

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 67RH	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/30/2023
NAME OF PROVIDER OR SUPPLIER RULEVILLE NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 800 STANSEL DR RULEVILLE, MS 38771		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) conducted an annual recertification survey and a complaint investigation (CI) MS #23397 at the facility from 11/28/23 through 11/30/23. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements and cited regulatory deficiencies at M500, M635, M640, M705 and M815. The SA determined the facility was in compliance for CI MS #23397 and no deficiencies were cited related to the complaint. The census at the time of the survey was 110 and the facility was licensed for 111 beds.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate	M 500		1/5/24

Mississippi State Department of Health

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

TITLE

(X6) DATE

Electronically Signed

12/19/23

MSDH - Health Facilities Licensure and Certification

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M 500	Continued From page 1 medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident 's choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion,	M 500		

MSDH - Health Facilities Licensure and Certification

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M 500	Continued From page 2 discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care;	M 500		

MSDH - Health Facilities Licensure and Certification

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M 500	Continued From page 3 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level II	M 500	On 12/01/23, CNA #2 was inserviced by	

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M 500	Continued From page 4 Based on observation and interview, the facility failed to maintain a dining experience that promotes dignity as evidenced by staff standing while providing feeding assistance to one (1) of three (3) residents who required feeding assistance in the dining room. Resident #38. Findings Include: An observation of the lunch meal service in the west dining room for Resident #38 on 11/28/23 at 12:48 PM, revealed that the resident was sitting in his wheelchair at the table and Certified Nursing Assistant (CNA) #2 was standing beside the resident feeding him lunch. Upon interview with CNA #2 on 11/28/23 at 12:50 PM, she stated that she should not be standing while feeding Resident #38. She stated that she should be sitting at eye level while feeding so the resident does not feel intimidated with staff standing over him. CNA #2 stated that she only stands when there are not enough chairs in the dining area to sit in. An observation of the breakfast meal service in the west dining area for Resident # 38 on 11/29/23 at 8:13 AM, revealed that the resident was sitting in his wheelchair at the table with CNA #5 standing beside the resident feeding him breakfast. Upon interview with CNA #5 on 11/29/23 at 8:14 AM, she agreed that she should not be standing to feed the resident. CNA #5 stated that she only stands while feeding residents if they do not have chairs to sit in. During an interview with CNA #4 on 11/29/23 at 8:16 AM, she stated that they frequently do not	M 500	the Director of Nursing (DNS) and Executive Director (ED) on proper feeding while sitting down of residents who required feeding assistance in the dining room. All residents who required feeding assistance in the dining room have the potential to be affected. Beginning on 12/01/23, the Director of Nursing (DNS) and Executive Director (ED) conducted an inservice for all Certified Nursing Assistants (CNA) on ensuring staff use proper feeding technique of sitting down while providing residents who require feeding assistance in the dining room. Beginning on 12/04/23, the Assistant Director of Nursing (ADNS) will audit/observe the dining room feeding assistants, five (5) days per week times 2 weeks, then two (2) days per week times 10 weeks to ensure Certified Nursing Assistants (CNAs) are using proper feeding techniques of sitting down while providing residents who require feeding assistance in the dining room. Any concerns will be immediately addressed by the Director of Nursing (DNS). All findings will be corrected immediately with results being sent to the Executive Director for review and then to the Quality Assurance committee monthly times three (3) starting with the 01/03/24 Quality Assurance meeting.	

MSDH - Health Facilities Licensure and Certification

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M 500	Continued From page 5 have chairs in the west dining room sit to in and have to stand to feed residents. During an interview with the Director of Nursing (DON) and Administrator on 11/29/23 at 8:40 AM, they both agreed that staff should not be standing while feeding residents as it does not promote the resident's dignity. An interview with the Administrator on 11/30/23 at 1:00PM, and review of the statement provided on facility letterhead and signed by the Administrator on 11/30/23 revealed, "(Proper Name of Facility) does not have an applicable policy in relation to dining and feeding." Record review of the Face Sheet for Resident #38 revealed that he was admitted to the facility on 5/11/2015 with diagnoses that include Dementia and Neurofibromatosis. Record review of Resident #38 's Annual Minimum Data Set Assessment (MDS) with an Assessment Reference Date (ARD) of 9/1/23, revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating the resident was cognitively intact.	M 500		
M 635	45.21.7 Gastric feeding Gastric feeding. Residents who are eating alone or with assistance are not fed by a gastric tube unless their clinical condition indicates that the use of a gastric feeding tube is unavoidable. The residents who are fed by a gastric tube receive the treatment and services to prevent complications or to restore if possible, normal eating skills.	M 635		1/5/24

