PRINTED: 01/28/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		255220	B. WING _				C 22/2019
NAME OF P	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE	, 00,	
				431	WEST RACE STREET		
SHARKEY	-ISSAQUENA NURSING	HOME		RO	LLING FORK, MS 39159		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	3	F	000			
	CI MS #16118, CI M	S #16119 & CI M S#16120					
	survey at the facility, for CI MS #16118, CI #16120. The SA dete compliance with the r for Medicare and Med MS #16120 regarding Neglect, and failure to the physician and proresulted in harm to R amputation of his left 05/09/19, the facility in 4th toenail was detact and wrapped by Licel #2 at that time, hower notified of the incident for the toe. The facility and treat the 4th left to and one half weeks large observed swollen and assessed the toe and one plus (1+) edemal pus. Resident #1 was hospital for evaluation regional hospital for so Diagnoses included Confection. On 06/04/19 to the hospital with diffractures of the Left x-ray on 06/04/19), Left to the foot infections of his 4th toe on the left foot infections of his 4th toe on the left standard the summer of the left foot infections of his 4th toe on the left standard the summer of the left foot infections of his 4th toe on the left standard the summer of the left foot infections of his 4th toe on the left standard the summer of the left foot infections of his 4th toe on the left standard the summer of the left foot infections of his 4th toe on the left standard the summer of the left foot infections of his 4th toe on the left standard the summer of the left foot infections of his 4th toe on the left standard the summer of the left foot infections of his 4th toe on the left standard the summer of the left standard the summer of the summ	esident #1, due to the fourth (4th) toe. On dentified that Resident #1's ched. The toe was cleaned nsed Practical Nurse (LPN) wer the Physician was not at to provide treatment orders y did not accurately assess toe, and on 06/04/19 (three ater), the left 4th toe was didiscolored. LPN #2 didescribed it to be cyanotic, with moderate bleeding and a transferred to the local not, then transferred to a surgical treatment. Cellulitis and Wound 9, Resident #1 was admitted					
ADORATE		•			T.T. C.		(VC) DATE
ABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURI	E		TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

09/20/2019

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.

Electronically Signed

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
			7 50.125.			(С
		255220	B. WING _			08/	22/2019
	ROVIDER OR SUPPLIER	НОМЕ	Ì	43	REET ADDRESS, CITY, STATE, ZIP CODE 1 WEST RACE STREET DLLING FORK, MS 39159		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 000 F 580 SS=G	and F842 at a non-haccomplaint CI MS #16 The SA did not subst anonymous complaint Neglect related to an deficiencies were cite. The SA did not subst complaint regarding (Activities of Daily Liviand Hydration. No deto MS #16119. Notify of Changes (In CFR(s): 483.10(g)(14) Notific (i) A facility must immonsult with the resid consistent with his or representative(s) where (A) An accident involvesults in injury and hydration intervention (B) A significant change the status in either life-th clinical complications (C) A need to alter the a need to discontinue.	F656, F687, at harm levels arm level, related to the 120. antiate CI MS #16118, an it, regarding Abuse and unwitnessed fall. No ed related to MS 16118. antiate CI MS #16119, a Quality of Care/Treatment, ing (ADL) care, Weight Loss ifficiencies were cited related in items (i) (i) (ii) (iv) (15) cation of Changes. idiately inform the resident; ent's physician; and notify, her authority, the resident enthere isving the resident which is the potential for requiring in; ge in the resident's physical, items as the potential for requiring in; ge in the resident's physical, items as the potential for requiring in; ge in the resident's physical, items as the potential for requiring in; ge in the resident's physical, items as the potential for requiring in; ge in the resident's physical, items as the potential for requiring in; ge in the resident's physical, items as the potential for requiring in; ge in the resident's physical, items as the potential for requiring in; ge in the resident's physical, items as the potential for requiring in; ge in the resident's physical, items as the potential for requiring in; ge in the resident's physical, items as the potential for requiring in; ge in the resident's physical, items as the potential for requiring in; ge in the resident's physical, items as the potential for requiring in; ge in the resident's physical, items as the potential for requiring in; ge in the resident's physical, items as the potential for requiring in; ge in the resident's physical, items as the potential for requiring in; ge in the resident which is a status (that is, a in the resident's physical in the resident's physical in the resident's physical in the resident's physical in the resident which is a status (that is, a in the resident's physical in the resident's ph		5580	DEFICIENCY)		10/1/19
	§483.15(c)(1)(ii).	fication under paragraph (g)					

OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		(X3) DATE SURVEY COMPLETED
	255220	B. WING		C 08/22/2019
	G HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 431 WEST RACE STREET ROLLING FORK, MS 39159	1 00/22/2013
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	D BE COMPLETION
(14)(i) of this section all pertinent informat is available and prove physician. (iii) The facility must resident and the section (iv) A change in resident (e)(10) of this section (iv) The facility must update the address phone number of the representative(s). §483.10(g)(15) Admission to a computation is a composite of \$483.5) must disclosits physical configurations that compropert, and must specific room changes between the resident specific policy review, physician of a change five (5) residents observed to the facility's failure were received for the assessments of the	also promptly notify the ident representative, if any, in or roommate assignment assignment as specified in paragraph in as specified in paragraph in a record and periodically (mailing and email) and a resident set in its admission agreement ation, including the various ise the composite distinct fy the policies that apply to een its different locations. T is not met as evidenced view, staff interview, and the facility failed to notify the ge in condition for one (1) of served for foot care, Resident sident #1 was observed with fithe left 4th toe. As a result to to notify the MD, no orders are treatment of the toe, and no foot were performed, which	F 58	1. Resident □s physician was notified the change in condition on 6/4/2019 6/4/2019 Resident received order to transfer to Local Hospital for evaluate Resident record reflected the notificate of change on 6/4/2019. 2. All residents have the potential to affected. On 8/27/2019, an audit was	. On tion. ation be
,	Continued From page (14)(i) of this section all pertinent informatis available and proving the tresident and the resiwhen there is- (A) A change in roor as specified in §483 (B) A change in roor as specified in §483 (B) A change in resident and the resiwhen there is- (A) A change in resident and the resiwhen there is- (A) A change in roor as specified in §483 (B) A change in resident and the resiwhen there is- (A) A change in resident and the r	PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 2 (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced	ROVIDER OR SUPPLIER Y-ISSAQUENA NURSING HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 2 (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. 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Resident #1	ROVIDER OR SUPPLIER 7-ISSAQUENA NURSING HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LISC IDENTIFYING INFORMATION) Continued From page 2 (1/4)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to notify the Ephysician of a change in condition for one (1) of five (5) residents observed for foot care, Resident #1. On 05/09/19, Resident #1 was observed with a detached toenail of the left 4th toe. As a result of the facility similure to notify the MD, no orders were received for the treatment of the toe, and no assessments of the foot were performed, which resulted in harm to Resident #1. Resident #1.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED	
		255220	B. WING			08/22/2019	
NAME OF PR	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP COD		70722720 TO	
				431 WEST RACE STREET			
SHARKEY	-ISSAQUENA NURSING	HOME		ROLLING 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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE EAPPROPRIATE	(X5) COMPLETION DATE	
F 580	Continued From page	e 3	F 5	30			
	development of redne pus to the 4th left toe was transferred to the evaluation, and diagr and Infection of the L transferred to a regio intervention. During t #1 required an ampu	ess, swelling, bleeding, and . On 06/04/19, Resident #1 e local hospital for nosed with severe Cellulitis		ensure Resident Physician and Representatives were notified No new issues noted. (injury/Decline/Room). 3. On 8/23/2019 the facility ald Clinical Workup Meeting tempinclude notification of change to include phone and fax confin-service conducted by Staff Development Nurse to Nursin Licensed Practical Nurse and	d of results. Itered its plate to verification firmations. Ing Staff I Registered		
	Resident Medical Sta Care-MS-06/94, revis change in medical sta physical, psychologic as compared to the re- the initial assessment inform the resident; of physician; and if known representative or an when there is: 1. An a resident which results potential for requiring	sed 06/02/99, revealed, "A atus is defined as any sal and/or medical deviation esident's status as noted in t. A facility must immediately consult with the resident's wn, notify the resident's legal interested family member accident involving the in injury and has the physician intervention; 2. A the resident's physical,		Nurse of notification of changlisted in Resident Care Manu on 08/23/2019. In-service cor Staff Development Nurse to Administrative Nursing Staff t fax confirmations when Team state that a facsimile was ser physician as notification, the workup meeting template, to documentation is saved in the book. If no facsimile may be the Administrative Nursing St ensure notification occurred a departmental note is complet Performed on 08/23/2019.	al performed inducted by so monitor for Members in to the new clinical ensure that it facsimile found that aff to call to and a ed.		
	at 3:44 PM, with the revealed the absence foot. Skin was intact Review of the Depart dated 05/09/19 at 10 LPN #2, revealed, "R	mental Notes-Charge Nurse, :45 AM, documented by esident pulled toenail bed on d and wrapped". There was		collected and monitored daily weeks initiated on 8/27/2019. Nurses will monitor notificatio daily in Clinical Workup meet findings will be reported mont Assurance by Director of Nur Assurance Committee will: Meffectiveness of the plan of comonthly x 3 months, and qua thereafter. The Quality Assurance	r for six Director of on of change ing. All thly to Quality ses. Quality onitor orrection		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER: A. BUILDII			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		255220	B. WING			l	C 22/2019	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	22/2013	
				43	31 WEST RACE STREET			
SHARKEY	-ISSAQUENA NURSING	HOME		R	OLLING FORK, MS 39159			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTIV PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPROL DEFICIENCY)			(X5) COMPLETION DATE	
F 580	Practitioner (NP) were	e notified. Further review of	F	580	Committee will make further			
	•	es-Charge Nurse, dated			recommendations on training or			
	05/31/19 at 10:52 AM				modification to the Clinical Workup			
	#1/Treatment Nurse,				Meeting as necessary. The Director of			
	,	nds today. No new orders at tment Note-Charge Nurse,			Nurses is responsible for on-going			
	•	8 PM, documented by LPN			monitoring and compliance.			
		is One) pitting edema noted						
		loves bandage wrapped						
		pinky toe. Cyanosis.						
		nd pus noted. 4:45 PM						
		(Initials For Local Hospital)						
	ER. Transported from	• • •						
	•	ЛТ (Emergency Medical						
	Technicians). RP (Re	sponsible Person) notified".						
