her certification, but nothing was ever done. The RD revealed she comes to the facility two times per month. The DM revealed she had one day of training at a sister facility with the Dietary Manager before she started working at this facility full time. The DM revealed that she had no prior experience in a nursing facility. An interview on 5/17/23 at 2:40 PM, with the Administrator revealed she had not been made aware when she started in August of 2022 that the Dietary Manager had not completed her DM certification course. She is not sure when or how she finally discovered that. She revealed that she sent the information to their corporate office around April of this year to get approval for funding to pay for the DM to take the certification	M 175		

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M 175	Continued From page 8 course and confirmed that the DM will start her course sometime this month. An interview on 5/18/23 at 10:30 AM, with the Administrator confirmed that 12 months was too long to wait to get the DM signed up for her certification course. She revealed that she and the DM had discussed the certification course and that the DM had agreed to pay for it with her own personal credit card and get reimbursement back from the company later. She stated she failed to follow up with her and that was her responsibility. Record review revealed that the DM's hire date was 5/9/22.	M 175		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate;	M 500		6/22/23

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M 500	Continued From page 9 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 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,	M 500		

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M 500	Continued From page 10 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; 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;	M 500		

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M 500	Continued From page 11 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 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:	M 500		

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M 500	Continued From page 12 Level II Based on observation, staff and resident interviews, and facility policy review the facility failed to respect the dignity of a resident as evidenced by not completely covering the resident's naked body while transporting the resident to the shower for one (1) of 67 resident's observed, Resident #33 Findings Include: Record review of the facility policy titled, "Dignity and Respect" with no revision date revealed under "Procedure...#4 Privacy of a resident's body shall be maintained during toileting, bathing, and other activities of personal hygiene, except when staff assistance is needed for the resident's safety." An observation on 05/17/23 at 3:36 PM, revealed Certified Nurse Assistant (CNA) #2 pushing Resident #33 down the hall in a shower chair covered in the front with a white facility blanket and no covering over his bare buttocks, which were visible from the back side of the chair as he was being pushed down the hallway. An interview on 5/17/23 at 3:38 PM, with CNA #2 revealed she did not realize that Resident #33 was not covered in the back but knows they should be because that is an invasion of the resident's privacy, and she has been taught by the staff that she should make sure they are completely covered. An interview on 5/17/23 at 3:41 PM, with Licensed Practical Nurse (LPN) #3 confirmed that a resident should be completely covered when they are taken to the shower. She stated, "Please	M 500	1. On 5/17/23, Resident #33 was covered on his return trip from the shower by CNA#2. On 5/17/23, CNA #2 was in-serviced by DON on ensuring privacy of a resident□s body shall be maintained during toileting, bathing, and other activities of personal hygiene, except when staff assistance is needed for the resident□s safety. 2. This alleged deficient practice has the potential to affect all residents. 3. On 05/17/23, in-service began with nursing staff on resident□s rights including ensuring privacy of a resident□s body shall be maintained during toileting, bathing, and other activities of personal hygiene, except when staff assistance is needed for the resident□s safety. Room Rounds initiated on 06/16/23. Medical Director also made aware of all findings. 4. Beginning on 5/17/23, DON will observe during walking rounds 5 days per week x 4 weeks, then monthly x 2 months to ensure residents are covered appropriately during care. Any issues will be immediately corrected. Director of Nursing will report results of the audit to Quality Assurance Performance Improvement Committee (QAPI) monthly x 3 months starting 06/22/2023 and as needed for review/revision.	

