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 _____	12/17/2019

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 from 12/15/19 to 12/17/19. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements of participation. The SA cited the regulatory deficiencies F656, F812, and F880. The facility held a license for 54 beds, with a census of 42 at the time of survey.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the	F 656		1/17/20

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F 656	Continued From page 1 findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to develop a care plan for anticoagulant medication for two (2) of 12 resident care plans reviewed, Residents #24 and #34. Findings include: Record review of the "Care Plan" policy, undated, revealed a comprehensive care plan will be developed for each resident, that includes measurable, objective goals, with specific timeframes for meeting those goals. Resident #24 Record review of the comprehensive care plan for Resident #24, revealed no care plan was developed for the anticoagulant, Coumadin, and its possible side effects, which would include bleeding.	F 656	1. Resident #24 and #34 care plan updated on 12/18/19 to reflect Resident anticoagulant therapy and its possible side effects, which could include bleeding by Minimum Data Set Coordinator. 2. Minimum Data Set Coordinator, conducted a 100% audit on anticoagulant care plans on 12/18/2019. Audit indicated that one additional Resident needed care plans related to anticoagulant therapy, and its possible side effects, which could include bleeding.Minimum Data Set Registered Nurse added safety measures on medical echarting on 12/18/2019 which included its possible side effects, which could include bleeding. Daily Care guide updated by Minimum Data Set Coordinator for intervention to monitor Residents for abnormal bleeding and/or bruising on 12/27/2019 for all Residents	

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F 656	Continued From page 2 Record review of Resident #24's December 2019 Physician Orders, revealed an order dated 11/20/19, for Coumadin 3 milligram (mg) daily at bedtime. Resident #34 Record review of the care plan for Resident #34, revealed a care plan for administering an anticoagulant as ordered, however, there was no care plan developed for monitoring possible side effects, which would include bleeding. Record review of Resident #34's December 2019 Physician Orders, revealed an order dated 10/31/19, for Eliquis 5 mg twice daily. Record review of the nurse's notes, dated 10/31/19 at 11:56 AM, revealed the physician visited Resident #34, with new orders noted to send to a local clinic for an ultrasound for deep vein thrombosis to the left leg, discontinue Xarelto, and add Eliquis 5 mg twice daily. On 12/16/19 at 4:20 PM, an interview with Registered Nurse (RN) #2 revealed she is responsible for developing resident care plans. RN #2 confirmed Resident #34 did not have a care plan developed for the Eliquis medication, and Resident #24 did not have a care plan developed for taking the anticoagulant Coumadin, or the monitoring for signs and symptoms related to taking an anticoagulant. On 12/17/19 at 10:00 AM, an interview with the Director of Nursing (DON) confirmed a care plan should be developed for any resident that is taking an anticoagulant, with interventions, which should include: monitor for bruising, bleeding or signs of bleeding, and the staff should be	F 656	using anticoagulants. All Residents on anticoagulants are at risk. 3. In-service conducted on 12/27/2019 by Administrator on Care Planning policy and ensuring that care plan reflects current level of care for Residents. Audit conducted by Director of Nurses on Care plans of new admissions, new orders of anticoagulant medication, and readmissions once weekly for six weeks to ensure Care Plans have been updated initiated on12/27/2019. Inservice Director of Nurses to perform high risk meetings weekly to include monitoring of anticoagulant therapy and its possible side effects, which could include bleeding which includes Resident Care plan by Administrator on 1/6/2020. High risk meeting attendees include Infection Control Preventionist, Medical Records Clerk, Director of Nurses, and Minimum Data Set Nurse. 4. Weekly High Risk Meeting will monitor anticoagulant therapy usage beginning 12/18/2019 by Director of Nurses. All findings will be reported monthly to Quality Assurance by Registered Nurse Director of Nurses. They will monitor the effectiveness of the high risk meeting to ensure that care plans have been addressed for anticoagulant usage and risks are identified. Quality Assurance team will: Monitor effectiveness of the plan of correction monthly x three months then quarterly thereafter. The Quality Assurance committee will make further recommendations such as increased	

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F 656	Continued From page 3 cautious shaving residents on an anticoagulant.	F 656	training, corrective action against Team Members, and care plan reflections as needed.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (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. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, the facility failed to label and date food stored in the refrigerator and freezer for one (1) of two (2) kitchen tours. Findings include: Record review of the "Storage of Frozen Food" policy, undated, revealed the facility ensures the quality and safety of frozen food through accepted storage practices. Frozen foods are	F 812	1. Employee Cook #1 discarded squash and pudding on 12/14/2019 at 11:05 AM. 2. Dietary Manager audited food stored for labels and dates on 12/15/2019 and found no other issues of labeling and dating issues. All Residents have the potential to be affected. 3. An inservice conducted on 12/18/2019 by Dietary Manager with Dietary Staff on	1/17/20

