STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25BN	A. BUILDING: _____ B. WING _____	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MADISON HEALTH AND REHAB	111 KELLY BLVD MADISON, MS 39110

(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 complaint investigations (CI) MS 27198 and CI MS 27119 at the facility from 1/14/25 through 1/16/25. 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 deficiencies were cited at M 500, M 610, M 705, M 815 and M 1570. The SA determined the facility was not in compliance with CI MS 27198 and CI MS 27119 regarding Activities of Daily Living and cited M 610. The facility had a census of 56 at the time of survey and held a license for 60 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		2/14/25

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	25BN	A. BUILDING: _____ B. WING _____	01/16/2025

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THE MADISON HEALTH AND REHAB	111 KELLY BLVD MADISON, MS 39110

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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		

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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		

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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 1/16/2025, Residents #10, #36, and	

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M 500	Continued From page 4 Based on resident and staff interview, record review, and facility policy review, the facility failed to honor resident's rights to make health care decisions for three (3) of 24 residents reviewed for advanced directives. Resident #10, #36, and #48 Findings Include: Record review of the facility policy titled "Do Not Resuscitate No Code Status Policy" dated 2/2024 revealed, "It is the policy of this facility to inform residents of the right to choose to have CPR (cardiopulmonary resuscitation) or no CPR to be performed at such time of imminent death. ... The code status form will be completed at the time of admission." Resident #10 Record review of Resident #10's "Order Summary Report" revealed, DNR (Do Not Resuscitate): Need for death with dignity related to choice of code status DNR per family/Resident Representative (RR) request. Record review of the "Code Status" form for Resident #10 revealed a family member signed the form dated 10/16/24, with no signature from the resident. An interview with Resident #10 on 1/15/25 at 10:35 AM revealed he can make his own decisions and sign his paperwork. He stated that when he was admitted to the facility, he did not recall anyone asking him whether he wanted to be a full code or DNR and admitted that he did not sign any paperwork on it. He stated that it should be his choice since "I can make my own decisions."	M 500	#48 reviewed, selected, and signed their advanced directives, code status forms. "All competent Residents have the potential to be affected by this deficient practice "In-services were conducted by the administrator on 1/16/2025 with the director of nursing, social services director, and medical records for all competent residents to complete their own code status form upon admitting into the facility. Effective 1/16/2025, the administrator and social services director is reviewing all Resident charts to ensure each competent patient has signed their own advance directive code status form. Effective 1/16/2025, all competent Residents will have the right to review, select, and sign their own advance directive code status form. This form will be reviewed, completed, and signed by all competent Residents upon admitting into the facility. "Beginning 1/20/2025, Social Service Director and Medical Record personnel will perform weekly audits on all Residents charts to ensure each competent resident has completed their own code status form times three months. Observations will be brought forth by the administrator to the quality assurance committee monthly, beginning 2/13/2025, times three months to assure substantial compliance has been achieved.	

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	25BN	A. BUILDING: _____ B. WING _____	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MADISON HEALTH AND REHAB	111 KELLY BLVD MADISON, MS 39110

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M 500	Continued From page 5 Record review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/22/2024 for Resident #10 revealed, under Section C, a Brief Interview for Mental Status (BIMS) summary score of 13, which indicated the resident was cognitively intact. Record review of the "Admission Record" revealed the facility admitted Resident #10 on 10/16/2024 with diagnoses that included Chronic Systolic (Congestive) Heart Failure, and Chronic Obstructive Pulmonary Disease with (Acute) Exacerbation. Resident #36 Record review of Resident #36's "Order Summary Report" revealed full code related to family/Resident Representative choice of code status. Resident is a full code. Record review of the "Code Status" form for Resident #36 revealed a family member signed the form dated 10/31/24, with no signature from the resident. An interview with Resident #36 on 11/15/25 at 11:45 AM, revealed when she was admitted to the facility, she did not sign her code status form, and no one spoke to her about it. She stated that she can still make her own decisions, and even though she has Parkinson's, and it may take her a little longer, she can still sign. Record review of Resident #36's MDS with an ARD of 11/06/2024 revealed, under Section C, a BIMS summary score of 14, which indicated the resident was cognitively intact.	M 500		