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(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 500	Continued From page 13 tell me you did not see that on this hall, because we just talked about that with the staff." When the State Agent (SA) confirmed that she had seen a resident's bare buttocks in a shower chair going down the hall, she confirmed that was a dignity issue and should not have happened. An interview on 5/17/23 at 4:00 PM, with the Administrator confirmed that the resident's bare buttocks being exposed while being taken to the shower in a shower chair is not respecting the resident's dignity. An interview on 5/18/23 at 8:40 AM, with Resident #33 revealed he was not aware until a couple of days ago that he was not completely covered when they took him to the shower. Record review revealed the facility had an in-service titled "Dignity and Respect" on 3/30/23 and CNA #2 had attended. Record review of Resident #33's Admission Record revealed the resident was admitted to the facility on 10/31/21 with medical diagnoses that included Atherosclerotic Heart Disease of Native Coronary Artery Without Angina Pectoris. Record review of Resident #33's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/15/23 revealed in Section C a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident is cognitively intact.	M 500		
M 655	45.21.11 Special needs Special needs. Each resident with special needs shall receive proper treatment and care. These special needs shall include, but are not limited to	M 655		6/22/23

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	71IH	A. BUILDING: _____ B. WING _____	06/01/2023

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M 655	Continued From page 14 injections; parenteral and enteral fluids; colostomy, ureterostomy, ileostomy care; tracheostomy care; tracheal suction; respiratory care; foot care; and prostheses. This Statute is not met as evidenced by: Level II Based on observation, staff interview, record review and facility policy review the facility failed to change an oxygen (O2) humidifier bottle and tubing weekly as ordered for one (1) of four (4) residents reviewed for oxygen therapy. Resident #17 Findings include: Record review of the facility policy titled, "Oxygen Education," with a date of September 12, 2013, revealed ... "Important facts: All tubing is changed once a week and clearly marked with the days date..." Record review of the facility policy titled, "Oxygen Administration," with a Procedure revised date of August 25, 2014, revealed ... "Steps in the Procedure ... 9 ... Be sure there is water in the humidifying jar (if used) and that the water level is high enough that the water bubbles as oxygen flows through ...11. Periodically re-check the water level in the humidifying jar ..." An observation of Resident #17 on 5/15/23 at 11:00 AM, revealed the O2 humidifier bottle dated 4/18/23 with no date on tubing connected to the humidifier. An observation of Resident #17 on 5/16/23 at	M 655	1. On 5/16/23, the humidifier bottle and oxygen tubing was replaced by Director of Nursing (DON) For Resident #17. The alleged deficient practice has the potential to affect all residents on oxygen. DON completed audit on 05/16/23 of all residents requiring oxygen therapy. 2. Residents who require respiratory equipment have the potential to be affected by the alleged deficient practice. 3. On 5/16/23, the DON reviewed all other residents on oxygen to ensure their humidifier bottle was not empty and was dated along with the oxygen tubing being appropriately dated. On 5/17/2023, the clinical educator In-service began with nurses on policy for ensuring humidified oxygen and tubing are changed and dated appropriately. 4. Starting 05/16/2023 DON will monitor weekly x 4, then monthly x 2 to ensure humidified oxygen and tubing are changed and dated appropriately. Any identified tubing or humidified bottles will be immediately replaced with correct date. Director of Nursing will report results of the audit to Quality Assurance Performance	

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M 655	Continued From page 15 2:08 PM, revealed an empty O2 humidifier bottle with date of 4/18/23 and no date to tubing connected to the humidifier bottle. An interview with Licensed Practical Nurse (LPN) #1 on 5/16/23 2:10 at PM, confirmed the oxygen humidifier bottle was empty with a date of 4/18/23 and confirmed there was no date on the oxygen tubing for Resident #17. LPN #1 revealed the humidifier bottle and tubing should be changed weekly and dated to prevent possible infections and to ensure moisturization of the oxygen to prevent drying and nasal discomfort and sores in the nose. An interview with the Director of Nursing (DON) on 5/16/23 2:12 at PM, she confirmed "Absolutely" the oxygen Humidifier bottle and tubing for Resident #17 should have been changed every week and more if needed. She revealed with the date 4/18/23 on the humidifier bottle there was no way it had been changed. The DON went on to say possible complications from failing to change the humidifier bottle and tubing is possible respiratory infections. Record review of the "Order Summary Report" with active orders as of 5/17/23 revealed an order dated 10/20/2019 "Change humidifier bottle and O2 tubing weekly and prn (as needed).. every night shift every Fri (Friday)." Record review of the Treatment Administration Record (TAR) for April 2023 and May 2023 for Resident #17 revealed "Change humidifier bottle and O2 tubing weekly and prn (as needed).. every night shift every Fri (Friday)." The TAR was initialed and signed off as the humidifier bottles and O2 tubing as being changed every Friday night.	M 655	Improvement Committee (QAPI) monthly starting 6/22/23 x 3 months and as needed for review/revision.	

