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| SHARKEY-ISSAQUENA NURSING HOME | 431 WEST RACE STREET ROLLING FORK, MS 39159 |

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| F 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 Medicare and Medicaid requirements for participation and cited regulatory deficiencies at F550, F645, F686, F758, F812, and F880.<br><br>The census at the time of survey was 17 and the facility was licensed for 54 beds. | F 000 | | |
| F 550 SS=D | Resident Rights/Exercise of Rights<br>CFR(s): 483.10(a)(1)(2)(b)(1)(2)<br><br>§483.10(a) Resident Rights.<br>The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.<br><br>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.<br><br>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.<br><br>§483.10(b) Exercise of Rights. | F 550 | | 10/30/24 |

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

Electronically Signed | 10/24/2024

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| F 550 | Continued From page 1<br>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.<br><br>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.<br><br>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.<br>This REQUIREMENT is not met as evidenced by:<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 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. | F 550 | 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.<br><br>4. On 10/07/2024 the MDS nurse conducted a complete audit to insure all catheter bags were covered for privacy. | |

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| F 550 | Continued From page 2<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. | F 550 | 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. | |
| F 645 SS=D | PASARR Screening for MD & ID<br>CFR(s): 483.20(k)(1)-(3)<br><br>§483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability.<br><br>§483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with:<br>(i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission,<br>(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and<br>(B) If the individual requires such level of services, whether the individual requires specialized services; or | F 645 | | 10/30/24 |

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| F 645 | Continued From page 3 | F 645 | | |

(ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

§483.20(k)(2) Exceptions. For purposes of this section-
(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-
(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,
(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and
(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.

§483.20(k)(3) Definition. For purposes of this section-
(i) An individual is considered to have a mental

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| F 645 | Continued From page 4<br>disorder if the individual has a serious mental disorder defined in 483.102(b)(1).<br>(ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, staff interviews and facility policy review, the facility failed to accurately complete and request a Preadmission Screening and Resident Review (PASARR) for a resident with a history of mental illness for one (1) of 12 residents reviewed. Resident #106<br><br>Findings Include:<br><br>Record review of the facility policy titled, "Pre-Admission Screening PAS/PASRR" with a revision date of 6/13 revealed under, "Level II PASRR ... When Level 1 screening on the PAS (Preadmission Screening) indicates possible Mental Illness or Intellectual Disability/Developmental Disability and related conditions (RC) the DOM (Division of Medicaid) will notify Proper Name to review the case."<br><br>Record review of the Level 1 PAS (Pre Admission Screening) for Resident #106, with a submission date of 9/30/24, revealed under, "Referral Question #28. Does resident have any history of abusing alcohol or drugs? No" was marked. "#31. Does resident have any history of mental illness? No" was marked. "#32. Does resident take, or have a history of taking psychotropic medication(s)? No" was marked.<br><br>Record review of the "Face Sheet" revealed the | F 645 | 1. The Social Services Director #1 was educated by the Minimum Data Set (MDS) nurse and the Administrator as to the importance of correct documentation and confirming the final approval for all Preadmission Screening and Resident Review (PASARR) forms when submitted. Social Services Director edited the PASARR questions #28, Does resident have any history of abusing alcohol or drugs? to state "Yes" where "No" was marked; "#31, Does resident have any history of mental illness? "YES" was replaced with the incorrect answer of "No"; "#32, Does resident take, or have a history of taking psychotropic medication(s)? "YES" was marked to replace "NO" for Resident #106. Once the questions revealed the correct diagnosis and answers to questions #28,31, &32 the PASARR was resubmitted for Resident #106 on 10/04/2024. Minimum Data Set (MDS) nurse verified this correction as well as doing a 100% audit of previously submitted PASARR on all new admits since 09/02/2024. (date of re-opening)<br><br>2. All residents are affected by this deficiency. | |