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THE MADISON HEALTH AND REHAB	111 KELLY BLVD MADISON, MS 39110

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M 500	Continued From page 6 Record review of the "Admission Record" revealed the facility admitted Resident #36 on 10/31/2024 with diagnoses that included Hypoglycemia, Unspecified, and Parkinson's Disease without Dyskinesia. Resident #48 Record review of Resident #48's "Order Summary Report" revealed, full code related to family/Resident Representative choice of code status. Resident is a full code. Record review of the "Code Status" form for Resident #48 revealed a family member signed the form dated 11/19/24, with no signature from the resident. In an interview on 1/15/25 at 8:50 AM, Resident #48 revealed that she did not sign her Advance Directives when admitted to the facility. She stated that no one at the facility had spoken with her about her code status. Record review of the MDS with an ARD of 11/25/2024 for Resident #48 revealed, under Section C, a BIMS summary score of 14, which indicated the resident was cognitively intact. Record review of the "Admission Record" revealed the facility admitted Resident #48 on 11/19/2024 with diagnoses that included Multiple Fractures of Pelvis without Disruption of Pelvic Ring, and Chronic Kidney Disease, Stage 3. An interview with the Social Services Director on 1/15/25 at 1:15 PM, revealed that when a resident was admitted to the facility, she had been discussing their code status with the family representative or power of attorney (POA) and	M 500		

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	25BN	A. BUILDING: _____ B. WING _____	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MADISON HEALTH AND REHAB	111 KELLY BLVD MADISON, MS 39110

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M 500	Continued From page 7 had not been going over it with the resident. She confirmed that Residents #10, #36, and #48 did not sign their code status form, and they should have because it was their right. During an interview on 1/15/25 at 1:40 PM, the Administrator confirmed that the residents who were competent and able to sign their Advance Directive should be allowed to do so, and we should ensure that their wishes were honored. In an interview on 1/16/25 at 10:38 AM, the Director of Nurses (DON) confirmed that Residents #10, #36, and #48 were cognitive and able to make their own decisions and should have had the opportunity to decide what their end-of-life wishes were.	M 500		
M 610	45.21.2 Activities of daily living Activities of daily living. Each resident shall receive assistance as needed with activities of daily living to maintain the highest practicable well being. These shall include, but not be limited to: 1. Bath, dressing and grooming; 2. Transfer and ambulate; 3. Good nutrition, personal and oral hygiene; and 4. Toileting. This Statute is not met as evidenced by: Level II Based on observation, resident and staff interview, record review, and facility policy review, the facility failed to provide nail care, oral care and facial hair removal for resident's requiring	M 610	"Resident #1 had their facial hair removed and nail care provided on 1/15/2025 by the assigned CNA. Resident #7 had their nails trimmed and cleaned on 1/15/2025 by the assigned CNA. Resident #2 Received	2/14/25

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M 610	Continued From page 8 assistance with activities of daily living (ADLs) for three (3) of 16 sampled residents. Resident #1, #2, and #7 Findings Include: Record review of the facility policy, "ADL Care Policy" undated, revealed, "It is the policy of this facility to provide appropriate treatment and services in relation to ADL care to residents to ensure all ADL needs are met on a daily basis ..." Resident #1 An observation and interview on 1/14/25 at 9:20 AM revealed, Resident #1 with facial hair on her chin that was approximately three (3) to four (4) inches long. An interview with the resident revealed that she did not like facial hair and stated, "I want them gone." An observation and interview on 1/15/25 at 1:27 PM, with Certified Nursing Assistant (CNA) #1 revealed facial hair and fingernails should be taken care of during bath time or anytime it was noticed. She confirmed that Resident #1 had long hair on her chin and admitted it should have already been taken care of. Record review of the "Admission Record" revealed the facility admitted Resident #1 on 4/03/2017 with medical diagnoses that included Major Depressive Disorder and Muscle Weakness. Record review of Resident #1's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/27/24, revealed under Section C a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively	M 610	oral hygiene care on on 1/15/2025 by the assigned CNA. "All Residents have the potential to be affected by this deficient practice. "Effective 1/16/2025, activities of daily living hygiene, oral care, hair care, and nail care is being completed on a daily basis by all shifts. Inservice conducted on 1/16/2025 by administrator for nursing staff to educate the importance of activities of daily living care towards all residents on a daily basis. As of 1/20/2025 clinical supervisors are evaluating all Residents weekly to ensure ADL care is being provided for. Any issues notated will immediately be addressed by assigned licensed practical nurse and assigned certified nurse aide. "Effective 1/16/2025, the administrator and director of nursing will each assess 3 different patients weekly to ensure activities of daily living care is being completed on residents times three months. The weekly observation reports will be brought forth by the administrator to the quality assurance committee monthly, beginning 2/13/2025, times three months to assure substantial compliance has been achieved.	

