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 |
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| | 63CI | A. BUILDING: _____ B. WING _____ | 10/03/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| SHARKEY-ISSAQUENA NURSING HOME | 431 WEST RACE STREET ROLLING FORK, MS 39159 |

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| M 000 | Initial Comments<br><br>The State Agency (SA) conducted an annual recertification survey at the facility from 10/1/24 through 10/3/24. During the survey, the SA determined the facility was not in compliance with the Minimum Standards of Operation for Institutions for the Aged or Infirm, state licensure requirements and deficiencies were cited at M475, M500, M585, M615, and M815.<br><br>The facility held a license for 54 beds at the time of the survey, and the facility census was 17. | M 000 | | |
| M 475 | 45.16.6 Employee Testing for Tuberculosis<br><br>Employee Testing for Tuberculosis<br><br>1. Each employee, upon employment of a licensed entity and prior to contact with any patient/resident, shall be evaluated for tuberculosis by one of the following methods:<br><br>a. IGRA (blood test) and an evaluation of the individual for signs and symptoms of tuberculosis by medical personnel; or<br><br>b. A two-step Mantoux tuberculin skin test administered and read by a licensed medical/nursing person certified in the techniques of tuberculin testing and an evaluation of the individual for signs and symptoms of tuberculosis by a licensed Physician, Physician ' s Assistant, Nurse Practitioner or a Registered Nurse.<br><br>2. The IGRA/Mantoux testing and the evaluation of signs/symptoms may be administered/conducted on the date of hire or administered/read no more than 30 days prior to the individual ' s date of hire; however, the | M 475 | | 10/30/24 |

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| M 475 | Continued From page 1<br>individual must not be allowed contact with a patient or work in areas of the facility where patients have access until receipt of the results of the IGRA/assessment or at least the first of the two-step Mantoux test has been administered,/read and assessment for signs and symptoms completed.<br><br>3. If the Mantoux test is administered, results must be documented in millimeters. Documentation of the IGRA/TB skin test results and assessment must be documented in accordance with accepted standards of medical/nursing practice and must be placed in the individual ' s personnel file no later than 7 days of the individual ' s date of employment. If an IGRA is performed, results and quanitive values must be documented.<br><br>4. Any employee noted to have a newly positive IGRA, a newly positive Mantoux skin test or signs/symptoms indicative of tuberculin disease (TB) that last longer than three weeks (regardless of the size of the skin test or results of the IGRA), shall have a chest x-ray interpreted by a board certified Radiologist and be evaluated for active tuberculosis by a licensed physician within 72 hours. The employee shall not be allowed to work in any area where residents have routine access until evaluated by a physician/nurse practitioner/physician assistant and approved to return. Exceptions to this requirement may be made if the employee is asymptomatic and;<br><br>a. The individual is currently receiving or can provide documentation of having received a course of tuberculosis prophylactic therapy approved by the Mississippi State Department of Health (MSDH) Tuberculosis Program for | M 475 | | |

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| M 475 | Continued From page 2 | M 475 | | |

tuberculosis infection, or

b. The individual is currently receiving or can provide documentation of having received a course of multi-drug chemotherapy approved by the MSDH Tuberculosis Program; or

c. The individual has a documented previous significant tuberculin skin reaction or IGRA reaction.

4. For individuals noted to have a previous positive to either Mantoux testing or the IGRA, annual re-evaluation for the signs and symptoms must be conducted and must be maintained as part of the employee ' s annual health screening. A follow-up annual chest x-ray is NOT required unless symptoms of active tuberculosis develop.

5. If using the Mantoux method, employees with a negative tuberculin skin test and a negative symptom assessment shall have the second step of the two-step Mantoux tuberculin skin test performed and documented in the employees ' personal record within fourteen (14) days of employment.