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F 812	Continued From page 4 dated when received. The first in, first out method is used: products with the earliest date are stored in front of products with a later date. Frozen food is stored in the original package. Record review of the "Storage of Refrigerated Food" policy, undated, revealed the facility ensures the quality and safety and sanitation of refrigerated foods through accepted storage practices. All opened foods are labeled with common name of food, date stored, and use-by-date. On 12/15/19 at 10:51 AM, observation in the kitchen, revealed a zip-lock plastic bag of squash, in the freezer, without a date or label, a plastic bag of cut broccoli, without a date or label, and eight (8) cups of pudding on a metal pan, covered with plastic wrap, were in the cooler, without a date or label. On 12/15/19 at 10:57 AM, an interview with Dietary Staff (DS) #1, confirmed the squash and broccoli were in plastic bags, without a date or label. DS #1 revealed she did not know when they were put in the freezer, she thought it might have been last week. DS #1 confirmed the pudding did not have a date, and she thought it was from 12/14/19. DS #1 revealed whoever places the food in the freezer, or cooler, is responsible for labeling it with the date. On 12/15/19 at 11:57 AM, an interview with the Dietary Manager (DM), revealed the DS called her and told her about the pudding, squash, and broccoli, not labeled or dated. The DM revealed staff knew if they find anything without a label or date, they should throw it away, no matter what it is.	F 812	storage of frozen and refrigerated food. A form was initiated titled Food Label Log to monitor for labels and dates of food for refrigerated and frozen items initiated on 1/1/2020. Dietary Manager will audit use of the Food Label Log weekly for six weeks. Cooks will be responsible for using the Food Label Log each shift initiating on 1/6/2020. 4. The Dietary Manager will report Food Label Log performance to administrator weekly for six weeks initiating on 1/10/2020. The Dietary Manager will report Food Label Log performance during Quality Assurance meeting monthly for three months. The Quality Assurance committee will make further recommendations such as increased training, corrective action against Team Members, and care plan reflections as needed.	

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F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control 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. §483.80(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: §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 §483.70(e) and following accepted national standards; §483.80(a)(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; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		1/17/20

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F 880	Continued From page 6 (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. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(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 facility policy review, the facility failed to prevent the likelihood of infection, during medication administration, for one (1) of three (3) of six (6) residents observed for medication administration. Findings include: Review of the "Infection Control - Standard and Transmission-based Precautions", policy,	F 880	1. No Residents had adverse affects from deficient practices. Medication cart was cleaned by Nurse #1 on 12/16/2019. Inservice conducted by Staff Development Coordinator on 12/16/2019 related to hand washing during medication pass, and providing barrier between objects during medication pass with Nurse 1 Licensed Practical Nurse. 2. All Residents have potential to be	

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F 880	Continued From page 7 undated, revealed: It is the policy of the facility to ensure that appropriate infection prevention and control measures are taken to prevent the spread of communicable disease and infections in accordance with State and Federal Regulation, and national guidelines. Procedure: Standard Precautions, 1. All staff are to adhere to standard precautions. a. Personal protective equipment is to be worn to protect health care workers (i.e. have a barrier) from contact with body fluids. b. Personal protective equipment includes gloves, gowns, masks, goggles and or face shield. c. The personal protective equipment worn will vary by task being performed and likelihood of exposure to body fluid. 2. Standard precautions apply to all residents. Review of the "Hand Hygiene", policy, with an effective date of 12/31/17, revealed: It is the policy of this facility to conduct proper hand hygiene consistent with accepted standards of practice....Staff must perform hand hygiene (even if gloves are used):...7. Before and after contact with the resident...9. After contact with blood, body fluids, visibly contaminated surfaces or after contact with objects in the resident's room. On 12/16/19 at 09:12 AM, observation of Medication (MED) Pass, with Licensed Practical Nurse (LPN) #1, revealed LPN#1 did not wear gloves while administering medications to Resident #44. LPN #1 returned to the medication cart and did not wash her hands, or use hand sanitizer, before preparing medications for Resident #20. LPN #1 donned one (1) glove on her right hand and walked to Resident #20, who was sitting in an upright Gerichair in the lobby, and placed the bottle of Artificial Tears on the resident's lap tray, without a barrier. She	F 880	affected by the deficient practice. 3. Inservice conducted by Staff Development Coordinator related to hand washing during medication pass, and providing barrier between objects during medication pass with all licensed staff initiated by 1/10/2019. Hand washing competencies performed by all Licensed Nursing Staff initiated 1/16/2020 administered by Infection Control Preventionist. Infection Control Preventionist to conduct audits of Licensed Staff three times weekly for six weeks for proper infection control during medication pass initiated on 1/16/2020. 4. All findings will be reported monthly to Quality Assurance by Registered Nurse Director of Nurses. The Quality Assurance team will monitor effectiveness of the plan of correction monthly x three months then quarterly thereafter. The Quality Assurance committee will make further recommendations such as increased training, corrective action against Team Members, and care plan reflections as needed.	

