TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 000 INITIAL COMMENTS F 000 The State Agency (SA) conducted an annual recertification survey at the facility from 7/12/17 to 7/14/17. During the survey the SA determined the facility was not in compliance with Medicare and Medicaid requirements for participation. The SA cited the regulatory deficiencies F253 and F441. F 000 At the time of the survey, the census was 47, and the facility held a license for 54 beds. F 253 F 253 483.10(i)(2) HOUSEKEEPING & MAINTENANCE F 253 SS=E SERVICES (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior, This REQUIREMENT is not met as evidenced by; F 253 Based on observation, staff interview, and record review, the facility failed to provide effective maintenance services as evidenced by the deficient practices. 3. Maintenance Surgervise & staff Inserviced 07/26/2017, on proper replacement of A/C filters and reporting of broken air conditioner filters and front covers, non-functioning window blinds, missing door sweep on the bottom of an outside exit door, and rough, raised sheet rock surrounding the wall mounted sinks in the resident's bathrooms. These observations were for 19 of 29 resident rooms, and three (3) of three (3) dining areas. 1. No resident had adverse affects from deficient practices. 3. Maintenance Superviso & staff Inserviced 07/26/2017, on proper replacement of A/C filters and reporting of proken items & bindis to Nursing Home Administrator. A/C filters and report	TATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (X3) DA	D. 0938-039 ATE SURVEY OMPLETED
NAME OF PROVIDER OR SUPPLIER Image: Construct of the supervise staff STREET ADDRESS, CITY, STATE, 2IP CODE 431 WEST RACE STREET SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION Construction PREFIX EACH ORRECTIVE ACTION SHOULD BE Construction Construction Construction F 000 INITIAL COMMENTS F 000 F 000 F 000 F 000 F 253 F 000 The State Agency (SA) conducted an annual recertification survey at the facility from 7/12/17 to 7/14/17. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements for participation. The SA cited the regulatory deficiencies F253 and F441. F 253 8/4/ SS=E SERVICES F 253 8/4/ i)(2) HOUSEKEEPING & MAINTENANCE F 253 8/4/ i)(2) HOUSEKEEPING & MAINTENANCE F 253 8/4/ SS=E SERVICES Sector observation, staff interview, and record review, the facility failed to provide effective maintenance services as evidenced by torken air conditioner filters and front covers, non-functioning window blinds, missing door sweep on the bottom of an outside exit door, and rough, raised sheet rock surrounding the wall mounted sinks in the resident's bathrooms. These observations were for 19 of 29 resident rooms, and three (3) of			255220			7/4 4/2047
SHARKEY-ISSAQUENA NURSING HOME 431 WEST RACE STREET ROLLING FORK, MS 39159 (M) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH OERCENCY MUST BE PRECEDED BY FULL REQUIDENCY OR LSC IDENTIFYING INFORMATION) IP PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH OERCENCY MUST BE PRECEDED BY FULL REQUIDENTIFYING INFORMATION) ID PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY F 000 INITIAL COMMENTS F 000 The State Agency (SA) conducted an annual recertification survey at the facility from 7/12/17 to 7/14/17. During the survey the SA determined the facility was not in compliance with Medicare and Medicaid requirements for participation. The SA cited the regulatory deficiencies F253 and F441. F 253 F 253 483 10(i)(2) HOUSEKEEPING & MAINTENANCE see: SERVICES F 253 SEE SERVICES F 253 Mithefacility field a license for 54 beds. see: secsary to maintain a sanitary, orderly, and comfortable interior, This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to provide effective maintenance services as evidenced by broken air conditioner filters and fond covers, non-functioning window blinds, missing door sweep on the bottom of an outside exit door, and rough, raised sheet rock surrounding the wall mounted sinks in the resident's bathrooms. These observations were for 19 d 29 resident rooms, and three (3) of three (3) dining areas. 1. No resident had adverse affects from deficient practices. 3. Maintenance Supervisor & staff Inserviced 07/26/2017, or proper replacement of A/C filters and reporting of broken items & blinds to Nursing Home or prior to 10/01/2017 to be installed by 100/8/2017.	NAME OF F	ROVIDER OR SUPPLIER				//14/2017
PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) PRÉFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Con- the Construction structure of the construction should be cross-REFERENCED TO THE APPROPRIATE DEFICIENCY) Con- the Constructure of the constructure	SHARKE	Y-ISSAQUENA NUR	SING HOME	43	31 WEST RACE STREET	