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	25BN	A. BUILDING: _____ B. WING _____	01/16/2025

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THE MADISON HEALTH AND REHAB	111 KELLY BLVD MADISON, MS 39110

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M 610	Continued From page 9	M 610		

intact.

Resident #7

On 1/14/25 at 9:00 AM, an observation and interview with Resident #7 revealed she had fingernails approximately one-half (1/2) to three-fourths (3/4) inches in length past the tips of the fingers. She admitted that she had never had fingernails this long before, and stated, "I keep them very short; I feel like they are like claws now." The resident revealed she had been at the facility since December, and no one had offered to clip her nails.

An observation and interview on 1/15/25 at 1:20 PM of Resident #7 with CNA #1 revealed that fingernails should be checked every day, cleaned and clipped when needed. She confirmed Resident #7's fingernails were long and Resident #7 stated to CNA #1, "I have never had my nails this long before and I want them cut." CNA #1 stated that with the resident's fingernails that long she could scratch herself and cause skin tears or the spread of bacteria.

On 1/16/25 at 8:30 AM, an interview with Registered Nurse (RN) Supervisor revealed that the nurses should be checking behind the aides to make sure the resident needs were taken care of. She revealed she was not aware Resident #7 had long fingernails and confirmed that nail care should be included in their personal hygiene task.

On 1/16/25 at 9:10 AM, an interview with the Director of Nursing (DON) confirmed that the nurses and the aide supervisor should be overseeing the completion of ADL care. He revealed that anyone who noticed a need with a

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	25BN	A. BUILDING: _____ B. WING _____	01/16/2025

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THE MADISON HEALTH AND REHAB	111 KELLY BLVD MADISON, MS 39110

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M 610	Continued From page 10	M 610		

resident should take care of the problem or tell someone who could.

Record review of the "Admission Record" revealed the facility admitted Resident #7 on 12/20/24 with a medical diagnosis of Rhabdomyolysis.

Record review of Resident #7's MDS with ARD of 11/26/24 revealed under Section C, a BIMS score of 10, which indicated the resident was moderately cognitively impaired.

Resident #2

An observation of Resident #2 on 1/14/25 at 8:09 AM revealed the resident was trying to talk and a thick white substance was observed on her upper and lower teeth and gums.

An observation of Resident #2 on 1/15/25 at 8:06 AM revealed no change in the resident's teeth and gums.

An observation and interview on 1/15/25 at 3:10 PM, with CNA #2 revealed she was assigned to Resident #2 today on day shift. She confirmed the resident had excess buildup on her teeth and that she did not brush the residents' teeth today. She explained that the resident was on the "get up" list and that the night shift should have done it. She admitted that she should have checked behind them to ensure it was done.