6. The IGRA or the two-step protocol is to be used for each employee who has not been previously skin tested and/or for whom a negative test cannot be documented within the past 12 months. If the employer has documentation that the employee has had a negative TB skin test within the past 12 months, a single test performed thirty (30) days prior to employment or immediately upon hire will fulfill the two-step requirements. As above, the employee shall not have contact with residents or be allowed to work in areas of the facility to which residents have

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| M 475 | Continued From page 3<br>routine access prior to reading the skin test, completing a signs and symptoms assessment and documenting the results and findings.<br><br>7. All staff noted as negative per the IGRA blood test or who do not have a significant Mantoux tuberculin skin test reaction (reaction of less than 5 millimeters in size) shall be retested annually within thirty (30) days of the anniversary of their last IGRA or Mantoux tuberculin skin test. Staff exposed to an active infectious case of tuberculosis between annual tuberculin skin tests shall be treated as contacts and be managed appropriately. Individuals found to have a significant Mantoux tuberculin skin test reaction and a chest x-ray not suggestive of active tuberculosis, shall be evaluated by a physician or nurse practitioner/physician assistant for treatment of latent tuberculin infection.<br><br>This Statute is not met as evidenced by:<br>Level II Widespread<br><br>Based on record reviews, staff interviews, and facility policy review, the facility failed to establish and maintain an infection prevention and control program designed to prevent the transmission of communicable diseases and infections. This failure was evidenced by the facility's failure to administer a second-step tuberculin (TB) skin test to 34 of 37 employees, who had no documentation of a negative TB skin test within the last 12 months.<br><br>Findings Include:<br><br>A review of the facility's policy titled "TB Testing MS," with a revision date of 4/14, revealed, "...Employee Testing for | M 475 | 1. On 10/03/2024 it was determined that the facility was not in compliance with the two step tuberculosis regulation and in house policy. 34 of 37 employees had not been given a two step Tuberculosis Test. On 10/07/2024 all 34 employees were given a repeat tuberculosis test step one and documented in the employee TB Book. On 10/09/2024 the tuberculosis test for each employee was read by the Director of Nursing; each employee was negative. On 10/21/2024 the second step of the Two Step Tuberculosis test was given to each employee by the Director of Nursing and read by the Director of Nursing; each test was negative on 10/23/2024.<br><br>2. All residents and staff in the facility have | |

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| M 475 | Continued From page 4<br><br>Tuberculosis...Employees with a negative tuberculin skin test and a negative symptom assessment shall have the second step of the two-step Mantoux tuberculin skin test administered, read, and documented in the employee's personnel record within fourteen (14) days of employment."<br><br>A review of the facility's "TB Skin Test Placement" documentation for new hires revealed that 34 of 37 employees had no documentation of a second-step TB skin test or proof of a negative TB skin test within the last 12 months prior to hire. There was no evidence that any of these employees were offered or received a second-step TB skin test.<br><br>In an interview with the Business Office Manager on 10/3/24 at 9:15 AM, she stated that she was responsible for coordinating and ensuring that new employees receive TB skin tests. She admitted that she was not aware that employees were required to have a two-step TB skin test if they did not have proof of a negative TB skin test within the last 12 months.<br><br>During an interview with the Administrator (ADM) and Director of Nursing (DON) on 10/3/24 at 10:00 AM, they both stated that they had never heard that a two-step TB skin test was required for staff or residents and confirmed that the facility had always only performed one TB skin test.<br><br>In a follow-up interview with the ADM, on 10/3/24 at 10:15 AM, she agreed that a second-step TB skin test should have been performed on the 34 employees. She acknowledged that not administering a TB skin test to staff or residents could potentially spread TB within the facility. | M 475 | the potential to be affected by this deficient practice.<br><br>3. On 10/03/2024, the Administrator educated all staff with an in-service on the two step tuberculosis policy. On 10/07/2024 the Business Office Manager conducted a 100% audit to determine which staff would need to be retested in the two step tuberculosis testing mandate. On 10/07/2024 34 of the 37 staff were given a tuberculosis skin test. One 10/09/2024 these test were read by the Director of Nursing. As of 10/09/2024 every employee in the facility has had a two step tuberculosis as well as the signs and symptoms completed.<br><br>4. The Business Office Manager will monitor to verify that each employee is given a TB skin test annually during the month of February as the per usual company policy. The Administrator will be a back up auditor to the Business Office Manager, each will review the new new hires to verify that both steps of the two step tuberculosis test is complete; The Business Office Manager will perform this audit on a monthly basis for 3 months. Findings from the Business Office Manager will be reviewed by the QAPI committee starting 10/30/2024 and reviewed monthly until 12/31/2024. | |

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| M 500 | 45.17.2 Residents' Rights<br><br>Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility:<br><br>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;<br><br>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;<br><br>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 | M 500 | | 10/30/24 |