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M 635	Continued From page 6 This Statute is not met as evidenced by: Level II Based on observation, interview and record review, the facility failed to ensure a resident with a gastrostomy tube received care to prevent complications as evidenced by failure to check tube placement prior to medication administration for Resident #88; for one of five care observations. Findings Include: Review of the facility policy titled, "Tube Feeding", with a revision date of July 2018, revealed the policy/procedure failed to address the checking of residual with a gastrostomy tube (G tube) when administering medications. Record review of the November 2023 Physician Orders for Resident #88 revealed an order dated 1/18/23, "CHECK PLACEMENT OF G TUBE VIA RESIDUAL. CHECK HOLD IF RESIDUAL IS > 100 CC ..." Record review of the Electronic Medication Administration Record (eMAR) for Resident #88 revealed "CHECK PLACEMENT OF G Tube VIA RESIDUAL", dated 1/18/23. Observation on 11/29/23 at 8:40 AM, revealed Licensed Practical Nurse (LPN) #1 failed to check placement of the G tube prior to administering medications and flushing the tube. In an interview on 11/29/23 at 8:55 AM, LPN #1 revealed she was "nervous" and forgot to check residual prior to administering the medication. On 11/30/23 at 10:50 AM, in an interview, both the Director of Nurses (DON) and Registered	M 635	On 12/01/23, Resident #88 was assessed by Director of Nursing (DNS) for gastrostomy tube complications for failure to check tube placement prior to administering medication. LPN #1 was educated immediately on 11/29/23 by the DNS for failure to check tube placement prior to medication administration. Any resident on gastrostomy tube could be affected. Starting on 12/01/23, DNS and Executive Director (ED) initiated in-servicing of all Licensed Practical Nurses (LPNs) and Registered Nurses (RNs) ensuring staff check tube placement prior to medication administration. Beginning on 12/04/23, Director of Nursing (DNS) and/or Assistant Director of Nursing (ADNS) will audit/observe gastrostomy feedings and medication administration audits with implementation of checkoffs five (5) times a week for 4 weeks, then two (2) times a week for 8 weeks. Any concerns noted by DNS and/or ADNS will be corrected immediately with results being sent to the Executive Director for review and then to the Quality Assurance committee monthly times three (3) starting with the 01/03/24 Quality Assurance meeting.	

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M 635	Continued From page 7 Nurse (RN) #1 confirmed that a G tube residual should checked prior to medication administration. Interview on 11/30/23 09:02 AM, with Resident #88 revealed the resident was unable to answer questions when asked. Record review of the facility Face Sheet revealed the facility admitted Resident #88 on 2/14/22. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/9/23 revealed staff assessment noted as moderate cognitive impairment.	M 635		
M 640	45.21.8 Accidents Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies. This Statute is not met as evidenced by: Level II Based on observation, resident and staff interview, and record review, the facility failed to prevent the potential for an accident by not utilizing appropriate staff when transferring a resident for one (1) of five (5) residents reviewed. Resident #90 Findings include: An observation on 11/28/23 at 10:26 AM revealed Nursing Assistant (NA) #1 had Resident #90 in a	M 640	On 12/01/23 Resident #90 was assessed by Director of Nursing (DNS) for any negative findings related to resident transfer. No negative findings were noted. On 12/04/23, Nursing Assistant (NA) #1 was in-serviced on utilizing appropriate staff when transferring a resident. Residents who require a total body lift for transfer have the potential to be affected. Starting on 12/01/23, DNS and Executive	1/5/24