The State Agency (SA) conducted an annual recertification survey at the facility from 7/12/17 to 7/14/17. During the survey the SA determined the facility was not in compliance with Medicare and Medicaid requirements for participation. The SA cited the regulatory deficiencies F253 and F441.F2538/4/At the time of the survey, the census was 47, and the facility held a license for 54 beds.F 2538/4/F253483.10(i)(2) HOUSEKEEPING & MAINTENANCE SEEF 2538/4/SEE(i)(2) HOUSEKEEPING & MAINTENANCE SEEF 2538/4/(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: maintenance services as evidenced by broken air conditioner filters and front covers, non-functioning window blinds, missing door sweep on the bottom of an outside exit door, and rough, raised sheet rock surrounding the wall mounted sinks in the resident's bathrooms. These observations were for 19 of 29 resident rooms, and three (3) of three (3) dining areas.1. Nor esident had adverse affects from deficient practices. 3. Maintenance Supervisor & staff Inserviced 07/26/2017, on proper replacement of A/C filters and reporting of broken items & blinds to Nursing Home Administrator. A/C filters were replaced 07/17/2017. New blinds for all affected rooms have been ordered by Hospital Administrator to be delivered to facility on or prior to 10/01/2017 to be installed by 10/06/2017. Weather stripping was	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETIO DATE
recertification survey at the facility from 7/12/17 to 7/14/17. During the survey the SA determined the facility was not in compliance with Medicare and Medicaid requirements for participation. The SA cited the regulatory deficiencies F253 and F441. At the time of the survey, the census was 47, and the facility held a license for 54 beds. SS=E SERVICES (i)(2) HOUSEKEEPING & MAINTENANCE SS=E SERVICES (i)(2) HOUSEKEEPING & MAINTENANCE SS=E (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to provide effective maintenance services as evidenced by service on the bottom of an outside exit door, and rough, raised sheet rock surrounding the wall mounted sinks in the resident's bathrooms. These observations were for 19 of 29 resident rooms, and three (3) of three (3) dining areas. Findings include: During the environmental tour of the facility with	F 000	INITIAL COMMEN	TS	F 000		
F 253the facility held a license for 54 beds.F 2538/4/SS=ESERVICESF 2538/4/(i)(2) HOUSEKEEPING & MAINTENANCEF 2538/4/Based on observation, staff interview, and record review, the facility failed to provide effective maintenance services as evidenced by broken air conditioner filters and front covers, non-functioning window blinds, missing door sweep on the bottom of an outside exit door, and rough, raised sheet rock surrounding the wall mounted sinks in the resident's bathrooms. These observations were for 19 of 29 resident rooms, and three (3) of three (3) dining areas.9/1/17/2017. New blinds to Nursing Home Administrator to be delivered to facility on or prior to 10/01/2017 to be installed by 10/06/2017. Weather stripping was		recertification surve 7/14/17. During the facility was not in c Medicaid requirement	ey at the facility from 7/12/17 to survey the SA determined the ompliance with Medicare and ents for participation. The SA			
 necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to provide effective maintenance services as evidenced by broken air conditioner filters and front covers, non-functioning window blinds, missing door sweep on the bottom of an outside exit door, and rough, raised sheet rock surrounding the wall mounted sinks in the resident's bathrooms. These observations were for 19 of 29 resident rooms, and three (3) of three (3) dining areas. Findings include: During the environmental tour of the facility with 		the facility held a lid 483.10(i)(2) HOUS	cense for 54 beds.	F 253		8/4/17
Internatice Supervisor #1, 017713/17, at 10.00Internatice Supervisor #1, 017713/17, at 10.00Internatice Supervisor extractor of 112/2017. Walls in 7/8, 20/21, 22/23, 26/27, 30/31, and 32/33 restrooms have been repaired by Maintenance Supervisor1. The plastic air conditioner filter framework wasto correct sheet rock bubbles 08/04/2017.		necessary to maint comfortable interio This REQUIREME by: Based on observa review, the facility f maintenance servic conditioner filters a non-functioning wir sweep on the botto rough, raised shee mounted sinks in th These observation rooms, and three (1) Findings include: During the environe Maintenance Supe until 11:30 AM, the observed:	ain a sanitary, orderly, and r; NT is not met as evidenced tion, staff interview, and record called to provide effective ces as evidenced by broken air nd front covers, ndow blinds, missing door of an outside exit door, and t rock surrounding the wall ne resident's bathrooms. s were for 19 of 29 resident 3) of three (3) dining areas. mental tour of the facility with rvisor #1, on 7/13/17, at 10:00 following findings were		deficient practices. 2. All residents have potential to be affected by the deficient practices. 3. Maintenance Supervisor & staff Inserviced 07/26/2017, on proper replacement of A/C filters and reporting of broken items & blinds to Nursing Home Administrator. A/C filters were replaced 07/17/2017. New blinds for all affected rooms have been ordered by Hospital Administrator to be delivered to facility on or prior to 10/01/2017 to be installed by 10/06/2017. Weather stripping was replaced in dining room exit door on 07/14/2017. Walls in 7/8, 20/21, 22/23, 26/27, 30/31, and 32/33 restrooms have been repaired by Maintenance Superviso	r