	There was no docum	entation of MD notification.						
	In an interview with L	PN #1/Treatment Nurse, on						
		she confirmed she was						
		ool Room on 05/09/19, and						
		t fourth toenail was "hanging						
		stated she did not observe						
	_	ail bed. LPN #1 said she						
		the toe hurt, and he said cleaned the nail bed with						
	•	ought she put antibiotic pand aid. LPN #1 said she						
		dent #1 had pulled his						
		he had done to dress it.						
		said that was fine and gave						
	no further orders. LPN	<u> </u>						
		medical record, or write an						
		nt and the following day, she						
		and cleaned it again and it						
		ed that no further treatment						
	was needed, it really	wasn't an open area and						
		or deformity noted to the						
	_	PN #1 confirmed she did						
	not notify the physicia	n or receive further orders						

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	, ,	ATE SURVEY DMPLETED	
		255220	B. WING			C 08/22/2019	
	ROVIDER OR SUPPLIER	G HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 431 WEST RACE STREET ROLLING FORK, MS 39159	1	33,22,20.10	
(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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 580	The SA called the nawhere the NP worked but was not able to a The SA left a messar have the NP return for return call from the I An interview, on 08/#2 revealed she was 05/09/19, in which is Whirlpool Room by #4/Whirlpool CNA. Let reported Resident # and pulled it off. LPI toenail of the left foot there was blood over she did not observe the left 4th toe that of LPN #1, the Treatmer Room and LPN#1 and day. LPN #2 said she the nurse's note that toenail off per report but did not perform the resident's Physical During an interview (LPN) #2, on 08/20/she was assigned to but had not been as month. LPN #2 said Whirlpool Room by Assistants (CNAs), I names. LPN #2 repowas very swollen, all	toenail was pulled off. ame of the medical clinic ad, on 8/22/19 at 10:21 AM, speak to the NP at that time. ge with the Receptionist to the call. The SA did not get a NP. 20/19 at 1:08 AM, with LPN s aware of a prior incident, on the was called into the CNA #1 and CNA PN #2 said the CNAs 1 was picking at the toenail N #2 said she observed the arth toe was detached and or the nail bed. LPN #2 said any swelling or redness to day. LPN #2 said she called tent Nurse, into the Whirlpool ctually dressed the toe that the documented the incident in the resident had pulled his by the CNAs on 05/09/19, the dressing change, or notify cian. with Licensed Practical Nurse 19, at 1:53 PM, she stated to Resident #1 on 06/04/19, signed to Resident #1 that she was called into the	F 58				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		255220	B. WING _			08/2	; 22/2019	
	ROVIDER OR SUPPLIER	G HOME		STREET ADDRESS, CITY, STATE, 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 PREFI) TAG	X (EACH CORRECTIVE CROSS-REFERENCED	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 580	the left fourth toe ca was hollering out in observed pus and a and the toe appeare said she had no kno ordered for the left for left for the left fo	d she took a blue bandage off refully because Resident #1 pain. LPN #2 said she little blood on the bandage, d deformed and blue. LPN #2 wledge of any treatment	F	580 DEFIC	CIENCY)			
	Physical, dated 6/4/Resident #1 was brown swelling and rednes swelling and rednes smell to the left foot plantar surface of the suspected fracture of the left foot, on 06/0 fractures with widen (DIP). The resident in	19, at 9:00 PM, revealed bught into the ED with severe is of the left foot, and severe is of the left fourth toe, a foul and a laceration of the left fourth digit. and, if the left fourth toe. X-ray of 4/19, revealed, "Fourth toe led distal interphalangeal joint required multiple antibiotics in and was aggressively washed						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	PLE CONSTRUCTION B	(X3) DATE SURVEY COMPLETED
		255220	B. WING		08/22/2019
	ROVIDER OR SUPPLIER	IG HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 431 WEST RACE STREET ROLLING FORK, MS 39159	1 00/22/2019
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETION
F 580	documentation that require additional eresident was admit diagnoses of Phala Toe-Open, Infected Joint) to the Fourth Orthopedic was conceived by the Fourth Orthopedic was conceived a summan Resident #1 was a conceived a summan Resident #1 was a conceived a summan Resident #1's feet of the 4th left toe was Ultra Sound Lower Bilateral, performed mild atherosclerotic was unobtainable. hemodynamically solower extremity was discharged back to 06/13/19. Record review of a dated 06/04/19 at 4 Injury: Localized tis incident and descriptions and blocarefully removed by the same and blocarefully removed by the same additional removed by the same additi	the wound was old and would evaluation and wash out. The ted to the hospital with inx Fracture Left Fourth IMTP (Metatarsophalangeal Toe Left, and Cellulitis. Insulted. The of Regional Hospital) ry, dated 06/16/19, revealed dimitted to the hospital from a for left foot infections. The residuly treated and underwent of the structure of the survey revealed only amputated). Record review of Extremity Arterial Duplex of the one of the condition of the survey revealed only amputated). Record review of Extremity Arterial Duplex of the one of the condition of the survey revealed only the condition of the survey revealed only the survey revealed	F 58		
	moderate bleeding of local hospital's E called". The Incider dated 06/06/19, by	pandage. Cyanosis and noted. Pain scale of 9. (Name imergency Room) nurse nt Report was signed and Licensed Practical Nurse dent Report documented the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MU IDENTIFICATION NUMBER: A. BUIL		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		255220	B. WING		C 08/22/2019
	ROVIDER OR SUPPLIER	G HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 431 WEST RACE STREET ROLLING FORK, MS 39159	1 00/22/2013
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLETION
F 580	PM, but no documer notified. Review of Resident and Electronic Treatment (ETARs) for May, Jurevealed no orders of toe. An interview with the on 8/21/19, at 2:06 Fe policy that the MD stochanges in the reside was not followed for stated LPN #1 should also should have reported to him by stochanges in the toe was tated RN #1 was thout, and would have following up on the interview with the at 3:30 PM, revealed self-propelled in his reported to him by stochould have normal routine with releft foot was noted to room. He stated an been done for the determinant of	anotified on 06/04/19 at 5:00 attation that the physician was attation that the physician Records and the Administration Records and July, and August 2019 or treatment for the left 4th are Director of Nursing (DON). PM, revealed it is the facility and be notified of any ent's condition and the policy Resident #1's toenail. She do have followed up on it, and corted it to the RN and MD. It was not in the building, on ident #1's toenail was 104/19, when the worsening was discovered. The DON is supervisor while she was been responsible for anotident. The Administrator, on 08/21/19, if Resident #1 was wheelchair and it was staff that earlier in the day on and had been going about his ano complaints of pain until the obe swollen in the shower incident report should have etached toenail on 05/09/19, been notified, and a doctor's eatment of the left 4th toe. atted the staff should have	F 58		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		255220	B. WING				C 22/2019
	ROVIDER OR SUPPLIER	HOME		4	TREET ADDRESS, CITY, STATE, ZIP CODE 31 WEST RACE STREET ROLLING FORK, MS 39159		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600 SS=G	Resident #1 was adn 01/25/18, with a diag Review of the Physic August 2019, revealed in Left Leg, Acquired Toe(s), Encounter for Aftercare, Major Dep Record review of the (MDS) Assessment, Reference Date (ARI the resident had a Br Status (BIMS) score impaired cognitive sk Section G of the asseresident required extrapersons for bed mob and that he was total Free from Abuse and CFR(s): 483.12(a)(1) §483.12 Freedom from Exploitation The resident has the neglect, misappropria and exploitation as dincludes but is not lin corporal punishment, any physical or chemitreat the resident's misappropria and exploitation or chemitreat the resident's misappropria and exploitation as dincludes but is not lin corporal punishment, any physical or chemitreat the resident's misappropria and exploitation or chemitreat the resident's misappropria and exploitation as dincludes but is not lin corporal punishment, any physical or chemitreat the resident's misappropria and exploitation as dincludes but is not lin corporal punishment, any physical or chemitreat the resident's misappropria and exploitation as dincludes but is not lin corporal punishment, any physical abuse, corporate punishment, and punishment punishment punishment punishment punishment punishment punishment punishment punishment	Face Sheet revealed nitted by the facility, on nosis of Pain in Left Leg. ian Orders for the month of ed current diagnoses of Pain Absence of Other Left Other Specified Surgical ressive Disorder. 30 Day Minimum Data Set with an Assessment D) of 07/11/19, revealed that ief Interview for Mental of 3, indicating severely cills for daily decision making. The ensive assistance of two (2) dility, dressing, and toileting ly dependent for bathing. I Neglect The Abuse, Neglect, and right to be free from abuse, ation of resident property, effined in this subpart. This nited to freedom from a involuntary seclusion and a ical restraint not required to edical symptoms. The Abuse of Pain Month of Pain M		580			10/1/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	\ \ \ \ \ \ \	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		255220	B. WING			C 08/22/2019	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	00/22/2013	
				431 WEST RACE STREET			
SHARKEY	-ISSAQUENA NURSING	HOME	ROLLING FORK, MS 39159				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 600	Continued From pag	e 10	F 60	00			
	•	riew, staff interview, and		Resident received wour	nd care		
		the facility failed to provide		services on 6/4/2019 and tra			
		services to prevent neglect		Sharkey Issaquena Commu			
	•	residents reviewed for		for emergency services on 6			
	, , , , , , , , , , , , , , , , , , , ,	ons, Resident #1. The facility		Resident received counselin			
		toenail to Resident #1's left		Service Director on 6/4/2019	~ .		