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| F 645 | Continued From page 5<br>facility admitted Resident #106 on 9/2/24 with medical diagnoses that included Schizophrenia, Unspecified psychosis,<br>Alcohol use unspecified with intoxication delirium, and Major Depressive Disorder.<br><br>Record review of the "Physician Orders" for Resident #106 revealed an order dated, 9/2/24, "Cymbalta (antidepressant) 60 MG (milligrams) PO (by mouth) daily".<br><br>An interview with Social Services (SS) #1 on 10/2/24 at 9:20 AM revealed, she was the person responsible for completing the PAS for residents. She confirmed that she made an error when completing Resident #106's level 1 screening and stated, "I did not see that she had a Schizophrenia diagnosis." SS #1 revealed she was aware the resident took an antidepressant medication, but was not aware it was considered a psychotropic medication. She revealed the resident did have a history of alcohol abuse and agreed she did not answer the questions accurately. SS #1 confirmed, if the initial level 1 screen was not completed accurately, Resident #106 might not get the mental health services needed.<br><br>An interview with the Administrator (ADM) on 10/2/24 at 9:25 AM revealed, it was her expectation for the PASARR's to be completed accurately, so Resident #106 gets any specialized services indicated. | F 645 | 3.The Social Services Director is responsible for submission of all Preadmission Screening and Resident Review (PASARR) and will monitor all submissions for the next 3 months with a monthly report of findings reviewed by the administrator. After that she will monitor all submission for accuracy on a monthly basis continually. We are a small bed facility so this audit will be done monthly as we continue to admit new residents trying to rebuild our population.<br><br>4. Minimum Data Set (MDS) nurse will be working directly aside the Social Services Director to review all new admissions in the next 3 months beginning October 3, 2024, for Mental Illness (MI) or Intellectual Disabilities (ID) diagnosis and accuracy, she will review Preadmission Screening and Resident Review (PASARR) monthly until December 31, 2024. The findings and documentation will be brought before the QAPI committee on October 30, 2024 to review and revise the Plan of Correction if additional concerns are identified. This documentation will be reviewed monthly by the QAPI committee for a minimum of 3 months. | |
| F 686 SS=D | Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)<br><br>§483.25(b) Skin Integrity<br>§483.25(b)(1) Pressure ulcers. | F 686 | | 10/30/24 |

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| F 686 | Continued From page 6<br>Based on the comprehensive assessment of a resident, the facility must ensure that-<br>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and<br>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.<br>This REQUIREMENT is not met as evidenced by:<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) | F 686 | 1. On 10/03/2024 an in-service was performed by the Director of Nursing for the nurses to educate them on wound 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 | |

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| F 686 | Continued From page 7<br>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 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.<br><br>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.<br><br>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" | F 686 | 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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| F 686 | Continued From page 8 | F 686 | | |

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 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

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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 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.

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.

Record review of the "Face Sheet" revealed the facility admitted Resident #104 on 9/4/24 with a medical diagnosis that included Unspecified dementia.

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| F 758 | Continued From page 10 | F 758 | | |
| F 758 SS=D | Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)<br><br>§483.45(e) Psychotropic Drugs.<br>§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:<br>(i) Anti-psychotic;<br>(ii) Anti-depressant;<br>(iii) Anti-anxiety; and<br>(iv) Hypnotic<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that---<br><br>§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;<br><br>§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;<br><br>§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and<br><br>§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or | F 758 | | 10/30/24 |

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| F 758 | Continued From page 11<br>prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.<br><br>§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, record review, and facility policy review, the facility failed to ensure a resident receiving an as needed (PRN) psychotropic medication had a stop date for one (1) of two (2) medication reviews. Resident #108<br><br>Findings Include:<br><br>Review of the facility policy titled "Psychotropic Medications for PRN (as needed) Use and Gradual Dose Reduction (GDR) Reviews" undated, revealed under, "Policy: ... PRN use of psychotropic medications will be strictly regulated and monitored to comply with CMS (Centers for Medicare and Medicaid Services) regulations and ensure resident safety...Time Limitation: PRN orders for psychotropic medications must be limited to 14 days. After 14 days, the attending physician must review the resident's condition before extending the PRN order for continued use. This review must include a clinical evaluation to determine if continued PRN use is necessary."<br><br>Record review of the September 2024 Medication Administration Record (MAR) for Resident #108, revealed an order dated 9/3/24, "Lorazepam 1 | F 758 | 1. The PRN (as needed) order of psychotropic drug was given to Resident #108 on 09/03/2024 but was not given a stop date. The PRN psychotropic medication was evaluated on 10/04/2024 by her Physician and renewed for another 14 day; Resident #108 did not take any of the PRN psychotropic medication within the renewed 14 day period so this medication was discontinued on 10/18/2024 by the Director of Nurses per Physician order.<br><br>2.All residents with PRN (as needed) psychotropic medications have the potential to be affected.<br><br>3.On 10/03/2024 the facility administrator reviewed the regulation and policy for PRN psychotropic drugs with the Director of Nursing; The Director of Nursing understood the regulation perfectly and did an in-service educating all other Nursing staff. A 100% audit was completed by the Director of Nursing to assure that all PRN psychotropic drug | |