An observation and interview with the DON on 1/15/25 at 3:22 PM described Resident #2's teeth as "plaque buildup and food particles." He revealed that the aides and nurses were responsible for oral care and brushing the resident's teeth. The DON stated that the resident

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MADISON HEALTH AND REHAB	111 KELLY BLVD MADISON, MS 39110

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M 610	Continued From page 11 could develop decay and cavities from not getting the appropriate oral care. Record review of the "Admission Record" revealed the facility admitted Resident #2 on 10/28/20 with medical diagnoses that included Dysphagia and Left Wrist Drop.	M 610		
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, staff and resident interviews, and facility policy review, the facility failed to properly store medications, as evidenced by, medications left in a resident's room for one (1) of 16 sampled residents. Resident #41 Findings Include: Record review of the facility policy "Medication Storage" dated 01/2024, revealed "It is the policy of this facility to ensure all medications housed on	M 705	"Resident #41 had their eye drops and pain cream removed from the resident room and placed in the nurse cart on 1/15/2025 by assigned licensed practical nurse. "All Residents have the potential to be affected by this deficient practice. "Effective 1/16/2025, all resident medications are being stored appropriately on the nurses carts and med storage room. Inservice conducted with Nursing staff on 1/16/2025 by administrator to inform nursing staff of proper medication	2/14/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MADISON HEALTH AND REHAB	111 KELLY BLVD MADISON, MS 39110

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M 705	Continued From page 12 our premises will be stored in the medication cart and/or medication rooms according to the manufacturer's recommendation....." An observation on 1/14/25 at 11:00 AM and 2:00 PM revealed a one-ounce bottle of lubricant eye drops and a two-ounce tube of pain relief cream on the overbed table in Resident #41's room. An interview on 1/14/25 at 2:50 PM, with Resident #41 revealed he brought his eye drops and pain cream from home, and he applied them himself. He revealed that he used the eye drops every day and that he hardly ever used the pain cream. The resident explained he kept these items in his room so he could use them as needed. An observation and interview with Licensed Practical Nurse (LPN) #1 on 1/15/25 at 9:58 AM, confirmed Resident #41 had a bottle of lubricant eye drops and a tube of pain cream on his bedside table. She revealed the resident had not been assessed for self-administration and explained medications were not supposed to be in his room. LPN #1 agreed that leaving medications in a resident's rooms was a risk, and another resident could enter his room and take something they were not supposed to have. An interview on 1/15/25 at 10:40 AM, with the Director of Nursing (DON) confirmed that leaving medications in a resident's room should not happen. He revealed that some residents were used to self-administering medications at home before coming into the facility, and it was often hard for them to adjust. The DON stated that if a resident requested to self-administer their medications, then an assessment should have been done to ensure they were competent and knew how to use it. He revealed this one must	M 705	storage. on 1/17/2025, rounds conducted on all rooms by administrator, director of nursing, and staffing director to ensure medications were not being stored incorrectly in Resident rooms. On 1/17/2025, the director of nursing audited all nursing carts and med storage room to ensure medications were being stored properly. "Effective 1/16/2025, weekly rounds are being conducted by the administrator and director of nursing to audit three Residents each to ensure medication is being properly stored times three months. The weekly observation reports will be brought forth by the administrator to the quality assurance committee monthly, beginning 2/13/2025, times three months to assure substantial compliance has been achieved.	

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M 705	Continued From page 13 have slipped through the cracks and explained that someone should have seen the medications in Resident #41's room and removed them. Record review of Resident #41's "Admission Record" revealed an admission date of 9/10/24, with medical diagnoses that included Unspecified Injury of Left Lower Leg, Muscle Weakness, and Need for Assistance with Personal Care. Record review of Resident #41's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/19/24, revealed, under Section C, a Brief Interview for Mental Status (BIMS) score of 15, which indicated he was cognitively intact.	M 705		
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 Widespread Based on observations, staff interviews, and facility policy review the facility failed to ensure items in the walk-in kitchen refrigerator were labeled and dated, discarded by the expiration date, and arranged in a manner to prevent possible cross-contamination for one (1) of three (3) kitchen tours Findings include: Review of the facility policy titled, "Labeling and	M 815	"On 1/14/2025, the unlabeled, expired Yoplait yogurt and tropical fruit supreme was discarded from the facility by dietary manager. On 1/14/2025, the improperly stored and improperly labeled chicken salad, pimento cheese, liquid eggs, chopped ham, sausage and peppers, and boiled eggs were discarded from the facility by the dietary manager. On 1/14/2025, the improperly stored and improperly labeled chicken and pork were discarded from the facility by the dietary manager.	2/14/25