		and failed to perform		Sharkey Issaquena Commun			
		ovide treatments to the		Resident did not show signs			
	T	ther skin alteration. On,		psychosocial harm.	0.1		
		identified a wound to the left		poyenesses			
	4th toe with redness,			2. There are twelve reside	nts currently		
		esident #1 was sent to the		receiving wound care on 8/2	•		
		luation, and then transferred		facility will ensure that reside			
	-	tal for surgical intervention.		provided services as ordered			
		gnosed with Severe Cellulitis		physician, and changes of co	-		
		_eft 4th toe, and Multiple		reported to physician. Body			
	Fractures to the 4th I	eft toe. Resident #1 was		performed of all Residents b	y Director of		
	admitted to the hospi	ital and received intravenous		Nurses on 8/25/2019. No ne	w injuries		
	(IV) antibiotics for inf	ection. Resident #1 required		found by audit on 8/25/2019			
	an amputation to the	Left 4th toe during the					
	hospitalization. Resid	dent #1 returned to the facility		In-service performed by	Staff		
	on 06/13/19.			Development Coordinator or	n neglect and		
				abuse with all staff performe			
	Findings include:			08/22/2019. In-service perfo	rmed by Staff		
				Development Coordinator fo			
		's policy titled, "Abuse and		Practical Nurses and Registe			
		31/17, revealed, POLICY: It		performed on 8/23/19 consis	-		
		cility to prohibit and prevent		attaining doctors orders to e			
	_	pitation of residents, and		up of necessary services to			
	misappropriation of r			potential of neglect. Social S			
		the failure of the facility, its		Director will interview cogniti			
		e providers to provide goods		weekly for six weeks to ensu			
		ident that are necessary to		have no complaints of abuse	-		
		pain, mental anguish or		performed on 8/29/2019. Hig	-		
		revention: The facility will		Meeting template altered to	-		
		oing assessment, care		audits of Residents for the p	•		
		ate interventions and		have Director of Nurses insp			
	monitoring of residen	its with needs and behaviors		completion of body audits be	ertormed by	1	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY
		255220	B. WING _				C 22/2019
NAME OF P	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	22/2013
				4	31 WEST RACE STREET		
SHARKEY	-ISSAQUENA NURSING	HOME		R	OLLING 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From page	e 11	F 6	300			
	which might lead to co	onflict or neglect.			Wound Care Nurse on 9/04/2019.		
	of Nursing (DON), on revealed the absence #1's left foot. The skir Treatment Administra May, June, July, and orders or treatment for ETARs did address to Nurse (RN) as neede was documented was agency RN. Review of Resident # revealed an order dat Body Audits, and on CRN PRN. Review of the Depart dated 05/09/19 at 10 LPN #2, revealed, "Rolleft foot. Area cleaned no documentation the notified. Record review of the 05/09/19 until 06/04/1 documentation of any Resident #1's left 4th skin assessments refiskin was intact, with the skin street in the skin assessments refiskin was intact, with the skin assessments refised.	e of the 4th toe on Resident in was intact with no swelling. tion Records (ETARs) for August 2019, revealed no or the left 4th toe. The benail care by the Registered in the denail care by the last date it is on, March 3, 2019, by an or in the left 4th toe. The benail care by the Registered in the denail care by an or in the left 4th toe. The benail care by an or in the left 4th toe. The benail care by an or in the left 4th toe. The benail care by an or in the left 4th toe. The benail care by an or in the left 4th toe. The left 4th toe. The left 4th toe. The benail care by an or in the left 4th toe.			4. High Risk Meetings will be reviewed monthly to Quality Assurance by Direct of Nurses. Quality Assurance Committe will: Monitor effectiveness of the plan of correction monthly x 3 months then quarterly. The Quality Assurance Committee will make further recommendations as needed.	tor ee	
		mental Notes-Charge Nurse, 52 AM, documented by LPN revealed, "(Name of					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		255220	B. WING _			C 08/22/2019	
	ROVIDER OR SUPPLIER	НОМЕ		STREET ADDRESS, CITY, STATE, ZIP CODI 431 WEST RACE STREET ROLLING FORK, MS 39159	•	00/22/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COI ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 600	Physician) made rour this time". The Department Note 06/04/19 at 4:48 PM, revealed: "+1 (Plus O left foot. Nurse remove around 4th toe next to Moderate bleeding, a resident transferred to ER. Transported from stretcher safely by EM Technicians). Record review of a Redated 06/04/19 at 4:1 tissue edema to Resided ocumented: "Nurse Edema noted to left for bandage wrapped are to bandage. Nurse cat Cyanosis and modera scale of 9. (Initials of Room) nurse called". signed and dated 06/Nurse (LPN) #2. The documented the reside of 06/04/19 at 5:00 PM. Incident Report reveal (local) Emergency Me ER. Review of the Rename or date on the followup for the conditated the left 4th toe pathological fracture. the resident returned 06/13/19, with orders	e-Charge Nurse, dated documented by LPN #2, ne) pitting edema noted to res bandage wrapped or pinky toe. Cyanosis. Ind pus noted. 4:45 PM or (Initials For Local Hospital) or W/c (wheelchair) to MT (Emergency Medical dent #1's left toe. The report summoned to shower room. For the summoned to shower room. The leading to fourth toe with bound. Pus and blood noted refully removed bandage. The local Hospital Emergency The Incident Report was 106/19, by Licensed Practical Incident Report tent's family was notified on Further review of the led Transportation by: edical Technician to local sident Incident Followup, no form, revealed the 24 Hour lition and injury appearance was amputated due to Additional Followup stated	F				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED		
		255220	B. WING		,	C 08/22/2019	
	ROVIDER OR SUPPLIER	НОМЕ	'	STREET ADDRESS, CITY, STATE, ZIP COL 431 WEST RACE STREET ROLLING 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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 600	06/04/19, revealed C (CNA) #3 noted Resi and warm, bleeding warm, bleeding was alleft toe. (An interview with the Administrato documented the wrought toe). The report of fracture through the k (end of toe) of the thick Resident #1 propelle. The Nurse Practition on 06/04/19, and standue to trauma or athle noted the resident has Body Audit was done she noted skin was in performed on all resion 06/07/19. (Record rerevealed Resident #1 LPN #1/Treatment N intact. LPN #1 docum was intact, and the resident that the stime). Record review of the Room Note, dated 06 upon physical exam l'Extremities remarkated foot and calf. There is distal foot, and the toon the plantar surface left forth toe. Wound joint, and it is deep, par Impression: Cellulitis	ertified Nursing Assistant dent #1's 3rd left toe was red was noted under the third in open area under the 3rd in open area under the been the documented: Small chip passe of the distal phalanx in open area under the deleta in open area under the self in open are	F 60				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		255220	B. WING _			C 08/22/2019
	ROVIDER OR SUPPLIER	G HOME		STREET ADDRESS, CITY, STATE, ZIP C 431 WEST RACE STREET ROLLING FORK, MS 39159	CODE	00/22/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 600	was transferred to a ambulance on 06/04 Record review of the hospital Emergency Physical, dated 06/0 Resident #1 was broswelling and redness suspected fracture of the left foot on 06/04 fractures with widene (DIP). Physical exant from the left foot. Lasurface at the left for metatarsophalangea Musculoskeletal: And the left fourth digit, for as above. Foul smel digit and diffusely over left foot. Multiple and on 06/04/19. Review of the hospit dated 06/13/19, revealed of the hospit dated 06/13/19, revealed to the hospit dated 06/13/19, revealed of the hospit control of the hospit dated 06/13/19, revealed 06/13/19, revealed of the hospit dated 06/13/19, revealed 06/13/19, revealed of the hospit dated 06/13/19, revealed 06/13/19,	regional hospital by /19, at 5:43 PM. regional/second receiving Department (ED) History and 4/19, at 9:00 PM, revealed rught into the ED with severe s of the left fourth toe, with if the left fourth toe. X-ray of /19, revealed, "Fourth toe ed distal interphalangeal joint mination revealed, "Foul smell ceration of the plantar urth digit at the il joint (MTP) kle/foot: Diffuse swelling of cot, erythematous, laceration I area of erythema to that er the dorsal aspect of the tibiotics were given in the ED al's Discharge Summary, ealed Resident #1 was ital, on 06/04/19, with x Fracture Left Fourth MTP Fourth Toe Left, and c was consulted and the an amputation of the left ra Sound Lower Extremity eral, performed on 06/11/19, therosclerotic changes. Left unobtainable. No other	F	500		
	Record review of Ult Arterial Duplex Bilate revealed only mild a ankle pressure was evidence of hemody in either lower extrer	ra Sound Lower Extremity eral, performed on 06/11/19, therosclerotic changes. Left				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		255220	B. WING _			C 08/22/2019		
	ROVIDER OR SUPPLIER	G HOME		STREET ADDRESS, CITY, STATE, ZIP CO 431 WEST RACE STREET ROLLING FORK, MS 39159		33,22,2310		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFII TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
F 600	(CNA) #2, on 08/21 06/04/19, she was is she said to CNA #3 did they miss that". "it was just hanging Resident #1 had be was why she hadn't said Resident #1 did CNA #2 reported Rebaths in the evening daytime activity usu. An interview, with CPM, revealed she did #1's toenail falling obtaining Resident #1 left foot was swoller to the nurse. CNA # looking and that the kinda (sic) scared in never seen before, pop or something". blue bandage wrappleft foot. CNA #3 repatch foot. CNA #3 said Reside couple of times and seen his feet. She sanything and alwayshim to bed. An interview, on 08/CNA #1/Whirlpool CResident #1's toe with the couple of times and seen his feet. She sanything and alwayshim to bed.	certified Nursing Assistant /19 at 1:06 PM, revealed on in the Whirlpool Room, and , "Look at that man's toe, how CNA #2 said when she saw it, by a thread". She stated en refusing baths, and that is seen it until that day. CNA #2 id not act like the toe hurt him. esident #1 usually got his godue to he attended a	F	500				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		I ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		255220	B. WING				C / 22/2019	
	ROVIDER OR SUPPLIER			431 V	ET ADDRESS, CITY, STATE, ZIP CODE VEST RACE STREET LING FORK, MS 39159	1 00/	22/2019	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 600	she could not remen CNA #1 said she did #1's feet because he preferred to keep his Record review of Re Tasks, revealed the bath on 05/09/19, 05 and 05/25/19. A spot 05/28/19 and 6/01/19 condition on, 05/17/19 whirlpool bath on 05/09/19 whirlpool bath on 05/09/19 whirlpool bath on 05/09/19 and 6/01/19 condition on, 05/17/19 whirlpool bath on 05/09/19 whirlpool bath on 05/09/19 whirlpool bath assist physical assist. Whire Thursday, and Satur on opposite days. Moreover the days of the whirlpool bath on 05/09/19 called into the Whirlpool to Resident #1's toe detached and that the bed. LPN #2 said the redness to the left 4t LPN #1, the Treatmer Room. LPN #2 report that day. LPN #2 said nurses note Resident per report by the CN not perform the dress she did not notify the detached toenail.	nber the date of the incident. not recall seeing Resident refused a tub bath and socks on. sident #1's Completed Care resident received a shower 6/11/19, 05/18/19, 05/21/19, nge bath on 5/14/19, 9. Skip baths due to medical 19, 05/31/19, and 06/05/19. A //23/19. #1's Daily Care Guide t was as risk for skin stance was two (2) person Ipool bath on Tuesdays, days, and offer sponge bath	F	600				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		255220	B. WING		C 08/22/2019		