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| M 500 | Continued From page 6<br>understanding the consequences of such action;<br><br>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;<br><br>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, free from restraint, interference, coercion, discrimination, or reprisal;<br><br>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;<br><br>7. is free from mental and physical abuse;<br>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 | M 500 | | |

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| M 500 | Continued From page 7<br>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;<br>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;<br><br>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;<br><br>11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care;<br><br>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);<br><br>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); | M 500 | | |

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| M 500 | Continued From page 8<br><br>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);<br><br>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<br><br>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.<br><br>This Statute is not met as evidenced by:<br>Level II<br><br>Based on observations, staff interviews, and facility policy review, the facility failed to conceal the urine collection bag for a resident's indwelling urinary catheter, thus failing to maintain the dignity of a resident, for one (1) of two (2) residents with urinary catheters. (Resident #51).<br><br>Findings Include:<br><br>A review of the facility's policy titled "Resident Rights" revealed, "It is the policy of this facility to ensure that the rights of the residents residing at this facility are upheld in the highest regard... 2. Each resident has the right to a dignified | M 500 | 1. On 10/03/2024 the urinary catheter bags were assessed by the Director of Nursing to ensure privacy devices were present. We had 2 residents in the facility that have urinary catheter bags and both bags were covered to ensure privacy and dignity for the residents.<br><br>2. All residents with urinary catheter bags present have the potential to be affected.<br><br>3.On 10/03/2024 an in-service was done by the Director of Nursing to educate nursing staff on urinary catheter bag dignity and privacy. All residents with catheter bags were then reevaluated to make sure bags were continued to be covered. | |

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| M 500 | Continued From page 9<br>existence..."<br><br>During observations on 10/01/24 at 10:50 AM and 1:28 PM, it was noted that Resident #51's door was open, and an indwelling catheter bag was visible hanging on the side of the bed, without a privacy cover.<br><br>In a follow-up observation and interview on 10/01/24 at 1:29 PM, Registered Nurse (RN) #1 confirmed that the catheter bag had no privacy cover and agreed that it should have been covered to maintain the resident's dignity.<br><br>During an interview on 10/01/24 at 1:31 PM, the Director of Nursing (DON) verified that Resident #51's catheter bag should have been covered and stated that leaving it uncovered could cause embarrassment for the resident.<br><br>A record review of the Face Sheet revealed that the facility admitted Resident #51 on 9/11/24 with diagnoses including Neuromuscular dysfunction of bladder. | M 500 | 4. On 10/07/2024 the MDS nurse conducted a complete audit to insure all catheter bags were covered for privacy. The MDS nurse created a weekly audit sheet to perform and document the findings to correct if necessary and bring before the QAPI committee meeting on 10/30/2024. This audit and documentation will be done and brought before the QAPI committee monthly times 3 months and documentation will be for a minimum of 3 months on a weekly basis. | |
| M 585 | 45.20.2 Tuberculosis (TB)<br><br>Tuberculosis (TB). Admission Requirements to Rule Out Active Tuberculosis (TB)<br><br>1. The following are to be performed and documented within 30 days prior to the resident ' s admission to the " Licensed facility " :<br><br>a. TB signs and symptoms assessment by a licensed Physician, Physician ' s Assistant or a Licensed Nurse Practitioner, and<br><br>b. A chest x-ray taken and a written interpretation. | M 585 | | 10/30/24 |

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| M 585 | Continued From page 10<br><br>2. Admission to the facility shall be based on the results of the required tests as follows:<br><br>a. Residents with an abnormal chest x-ray and/or signs and symptoms assessment shall have the first step of a two-step Mantoux tuberculin skin test (TST) placed and read by certified personnel OR an IGRA (blood test) drawn and results documented within 30 days prior to the patient ' s admission to the " Licensed facility " . Evaluation for active TB shall be at the recommendation of the MSDH and shall be prior to admission. If TB is ruled out and the first step of the TST is negative, the second step of the two-step TST shall be completed and documented within 10-21 days of admission. TST administration and reading shall be done by certified personnel. If an IGRA (blood test) is done, TST (first and/or second step) is not done.<br><br>b. Residents with a normal chest x-ray and no signs or symptoms of TB shall have a baseline IGRA test (blood test) OR a TST performed with the initial step of a the two-step Mantoux TST placed on or within 30 days prior to the day of admission. IF TST is done, the second step shall be completed within 10-21 days of the first step. TST administration and reading shall be done by certified personnel. If an IGRA (blood test) is done, a TST is not done (first or second step).<br><br>c. Residents with a significant TST OR positive IGRA (blood test) upon baseline testing or who have documented prior significant TST shall be monitored regularly for signs and symptoms of active TB (cough, sputum production, chest pain, fever, weight loss, or night sweats, especially if the symptoms have lasted longer than three | M 585 | | |