MSDH - Health Facilities Licensure and Certification

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M 640	Continued From page 8 total body lift and had stopped the transfer of Resident #90 with the resident lifted approximately one (1) foot above the bed. NA #1 left the resident suspended over the bed and walked to doorway and stepped into the hallway looking down the hallway for other staff to assist her in transfer the resident. An interview, on 11/29/23 at 02:32 PM with the Director of Nurses (DON) revealed that she was very "rattled" over this, mainly because of resident safety. She stated that the facility has trained and done in-service education on this. The DON stated that they had plenty of CNA's working yesterday that could have helped her. At no point should this have happened. The DON stated that they have not had any accident or incident reports involving lifts. An interview on 11/29/23 at 02:43 PM, with the Administrator (ADM) stated she is extremely upset because staff know better. An interview, with Nurse Aide #1 on 11/30/23 at 8:35 AM, she revealed she knew that she was not supposed to lift a resident in the lift without two people and should have never left Resident #90 suspended in the air to look for the other Certified Nurse Assistant (CNA). She revealed the CNA she was assigned to work with had stepped out of the room and confirmed she should have waited until the CNA returned before lifting Resident # 90. The NA then revealed a possible concern from using the lift without assistance and leaving Resident #90 unattended in the lift was that the resident was at an increased risk of falling. An interview with Resident #90 on 11/30/23 at 8:45 AM, she revealed she is not scared of the lift and had no concerns.	M 640	Director (ED) initiated in-servicing of all Certified Nursing Assistants (CNAs) and Nurse Trainee Aides ensuring staff use proper lift transfer techniques to ensure safe transfer of all residents. Beginning 12/04/23, the facility DNS will observe three (3) lift transfers five (5) times per week times 4 weeks, then one (1) lift transfer per week times 8 weeks to ensure safe transfers. All findings will be corrected immediately with results being sent to the Executive Director for review and then to the Quality Assurance committee monthly times three (3) starting with the 01/03/24 Quality Assurance meeting.	

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M 640	Continued From page 9 An interview and record review of Resident #90's Minimum Data Set (MDS) with the DON on 11/30/23 at 12:33 PM, confirmed after review of the MDS dated 11/30/23, it revealed Section G: "Functional Status" for Transfers was coded as Total Dependence of two staff. Record review of the Face Sheet for Resident #90 revealed she was admitted to the facility on 8/17/22 with diagnoses that included Cerebral Palsy, Anxiety, and Depression. Review of Section C of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/12//23 revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated Resident #90 was cognitively intact.	M 640		

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M 640	Continued From page 10 Based on observation, resident and staff interview, and record review, the facility failed to prevent the potential for an accident by not utilizing appropriate staff when transferring a resident for one (1) of five (5) residents reviewed. Resident #90 Findings include: An observation on 11/28/23 at 10:26 AM revealed Nursing Assistant (NA) #1 had Resident #90 in a total body lift and had stopped the transfer of Resident #90 with the resident lifted approximately one (1) foot above the bed. NA #1 left the resident suspended over the bed and walked to doorway and stepped into the hallway looking down the hallway for other staff to assist her in transfer the resident. An interview, on 11/29/23 at 02:32 PM with the Director of Nurses (DON) revealed that she was very "rattled" over this, mainly because of resident safety. She stated that the facility has trained and done in-service education on this. The DON stated that they had plenty of CNA's working yesterday that could have helped her. At no point should this have happened. The DON stated that they have not had any accident or incident reports involving lifts. An interview on 11/29/23 at 02:43 PM, with the	M 640		

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M 640	Continued From page 11 Administrator (ADM) stated she is extremely upset because staff know better. An interview, with Nurse Aide #1 on 11/30/23 at 8:35 AM, she revealed she knew that she was not supposed to lift a resident in the lift without two people and should have never left Resident #90 suspended in the air to look for the other Certified Nurse Assistant (CNA). She revealed the CNA she was assigned to work with had stepped out of the room and confirmed she should have waited until the CNA returned before lifting Resident # 90. The NA then revealed a possible concern from using the lift without assistance and leaving Resident #90 unattended in the lift was that the resident was at an increased risk of falling. An interview with Resident #90 on 11/30/23 at 8:45 AM, she revealed she is not scared of the lift and had no concerns. An interview and record review of Resident #90's Minimum Data Set (MDS) with the DON on 11/30/23 at 12:33 PM, confirmed after review of the MDS dated 11/30/23, it revealed Section G: "Functional Status" for Transfers was coded as Total Dependence of two staff. Record review of the Face Sheet for Resident #90 revealed she was admitted to the facility on 8/17/22 with diagnoses that included Cerebral Palsy, Anxiety, and Depression. Review of Section C of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/12//23 revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated Resident #90 was cognitively intact.	M 640		