	ROVIDER OR SUPPLIER	G HOME	4	STREET ADDRESS, CITY, STATE, ZIP CODE I31 WEST RACE STREET ROLLING FORK, MS 39159	1 00/22/2010		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION		
F 600	nurse assigned to R was called into the N LPN #2 reported Re swollen, and what a swelling seemed to toe. LPN #2 said the LPN #2 said there w 4th toe, and she ren carefully. LPN #2 sa little blood on the ba deformed and blue. knowledge of any tr 4th toe. On 08/20/19 at 1:30 #1/Treatment Nurse the Whirlpool Room observed Resident; "hanging by a little p not observe any blo stated she cleaned saline, and she thou ointment on it and a told the Nurse Pract had pulled his toena to dress it. LPN #1 s fine and gave no fur document this in the the following day, sl cleaned the nail bed #1 confirmed no fur due to it really wasn no swelling or defor that day. LPN #1 st on 06/04/19, she wa when the Social Wo Resident #1 was tal-	ge 17 8 PM, revealed she was the desident #1 on 06/04/19, and Whirlpool Room by the CNAs. It is left foot was very larmed her was that the be coming from the left 4th de other toes were not swollen. Was a blue bandage on the left inoved the blue bandage and she observed pus and a landage, and the toe appeared LPN #2 said she had no leatment ordered for the left of PM, an interview with LPN is, revealed she was called to leatment ordered for the left of PM, an interview with LPN is, revealed she was called to leatment ordered for the left of PM, an interview with LPN is, revealed she was called to leatment ordered for the left of PM, an interview with LPN is, revealed she was called to leatment ordered for the left of PM, an interview with LPN is, revealed she was called to leatment ordered for the left of the nail bed with normal light she put antibiotic leatment was head done stated the NP said that was ther orders, but she did not leatment was fine. LPN is the treatment was fine. LPN is the treatment was needed, with an open area and there was mity noted to the left 4th toe ated in regards to the incident, as already gone for the day wrker called her reporting that went to the Emergency Room is she had performed body	F 600				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		255220	B. WING _	B. WING		C 8/ 22/2019
	ROVIDER OR SUPPLIER	НОМЕ		STREET ADDRESS, CITY, STATE, ZIP CO 431 WEST RACE STREET ROLLING FORK, MS 39159		0/22/2010
(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 C ((EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 600	Whirlpool Room, and audit in the medical resident #1's skin was had heard the left food or a Whirlpool CNA heapplied a dressing to someone had to have wrapped it, and not to went to talk to the NF that fast and the NP something or it could fungus, but she though fracture. LPN #1 states skin audits and she were with the skin audits and she will whirlpool Room. LPN resident's face, front #1 stated, "I wouldn't Review of Resident #1 dated 05/07/19, 05/12 revealed the skin was were documented by LPN #1 documented 06/12/19, that stated #1 was in the hospital In an interview, on 08 confirmed she docum Resident #1, on 06/0 do a skin inspection. would write the body the the computer and she thinks she may hame. LPN #1 said the said of the skin was the she was had a skin inspection.	I weekly while he was in the she documented a body ecord, on 06/04/19, that as intact. LPN #1 said she at was wrapped and LPN #2 ad removed the dressing. did not know who had the foot. LPN #1 said eseen it before that day, old her. LPN #1 stated she to ask how it got that bad said he could have hit it on have been athletes foot ght it was determined a ed she was responsible for sually does them in the I #1 said she looks at the and back, and the feet. LPN have missed that". Et's Skin Inspection Reports, 4/19, 05/21/19, and 06/04/19 is intact. The skin inspections LPN #1/Treatment Nurse. a Skin Inspection Report on the skin was intact. Resident	F 6	500		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		255220	B. WING _			l	22/2019
	ROVIDER OR SUPPLIER	НОМЕ		431 V	EET ADDRESS, CITY, STATE, ZIP CODE WEST RACE STREET LLING FORK, MS 39159	1 00/	22/2013
(X4) ID PREFIX TAG			ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	she was not aware the nail had come off. LP her into the Whirlpool said Resident #1's left and his whole left foo #3 said she looked at "you need to send hir." An interview with the Resident #1, on 08/2 he was not notified of 05/09/19, and he received he was told of the ambe had not given any left 4th toe. The MD's resident on 05/31/19, for edema, but did no stated there was a coof changes. Review of the MD's Notated 05/31/19 at 9:3 to the right or left food during the visit and all Will continue current. During an interview work (DON), on 08/21/19 af facility's policy was not on the right of the restated LPN #1 should injury and should have Registered Nurse (RI she was not in the burner the worsening of the	N #3 on 08/21/19, revealed at Resident #1's left 4th toe N #3 recalled LPN #2 called Room on 06/04/19. LPN #3 ft 4th toe was "big and red", t was red and swollen. LPN the foot and toe, and said, mout". Medical Doctor (MD) for 1/19, at 9:09 AM, revealed the detached toenail on alled being surprised when uputation. The MD confirmed orders for a bandage to the stated he had seen the and he looked at his ankles of remove his shoes. The MD concern regarding notification when the state is the mouth of the state	F	600			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION IG	l ^{(×}	(X3) DATE SURVEY COMPLETED	
		255220	B. WING			C
	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP COI 431 WEST RACE STREET ROLLING FORK, MS 39159	DE	08/22/2019
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 600	been responsible for incidents. During the interview of the toen after he went to the hinterview, on 8/21/19, review of the Electror Records (ETARs), wittoenail care was doct June 2019, July 2019 RN #1 stated, "Just we care would do it. Usu guess it wasn't done. not done". The interview with the at 1:13 PM, revealed Accident/Incident Rep Resident #1's left 4th confirmed there was the left 4th toe wound the Administrator, on revealed an incident done on 05/09/19, the notified, and a doctor treatment of the left 4 also said the staff shot toe from 05/09/19, aff The Administrator review began, on 06/05/19, of treatments, orders, all they were found, and met to review this incidents.	was out, and would have following up on the with Registered Nurse (RN) 57 AM, she stated, "I didn't hil. I remember discussing it ospital on 06/04/19". Further at 3:16 PM, and record hic Treatment Administration th RN #1, revealed no amented on the May 2019, and August 2019 eTARs. Whatever RN is doing toenail hally on the weekends. I lf it's not documented, it's Administrator, on 08/20/19 the facility did not do an boort, on 05/09/19, regarding toe nail. The Administrator no Physician's Orders for a care. Further interview with 08/21/19 at 3:30 PM, report should have been be MD should have been be MD should have been be MD should have been be more obtained for the toe. The Administrator hould have followed up on the later the nail was detached. We aled in-services were with Nursing Services for and reporting injuries when the Quality Assurance Team ident on 06/07/19.	F 6			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		255220	B. WING			08/	22/2019
	ROVIDER OR SUPPLIER -ISSAQUENA NURSING	НОМЕ		۱,	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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656 SS=G	include Pain in Left Le Other Left Toe(s), End Surgical Aftercare, Marchael Surgical Surgical Aftercare, Marchael Surgical Aftercare	eft Leg. Current diagnoses eg, Acquired Absence of counter for Other Specified ajor Depressive Disorder. Minimum Data Set (MDS), Reference Date (ARD) of at Resident #1 had a Brief status (BIMS)score of 3, paired cognitive skills for . Comprehensive Care Plans cility must develop and densive person-centered sident, consistent with the at \$483.10(c)(2) and cludes measurable ames to meet a resident's mental and psychosocial ded in the comprehensive apprehensive care plan must		656			10/1/19
	treatment under §483 (iii) Any specialized so rehabilitative services provide as a result of	.10(c)(6). ervices or specialized the nursing facility will					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G	COMPLETED	
		255220	B. WING		08/22/2019
	ROVIDER OR SUPPLIER	ı		STREET ADDRESS, CITY, STATE, ZIP CODE 431 WEST RACE STREET ROLLING FORK, MS 39159	00/22/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 656	findings of the PASA rationale in the resid (iv)In consultation wiresident's representation (A) The resident's good desired outcomes. (B) The resident's profuture discharge. Fact whether the resident community was assolicated contact agencial entities, for this purp (C) Discharge plans plan, as appropriate, requirements set for section. This REQUIREMEN' by: Based on staff intential facility policy review, and implement a platial accurate skin assess. Resident #1's left four identified by the facility resulted in infection are resident's toe. This of (1) of five (5) resident Findings include: Review of the facility undated, revealed, "If facility that the interdiaccordance with the and/or responsible prodevelop a comprehere resident that includes objective goals with several end."	RR, it must indicate its ent's medical record. the the resident and the ative(s)- coals for admission and deference and potential for collities must document as desire to return to the essed and any referrals to be and/or other appropriate cose. In the comprehensive care in accordance with the hin paragraph (c) of this are not met as evidenced wiew, record review, and the facility failed to develop an of care, which included ements and treatments for arth (4th) toenail detachment, ity on 05/09/19, which and amputation of the oncern was identified for one to care plans reviewed. The policy: It is the policy of the isciplinary team, in resident and his/her family arty, as appropriate, will insive care plan for each	F 6	1. Resident care plan updated on 9/10/2019 to reflect Resident amputar and to address the behavior of Reside#1 picking his toenails by Administrate 2. Director of Nurses, 100% audit on Resident foot care for any potential risareas and needs performed on 08/28/2019. No new risk areas or work care needed as of 08/28/2019. Minim Data Set Registered Nurse to review Resident scharts for one hundred percent completion of skin related car plans completed on 08/22/2019. Audi indicated that seven Residents needed care plans related to skin break down four Resident scharts Care plans were upon to reflect most recent wound care changes. Minimum Data Set Register Nurse to update Care Plans of Reside with current skin integrity needs	ent or. sk und um ee t ed , lated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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				431 WEST RACE STREET		
SHARKEY	-ISSAQUENA NURSING	HOME		ROLLING FORK, MS 39159		
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F 656	Continued From pag		F 656	3		
	in the care plan will b resident's medical, n	oe followed to meet the		completed on 08/22/2019.		
