STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255220	A. BUILDING _____ B. WING _____	07/14/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey at the facility from 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.	F 000		
F 253 SS=E	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (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 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 Maintenance Supervisor #1, on 7/13/17, at 10:00 until 11:30 AM, the following findings were observed: 1. The plastic air conditioner filter framework was	F 253	1. No resident had adverse affects from 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 Supervisor to correct sheet rock bubbles 08/04/2017.	8/4/17

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

Electronically Signed | 08/22/2017

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F 253	Continued From page 1 cracked, and the white filter material inside the framework was torn and frayed in the air conditioner wall units for two (2) units in the Dementia Unit Dining Room, and in Resident Rooms #7, #8, #9, #11, #18, #19, #20, #22, #24, #26, #27, #28, and #29. 2. The air conditioner front cover in Resident Room #20 was cracked in two (2) places at the top right and left corners, and the control panel plastic tab was broken off with the control panel door lying on the floor in the corner. The air conditioner front cover in Resident Room #29 was cracked in two (2) places at the top right and left corners, and appeared to be held in place with a tan colored glue substance. 3. There were no wands to open and close the window blind slats in Resident Rooms #6, #7, #8, #9, #10, #12, #16, #19, #20, #22, #24, #25, #26, #27, #28, #29, #30, #31, #32. The Main Dining Room on the West Hall had four (4) windows, and the Main Dining Room on the South Hall had one (1) window without a wand to open and close the window blinds. In Resident Room #19, the blind cord that raises and lowers the blind was tied to the handle on the right side of the window with the blind raised at an angle slanted downwards toward the left corner of the window. 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. 5. The sheet rock in the Resident Room bathrooms was bulging with a bubbled appearance on the right and left sides of the wall mounted sinks in shared bathrooms #7/8, #20/21,	F 253	4. Maintenance Supervisor, Social Service Designee will monitor 10% of all affected rooms once weekly times 3 months and report all discrepancies to the Quality Assurance Committee for review and appropriate action will be taken until substantial compliance is achieved and maintained.	

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	255220	A. BUILDING _____ B. WING _____	07/14/2017

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F 253	Continued From page 2 #22/23, #26/27, #30/31, and #32/33. These were approximately five (5) inch circular areas. An interview with Maintenance Supervisor #1, on 7/13/17, at 11:30 AM, revealed he had requested new air conditioner filters and blinds from the (Name of Hospital). He stated he had ordered the filters, but they never came in, and in regards to the blinds he was told they didn't have any. He stated the sheet rock was buckling due to moisture. In an interview with the (Name of Hospital) Administrator on 7/13/17, at 4:10 PM, revealed the hospital had taken over in January 2016, and he was not aware of any problems with the blinds, air conditioning or sheet rock in the resident's bathrooms. The (Name of Hospital) Administrator stated he depended on the nursing home administrator to take care of the nursing home problems, and relay them to him. During a tour of the facility, on 7/13/17, at 4:40 PM, with the (Name of Hospital) Administrator, he confirmed the air conditioner filters were broken, the blinds were non-functional, and the sheet rock was buckling next to the sinks in the resident's bathrooms. He also confirmed the door sweep was missing from one half of the exit door in the Main Dining Room. During an interview with the Nursing Hone Administrator, on 7/13/17, at 5:30 PM, she said she made rounds weekly, and that she was aware of the problems with the blinds, and air conditioner filters. Record review of the facility's Corrective Action Plan, dated 10/14/16, revealed Maintenance	F 253		

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F 253	Continued From page 3 Supervisor #1 had requested air conditioner unit filters from hospital staff. Another Corrective Action Plan, dated 9/6/16, revealed window blinds were requested.	F 253		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (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: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F 441		8/4/17

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F 441	Continued From page 4 (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of the the Rosie Smart Meter Blood Glucose Monitoring System's User Guide, the facility failed to prevent the potential spread of infection by failing to appropriately disinfect blood glucose monitors between resident use for two (2) of two	F 441	1. No resident using Blood Glucose Monitor had adverse affects from deficient practice. LPN# 2, RN# 1 were immediately counseled by Director of Nursing Service on correct Policy/Procedure, 07/14/2017 to prevent	

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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. Interview, on 7/14/17 at 10:45 AM ,with the Director of Nurses (DON) revealed the facility did not have a policy for cleaning/disinfecting the blood glucose monitor. Un-sampled Resident A An observation and interview, on 7/13/17 at 11:05 AM, revealed Licensed Practical Nurse (LPN) #1 cleaned the glucometer with an alcohol prep pad before and after performing Un-sampled Resident A's blood glucose finger stick. Interview at this time with LPN #1 revealed that is what she always cleans it with. LPN #1 confirmed she did not know what the manufacturer's recommendation was for disinfecting the glucometer between resident uses.	F 441	potential for spread of infection. 2.All residents using Blood Glucose Monitor have potential to be affected by deficient practice. The facility will develop Policy/Procedure concerning cleaning of the Blood Glucose Monitor with bleach disinfectant wipes. 3. Local Contracted Consultant in-serviced employees 07/19/2017 on Policy/Procedure performing FSBS and proper cleaning Blood Glucose Monitor and competency checklist began. 4. Each nurse will be checked off on performing glucose checks, including cleaning of Blood Glucose Monitor. 10% per week X 3 months on Competency checklist will be done and documented and presented to Quality Assurance Team. Quality Assurance Committee will review and appropriate action will be taken to maintain compliance.	

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F 441	Continued From page 6 Un-sampled Resident B An observation, on 7/14/17 at 10:30 AM, revealed Registered Nurse (RN) #1 cleaned the glucometer before and after checking Un-sampled Resident B's blood glucose finger stick with an alcohol prep pad. Interview, on 7/14/17 at 10:35 AM, with RN #1 revealed she did not know what the manufacturer's recommendation, or the facility's policy was for cleaning the glucometer. Interview, on 7/14/17 at 10:40 AM, with LPN #2 revealed she cleans the glucometer with a germicidal wipe before and after each use. Interview with the DON, on 7/14/17 at 10:45 AM, revealed she thought the nurses could use either alcohol or germicidal wipes to clean the glucometer. The DON confirmed, after reading the manufacturer's manual, that Clorox or other germicidal wipes are recommended for appropriate cleaning. The DON also confirmed she had not done any training on cleaning and disinfecting the glucometers.	F 441		

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	255220	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/12/2017**

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K 000	INITIAL COMMENTS 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 000		
K 211 SS=D	NFPA 101 Means of Egress - General 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 STANDARD is not met as evidenced by: Based on observation and interviews, the facility failed to properly maintain exit egress as per NFPA 19 2.2.2.5.2. 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 had a keypad that required a code to unlock. Based on interview, not all the staff members knew the code to unlock the Dementia Unit door.	K 211	FIRE SAFETY Received AUG 23 2017 MSDH-HFLC & CONSTRUCTION 1. No adverse affects noted from deficient practice. 2. All residents have potential to be affected by deficient practice 3. New closure for means of egress and key pads installed by Systronic to correct deficient to maintain freedom of any or all obstructions in case of emergency. 4. Maintenance Supervisor will report any discrepancies to Quality Assurance Committee for review and appropriate action taken to maintain compliance. 8-23-17 Accepted By Mail	7/17/17

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

Electronically Signed — 08/22/2017

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.