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M 705	Continued From page 12	M 705		
M 705	45.24.2 Policies and procedures Policies and procedures. Each facility shall have policies and procedures to assure the following: 1. Accurate acquiring; 2. Receiving; 3. Dispensing; 4. Storage; and 5. Administration of all drugs and biologicals. This Statute is not met as evidenced by: Level II Based on observation, interview, policy review, and record review, the facility failed to ensure controlled medications were stored in a secure locked container for two (2) of six (6) narcotic storage containers. Findings Include: Review of the facility policy, "Medication Storage" revealed, "Medication supply must be accessible only to licensed nursing personnel, or staff members lawfully authorized to administer medications. All drugs, treatments, and biologicals must be stored securely and following the manufacturer's labeled recommendations, or per facility policy." Observation on 11/28/23 11:03 AM of the West Wing Nurses Station medication room revealed a medication refrigerator with a red lock box for controlled drugs. The medication box was not locked but was secured to the refrigerator shelf. The box contained 12 single dose vials of	M 705	On 11/30/23, Director of Nursing (DNS) ensured controlled medications were stored in a secure locked container. No resident ill effects were noted. Any resident who receives controlled medications could be affected. Starting on 12/05/23, Maintenance Director secured the locked controlled medication storage containers to medication room refrigerators. Beginning on 12/05/23, Executive Director (ED) initiated in-servicing of the Maintenance Director, Licensed Practical Nurses (LPNs), and Registered Nurses (RNs) nursing staff to ensure that there is a secure locked container for two (2) controlled medication storage containers in medication room refrigerators. Starting on 12/04/23, Director of Nursing (DNS) conducted a 100% controlled medication storage containers audit.	1/5/24

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 67RH	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/30/2023
NAME OF PROVIDER OR SUPPLIER RULEVILLE NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 800 STANSEL DR RULEVILLE, MS 38771		
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M 705	Continued From page 13 Lorazepam and one (1) multidose vial of Lorazepam. The observation was confirmed by Licensed Practical Nurse (LPN) #3 and LPN #4. Neither LPN had a key to lock the box. LPN #3 said the box is never locked but confirmed the medications are counted at shift change. Observation on 11/28/23 11:20 AM of East Wing Nurses Station medication room revealed a medication refrigerator with a red controlled medication lock box containing 17 Lorazepam single use vials and 2 multidose vials of Lorazepam. This box was locked but was not secured to the refrigerator. LPN #2 stated the refrigerator medication controlled medication box had never been secured to the refrigerator since he had worked here. Observation on 11/29/23 at 10:27 AM revealed East Wing controlled medication lock box remained unsecured to the refrigerator and West Wing box remained unlocked. On 11/29/23 01:00 PM, a phone interview with the pharmacy consultant revealed the narcotic lock box is located behind two locked doors; the med room door and the refrigerator door. The pharmacy consultant stated the lock box must be attached to the refrigerator. He was not aware of the box not being attached to the refrigerator on the East Wing. Interview on 11/29/23 01:03 PM with the Administrator, revealed she was unaware of the controlled medication boxes in the medication rooms on West Hall being unlocked or that the controlled medication box was not secured on the East Wing. She stated she was going to take care of the boxes being unlocked and unattached immediately.	M 705	Assistant Director of Nursing (ADNS) will monitor for a secure locked container for controlled medications storage containers two times a week for 8 weeks, then one (1) time a week for 4 weeks. Any concerns noted by ADNS are reported to the Director of Nursing (DNS). All findings will be corrected immediately with results being sent to the Executive Director for review and then to the Quality Assurance committee monthly times three (3) starting with the 01/03/24 Quality Assurance meeting.	

MSDH - Health Facilities Licensure and Certification

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M 815	45.29.1 Safe Food Handling Procedures Safe Food Handling Procedures. Food shall be prepared, held, and served according to current Mississippi State Department of Health Food Code Regulations. This Statute is not met as evidenced by: Level II Based on observations, staff interviews, record review, and facility policy review, the facility failed to maintain clean ice machines, as evidenced by observations during the annual survey of two (2) of two (2) unclean ice machines, for 96 of 105 residents in the nursing facility who use ice. Findings Include: Review of the facility policy titled, "Ice Handling and Cleaning," for the Guideline and Procedure Manual ... 2020, revealed "Guideline: Ice will be stored and served to residents in a sanitary manner. Procedure: ... 6. Ice machine will be emptied at least quarterly and thoroughly cleaned with an approved sanitizer to remove any settlement or mineral build-up..." An observation on 11/28/23 at 10:35 AM, of the ice machine in the kitchen, revealed a black buildup that was located on the upper right side of the opening of the ice container under the door to the ice storage bin. An observation and interview on 11/28/23 at 10:38 AM, with the Kitchen Aide #2, revealed her use of a wet white paper towel to wipe over the black buildup that was located on the upper right	M 815	On 11/29/23, Maintenance Director cleaned the two (2) ice machines. No resident ill effects were noted. Any resident who receives ice could be affected. Starting on 12/01/23, Executive Director (ED) initiated in-servicing of the Maintenance Director and Certified Dietary Manager to ensure that there are clean ice machines. Starting on 12/04/23, Certified Dietary Manager (CDM) will be conducted a 100% ice machine audit for evidence of unclean ice machines per cleaning schedule five (5) times a week for 6 weeks, then two (2) times a week for 6 weeks. Any concerns noted by CDM are reported to the Director of Nursing (DNS). All findings will be corrected immediately with results being sent to the Executive Director for review and then to the Quality Assurance committee monthly times three (3) starting with the 01/03/24 Quality Assurance meeting.	1/5/24