		to maximize the resident's		3. In-service conducted by Administra	ator	
	level of functioning a			on Care Planning policy and ensuring		
		4,		care plan reflects current level of car		
	Review of Resident #	‡1's Care Plan, dated		Residents. Initiated on 9/10/2019, alt		
		potential for impaired skin		of High Risk Meeting to include moni		
	integrity. The Goal in	cluded the resident would		of care plans which include care plan	ns	
	not have any skin bre	eakdown or alterations. The		related to wound care. Audit conduct	ed by	
	most recent Target D			Administrator of departmental notes	once	
	08/09/19, and 04/30/			weekly for six weeks to ensure Care		
		ff observes the resident's		Plans have been updated initiated or		
		e care and notifies the nurse		9/10/2019. Care plans audit related t		
		ify the doctor. Ensure Body		current wounds to be performed mor		
		ast once a week by a nurse.		by Director of Nurses each month for	•	
		Care Plan revealed there		three months initiated on 9/18/2019.		
		on for the identification of the				
	detached toenail on (4. High Risk Meeting will completion		
		/04/19, and amputation of the		effectiveness will be monitored durin		
		re Plan also did not address		Quality Assurance Meetings. All findi	ngs	
	the benavior of Resid	dent #1 picking his toenails.		will be reported monthly to Quality	-4	
	A : t :- 00/0	00/40 -t 4:00 DM		Assurance by Registered Nurse Dire		
		20/19 at 1:30 PM, revealed		of Nurses. Quality Assurance team v	/III:	
		urse, confirmed she was ol Room on 05/09/19, by a		Monitor effectiveness of the plan of		
		or Room on 05/09/19, by a ne observed Resident #1's		correction monthly x 3 months then quarterly thereafter. The Quality		
		nanging by a little piece".		Assurance committee will make furth	or	
		not see any blood on the		recommendations such as increased		
		said she cleaned the nail bed		training, corrective action against Tea		
		aid, but did not document in		Members, and care plan reflections a		
		.PN #1 stated she cleaned		needed.		
		next day without any open				
		id she did not observe any				
		to the left 4th toe at the time.				
		ad already gone for the day,				
		ne Social Worker called her				
		was taken to the ER. LPN				
		erformed body audits on				
		n the Whirlpool Room and				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG		ATE SURVEY OMPLETED
		255220	B. WING _			C 08/22/2019
	ROVIDER OR SUPPLIER	G HOME		STREET ADDRESS, CITY, STATE, ZIP COL 431 WEST RACE STREET ROLLING FORK, MS 39159	•	00/22/2013
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CC ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 656		ge 24 ented a body audit in the Skin Intact" on 06/04/19. LPN	F6	556		
	#1 stated she was re that she usually doe Room. LPN #1 confi would look at the res	esponsible for skin audits and sthem in the Whirlpool rmed during a body audit she sident's face, front and back and that she wouldn't have				
	at 1:08 PM, revealed treatments at this tin #2 stated the CNA to pulled his toenail off on 5/9/19. LPN #2 stoenail and found the blood over the nail be observe any swelling at that time, and call to the Whirlpool Roc #2 said she made a regarding the reside	ted with LPN #2, on 08/20/19 d she was not aware of any ne for Resident #1's toe. LPN old her Resident #1 had while in the whirlpool room tated she assessed the te toenail was detached, with ted. LPN #2 said she did not g or redness to the left 4th toe ted LPN #1/Treatment Nurse om, who dressed the toe. LPN note in the nurse's notes nt pulling the toenail off, but trysician notification or get				
	An interview, with C PM, revealed they w 06/04/19, and notice and reported it to the was "reddish looking good at all. It kinda (something like I'd ne like it was going to p stated there was a buthe 4th toe of the lef Resident #1 would p would sometimes have was picking at the time.	NA #3, on 08/21/19, at 1:15 were bathing Resident #1 on ad his left foot was swollen, a nurse. CNA #3 said the toe ag and that the toe didn't look (sic) scared me, it was ever seen before. It looked upp or something". CNA #3 fulue bandage wrapped around at foot. CNA #3 reported that bick at his toenails and he ave a bandage on the toe he me. CNA #3 said Resident #1 couple of times and that was				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		ATE SURVEY DMPLETED
		255220	B. WING _			C 08/22/2019
	ROVIDER OR SUPPLIER	в ном е		STREET ADDRESS, CITY, STATE, ZIP CODE 431 WEST RACE STREET ROLLING FORK, MS 39159	•	00/22/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COI ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 656	never complained of socks on when she per Record review of the Emergency Department Physical, dated 06/0 Resident #1 was brown swelling and redness suspected fracture. 206/04/19, revealed from Physical exam reveation, a laceration of the toe and diffuse swell foot. Multiple antibior 06/04/19. The resident hospital with diagnost Fourth Toe-Open, In (Metatarsophalanges Cellulitis. Orthopedic resident underwent a fourth toe. Resident the nursing home on During an interview, (LPN) #2, on 08/20/1 was called into the V	In his feet. She stated he anything and always had but him to bed. It regional receiving hospital ent (ED) History and 4/19, at 9:00 PM, revealed ught to the ED with severe softhe left foot, on ractures of the left foot, on ractures of the left 4th toe. Ited a foul smell from the left he plantar surface of the 4th ing of the left 4th toe and rics were given in the ED on int was admitted to the ses of Phalanx Fracture Left fected MTP at Joint) Fourth Toe Left, and was consulted and the en amputation of the left #1 was discharged back to 06/13/19. Licensed Practical Nurse 9, at 1:53 PM, stated she Whirlpool Room on 06/04/19,	F	356		
	said Resident #1's less he was alarmed the the left 4th toe. LPN bandage on the left aremoved the bandage blood on the bandage looked deformed and Review of Resident and dated 05/07/19, 05/1	ing Assistant (CNA). LPN #2 If foot was very swollen, and It swelling was coming from If a swelling was coming from If a swelling was a blue If the toe, and when she If a sid the toe If a blue. If a skin Inspection Reports, If a skin Inspections				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		DATE SURVEY COMPLETED
		255220	B. WING _			C 08/22/2019
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 431 WEST RACE STREET ROLLING FORK, MS 39159	l	06/22/2019
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 656	were documented by LPN #1 documented 06/12/19, that stated #1 was in the hospital In an interview, on 0 confirmed she docur Resident #1, on 06/0 do a skin inspection, would write the body the the computer and she thinks she may I name. LPN #1 said ton Tuesdays, even the were for Thursdays. There was no documedical record regal assessments of the nail bed. During an interview which was the did not know that the did not know the stated she did not know the stated she did not know the cellulitis resulting the cellulitis resulting the toe, the resulting his toenail picking beinjury were not care to the facility on 06/11.	A LPN #1/Treatment Nurse. I a Skin Inspection Report on Ithe skin was intact. Resident all on 06/12/19. 8/21/19 at 1:45 PM, LPN #1 mented a skin audit for 04/19, but she actually did not LPN #1 said sometimes she audits down, and then go down, and then go down, and then go down in LPN #1 said mave clicked the wrong hese skin reports were done shough the Physician's Orders mented care plan in the reding the toenail detachment, mail bed, or treatments to the with Registered Nurse (RN) et (MDS)/Care Plan Nurse,	F 6	56		

AND PLAN OF CO		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	COMPLETE	
		255220	B. WING _		08/22/2	019
	VIDER OR SUPPLIER	S HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 431 WEST RACE STREET ROLLING FORK, MS 39159	1 00/22/2	0.10
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE COI	(X5) MPLETION DATE
a for RR 0 RA in TA R (NR S for in S fo	elecord review of the desident #1 was addressed to the Physic august 2019 revealed Left Leg, Acquired Decord review of the MDS) Assessment of the MDS) Assessment of the MDS) Assessment of the MDS As	Face Sheet revealed mitted by the facility, on posis of Pain in Left Leg. Sian Orders for the month of ed current diagnoses of Pain I Absence of Other Left or Other Specified Surgical pressive Disorder. 30 Day Minimum Data Set with an Assessment D) of 07/11/19, revealed in sident had a Brief Interview pre of 3, indicating severely cills for daily decision making. Personal revealed that the pensive assistance of two (2) possible dependent for bathing. (i)(i)(ii) are. Pents receive proper treatment mobility and good foot ust: and treatment, in accordance including ions from the resident's	F6		10/~	1/19

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	I` ´c		(X3) DATE COMP	SURVEY PLETED
		255220	B. WING _				C 22/2019
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				43	31 WEST RACE STREET		
SHARKEY	'-ISSAQUENA NURSING	HOME		R	OLLING FORK, MS 39159		
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TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
F 687	Continued From page	≥ 28	F 6	387			
	by:						
	Based on observatio	n, staff interview, record			1. Treatment to Resident #1 complete	d	
	review, and facility po	olicy review, the facility failed			by Nurse #2 on 06/04/2019. Resident v	vas	
	to ensure proper foot	treatment and care to			taken to Local Hospital on 06/04/2019.		
	prevent complications	s for one (1) of five (5)			Resident returned on 06/13/2019 with	a	
		r foot care, Resident #1.			return order to continue wound care ur		
		etachment/injury to the left			healed and physician therapy evaluation	n.	
	l ' '	/09/19. On 06/04/19, due to					
	-	ot/skin care, treatment, and			2. All Residents have potential to be		
	accurate assessment				affected by the deficient practices. Fac	cility	
		nitted to the hospital for			will ensure that physician orders are	_	
		ction, and Multiple Fractures			received when wound care is needed t		
	to the Left Toe. Resid	•			ensure wound and foot care is perform until healed.	eu	
	hospitalization.	t 4th foe duffing the			unui nealed.		