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUM/ ERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/25/2017 FORM APPROVED

			PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		255220	B. WING		074	4/2047
NAME OF	PROVIDER OR SUPPLIEF	A CONTRACTOR OF A CONTRACTOR O		STREET ADDRESS, CITY, STATE, ZIP CC		14/2017
				431 WEST RACE STREET		
SHARKE	Y-ISSAQUENA NUR	SING HOME		ROLLING FORK, MS 39159		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 253	Continued From n	ago 1	E 25	0		
F 253	cracked, and the v framework was to conditioner wall un Dementia Unit Dir Rooms #7, #8, #9 #26, #27, #28, and 2. The air conditio Room #20 was cra- top right and left of plastic tab was bro- door lying on the f conditioner front of was cracked in tw left corners, and a with a tan colored 3. There were no window blind slats #9, #10, #12, #16, #27, #28, #29, #30 Room on the Wes and the Main Dinition one (1) window wit the window blinds blind cord that rais tied to the handle with the blind raise	white filter material inside the rn and frayed in the air hits for two (2) units in the hing Room, and in Resident , #11, #18, #19, #20, #22, #24, d #29. ner front cover in Resident acked in two (2) places at the orners, and the control panel loor in the corner. The air over in Resident Room #29 o (2) places at the top right and uppeared to be held in place	F 25	4. Maintenance Supervisor, S Designee will monitor 10% o rooms once weekly times 3 r report all discrepancies to the Assurance Committee for re appropriate action will be tak substantial compliance is act maintained.	f all affected months and e Quality view and en until	
	4. The outside exit door in the Main Dining Room's door sweep was broken across one half of the width of the door with a one (1) inch tall gap to the outside.					
	bathrooms was bu appearance on the	in the Resident Room Ilging with a bubbled e right and left sides of the wall shared bathrooms #7/8, #20/21,				