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| M 585 | Continued From page 11<br>weeks) and if these symptoms develop, shall have an evaluation for TB per the recommendations of the MSDH within 72 hours.<br><br>d. Residents with a non significant TST or negative IGRA (blood test) upon baseline testing shall have an annual tuberculosis testing within thirty (30) days of the anniversary of their last test. Note: Once IGRA testing is used, IGRA testing should continue to be used rather than TST testing.<br><br>e. Residents with a new significant TST or newly positive IGRA (blood test) on annual testing shall be evaluated for active TB by a nurse practitioner or physician or physician ' s assistant.<br><br>f. Active or suspected Active TB Admission. If a resident has or is suspected to have active TB, prior written approval for admission to the facility is required from the MSDH TB State Medical Consultant.<br><br>g. Exceptions to TST/ IGRA requirement may be made if:<br><br>i. Resident has prior documentation of a significant TST/ positive IGRA.<br><br>ii. Resident has received or is receiving a MSDH approved treatment regimen for latent TB infection or for active TB disease.<br><br>iii. Resident is excluded by a licensed physician or nurse practitioner/physician assistant due to medical contraindications.<br><br>This Statute is not met as evidenced by:<br>Level II<br>Based on record reviews, staff interviews, and | M 585 | 1. On 10/03/2024 it was determined that the facility was not in compliance with the | |

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| M 585 | Continued From page 12<br>facility policy reviews, the facility failed to establish and maintain an infection prevention and control program designed to prevent the transmission of communicable diseases and infections. This failure was evidenced by the facility's failure to administer a second-step tuberculin (TB) skin test to one (1) of 17 residents. Resident #104.<br><br>Findings Include:<br><br>A review of the facility's policy titled "TB Testing MS," with a revision date of 4/14, stated: "Resident Testing for Tuberculosis...Residents...shall have a baseline Tuberculin Skin Test (TST) performed with the initial step of a two-step Mantoux TST placed within 30 days prior to the day of admission. The second step shall be administered, read, and documented within 10-21 days of the first step..."<br><br>A record review of "Medication Details" for Resident #104 revealed that she received a TB skin test prior to being admitted to the facility on 8/28/24. This test was read on 8/30/24 and the result was negative. There was no documentation present indicating that Resident #104 received a second-step TB skin test.<br><br>During an interview with the Administrator (ADM) and Director of Nursing (DON) on 10/3/24 at 10:00 AM, they both stated that they had never heard that a two-step TB skin test was required for staff or residents and confirmed that the facility had always only performed one TB skin test.<br><br>In an interview with the DON on 10/3/24 at 10:02 AM, she verified that Resident #104 did not have a second-step TB skin test. | M 585 | two step tuberculosis regulation and in house policy. Resident #104 had only been given the first step of a mandatory two step tuberculosis testing. On 10/07/2024, Resident #104 was given a repeat tuberculosis test step one and documented in the residents chart. On 10/09/2024 the tuberculosis test was read by the Director of Nursing to be negative. On 10/21/2024 the second step of the Two Step Tuberculosis test was given to Resident #104 by the Director of Nursing and read to be negative on 10/23/2024.<br><br>2. All residents and staff in the facility have the potential to be affected by this deficient practice.<br><br>3. On 10/03/2024, the Director of Nursing educated all nursing staff and social services director with an in-service on the two step tuberculosis policy. On 10/03/2024 the Director of Nursing did a 100% audit to ensure all residents have met the two step tuberculosis testing mandate. Each resident in the facility has had a two step tuberculosis as well as the signs and symptoms completed.<br><br>4. Starting 10/07/2024 the Social Services Director will closely monitor to verify that each new admit has had at least the first step of the two step tuberculosis test and follow through with making sure that the second step is done within the next 10-21 days after the first step was given. The Director of Nursing will be a back up auditor to the Social Services Director to review the new admission charts verifying that both steps of the two step | |