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M 815	Continued From page 14 Dating Inservice" revised 2/2023, revealed "All foods should be dated upon receipt before being stored. Food labels must include: The food item name, the date of preparation/receipt/removal from freezer, the "use by" date. ...Leftovers must be labeled and dated with the date they are prepared and the "use by" date. Review of the facility policy titled, "Food Storage: Cold Foods" revealed, 5 ..."All foods will be stored, wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination." An observation and interview on the initial tour of the kitchen with the Dietary Manager (DM) on 1/14/25 at 8:05 AM, revealed in the walk-in refrigerator two white opened containers with a manufacturer label of "Yoplait Vanilla Yogurt". The containers were not dated and had a manufacturer best-by date of Dec 24, 2024. An observation of a five-pound opened "Sysco Tropical Fruit Supreme" with no open date nor use-by date. The DM revealed she was unsure when it was opened. An observation of a five-pound white container of Wholesome Farm sour cream dated 12/17/24 with no use-by date, and a large clear plastic container dated 1/11 with no label or use-by date. The DM identified the food item as chicken salad. An unlabeled clear plastic container dated 1/7 with no use-by date, which the DM identified as pimento cheese, a 2-inch-deep rectangular metal pan unlabeled with a date of 1/14, with no use-by date, the DM identified as liquid eggs, a square clear container unlabeled with a date of 1/14, with no use-by date, the DM revealed that is chopped ham, a transparent plastic square container unlabeled with a date of 1/8 on one side and a date of 1/13 on the other side, the DM revealed they had this	M 815	"All Residents who receive meals from dietary have the potential to be affected by this deficient practice. "Effective 1/15/2025, all foods are correctly labeled, dated, and stored appropriately. Inservice conducted by administrator with all dietary staff on 1/15/2025 that all items need to be labeled and dated before being stored. Inservice also states once an item is opened, it must have a use by label of seven days after opening. Inservice conducted by administrator on 1/15/2025 on cross contamination and how to properly store separate items in separate containers. Inservice also states of any expired foods to be immediately removed from the facility. "Effective 1/15/2025, the dietary manager is conducting rounds twice a week to ensure all items are labeled appropriately, any expired items are being discarded from the facility, and that no cross contamination is occurring times three months. The weekly observation reports will be brought forth by the administrator to the quality assurance committee monthly, beginning 2/13/2025, times three months to assure substantial compliance has been achieved.	

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M 815	Continued From page 15 last night for supper and confirmed the food item was cooked sausage and peppers. She confirmed the date for the meal was last night but wasn't sure why they didn't change the date on the container. Observation revealed a small square pan unlabeled and undated which the DM confirmed the food items were four boiled eggs in a clear liquid and revealed she wasn't sure how long they had been there. An observation of a rectangular metal tray on the bottom shelf of the refrigerator revealed a labeled gallon-sized bag of chicken in a liquid substance; the bag was undated, and in the same pan wrapped in cellophane was an unlabeled and undated food item the DM identified as pork loin . A liquid substance was noted on the bottom of the metal tray where both food items were placed. The DM revealed they were both undated and should not have been in the same container thawing because this could cause bacteria, and the residents could get sick. She confirmed that the food items in the refrigerator were not properly labeled and dated and that all foods should have dates for when they should be discarded. In an interview on 1/14/25 at 8:20 AM with the Dietary Aide revealed that when the food items come in, he puts the dates that they arrived, and then when they open them, they are supposed to put that date and then a use by date. He confirmed the items in the walk-in refrigerator were not correctly labeled. In an interview on 1/15/25 at 12:05 PM, the Administrator confirmed that it is the facility policy that all food items be properly labeled, dated when they arrive at the facility, when they are opened and discarded within the proper time to prevent any food-borne illnesses.	M 815		

