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 _____	10/11/2018

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 10/09/2018 to 10/11/2018. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements for participation. The SA cited the regulatory deficiency, F658. At the time of this survey, the census was 53, and the facility held a license for 60 beds.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility policy review, the facility failed to administer eye drops as ordered by the physician for one (1) of 32 medication administration opportunities; Resident #17. Findings include: Review of the facility's "Drug Administration" policy, dated 06/94, revealed the complete act of medication administration entailed removing an individual dose from a previously dispensed, properly labeled container (including a unit dose container), verifying it with the physician's orders, giving the individual dose to the proper resident, and promptly recording the time and dose given.	F 658	Bullet #1 Corrective Action(s) For Identified Resident: Resident # 7 was immediately assessed by Registered Nurse Supervisor on 10/10/18 due to Licensed Practical Nurse #1 administered eye drops into the wrong eye and no adverse effects. Medical Director was notified of Resident #7 receiving eye drop in wrong eye on 10/10/18. No new orders noted. Immediate in-service for LPN #1 on 10/10/18 by Staff Development Coordinator. Bullet #2 How will other residents be identified	11/2/18

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

Electronically Signed — 11/02/2018

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F 658	Continued From page 1 An observation during medication administration on 10/10/2018 at 8:22 AM revealed Licensed Practical Nurse (LPN) #1 administered Ketorolac 0.5% ophthalmic (opth) solution one (1) drop into Resident #17's left eye. Review of the cumulative October 2018 Physician Orders for Resident #17, revealed an order dated 09/06/18 for Ketorolac 0.5% opth solution one (1) drop in right eye four times a day. An interview, with LPN #1, on 10/10/2018 at 8:38 AM, confirmed Ketorolac 0.5% opth solution one(1) drop was administered in Resident #17's left eye. LPN #1 stated she was nervous and administered eye drop in the wrong eye. Review of the Licensed Nurses Orientation Checklist for LPN #1, revealed, LPN #1 received training from LPN #2, on 09/06/2018, which included Medication Administration. An interview, with LPN #2, on 10/10/2018 at 8:40 AM, revealed, all nurses had completed a skills check off on medication administration. An interview, with the Administrator, on 10/10/2018 at 10:55 AM, revealed the Director of Nursing (DON) and the Staff Development Nurse are responsible for monitoring appropriate medication pass technique and accuracy. An interview, with the DON, on 10/11/2018 at 10:10 AM, revealed that it was the responsibility of the Nurse Trainer to make sure all new nurses are trained on proper medication pass procedure, and that medication administration should be monitored by the Nurse Trainer and the Staff	F 658	All Residents have potential to be affected by the deficient practices. Bullet #3 Systemic Changes or corrective measures: Medication error report performed and reviewed by attending Physician on 10/10/18. Immediate In-service with Licensed Practical Nurse on following the eye drop administration policy, staff member will read the medication administration record before all eye drop administration, and verify correct order of administration. Medication error report performed and reviewed by attending Physician on 10/10/18 for med error report regarding the administration of R#7 s eye drops were administered into the wrong eye was done and reviewed by attending Physician. Facility created an eye drop administration check off form which was approved by Quality Assurance Committee which includes Medical Director on 11/1/18. Staff Development Coordinator will perform return demonstration on all nursing staff by 11/1/18 of the eye drop administration policy, which includes: staff member will read the medication administration record before all eye drop administration, and verify correct order of administration. Eye drop inspections done three times weekly for 2 weeks and followed by once weekly for 2 weeks by Staff Development Coordinator by 11/30/18. No new adverse events resulted from audits. Verification of all orders of eye drops to ensure indication of which eye is specified in the order by Director of Nurses by 11/12/18.	

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F 658	Continued From page 2 Development Nurse. The DON confirmed that the administration of the eye drop in the wrong eye was a medication error. Review of the Face Sheet revealed, the facility admitted Resident #17 on 02/06/2017, with diagnoses which included Unspecified Dementia and Type II Diabetes Mellitus. Review of the Quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 07/31/2018, revealed Resident #17 scored 15 on the Brief Interview for Mental Status (BIMS) which indicated cognitively intact.	F 658	All ordered reviewed and no issues noted. Bullet #4 How will the corrective action measures be monitored: All findings will be reported monthly to Quality Assurance by RN DON. Quality Assurance team will: Monitor effectiveness of the plan of correction monthly x 3 months then quarterly, provide increased training for new nurses if necessary, assign random checks for return demonstration from nursing staff, in-service on reading and verifying medication administration record as needed. The quality assurance committee will make further recommendations as needed.	

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	255220	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/11/2018**

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K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility meets the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). There were no LSC deficiencies cited during this survey.	K 000		

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E 000	Initial Comments *EMERGENCY PREPAREDNESS* Survey conducted on 10/11/18 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were identified.	E 000		

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