	1103pitalization.				3. Orders obtained by attending Physic	ian	
	Findings include:				for all Residents to have routine	, all	
					inspection of toe nails weekly on		
	Review of the facility'	s policy titled, "Skin Care			09/03/2019. In-service performed by S	Staff	
	Policy & Procedure, I				Development Coordinator of Certified		
	-	icy of this facility that skin			Nurse⊡s Aides to inspect and report if		
		mized to the greatest extent			necessary toenail care needed during		
	possible through an a	aggressive approach			routine baths on 09/03/2019. Director	of	
	consisting of four con	nponents. Those are: I.			Nurses to perform 100% audit on		
	Prevention, Evaluation	n and Screening, II.			Resident foot care for any potential risk	(
		e, III. Treatment Orders, IV.			areas performed on 08/25/2019.		
		Overseeing these efforts will			In-service performed by Director of		
		rsing, who will have ultimate			Nurses of Registered Nurse Weekend		
		ring that this policy is applied			Supervisor on change in Treatment		
	consistently. I. Preve				Administration Record orders to reflect		
		nich are present, or which			inspection of toe nails bi-monthly on		
		ollowed carefully and treated			09/18/2019. Appropriate action taken		
	according to medical				against Licensed Practical Nurse #1 or		
		king rounds weekly on all			08/27/2019. Director of Nurses to perfo	rm.	
		ekly body audits. II. Ongoing			weekly audits of 25 percent all		
		umentation, reporting and			Resident □s feet to assess for any		
	•	al skin injuries at each			necessary foot care for six weeks on	-1	
	occurrence. III. Treati				8/25/2019. Director of Nurses to inspec	π	
	∣ observation/evaluatio	on of the affected skin area,			100 percent of skin inspection reports		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		255220	B. WING			l	C / 22/2019
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					31 WEST RACE STREET		
SHARKEY	-ISSAQUENA NURSING	HOME			ROLLING FORK, MS 39159		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 687	Continued From page	÷ 29	F	687			
F 68/	notify physician for the Treatment Regiment: problems will be immined in collaboration with the Carefully document coorder is sought for both by nursing personnel treatments. C. 9. Skir incorporated in the initial along with approached an increased awarence. An observation, with the (DON), on 08/20/19 affect revealed the absolute foot. The skin was review of the Departs dated 05/09/19 at 10 LPN #2, revealed, "Releft foot. Area cleaned no documentation the notified and there were the Department Noted 06/04/19 at 4:48 PM, revealed: "+1 (Plus Objection of the Noted of the Noted of the Noted of the Objection of the Record review of the Objection of the Resident #1's skin was not the Resident #1's skin was no	re treatment order. IV. Treatment for identified skin ediate and appropriate and he attending physician. A. condition. B. The physician's th direct care to the problem and for any associated a problems will be terdisciplinary plan of care is so that the entire staff has eas of those special needs. The Director of Nursing that 3:44 PM, of Resident #1's ence of the 4th toe on the intact with no swelling. The mental Notes-Charge Nurse, intact with no swelling. There was the Physician or NP were the no orders for treatment. The Charge Nurse, dated documented by LPN #2, ne) pitting edema noted to be bandage wrapped to pinky toe. Cyanosis. Ind pus noted. 4:45 PM to (Initials for Local Hospital) Donotification documented. Departmental Notes, from 9, revealed no left 4th toe, and that is intact, with the exception,	F	687	weekly during High Risk Meeting each week for eight weeks on 8/28/2019. Director of Nurses to audit skin and wound documentation from previous the months to ensure accuracy of documentation performed on 08/27/20 Facility Podiatrist performed care on Residents on 08/28/2019. 4. All findings will be reported monthly Quality Assurance by Registered Nurse Director of Nurses. Quality Assurance team will: Monitor effectiveness of the plan of correction monthly x 3 months then quarterly, provide increased trainifor foot care if necessary. The quality assurance committee will make further recommendations as needed.	19. to e	
		is intact, with the exception, skin tear was noted on an					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED			
		255220	B. WING			C 08/22/2019
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 431 WEST RACE STREET ROLLING FORK, MS 39159	ODE	00/22/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD BE THE APPROPRIAT	DATE
F 687	Continued From page	e 30	F	687		
	Electronic Treatment (ETARs) for May, Jurrevealed no orders or toe. The ETARs did a Registered Nurse (RI last date it was docur 2019, by an agency Frevealed an order data Body Audits, and on RN PRN. On 8/21/19, at 3:16 Freview of the Electron Records (eTARs) with care was documented 2019, July 2019, and stated, "Just whateve would do it. Usually owasn't done. If it's not Record review of the dated 06/04/19 at 4:1 was called to the sho #1's left foot was assedema noted to left for bandage wrapped are noted to the bandage bleeding noted. Pain Resident #1 was tran Room. The Incident F 06/06/19, by Licensed Review of the Residen ame or date on the Followup for the conditions.	sported to the Emergency Report was signed and dated d Practical Nurse (LPN) #2. ent Incident Followup, no form, revealed the 24 Hour dition and injury appearance th toe was amputated due				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		255220	B. WING			C 8/22/2019	
	ROVIDER OR SUPPLIER	ı		STREET ADDRESS, CITY, STATE, ZIP CODE 431 WEST RACE STREET ROLLING FORK, MS 39159		VOIZEIZOTO	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE	
F 687	o6/04/19, and signed revealed: Small chip the distal phalanx (er Resident #1's mobilit in a wheelchair. The assessed the wound believed it could be of foot. The NP also no circulation. The last 105/28/19, by LPN #1 intact. Body Audits we residents between 06 (Record review after Resident #1's Body #1/Treatment Nurse Record review of the Room Note, dated 06 upon physical exam "Extremities remarkated foot and calf. There it distal foot, and the toon the plantar surfact left forth toe. Wound joint, and it is deep, plantar for surgical prior to transfer, unlequickly". Record review as transferred to a ambulance on 06/04. Record review of the hospital Emergency Physical, dated 06/04 Resident #1 was bro	facility's Investigation, dated by the Administrator, fracture through the base of and of toe) of the third toe. It was by propelling himself Nurse Practitioner (NP) on 06/04/19, and stated he due to trauma or athlete's ted the resident had poor Body Audit was done on and she noted skin was been performed on all Bolo3/19 and 06/07/19. This report, revealed Audit on 06/04/19 by LPN revealed his skin was intact). (local hospital) Emergency Bolo4/19, at 5:03 PM, revealed by the Medical Doctor, able for swelling of the left is erythema primarily of the less. There is an open wound e, at the proximal joint of the goes all the way across the bossibly extending to bone. In wound infection, Plan: attention. Start antibiotics is she can be moved lew revealed that Resident #1 regional hospital by (19, at 5:43 PM. regional/second receiving Department (ED) History and 4/19, at 9:00 PM, revealed ught into the ED with severe	F 6	87			
	swelling and redness	s of the left fourth toe, with f the left fourth toe. X-ray of					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		255220	B. WING		08/22/2019	
	ROVIDER OR SUPPLIER	G HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 431 WEST RACE STREET ROLLING FORK, MS 39159	,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIV (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETION	
F 687	fractures with wider (DIP). Physical exal from the left foot. Lasurface at the left for metatarsophalange: Musculoskeletal: Ar the left fourth digit, if as above. Foul sme digit and diffusely or left foot". Multiple ar on 06/04/19. Review of the hospidated 06/13/19, reviadmitted to the hospidated 06/13/19, reviadmitted to the hospidagnoses of Phalar Toe-Open, Infected Cellulitis. Orthopedi resident underwent fourth toe. Record review of UI Arterial Duplex Bilat revealed only mild a ankle pressure was evidence of hemody in either lower extre was discharged bactof/13/19. An interview with LFPM, revealed there in which she was caby the CNA because left fourth (4th) toe viblood over the nail is not observe any sweeps.	4/19, revealed, "Fourth toe ed distal interphalangeal joint mination revealed, "Foul smell aceration of the plantar urth digit at the	F 687			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		255220	B. WING			C 8/22/2019	
	ROVIDER OR SUPPLIER	l		STREET ADDRESS, CITY, STATE, ZIP COD 431 WEST RACE STREET ROLLING FORK, MS 39159		10/22/2019	
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 687	Room and LPN#1 dru#2 said she documer Resident #1 had pull by the CNAs, on 05/0 perform the dressing document the physic incident, or an order the toenail. On, 08/20/19 at 1:30 #1/Treatment Nurse the Whirlpool Room, due to Resident #1's "hanging by a little pinot observe any bloo said she cleaned the and she thought she and a band aid. LPN Practitioner (NP) that toenail off and what s LPN #1 stated the NI no further orders. LP document this in the the following day, she cleaned the area aga confirmed no further to it really wasn't and swelling or deformity day. LPN #1 stated s day when the Social that Resident #1 was Room (ER) on 6/4/19 performed weekly bo while he was in the V confirmed she documedical record, on 00 #1's skin was intact.	e 33 N #1, into the Whirlpool essed the toe that day. LPN inted in the nurses note ed his toenail off per report 109/19, but she did not change. LPN #2 did not fan was notified of the for the treatment provided to the for the treatment provided to on 05/09/19, by the CNA is left fourth toenail was ece". LPN #1 stated she did d to the toenail bed. LPN #1 nail bed with normal saline, put antibiotic ointment on it #1 stated she told the Nurse is Resident #1 had pulled his she had done to dress it. Posaid that was fine and gave N #1 stated she did not medical record. LPN #1 said took the band aid off and fin and it was fine. LPN #1 treatment was needed due open area and there was no noted to the left 4th toe that the was already gone for the Worker called her reporting taken to the Emergency D. LPN #1 confirmed she dy audits on Resident #1 whirlpool Room. LPN #1 nented a body audit in the 5/04/19, that stated Resident LPN #1 said she had heard oped and LPN #2 or a	F 6	87			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG	· /	DATE SURVEY COMPLETED
		255220	B. WING			C