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| M 585 | Continued From page 13<br><br>In an interview with the Social Worker (SW) on 10/3/24 at 10:10 AM, she explained that she is responsible for coordinating admissions and ensuring that residents have the required paperwork before admission. She stated that the first step of the TB skin test is required before admission, and one of the TB Certified Registered Nurses (RN's) is responsible for following up and completing the second-step TB skin test. The SW added that the facility used to perform a two-step TB skin test but had stopped doing so, and she was unsure why.<br><br>In a follow-up interview with the ADM, on 10/3/24 at 10:15 AM, she agreed that a second-step TB skin test should have been performed on Resident #104. She acknowledged that not administering a TB skin test to staff or residents could potentially spread TB within the facility.<br><br>Record review of the "Face Sheet" revealed the facility admitted Resident #104 on 9/4/24 with a diagnosis of Essential Hypertension. | M 585 | tuberculosis test is complete; The Social Services Director will perform this audit on a monthly basis starting on 10/07/2024 and continue to monitor for 3 months. Finding from the Social Service Director will be reviewed by the QAPI committee starting 10/30/2024 and reviewed monthly until 12/31/2024. | |
| M 615 | 45.21.3 Pressure sores<br><br>Pressure sores. Residents with a pressure sore shall receive necessary treatment and service to promote healing and prevent the development of new pressure sores. Residents without pressure sores will not develop pressure sores unless the residents' clinical condition indicates they were unavoidable.<br><br>This Statute is not met as evidenced by:<br>Level II | M 615 | 1. On 10/03/2024 an in-service was performed by the Director of Nursing for the nurses to educate them on wound | 10/30/24 |

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| M 615 | Continued From page 14<br><br>Based on observations, record review, interviews and facility policy review, the facility failed to provide adequate care and treatment to a pressure ulcer to improve healing for Resident #104, for one (1) of 1 resident reviewed for pressure ulcers.<br><br>Findings Include:<br><br>Review of the facility policy titled "Wound Care" with a revision date of 10/2/24 revealed under, "Purpose: To provide standardized procedures for the prevention, identification, treatment, and ongoing management of wounds, ensuring the highest quality of care for all residents while maintaining compliance with local, state, and federal regulations ..." Also revealed under, "a. Treatment Plan - A treatment plan will be developed by the wound care team and documented in the resident's medical record. This plan may include: - Cleansing and dressing the wound. - Use of appropriate topical medications or advanced wound care products..."<br><br>An interview with the Director of Nursing (DON) on 10/1/24 at 12:32 PM revealed, she was doing the wound care until the facility hired someone, and explained that Resident #104 came from home with an area like a skin tear on her bottom. She revealed the family told her the resident had the area for a while and thought it was from sitting in a chair for long periods of time.<br><br>An observation of the sacral area for Resident #104, with the DON, on 10/2/24 at 12:30 PM revealed a broken area of skin that was open, round and located over a bony prominence between the upper aspects of the gluteal fold. The wound bed was 80 percent (%) red granulation tissue and 20 percent (%) white | M 615 | care protocols and following Doctor orders as well as giving a detailed description when discussing treatment over the phone with the physician. The correct wound care treatment for Resident #104 was given after the Doctor's assessment where the Resident received Duoderm vs Lantiseptic per Physician orders.<br><br>2. All residents have the potential to be affected.<br><br>3. On 10/16/2024 we had a wound care specialist come in and do a training with all nursing staff as to how to identify, describe, and treat wounds. We entered into a contract with this same wound care specialist where this individual agreed to continuing education and treatment on a weekly basis until December 31, 2024.<br><br>4. Director of Nursing and weekend RN will observe wound treatment for all residents that have wounds of any type starting 10/03/2024 on a daily basis for the next 3 months to ensure correct treatment and identification. Starting on 10/16/2024 all Nursing staff will have ongoing education on a weekly basis about how to stage wounds correctly as well as different types of treatment for the different stages of wounds. This education will be done weekly through December 31, 2024. The QAPI committee will review the education and wound care treatment during each monthly meeting starting on 10/30/2024 meeting and continuing until December 31, 2024. | |

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tissue (adherent slough). The wound edges were well-defined and rolled. No redness observed to the peri-wound and no sign of infection was noted.