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| F 758 | Continued From page 12<br>MG (milligram) tablet administer 1 mg (milligram) q (every) 12 hours as needed for anxiety or agitation" with no stop date. Documentation revealed the resident received doses on 9/5/24, 9/6/24, 9/11/24, and 9/20/24.<br><br>An interview with the Administrator (ADM) on 10/2/24 at 9:36 AM confirmed, Resident #108's lorazepam order did not have a stop date. She confirmed the medication should have had a stop date after 14 days to ensure the resident got the least amount of medication required to control her symptoms and re-evaluated by the physician to ensure the continued need.<br><br>Record review of the "Face Sheet" revealed the facility admitted Resident #108 on 9/2/24 with a medical diagnosis of Hemiplegia following unspecified cerebrovascular disease affecting the right dominant side. | F 758 | orders have stop dates no more than 14 days after initial order. No other PRN psychotropic orders were found.<br><br>4. Beginning 10/03/2024 the Medical Records Director will monitor by review all medication orders to ensure all PRN psychotropic drugs have a 14 day stop date and can not be continued until Physician evaluates and documents rationale to continue with new stop date. Medical Records Director will review all new orders Monday through Friday and the weekend orders on Monday. She will do this for a period of 3 months to ensure all PRN psychotropic medications have a 14 day stop date. The Director of Nursing will submit findings to the QAPI Committee on a monthly basis starting on 10/30/2024, going through 12/31/2024. | |
| F 812 SS=F | Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility. | F 812 | | 10/30/24 |

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| F 812 | Continued From page 13<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<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.<br><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 | F 812 | 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 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 | |

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| F 812 | Continued From page 14<br>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 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. | F 812 | 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 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. | |
| F 880 SS=F | Infection Prevention & Control | F 880 | | 10/30/24 |

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| F 880 | Continued From page 15<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>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.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§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 §483.71 and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a | F 880 | | |

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| F 880 | Continued From page 16<br>resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(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<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<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 one (1) of 17 residents (Resident #104) and 34 of 37 employees, who had no documentation of a negative TB skin test within the last 12 months. | F 880 | 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. Resident #104 had only been given the first step of a mandatory two step tuberculosis testing as well as 04 of 37 employees. On 10/07/2024, Resident #104 was given a repeat tuberculosis test step one and documented in the residents chart. On | |

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| F 880 | Continued From page 17<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... Employee Testing for 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>Resident #104<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>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.<br><br>Record review of the "Face Sheet" revealed the facility admitted Resident #104 on 9/4/24 with a diagnosis of Essential Hypertension.<br><br>Employee Testing | F 880 | 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. 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 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. On 10/03/2024, the Administrator educated all staff with an in-service on the two step tuberculosis policy. On 10/23/2024 the Business Office Manager conducted a 100% audit to ensure all staff have met the two step tuberculosis testing mandate. Every staff in the facility has had a two | |

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| F 880 | Continued From page 18<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 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. | F 880 | step tuberculosis as well as the signs and symptoms completed.<br><br>4. The Social Services Director will closely monitor all admissions starting 10/07/2024 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 Business Office Manager began to monitor employee tuberculosis testing on 10/07/2024 to verify that each employee is given a TB skin test annually during the month of February as the per usual company policy. The Director of Nursing will be a back up auditor to the Social Services Director and the Administrator will be a back up auditor to the Business Office Manager, each will review the new admission charts and new hires to verify that both steps of the two step tuberculosis test is complete; The Social Services Director and the Business Office Manager will perform this audit on a monthly basis for 3 months starting on 10/07/2024. Finding from both the Social Service Director and 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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| F 880 | Continued From page 19<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 and Resident #104. She acknowledged that not administering a TB skin test to staff or residents could potentially spread TB within the facility. | F 880 | | |