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 431 WEST RACE STREET ROLLING FORK, MS 39159		08/22/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 687	#1 revealed she did dressing to the foot. have seen it before to mention it to her. LPI talk to the NP to ask and the NP said here something, or it could fungus, but she thou a fracture. LPN #1 st skin audits and she ut the Whirlpool Room. the resident's face, fit LPN #1 stated, "I wo The interview with C (CNA) #2, on 08/21/1 was with Resident #1 06/04/19, and she saman's toe, how did the when she saw it, "it we CNA #2 said Resident #2 said Resident #3 stated Resident #4 and his toe was "red good at all. She states something like I'd ne like it was going to p said there was a blue the 4th toe of the left Resident #1 would p would sometimes ha was picking at the tir had refused baths a why she had not see	emoved the dressing. LPN not know who had applied a LPN #1 said someone had to hat day, wrapped it and not N #1 reported she went to how it got that bad that fast	F 6	87		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		255220	B. WING _			C 08/22/2019	
	ROVIDER OR SUPPLIER	НОМЕ	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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIAT		
F 687	#1/Whirlpool CNA rep Resident #1's toe wa the nurse, she though said she could not re- incident. CNA #1 said Resident #1's feet be and preferred to keep Interview on 08/20/19 Practical Nurse (LPN nurse assigned to Re #2 said she was calle by the Certified Nursi reported Resident #1 and what alarmed he seemed to be coming LPN #2 reported the and there was a blue LPN #2 said she rem carefully. LPN #2 said little blood on the bard deformed and blue. L knowledge of any tre- fourth toe. An interview, with LP she said she was not toe nail had come off remembered LPN #2 Room on 06/04/19. L left 4th toe was "big a foot was red and swe	on 08/20/19 at 1:22 PM, CNA corted she remembered is bleeding, and she called that it was LPN #2. CNA #1 member the date of the dishe did not recall seeing cause he refused a tub bath of his socks on. O at 1:53 PM, with Licensed (a) #2, revealed she was the esident #1 on 06/04/19. LPN and into the Whirlpool Rooming Assistant (CNA). LPN #2 is left foot was very swollen, in was that the swelling in from the left fourth toe. Other toes were not swollen, bandage on the left 4th toe. Oved the blue bandage in the she observed pus and a redage, and the toe appeared LPN #2 said she had no atment ordered for the left N #3, on 08/21/19, revealed aware Resident #1's left 4th LPN #3 said she called her into the Whirlpool PN #3 said Resident #1's and red", and his whole left into the, and said you need to	F	687			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	MULTIPLE CONSTRUCTION LIDING		COMPLETED	
		255220	B. WING _			C 08/22/2019	
NAME OF PROVIDER OR SUPPLIER SHARKEY-ISSAQUENA NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 431 WEST RACE STREET ROLLING FORK, MS 39159		08/22/2019	
(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 CORR ((EACH CORRECTIVE ACTION SHORT CROSS-REFERENCED TO THE APDEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 687	problems. Bath assist physical assist. White Thursday, and Satur on opposite days. Mecord review of Recards, revealed the bath on 05/09/19, 05 and 05/25/19. A spo 05/28/19 and 6/01/1 condition on, 05/17/whirlpool bath on 05 documented reports Resident #1's feet. Review of Resident dated 05/07/19, 05/206/04/19, revealed to inspections were do #1/Treatment Nurse Skin Inspection Reputime Resident #1 was An interview, on 08/2 LPN #1 stated she of done for Resident #2 actually do a skin inspections were down and go back to the coin. LPN #1 also said clicked on the wrong the skin inspections the order is for Thurse An interview with Received MD), on 8/21/19, at	t was as risk for skin stance was two (2) person alpool bath on Tuesdays, days, and offer sponge bath obile via wheelchair. sident #1's Completed Care resident received a shower 5/11/19, 05/18/19, 05/21/19, nge bath on 5/14/19, 9. Skip baths due to medical 19, 05/31/19, and 06/05/19. A 1/23/19. There were no of any concerns with #1's Skin Inspection Reports, 1/4/19, 05/21/19, and ne skin was intact. The skin cumented by LPN LPN #1 also documented a lort, on 06/12/19, at which is in the hospital. 21/19 at 1:45 PM, revealed locumented a skin audit was 1 on 06/04/19, but she did not spection. LPN #1 said d do the skin inspections, omputer later and log them she thinks she may have 1 name. LPN #1 said she did on Tuesdays, even though	F 6	87			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA (X2) MUI IDENTIFICATION NUMBER: A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		255220	B. WING		C 08/22/2019	
NAME OF PROVIDER OR SUPPLIER SHARKEY-ISSAQUENA NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 431 WEST RACE STREET ROLLING FORK, MS 39159	1 00/22/2013	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 687	surprised when he of The MD stated he he of 05/31/19, and he lo but did not remove Review of the MD's dated 05/31/19 at 9 to the right or left for during the visit and Will continue current. The Director of Nursan interview, on 08/facility's policy was should be notified or resident's condition should have followed detachment, and she Registered Nurse (I revealed she was not when Resident #1's 06/04/19, when the was discovered. The supervisor while she is the she was not should have the she was discovered. The supervisor while she is the she was discovered.	MD stated he recalled being was told of the amputation. and seen the resident on oked at his ankles for edema,	F 687	,		
	Registered Nurse (I didn't know about the discussing it after h 06/04/19". An interview with the at 1:13 PM, reveale Accident/Incident Resident #1's left 41	8/21/19 at 9:57 AM, with RN) #1, revealed she stated, "I ne toenail. I remember e went to the hospital on e Administrator, on 08/20/19 d the facility did not do an eport, on 05/09/19, regarding th toe nail. The Administrator is no Physician's Orders for				

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	ULTIPLE CONSTRUCTION LDING		ATE SURVEY OMPLETED	
		255220	B. WING _			C 08/22/2019	
NAME OF PROVIDER OR SUPPLIER SHARKEY-ISSAQUENA NURSING HOME SUMMARY STATEMENT OF DEFICIENCIES			1	STREET ADDRESS, CITY, STATE, ZIP CODE 431 WEST RACE STREET ROLLING FORK, MS 39159		00/22/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 687	revealed it was reporearlier in the day, on been going about his complaints of pain urbe swollen in the shot said Resident #1 self wheelchair. The Admreport should have be MD should have be order obtained for treather the Administrator als followed up on the to 05/09/19 (until 6/4/19). Record review of the Resident #1 was admon/25/18, with a diag Review of the Physic August 2019 reveale in Left Leg, Acquired Toe(s), Encounter for Aftercare, Major Dep Record review of the (MDS) Assessment, Reference Date (ARI resident had a Brief I (BIMS) score of 3, incognitive skills for da G of the assessment required extensive as	ted to him by staff that 06/04/19, the resident had normal routine with no util the left foot was noted to wer room. The Administrator repropelled himself in a inistrator stated an incident een done on 05/09/19, the notified and a doctor's atment of the left 4th toe. To said the staff should have the from the incident on 1). Face Sheet revealed nitted by the facility, on nosis of Pain in Left Leg. ian Orders for the month of dicurrent diagnoses of Pain Absence of Other Left of Other Specified Surgical ressive Disorder. 30 Day Minimum Data Set with an Assessment Di of 07/11/19, revealed the interview for Mental Status dicating severely impaired illy decision making. Section revealed that the resident esistance of two (2) persons sing, and toileting and that	F 6	87			
F 842 SS=D	Resident Records - In CFR(s): 483.20(f)(5),	dentifiable Information	F 8	42		10/1/19	

1 '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		X3) DATE SURVEY COMPLETED	
		255220	B. WING			C 08/22/2019	
NAME OF PROVIDER OR SUPPLIER SHARKEY-ISSAQUENA NURSING HOME				STREET ADDRESS, CITY, STATE, ZIF 431 WEST RACE STREET ROLLING FORK, MS 39159	CODE	00/22/2019	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHO			(X5) COMPLETION DATE	
F 842	(i) A facility may not resident-identifiable to (ii) The facility may resident-identifiable to accordance with a coagrees not to use or except to the extent to do so. §483.70(i) Medical re §483.70(i)(1) In accordance with a resident must maintain medicate that are- (i) Complete; (ii) Accurately docum (iii) Readily accessible (iv) Systematically or §483.70(i)(2) The facall information contain regardless of the form records, except where (i) To the individual, or representative where (ii) Required by Law; (iii) For treatment, part operations, as permit with 45 CFR 164.506 (iv) For public health neglect, or domestic activities, judicial and law enforcement purposes, research predical examiners, for a serious threat to he	elease information that is on the public. elease information that is on an agent only in ontract under which the agent edisclose the information he facility itself is permitted. cords. Index with accepted els and practices, the facility eal records on each resident ented; e; and eganized illity must keep confidential ented in the resident's records, and or storage method of the ented is release is or their resident ented by applicable law; yment, or health care ted by and in compliance	F	342			

DEFICIENCIES CORRECTION	L' IDENTIFICATION NUMBER.			(X3) DATE SURVEY COMPLETED
	255220	B. WING _		08/22/2019
NAME OF PROVIDER OR SUPPLIER SHARKEY-ISSAQUENA NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 431 WEST RACE STREET ROLLING FORK, MS 39159	00/22/2019
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION