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DEPARTMENT OF HEALTH AND HUM/ ERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/25/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			and the second se	O. 0936-0391 ATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		255220	B. WING			0	7/14/2017
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 431 WEST RACE STREET ROLLING FORK, MS 39159				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	((E.	PROVIDER'S PLAN OF COF ACH CORRECTIVE ACTION DSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 253	approximately five An interview with M 7/13/17, at 11:30 A new air conditioner (Name of Hospital) filters, but they new the blinds he was to stated the sheet roo moisture. In an interview with Administrator on 7/ the hospital had tak he was not aware of air conditioning or so bathrooms. The (N Administrator state home administrator home problems, ar During a tour of the PM, with the (Name confirmed the air of the blinds were nor was buckling next to bathrooms. He also was missing from of Main Dining Room. During an interview Administrator, on 7 she made rounds w aware of the proble conditioner filters.	0/31, and #32/33. These were (5) inch circular areas. laintenance Supervisor #1, on M, revealed he had requested filters and blinds from the . He stated he had ordered the er came in, and in regards to old they didn't have any. He ck was buckling due to the (Name of Hospital) 13/17, at 4:10 PM, revealed ken over in January 2016, and of any problems with the blinds, sheet rock in the resident's lame of Hospital) d he depended on the nursing r to take care of the nursing nd relay them to him. e facility, on 7/13/17, at 4:40 e of Hospital) Administrator, he onditioner filters were broken, n-functional, and the sheet rock to the sinks in the resident's o confirmed the door sweep one half of the exit door in the	F 2	53			

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Facility ID: 63CI

If continuation sheet Page 3 of 7

DEPARTMENT OF HEALTH AND HUM/ ERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/25/2017 FORM APPROVED OMB NO. 0938-0391

And the second se	JENTERS FOR MEDICARE & MEDICAID SERVICES				OMB NO. 0938-039		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1.	IPLE CONSTRUCTION		TE SURVEY	
		255220	B. WING		07	/14/2017	
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP CO 431 WEST RACE STREET ROLLING FORK, MS 39159			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR	SHOULD BE	(X5) COMPLETION DATE	
F 253		d requested air conditioner unit	F 25	53			
	Action Plan, dated were requested.	al staff. Another Corrective d 9/6/16, revealed window blinds					
F 441 SS=D)(e)(f) INFECTION CONTROL, AD, LINENS	F 44	1		8/4/17	
	(a) Infection prevention and control program.						
	The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:						
	investigating, and communicable dis volunteers, visitor providing services arrangement base conducted accord	reventing, identifying, reporting, controlling infections and seases for all residents, staff, s, and other individuals s under a contractual ed upon the facility assessment ling to §483.70(e) and following standards (facility assessment Phase 2);					
		ards, policies, and procedures which must include, but are not					
	possible commun	rveillance designed to identify icable diseases or infections pread to other persons in the					
		whom possible incidents of sease or infections should be					
		transmission-based precautions prevent spread of infections;					

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Facility ID: 63CI

If continuation sheet Page 4 of 7

DEPARTMENT OF HEALTH AND HUM/ ERVICES

PRINTED: 09/25/2017 FORM APPROVED

OLNIL	NOT ON MEDICANE	A WEDICAID SERVICES			JIVIB NO.	0938-0391
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		255220	B. WING		07/1	4/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
SHARKE	Y-ISSAQUENA NURS	SING HOME		431 WEST RACE STREET ROLLING FORK, MS 39159		
(VA) ID	SUMMADY ST		1.000		01	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 441	Continued From pa	age 4	F 441			
	(iv) When and how resident; including	isolation should be used for a but not limited to:			4	
	depending upon the involved, and (B) A requirement t	uration of the isolation, e infectious agent or organism hat the isolation should be the ssible for the resident under the				
	must prohibit emplo disease or infected	ces under which the facility byees with a communicable skin lesions from direct nts or their food, if direct t the disease; and				
		ene procedures to be followed direct resident contact.				
		cording incidents identified IPCP and the corrective e facility.				
		nel must handle, store, port linens so as to prevent the				
	annual review of its program, as neces This REQUIREME	The facility will conduct an IPCP and update their sary. NT is not met as evidenced				
	of the the Rosie Sn Monitoring System' to prevent the pote failing to appropriat	tion, staff interview, and review nart Meter Blood Glucose s User Guide, the facility failed ntial spread of infection by ely disinfect blood glucose esident use for two (2) of two		1. No resident using Blood Gluco Monitor had adverse affects from practice. LPN# 2, RN# 1 were immediately counseled by Directo Nursing Service on correct Policy/Procedure, 07/14/2017 to p	deficient or of	