Record review of the "Weekly Body Audit" for Resident #104 revealed the following documentation: "9/4/24 -Superficial open area measures 1-inch mild redness around area - Lantiseptic applied" signed by the DON. "9/11/24 - No redness with no change in open area Lantiseptic applied" signed by the DON. "9/16/24 - No change in open area Lantiseptic applied" signed by the DON. "9/24/24 - Lantiseptic applied - open area is the same and redness Duoderm ordered per Medical Director" signed by the DON.

Record review of the "Weekly Wound Assessment" for Resident #104 revealed the following documentation: Date "9/4/24", Stage "1 & (and) 2", Size ".55 inch", Tissue Appearance "red", Wound Edge Appearance "round intact", Drainage "none", Wound Pain "Yes sore", Response to Treatment "applied Lantiseptic" signed by the DON. Date "9/9/24", Stage "1 & (and) 2", Size ".55 inch" Tissue Appearance "red", Wound Edge Appearance "round intact", Drainage "none", Wound pain "sore", Response to Treatment "no change" signed by the DON. Date "9/24/24", Stage "1 &(and) 2" Size ".5-inch x ¾ (three-fourths) inch", Tissue Appearance, "red/white", Wound Appearance "red and white", Wound Edges "intact", Drainage "none", Wound Pain "sore" Response to Treatment "Duoderm q (every) 72 hours" signed by the DON.

Record review of Resident #104's Medication Administration Record (MAR) for September 2024 revealed an order dated 9/9/24, "Lantiseptic Skin Protectant PRN (as needed)" not initialed as

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administered for the month of September. Also revealed an order dated 9/24/24, "Duoderm CGF (controlled gel formula) 2.5-inch x 2.5-inch dressing change every 72 hours, begin 9/24/24."

An interview with the DON on 10/2/24 at 12:38 PM revealed Resident #104 admitted to the facility on 9/4/24 with the area of broken skin to her sacral area. She revealed that she thought the wound was a skin tear or a shearing and was not pressure related. She revealed she called the Medical Director (MD) the day the resident admitted, and he gave an order for Lantiseptic to be applied as needed. The DON acknowledged, "I might not have described the wound correctly." She confirmed they had been applying Lantiseptic (barrier ointment) to the open wound from admit until 9/24/24. The DON explained that the MD assessed the wound on 9/23/24 and changed the order to Duoderm for debridement. She confirmed that Lantiseptic was not an appropriate treatment to assist with healing for an open pressure wound and confirmed this could cause deterioration in the wound. She confirmed that her documentation lacked the total area (length x width x depth) of the wound, which was needed to determine if the wound was healing or getting larger.

A telephone interview with the Medical Director (MD) on 10/2/24 at 2:12 PM revealed, the first time he assessed Resident #104's sacral wound was on 9/23/24. He revealed that he did not give the wound a number (stage) and described the wound as, "Red and had a white film on it." He revealed that the information that was relayed to him when the resident admitted was the wound was a stage 1 and that was why he ordered Lantiseptic. The MD explained that Lantiseptic was a barrier and reduced friction and would be

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| M 615 | Continued From page 17<br>beneficial for a stage 1 wound. He confirmed, after assessing the wound, he determined the wound was not a stage 1, stopped the Lantiseptic and ordered Duoderm.<br><br>An interview with the Administrator (ADM) on 10/2/24 at 2:30 PM revealed she was not aware that the resident had a pressure wound. She revealed she was told the resident had something like a bite that was being treated. She confirmed Lantiseptic was not an appropriate treatment to promote healing of a pressure wound. The ADM confirmed the wound needed weekly assessments and measurements to track the status to determine if the wound was responding to the treatment or deteriorating.<br><br>Record review of the "Face Sheet" revealed the facility admitted Resident #104 on 9/4/24 with a medical diagnosis that included Unspecified dementia. | M 615 | | |
| M 815 | 45.29.1 Safe Food Handling Procedures<br><br>Safe Food Handling Procedures. Food shall be prepared, held, and served according to current Mississippi State Department of Health Food Code Regulations.<br><br>This Statute is not met as evidenced by:<br>Level II Widespread<br><br>Based on observations, staff interviews, record reviews, and facility policy review, the facility failed to check and record food temperatures before serving all meals for the last 30 of 30 days. | M 815 | 1. On 10/03/2024 Dietary Department was found to have not logged any food temperatures since 09/02/2024 (date of opening.) A log book was provided and used to record all food temps for all 3 meals (breakfast, lunch, and Supper) starting on 10/03/2024. Dietary department was provided with a | 10/30/24 |