§483.70(i)(3) The factorecord information accumant and unauthorized use. §483.70(i)(4) Medical for- (i) The period of time (ii) Five years from the there is no requirement (iii) For a minor, 3 yellegal age under State (iii) For a minor, 3 yellegal age under State (ii) A record of the residing of the residing of the resident review of determinations conduted (v) The results of any and resident review of determinations conduted (v) Physician's, nurse professional's progree (vi) Laboratory, radio services reports as retained to ensure accurate medicumented regarding body audits, for one of records reviewed, Reference (vi) Review of a typed statement of the progree (vi) Review of the progree (vi) Review of the progree (vii) Review of the progree (vii) Review of the progree (viii) Review of	I records must be retained required by State law; or the date of discharge when tent in State law; or the area are sident reaches the law. I dical record must containation to identify the resident; the plan of care and services by preadmission screening the plan of care and services by preadmission screening the plan of the State; by and other licensed the state; by and other diagnostic the plan of the services by the State; by and other diagnostic the plan of the services by preadmission screening the plan of the state; by and other diagnostic the plan of the state; by and other diagnostic the plan of the state; by and other diagnostic the plan of the state; by and other diagnostic the plan of the state; by and other diagnostic the plan of the state; by and other diagnostic the plan of the state; by and other diagnostic the plan of the state; by and other diagnostic the plan of the state; by and other diagnostic the plan of the state; by a state law; by a st	F8	1. Addendums to the medical rec Resident #1 by Administrator refle 09/20/2019 to reflect the false documentation of body audits ent Nurse #1. Resident care plan upo 9/10/2019 to reflect resident ampl and to address the behavior of Re #1 picking his toenails. Appropriataken against Licensed Practical on 08/27/2019.	ected on ered by lated on utation, esident te action Nurse #1
			affected by the deficient practices	
	CORRECTION ROVIDER OR SUPPLIER SUMMARY ST (EACH DEFICIENCE REGULATORY OR Continued From page §483.70(i)(3) The face record information age unauthorized use. §483.70(i)(4) Medical for- (i) The period of time (ii) Five years from the there is no requireme (iii) For a minor, 3 ye legal age under State §483.70(i)(5) The me (ii) Sufficient informat (ii) A record of the res (iii) The comprehensi provided; (iv) The results of any and resident review of determinations condu (v) Physician's, nurse professional's progre (vi) Laboratory, radio services reports as re This REQUIREMENT by: Based on record rev facility policy stateme to ensure accurate m documented regardir body audits, for one (records reviewed, Re Findings include: Review of a typed state letterhead, not dated Administrator, reveal	ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 40 §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy statement review, the facility failed to ensure accurate medical records were documented regarding Resident #1's skin and body audits, for one (1) of five (5) medical records reviewed, Resident #1.	CORRECTION 255220 B. WING_ SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 40 §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy statement review, the facility failed to ensure accurate medical records were documented regarding Resident #1's skin and body audits, for one (1) of five (5) medical records reviewed, Resident #1. Findings include: Review of a typed statement on the facility's letterhead, not dated, and provided by the Administrator, revealed the facility did not have a	ROVIDER OR SUPPLIER 255220 3 STREET ADDRESS, CITY, STATE, ZIP CODE 431 WEST RACE STREET ROLLING FORK, MS 39159 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 40 \$483,70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. \$483,70(i)(4) Medical records must be retained for- (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. \$483,70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (iv) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under \$483.50. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy statement review, the facility falled to ensure accurate medical records were documented regarding Resident #1's skin and body audits, for one (1) of five (5) medical records reviewed, Resident #1. Findings include: Review of a typed statement on the facility's letterhead, not dated, and provided by the Administrator, revealed the facility doll not have a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		255220	B. WING				22/2040
NAME OF D	ROVIDER OR SUPPLIER			S.	TREET ADDRESS, CITY, STATE, ZIP CODE	00/	22/2019
NAME OF T	TOVIDEIT OIT SOI I EIEIT						
SHARKEY	-ISSAQUENA NURSING	HOME			31 WEST RACE STREET		
				R	OLLING FORK, MS 39159		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 842	Continued From page	e 41	F 8	342			
	The statement includ	led an attachment to the			facility will ensure that Resident record	s	
		scipline and Discharge, which			are complete, accurately documented,	_	
		e with every team member.			readily accessible, and systematically		
	Number 38 indicated				organized by addressing concerns usir	na	
		r falsification of significant			corrective counseling. Medical Records	•	
		lical record, including, but			Coordinator will audit for incomplete or		
		ployer's Application for			inaccurate records and report any findi		
		eping, charting, or billing			will be corrected as necessary. Reside	•	
		cord", was against the			records for skin and wound inspections	5	
	facility's code of cond				were audited by Administrator on		
					8/27/2019. Audit resulted in eleven		
	On 08/21/19 at 1:45	PM, an interview with			residents resulting in no skin and wour	ıd	
	Licensed Practical N	urse (LPN) #1, revealed she			assessments, thirteen issues related to)	
	documented she per	formed a skin audit for			skin inspections. Addendums to Medic	al	
	Resident #1, on 06/0	4/19, but she actually did not			records related to this audit on 9/20/20	19	
	do a skin inspection.	LPN #1 said she would do			by Administrator.		
	the skin inspections a	and then go log them into the					
	computer at later time	es. LPN #1 said she thinks			3. In-service conducted by Staff		
	she clicked the wrong	g name.			Development Coordinator on documentation that is complete,		
	On 08/20/19 at 1:30	PM, an interview with LPN			accurately documented, readily		
	#1/Treatment Nurse,	confirmed she was			accessible, and systematically organize	ed,	
	responsible for the sl	kin audits and she usually did			and should follow the rules and ethical		
	the skin audits while	Resident #1 was in the			standards set forth by the employee		
	Whirlpool Room. LPN	N #1 said she looks at the			manual performed on 9/27/2019 with		
	resident's face, front	and back, and the feet. LPN			Nurses and Departmental Staff. Medic	al	
	#1 said she was calle	ed to the Whirlpool Room, on			record quarterly audit template to be		
	05/09/19, by the CNA	A because Resident #1's left			altered to include audit of weekly skin		
		anging by a little piece". LPN			inspections of all Residents on 9/27/20	19.	
	#1 stated she did not	t observe any blood to the					
		said she cleaned the nail bed			4. Weekly skin inspections deficiencies	;	
		nd she thought she put			will be reported by Medical Records		
	antibiotic ointment on it and a band aid. LPN #1				Coordinator to Quality Assurance Meet	ing.	
	•	Nurse Practitioner (NP)			Quality Assurance team will: Monitor		
		is toenail off and she had			effectiveness of the plan of correction		
	-	nt to it. LPN #1 reported the			monthly x 3 months then quarterly. The		
		e and gave no further orders.			Quality Assurance Committee will mak	е	
		id not document this in the #1 said the following day,			further recommendations as needed.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		255220	B. WING			C 08/22/2019	
NAME OF PROVIDER OR SUPPLIER SHARKEY-ISSAQUENA NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 431 WEST RACE STREET ROLLING FORK, MS 39159		1 00/22/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 842	and it was fine. LPN treatment was needed open area and there noted to the left 4th tregards to the incideral already gone for the called her reporting the ER. LPN #1 confibody audits on Resid Whirlpool Room, and body audit in the med that stated Resident said she had heard the LPN #2 or a Whirlpool dressing. LPN #1 revented applied a dressing someone had to have wrapped it and not more ported she went to got that bad that fast have hit it on someth athletes foot fungus, determined it was a fewouldn't have missed audits. Review of Resident # dated 05/07/19, 05/1 revealed the skin was were documented by LPN #1 also docume Report on 06/12/19, was in the hospital. The Resident #1's skin was an interview with the on 08/21/19, at 2:06	d off and cleaned it again #1 confirmed no further d due to it really wasn't an was no swelling or deformity oe that day. LPN #1 stated in int, on 06/04/19, she was day when the Social Worker hat Resident #1 was taken to irmed she performed weekly lent #1 while he was in the I she had documented a dical record, on 06/04/19, #1's skin was intact. LPN #1 he left foot was wrapped and of CNA had removed the realed she did not know who ing to the foot, and that he seen it before that day, hention it to her. LPN #1 talk to the NP to ask how it and the NP said he could ing, or it could have been but she thought it was fracture. LPN #1 stated, "I d that", during the skin #1's Skin Inspection Reports, #4/19, 05/21/19, and 06/04/19 s intact. The skin inspections the LPN #1/Treatment Nurse. Intend a Skin Inspection at which time Resident #1 The report documented	F 84	12			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		255220	B. WING_			C 08/22/2019	
NAME OF PROVIDER OR SUPPLIER SHARKEY-ISSAQUENA NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CO 431 WEST RACE STREET ROLLING FORK, MS 39159		00/22/2019	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTI			(X5) COMPLETION DATE	
F 842	the Skin Inspection R documented intact sk documented she had 06/12/19, while the reDON stated it was fal She stated "False dochappen, and it is agal Record review of the 05/09/19 until 06/04/1 documentation of the Resident #1's skin wa on 05/21/19, when a unspecified arm. Record review of the Resident #1 was adm 01/25/18, with a diagram Review of the Physic August 2019 revealed in Left Leg, Acquired Toe(s), Encounter for Aftercare, Major Dept Review of the most reset (MDS) Assessment Reference Date (ARE Section C that the reset and the section Review of the the section C that the reset and the section Review of the the section C that the reset and the section Review of the the section C that the reset and the section Review of the the section C that the reset and the section Review of the the section Review of the the section C that the reset and the section Review of the the section Rev	in on 06/04/19, and that she performed a body audit on sident was hospitalized. The sification of medical records. cumentation should never inst the policy". Departmental Notes, from 19, revealed no left 4th toe, and that as intact, with the exception, skin tear was noted on an sident had a since of Other Left Other Specified Surgical ressive Disorder. Departmental Notes, from 19, revealed no left 4th toe, and that as intact, with the exception, skin tear was noted on an side of Pain in Left Leg. It is norders for the month of the current diagnoses of Pain Absence of Other Left Other Specified Surgical ressive Disorder. Decent Day Minimum Data and with an Assessment 19, of 07/11/19, revealed in sident had a Brief Interview MS) score of 3, indicating	F	342			