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M1570	Continued From page 16	M1570		
M1570	48.58.1 Infection Control The following infection control standards shall be met: 1. The facility must maintain and document an effective infection control program that protects patients, families, visitors, and facility personnel by preventing and controlling infections and communicable diseases. 2. The facility must have an active surveillance program that includes specific measures for prevention, early detection, control, education, and investigation of infections and communicable diseases in the facility. There must be a mechanism to evaluate the effectiveness of the program(s) and take corrective action when necessary. The program must include implementation of nationally recognized systems of infection control guidelines to avoid sources and transmission of infections and communicable diseases. 3. The facility must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions. This Statute is not met as evidenced by: Level II Based on observation, staff interview, and facility policy review, the facility failed to follow Enhanced Barrier Precautions (EBP) while providing resident care for two (2) of three (3) direct care observations. Resident #28 and Resident #49	M1570	"Effective 1/16/2025, all nursing personnel are wearing enhanced barrier protective (EBP) gowns when performing peg care for resident #28. Effective 1/16/2025, all nursing personnel are wearing enhanced barrier protective gowns when administering foley catheter care to resident #49.	2/14/25

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M1570	Continued From page 17 Findings Include: Record review of the facility policy "Enhanced Barrier Precautions" with a revised date of 8/07/24, revealed under, "Policy Explanation and Compliance Guidelines:... 2. Initiation of Enhanced Barrier Precautions:... b. An order for enhanced barrier precautions will be obtained for residents with any of the following: Wounds ... and/or indwelling medical devices (...urinary catheters, feeding tubes ...) even if the resident is not known to be infected ..." Resident #28 An observation on 1/15/25 at 8:55 AM revealed Licensed Practical Nurse (LPN) #2 administered Resident #28's medications through a Percutaneous Endoscopic Gastrostomy (PEG) tube without wearing a gown for EBP. He revealed that EBP were supposed to be utilized when providing care to residents who had Covid-19 or open wounds. He stated that he did not think they had to follow the precautions for residents with PEG tubes. LPN #2 agreed that EBP were put in place to protect the residents and the staff to prevent the spread of germs. Record review of Resident #28's Order Summary Report with active orders as of 1/16/25 revealed an order for EBP related to PEG every shift and medication orders for administration through the PEG Tube. Record review of Resident #28's "Admission Record" revealed an admission date of 4/29/24 with medical diagnoses that included Ventricular Fibrillation and Dysphagia.	M1570	"Any resident with enhanced barrier protective orders has the potential to be affected by this deficient practice. "Effective 1/16/2025, all nursing personnel are abiding by infection control policies towards enhanced barrier precautions. As of 1/15/2025, Personal protective equipment (PPE) is readily located for all employees to use along with enhanced barrier protective guidelines. Inservice conducted on 1/16/2025 by administrator for all staff on infection control and enhanced barrier protection protocols and policies. "As of 1/20/2025, the infection preventionist nurse will conduct three observations weekly on staff to ensure employees are using personal protective equipment when performing care on residents under enhanced barrier precautions times three months. The weekly observation reports will be brought forth by the administrator to the quality assurance committee monthly, beginning 2/13/2025, times three months to assure substantial compliance has been achieved.	

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M1570	Continued From page 18 Resident #49 An observation on 1/15/25 at 10:50 AM revealed LPN #1 completed Resident #49's catheter care and changed the drainage bag without wearing a gown. LPN #1 revealed they (the staff) had to wear a gown if a resident had open wounds or something contagious like Covid-19. She stated that she was not aware that gowns had to be worn when providing catheter care. An interview on 1/15/25 at 11:25 AM, with the Director of Nursing (DON) revealed EBP were to be used with any residents who had indwelling medical devices to protect the residents from infection. He revealed the staff had been in-serviced and knew they were supposed to wear gloves and gowns when they provided care to these residents. Record review of Resident #49's "Admission Record" revealed an admission date of 12/09/24 with medical diagnoses that included Malignant Neoplasm of the Prostate and Chronic Kidney Disease. Record review of Resident #49's Order Summary Report with active orders as of 1/16/25 revealed, "Resident to be placed on EBP related to Foley" and there was an order for catheter care every day related to Retention of Urine diagnosis.	M1570		