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| M 815 | Continued From page 18<br>Findings Included:<br><br>A review of the facility's policy titled "Monitoring Temperatures of Cooked Foods" revealed, "Policy: The temperature of potentially hazardous cooked foods will be monitored to ensure that the foods are not in the danger zone (above 41 degrees F (Fahrenheit) and below 135 degrees F) for more than six hours... Cooking, holding, and storage temperatures should be recorded on a Food Temperature Monitoring Log. These logs should be maintained for at least three (3) months."<br><br>During an observation of the kitchen on 10/2/24 at 11:35 AM, it was noted that kitchen staff were serving lunch to the dining room residents from the steam table.<br><br>A record review of the meal temperature logbook revealed there was no documentation for breakfast, lunch, or dinner since 9/2/24.<br><br>In an interview with the Dietary Manager (DM) on 10/2/24 at 11:40 AM, she stated that the kitchen staff had not been checking or recording the meal temperatures because they did not have a logbook. She admitted that she hadn't considered using a piece of paper to log the temperatures and the logbook had just arrived the previous Friday. She stated that she had instructed the kitchen staff to begin recording meal temperatures before serving food and confirmed that no temperatures had been documented.<br><br>In an interview with the Dietary Cook on 10/2/24 at 11:45 AM, she revealed that food temperatures had not been checked because they did not have a thermometer and stated that they had a thermometer the previous day, but it could not be | M 815 | thermometer on 10/03/2024 by finding the thermometer that was misplaced. New thermometers were ordered on 10/03/2024 and they came in on 10/09/2024. Extra thermometers were ordered to have on hand for future lost or misplaced thermometers.<br><br>2. All residents in the facility have the potential to be affected by this deficient practice.<br><br>3. On 10/03/2024 the Administrator had an in-service with Dietary Staff to make sure they all understood the importance of checking food temperatures. The dietary staff were receptive and understood why they were to keep a log of these temperatures daily for all 3 meals (breakfast, lunch, & dinner). Corrective counseling was done by the administrator with the Dietary Manager on making sure that her staff were given proper instructions and the correct tools necessary to complete the task. A log for recording each meal temps daily was provided and new thermometer's were ordered and given to the Dietary Manager on 10/09/2024.<br><br>4. An audit was done on 10/07/2024 by the Dietician to check that the food temperature log is complete, She will be checking the log weekly on each Friday for the next 3 months starting on 10/11/2024; to ensure all food temps are being recorded. The Dietary Manager completed a 100% audit on 10/07/2024 to ensure that the Dietary Department has thermometer's and Log sheets on hand | |

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| M 815 | Continued From page 19<br>calibrated. She acknowledged that temperatures were not being taken and recognized that this could pose a health risk to the residents.<br><br>During a follow-up interview with the Dietary Manager on 10/2/24 at 11:52 AM, she confirmed that the thermometer from the previous day was not working and that she needed to purchase a new one.<br>She stated that she had ordered food thermometers for the kitchen, but they had not yet arrived. She admitted that it did not occur to her to obtain a thermometer from another source.<br>She also verified that failing to check food temperatures could result in foodborne illnesses.<br><br>In an interview with the Administrator (ADM) on 10/2/24 at 11:58 AM, she confirmed that she was unaware the kitchen did not have a food thermometer and did not check food temperatures at each meal. She emphasized that the purpose of checking food temperatures is to prevent burns to the residents and to reduce the risk of foodborne illness if the food is not maintained at a certain temperature. | M 815 | and that there is no shortage of needed supplies. The Dietary Manager will do a supply audit monthly for the next 3 months and will bring all findings to the QAPI meeting starting on 10/30/2024 to review and correct any deficient findings. The QAPI committee will continue to review the Dietary Food Temperature Log each month until 12/31/2024. | |