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F 880	Continued From page 8	F 880		

administered the medications by mouth, and opened the Artificial Tears, and placed the lid of the dropper bottle on top of the lap tray. LPN #1 touched Resident #20's face, by pulling the lower lid down, to instill eye drops to both eyes, with her ungloved hand. LPN #1 wiped the resident's face with the blanket, used to cover the resident's head. She then replaced the lid on the Artificial Tears, put the bottle in the carton, and placed it inside the top drawer of the medication cart . LPN #1 then prepared medications for Resident #45, without performing hand hygiene.

On 12/16/19 at 8:54 AM, an interview with LPN #1 confirmed she had not used proper hand hygiene between residents, during medication pass. LPN #1 stated it would be an infection control problem and could potentially spread germs from one patient to another. She stated having placed the Artificial Tears on the resident's lap tray, without a barrier, and then back into the cart, would contaminate the medication cart.

On 12/17/19 at 9:36 AM, during an interview, LPN #2/ Staff Coordinator stated by not washing hands, or using hand sanitizer between residents, there was a risk of cross contamination, which is an infection control issue. LPN #2 stated when Resident #20's bodily fluids (tears) came into contact with LPN #1's ungloved hand, potential infection could spread, and with flu season, it could be an epidemic quickly.

Record review of the Infection Control Orientation Checklist, signed by LPN #1 and verified by LPN #2/Staff Coordinator, on 9/24/19, revealed she had been trained on the explanation of infection process, Occupational Safety and Health Administration (OSHA) standards for blood borne

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F 880	Continued From page 9 diseases, epidemiology, and transmission/prevention of infection. LPN #1 also signed she understand the importance of hand washing in preventing infections and had been given an explanation of Standard precaution (Universal Precautions) and transmission based precautions, how, and when to use them. Record review of In-Service Training, presented by the Administrator, on 11/19/19 and 11/21/19, revealed LPN #1 had signed she attended. Content of the in-service included Standard Precautions.	F 880		

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K 000	INITIAL COMMENTS 42 CFR 483.70(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	Means of Egress - General CFR(s): 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 REQUIREMENT is not met as evidenced by: Based on observation and interviews, the facility failed to properly maintain exit egress as per NFPA 101 section 19.2.2.2.6. The deficient practice affected 14 of 47 residents in the facility on day of survey. Findings include: On December 23, 2019 at 10:40 AM, observation revealed a nailed closed gate obstructing and blocking the exit egress from the Dementia Unit and the Dining Room Area of the facility.	K 211	Maintenance Director on 12/24/2019 removed nails from the gate to allow functioning. Inservice with all staff initiated on 12/24/2019 in regards to properly maintain exit egress as per NFPA 101 section 19.2.2.2.6. Maintenance Director contacted Systronics for quote on replacing current gate to allow egress on and off the courtyard through a electrical door code. Administrator initiated weekly audit of egress on the facility ground each week for 6 weeks on 1/6/2020.	2/4/20
K 222 SS=D	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the	K 222		2/4/20

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K 222	Continued From page 1 use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system.	K 222		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255220	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/23/2019**

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

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K 222	Continued From page 2 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to properly maintain exit egress as directed by NFPA 101 section 19 2.2.2.4. The deficient practice affected 14 of 47 residents in the facility on day of survey. Findings include: On December 23, 2019 at 1:55 PM, observations revealed the following exit door deficiencies of the facility: 1. The magnetic, combination lock on exit door from the Dining Room Area did not release and open upon activation of the fire alarm system	K 222	Inservice with all maintenance staff initiated on 12/29/2019 in regards to properly maintaining egress through latches or locks by Administrator. Maintenance Director contacted Systronics for quote on replacing current hardware to provide an electrical door code access latch. Administrator initiated weekly audit of egress on the facilities exits each week for 6 weeks on 1/6/2020.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing	K 918		2/4/20

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	255220	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/23/2019**

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K 918	Continued From page 3 The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on document review, the facility failed to properly test the emergency generator as per NFPA 110 section 8.4.2. The deficient practice affected the entire facility on day of survey.	K 918	Inservice with all maintenance staff initiated on 12/29/2019 in regards to properly maintaining documentation related to generator test by Administrator. Maintenance Director contacted	

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	255220	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/23/2019**

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K 918	Continued From page 4 Findings include: During document review on December 23, 2019 at 2:12 PM, the facility could not provide documentation showing the weekly inspections and monthly load tests for the generator during the last calendar year of 2019.	K 918	Cummings Generator company for in-service on generator services on 1/6/2020. Cummings to arrive and provide education on 1/17/2020. New weekly generator audit form created by Administration on 1/6/2020. Administrator initiated weekly audit of generator checks weekly for 6 weeks.	

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	255220	A. BUILDING _____ B. WING _____	12/23/2019

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E 000	Initial Comments ********** Survey conducted on 12/23/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were cited.	E 000		

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

Electronically Signed | 01/10/2020

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.