MSDH - Health Facilities Licensure and Certification

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M 815	Continued From page 15 side of the opening of the ice container under the door to the ice storage bin and the black residue was observed to come off on the paper towel. She confirmed the ice machine was not clean. During an observation of the kitchen ice machine and interview with Maintenance #1 on 11/28/23 at 10:42 AM, he confirmed the black buildup that was located on the upper right side of the opening of the ice container under the door to the ice storage bin. The observation also revealed there was black mucus consistency buildup inside the top of the ice machine, that was observed on the bottom of the white side cover panel located over the right side of the door of the ice bin. Also, the observation revealed black and yellow buildup on the white panel that covered the element of the ice machine that freezes the ice cubes, black mucus consistency buildup that covered the white panel above the ice freezing element and the water that ran through the ice machine was observed to flow over the black mucus consistency buildup, and flowed down over the ice freezing element. The outer edges of the white plastic case that surrounded the ice freezing element were observed to have a black mucus consistency buildup. He confirmed the ice machine needed to be cleaned, revealed he was aware there was buildup collecting in the ice machine at a faster pace, and had changed his schedule to clean the ice machine every three (3) months. He revealed he was originally cleaning the ice machine every 6 months. Maintenance #1 noted he would complete a task check off in the computer, for each ice machine, and was not able to document cleaning details. State Agency and Maintenance #1 completed a second observation of the ice machine located in the East Wing nurse's station. Maintenance #1 revealed he cleaned the East Wing ice machine three (3)	M 815		

MSDH - Health Facilities Licensure and Certification

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M 815	Continued From page 16 weeks prior to survey, because it was broken. There was black residue observed in the top/inside of the machine located on the top and bottom white plastic case that surrounded the ice making element of the ice machine. The observation revealed that the water flowed over the black residue at the bottom of the white plastic case. Maintenance #1 confirmed there was black residue observed in the top/inside of the machine located on the top and bottom white plastic case that surrounded the ice making element of the ice machine. The observation revealed that the water flowed over the black residue at the bottom of the white plastic case. He confirmed that he did not completely clean the East Wing ice machine. An observation and interview on 11/28/23 at 10:51 AM with the Administrator confirmed the black buildup that was located on the upper right side of the opening of the kitchen ice container under the door to the ice storage bin. She also confirmed there was black mucus consistency buildup inside the top of the kitchen ice machine, that was observed on the bottom of the white side cover panel located over the right side of the door of the ice bin. The Administrator further confirmed the observation of the black and yellow buildup on the white panel that covered the element of the kitchen ice machine that freezes the ice cubes, confirmed the observation of the black mucus consistency buildup that covered the white panel above the ice freezing element and the water that ran through the kitchen ice machine was observed to flow over the black mucus consistency buildup, and flowed down over the ice freezing element. The Administrator also confirmed the outer edges of the white plastic case that surrounded the ice freezing element, of the kitchen ice machine, had a black mucus	M 815		

MSDH - Health Facilities Licensure and Certification

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M 815	Continued From page 17 consistency buildup. She further confirmed there was black residue in the top/inside of the East Wing ice machine located on the top and bottom white plastic case that surrounded the ice making element of the East Wing ice machine and confirmed that the water flowed over the black residue at the bottom of the white plastic case. The Administrator confirmed that Maintenance #1 was not adequately cleaning the ice machines and there was a possibility of sickness for the residents due to drinking fluids off the ice that was made in the unclean ice machines. Record review of the "Work History Report," revealed " The record review revealed there was one (1) ice machine cleaning task completed in the months of October 2023, August 2023, and July 2023. The record review did not reveal which ice machine was cleaned.	M 815		