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M 655	Continued From page 16 Record review of the Admission Record revealed that the facility admitted Resident #17 to the facility on 3/27/2013 with diagnoses of Chronic Obstructive pulmonary disease and sleep disorder. Record review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/26/23 revealed in Section C Resident #17 had a Brief Interview for Mental Status (BIMS) score of 99 indicating Resident #17 was unable to complete the interview.	M 655		
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 Based on observation, staff interview and facility policy review the facility failed to store food in a manner that meets professional standards as evidenced by unlabeled and undated food in the refrigerator, dry food stored uncovered and resident nourishment refrigerators with resident snacks that were unlabeled or undated for two (2) of four (4) survey days.	M 815	1. On 5/15/23, Dietary Staff #3 was in-serviced on labeling and dating cold leftovers by Dietary Manager. On 5/15/23, the diced tomatoes were discarded by Dietary Manager. On 5/16/23, the bag of powdered sugar was discarded by Dietary Manager. On 5/16/23, the Dietary Manager was in-serviced on ensuring food is to be stored in an airtight container by Clinical Educator. On 5/17/23, all the food in the nutrition refrigerators was discarded by Dietary Manager. 2. All residents have the potential to be affected by the alleged deficient practice.	6/22/23

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M 815	Continued From page 17 Findings include: Record review of the facility policy titled, "Food Storage" with a revision date of 8/18/11 revealed ... "Procedure ...2. All foods or food items not requiring refrigeration shall be stored above the floor, on shelves, racks, dollies, or other surfaces which facilitate thorough cleaning, in a ventilated room, not subject to sewage or wastewater backfill or contamination by condensation leakage, rodents, or vermin. All package food, canned foods or food items stored shall be kept clean and dry at all times ... 9. All leftover foods are to be stored in covered containers, dated, & labeled. Cooked leftovers are to be used reheating to 180 degrees Fahrenheit. If not used by the third (3rd) day, they are to be discarded. Cooked foods are to be reheated on (1) time only. Cold leftovers not used by the third (3rd) day are to be discarded..." Record review of a typed statement on facility letterhead, dated 5/18/2023, and signed by the Administrator revealed "(Proper Name of Facility) follows state and federal regulations regarding nourishment refrigerators and the dating of food for the resident. The facility does not have a separate policy." An observation and interview on 5/15/23 at 10:15 AM, during the initial tour of the kitchen revealed a plastic container of diced tomatoes in the refrigerator with no date or label on the container. Dietary Staff #3 confirmed that the unlabeled container was diced tomatoes, did not have a label or date, and should have. Dietary Staff #3 put a label on this container with a date for 5/18/23. When the State Agent (SA) asked the staff member if she put the tomatoes in that container in the refrigerator she stated, "No, I've	M 815	3. Dietary Manager audited kitchen for proper storage of food and expiration date and snacks with proper names and expiration dates on 5/16/23. On 5/16/23, the Clinical Educator in-serviced Dietary Manager on ensuring facility stores food in a manner that meets professional standards by labeling and dating food in the refrigerator and dry food and ensuring food is stored covered. On 5/15/23, the Dietary Manager in-serviced dietary staff/ on ensuring facility stores food in a manner that meets professional standards by labeling and dating food in the refrigerator and dry food, also on ensuring food is stored covered. On 6/13/23, clinical educator and Dietary Manager began in-servicing all nursing staff on only placing resident food that is labeled and dated into the nutrition refrigerators, including the time when each refrigerator is to be cleaned. 4. On 05/17/23, Assistant Director of Nursing (ADON) will monitor each refrigerator 5 times a week X 3 weeks and then monthly x 2 months during walking rounds to ensure food and snacks are labeled and stored properly. On 5/17/23, Dietary Manager will audit storage and labeling of foods 5 times a week x 3 weeks and then weekly x 8 weeks. Non-labeled food will be replaced and improper storage will corrected immediately. Director of Nursing will report results of the audit to Quality Assurance Performance Improvement Committee (QAPI) monthly x 3 months starting 6/22/23 and as needed for review/revision.	