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Event ID: KZHX11

Facility ID: 63CI

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DEPARTMENT OF HEALTH AND HUM/ ERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/25/2017 FORM APPROVED OMB NO 0938-0391

			and the second second second second	LE CONSTRUCTION		E SURVEY
		255220	B. WING			14/2017
NAME OF PROVIDER OR SUPPLIER SHARKEY-ISSAQUENA NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP COE 431 WEST RACE STREET ROLLING FORK, MS 39159	θE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 441	Continued From p	age 5	F 441			
	Continued From page 5 (2) blood glucose finger sticks observed. [Un-sampled Resident A and Un-sampled Resident B] Findings include: Review of the Rosie Smart Meter Blood Glucose Monitoring System's User Guide revealed to mitigate the risk of blood borne pathogen transmission (e.g. viral hepatitis), the meter must be properly cleaned and disinfected. The following disinfectant product (Clorox Germicidal Wipes) has been shown to be safe for use with the Rosie Smart Meter, but any disinfectant product with the EPA registration number of 67619-12 may be used on this device. If the meter is being operated by a second person who is providing testing assistance to the user, the meter should be disinfected prior to use by the second person.			potential for spread of infectio 2.All residents using Blood Glu Monitor have potential to be a deficient practice. The facility Policy/Procedure concerning of the Blood Glucose Monitor with disinfectant wipes. 3. Local Contracted Consultar in-serviced employees 07/19/2 Policy/Procedure performing f proper cleaning Blood Glucos and competency checklist beg 4. Each nurse will be checked performing glucose checks, in cleaning of Blood Glucose Mo per week X 3 months on Com checklist will be done and doo and presented to Quality Ass Team. Quality Assurance Com review and appropriate action taken to maintain compliance	ucose ffected by will develop cleaning of th bleach at 2017 on SBS and e Monitor gan. I off on acluding ponitor. 10% petency cumented urance nmittee will will be	
	Director of Nurses					
	An observation an AM, revealed Lice cleaned the glucor before and after po A's blood glucose time with LPN #1 r always cleans it w not know what the	d interview, on 7/13/17 at 11:05 nsed Practical Nurse (LPN) #1 meter with an alcohol prep pad erforming Un-sampled Resident finger stick. Interview at this revealed that is what she ith. LPN #1 confirmed she did manufacturer's was for disinfecting the				

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Event ID: KZHX11

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DEPARTMENT OF HEALTH AND HUMA ERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/25/2017 FORM APPROVED OMB NO 0938-0391

ULINIL	NOT ON MEDICAN	L & MILDICAID SLIVICLS	_			7. 0920-0391	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
	255220		B. WING		07/14/2017		
	NAME OF PROVIDER OR SUPPLIER SHARKEY-ISSAQUENA NURSING HOME			TREET ADDRESS, CITY, STATE, ZIP C 31 WEST RACE STREET COLLING FORK, MS 39159			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 441	Un-sampled Resid An observation, or Registered Nurse glucometer before Un-sampled Resid stick with an alcoh Interview, on 7/14/ revealed she did n manufacturer's rec policy was for clea Interview, on 7/14/ revealed she clear germicidal wipe be Interview with the I revealed she thoug alcohol or germicid glucometer. The D the manufacturer's germicidal wipes a appropriate cleaning	lent B n 7/14/17 at 10:30 AM, revealed (RN) #1 cleaned the and after checking lent B's blood glucose finger ol prep pad. 17 at 10:35 AM, with RN #1 ot know what the commendation, or the facility's ning the glucometer. 17 at 10:40 AM, with LPN #2 as the glucometer with a efore and after each use. DON, on 7/14/17 at 10:45 AM, ght the nurses could use either dal wipes to clean the DON confirmed, after reading s manual, that Clorox or other are recommended for ng. The DON also confirmed any training on cleaning and	F 441				

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Event ID: KZHX11

Facility ID: 63CI

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DEPARTMENT OF HEALTH AND HUMA! RVICES

PRINTED: 08/23/2017 FORM APPROVED

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SHARKEY-ISSAQUENA NURSING HOME STREET ADDRESS, CITY, STATE, ZIP CODE (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 CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COM K 000 INITIAL COMMENTS K 000 K 000 K 000 K 000 COM He facility must meet the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA) K 000 K 000	CENTER	RS FOR MEDICARE	& MEDICAIL SERVICES			OMB NO.	. 0938-0391
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SHARKEY-ISSAQUENA NURSING HOME STREET ADDRESS, CITY, STATE, ZIP CODE (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG ID PREFIX (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE A	- C.C.S.O.R.C. 2004 (2014) Control (2014)			1 N 8			
SHARKEY-ISSAQUENA NURSING HOME Ast WEST RACE STREET ROLLING FORK, MR 30159 (24) D PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PREFIX TAG PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PREFIX TAG PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PREFIX TAG CROSS-REFERENCE OT OT HE APPROPRIATE DEFICIENCY Control (CACH CONTROLL) DE CROSS-REFERENCE) OT OT CROSS-REFERENCE) OT OT APPROPRIATE DEFICIENCY Control (CACH CONTROLL) DE CROSS-REFERENCE) OT OT APPROPRIATE DEFICIENCY Control (CACH CONTROLL) DE CROSS-REFERENCE) OT OT CROSS-REFERENCE) OT OT APPROPRIATE DEFICIENCY Control (CACH CONTROLL) DE CROSS-REFERENCE) OT OT CROSS-REFERENCE) OT OT CONTROLL (CACH CONTROLL) DE CROSS-REFERENCE) OT OT CONTROLL (CACH CONTROLL) DE CROSS-REFER			255220	B. WING		07/	12/2017
PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-RECETIVE ACTION SHOULD ATTION THE STATE ACTION SHOULD ATTION STATES AT A SECTION SHOULD BE CROSS-RECETIVE ACTION SHOULD BE CR					431 WEST RACE STREET	ЭЕ	
 42 CFR 438.70(a) The facility must meet the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA) K 211 NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency. unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This condition affected one (1) of five (5) exits and 11 of the 47 residents in the facility on the day of survey. Findings include: On July 12, 2017 at 11:25 AM, observation revealed the security control lock on the Dementia Unit door did not release upon activation of the fire alarm system. The Dementia Unit door had a keypad that required a code to unlock. Based on interview, not all the staff members knew the code to unlock the Dementia 	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF	HOULD BE	(X5) COMPLETION DATE
 The facility must meet the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA) K 211 NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. This STANDARD is not met as evidenced by: Based on observation and interviews, the facility failed to properly maintain exit egress as per NFPA 19.2.2.5.2. This condition affected one (1) of five (5) exits and 11 of the 47 residents in the facility on the day of survey. Findings include: On July 12, 2017 at 11:25 AM, observation revealed the security control lock on the Dementia Unit door did not release upon activation of the fire alarm system. The Dementia Unit door did not release upon activation of the fire alarm system. The Dementia Unit door did not release upon activation of the fire alarm system. The Dementia Unit door did not release upon activation of the fire alarm system. The Dementia members knew the code to unlock the Dementia 	K 000	INITIAL COMMEN	TS	KO	00		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) D	LABORATOR	failed to properly m NFPA 19 2.2.2.5.2. This condition affect and 11 of the 47 re day of survey. Findings include: On July 12, 2017 a revealed the secur Dementia Unit doo activation of the fire Unit door had a key unlock. Based on it members knew the Unit door.	t 11:25 AM, observation to do not release upon e alarm system. The Dementia ypad that required a code to nterview, not all the staff e code to unlock the Dementia		deficient practice. 2. All residents have potential affected by deficient practice 3. New closure for means of e key pads installed by Systron deficient to maintain freedom obstructions in case of emerg 4. Maintenance Supervisor w discrepancies to Quality Assu Committee for review and app action taken to maintain comp	to be egress and ic to correct of any or all jency. ill report any irance propriate	(X6) DATE
LABORATORY DIRECTOR'S OR PROVIDENSOFFEIER REPERTATIVES STOLEN ORE			DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 08/22/2017

Electronically Signed

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.