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M 815	Continued From page 18	M 815		

not even used any tomatoes. I have no idea when they were put in the refrigerator." When the SA asked what she was putting on the label, she stated, "They are good for 3 days" then confirmed she did not know when they were put in the refrigerator. She revealed that since she did not know when they were put in the refrigerator then she could not verify they were still good and if they were not and were served to the residents then that could make them sick.

An observation on 5/16/23 at 10:00 AM, with the Dietary Manager (DM) revealed an opened 5-pound bag of powdered sugar that was more than half full being stored in an open cardboard box with one piece of lose plastic wrap laid over the top of the box. The DM revealed that the opened bag of powdered sugar stored in this manner could attract pests and rodents to the sugar. The DM confirmed the powdered sugar was not stored properly and should be stored in an airtight container.

An interview on 5/17/23 at 2:20 PM, with the Dietary Manager (DM) confirmed that each meal cart included snacks for the residents and if they are not used and need refrigerated then they are put in the nutrition refrigerator near each nurse's station. She revealed as far as she knew the nursing staff were responsible for cleaning those refrigerators and throwing out expired foods and confirmed that the dietary department does not keep those refrigerators clean.

An observation and interview with Certified Nursing Assistant (CNA) #1 on 5/17/23 at 2:50 PM, of the nutrition refrigerator for the 200 nurses station revealed there were nutrition shakes, salsa dip, an opened root beer can, a plastic bowl with food inside. None of the food items were

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M 815	Continued From page 19	M 815		

labeled or dated. CNA #1 confirmed this was the refrigerator that held resident snacks. She confirmed that the refrigerator had both resident and staff food inside with no labels or dates. She stated that she is not sure, but thinks it is supposed to be only resident's food kept in this refrigerator and that the nightshift CNAs are responsible for cleaning the refrigerators.

An observation and interview on 5/17/23 at 3:00 PM, of the nutrition refrigerator on the 100-hall revealed three cold cut sandwiches with meat and cheese wrapped in plastic wrap with no date or label. One of the sandwiches was half eaten, a plastic bowl with food, a pitcher of water, a gallon jug of tea, and nutrition shakes with no labels, dates, or names. An interview with Licensed Practical Nurse (LPN) #3 confirmed that the nutrition refrigerators are supposed to only hold resident food and snacks. LPN #3 reported that the night shift CNAs are responsible for cleaning and checking the temperature. She stated that all staff are responsible for cleaning and labeling and removing any out-of-date food. She confirmed that there was both resident and staff food in the refrigerator with no labels or dates. She confirmed that if the cold cut sandwiches had been served to a resident with no date, then it could make them sick.

An interview on 5/17/23 at 3:10 PM, with the Administrator confirmed that resident food in the nutrition refrigerators on the halls should be labeled and dated and that if out of date food was served to a resident, then it could make them sick.

An interview on 5/17/23 at 3:30 PM, with the Director of Nurses (DON) confirmed that only resident food is supposed to be kept in the snack

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M 815	Continued From page 20 refrigerators near each nurse's station. The DON stated that food should be dated and that night shift CNAs are supposed to clean the refrigerator and check temperatures. If out-of-date food were served to a resident then it could make them sick.	M 815		