STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255326	A. BUILDING _____ B. WING _____	05/10/2019

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PINE FOREST HEALTH AND REHABILITATION	1116 FOREST AVENUE JACKSON, MS 39206

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F 000	INITIAL COMMENTS The State Survey Agency (SA) conducted an annual recertification from 5/7/19 through 5/10/19. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements of participation. The SA cited the regulatory deficiencies F558, F603, F623, F655, F656, F657, F690, F695, F812, and F880. At the time of the survey, the census was 109 and the facility held a license for 120 beds.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview and family interview, record review, and facility policy review, the facility failed to ensure the appropriate size briefs was used to prevent possible skin breakdown for one (1) of six (6) resident incontinent care observations, Resident #45. Findings include: A review of the facility's in-service Attendance Record and Clinical Educational sign in sheets revealed the Topics and Objectives to address (Name of Medical Supply Company) products and Incontinent and Skin Care, dated	F 558	* On 5/9/2019 the Director of Nursing (DON) assessed Resident #45s skin condition and ensured she had the appropriate brief on. DON obtained and placed appropriate sized briefs in Resident #45s room. On 5/9/2019 the DON observed the residents skin and no alteration in skin condition was identified. The Medical Records Specialist added the task for Resident 98s care service plan with the appropriate size brief for this resident. * On 5/10/19 the Central Supply Aide notified Brief representative to ensure	6/13/19

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

Electronically Signed | 06/13/2019

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.

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F 558	Continued From page 1 10/16/8,10/17/18, revealed the Certified Nursing Assistants (CNAs) were trained on using the appropriate briefs for incontinent residents. A review of Resident #45's comprehensive care plan revealed Focuses, initiated on 03/14/19, for functional bladder incontinence related to end stage renal disease, and bowel incontinence related to immobility. Interventions included check resident every two (2) to three (3) hours and wash, rinse and dry perineum, change clothing PRN (as needed) and after incontinent episodes. An interview and observation, on 05/7/19 at 10:18 AM, revealed Resident #45 stated between her legs was red and hurts because her brief was to small. An observation at this time revealed Resident #45's skin between her legs was red and intact. Resident #45 stated she asked the CNA not to put on a brief because there were no briefs big enough to fit her. An observation, on 05/8/19 at 9:23 AM, revealed Resident #45 in bed watching television with a green brief tightly placed between her legs. An observation, on 05/8/19 at 4:24 PM, revealed Resident #45 in bed watching television with a blue brief placed under the resident because it was too tight to close per resident's family member. An observation, on 05/9/19 at 9:25 AM, revealed Resident #45 sitting in bed watching television with a blue brief placed under the resident because it was too tight to close. Registered Nurse (RN) #3/Unit Manager was in the room at this time, and observed the blue brief under	F 558	appropriate product order was placed for pending delivery. On 5/10/2019 the Central Supply Aide rounded on current residents and ensured appropriate sized briefs were correct and in use. * On 5/10/2019 the Medical Records Specialist implemented a ICSP (Individual Care Service Plan) task for residents who use briefs that included the type and size of brief each resident uses. The intent of this task will be for the direct care staff (CNA's)to view at the beginning of the shift and acknowledge. On 5/13/2019 the Certified Nursing Assistant (CNA's) were in-serviced on how to view the ICSP task and refer to it when needed. * On 5/10/2019 a weekly monitor of this system was initiated x 1 month then monthly by the Central Supply Aide to ensure task in place and cross matched to the appropriate size the resident is using. * For any new Residents who require briefs the Medical Records Specialist will ensure the task is initiated appropriately within 24 hours of entry. * The F558 plan of correction will be completed by the Central Supply Aide and the DON by 6/13/19. All findings will be brought to the monthly Quality Assurance (QA) meeting by Central Supply Aide and/or DON to be monitored and evaluated by the Committee for any further recommendations. The QA committee will consist of the Medical	

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F 558	Continued From page 2 Resident #45. During an interview, on 05/09/19 at 12:10 PM, Resident #45's sister, revealed the staff always put briefs on Resident #45 that is too small, and she has complained on several occasions to the Unit Manager. During an interview on, 05/10/19 at 12:28 PM, CNA #4 revealed the resident has not had any white large briefs in a long time. CNA #4 said she puts the briefs on the residents that are available. During an interview, on 05/10/19 at 12:26 PM, RN #3 revealed the resident is supposed to wear bariatric briefs. RN #3 said she did not know the resident was not wearing the proper briefs. RN #3 said the Director of Nursing (DON) was monitoring the briefs. During an interview, on 05/10/19 at 12:30 PM, the DON stated the bariatric briefs was issued to each resident. The DON stated she did not know the resident was not wearing the appropriate brief. The DON said it is the Unit Manager's responsibility to monitor the briefs, and make sure the CNAs were putting on the appropriate brief's. The DON said the facility has two (2) different types of green briefs. The DON stated after she investigated the briefs, she found out the staff was using the resident's green bariatric brief's for other residents. A review of Resident #45's Face Sheet revealed the facility admitted Resident #45, on 04/25/2016, with diagnoses which included Heart Failure, Systemic Lupus Erythematosus, Hypertension, and Chronic Pain.	F 558	Director, DON, Nurse Educator, Unit Managers, Minimum Data Set Nurse, Central Supply Aide, Dietary, Social Services and Maintenance.	

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F 558	Continued From page 3 A review of Resident #45's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date ARD) of 03/14/2019, revealed Resident #45 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact.	F 558		
F 603 SS=D	Free from Involuntary Seclusion CFR(s): 483.12(a)(1) §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure the resident was free from involuntary seclusion for one (1) of 23 resident observations. Resident #85. Findings include: Review of the facility's Infection Control Policy: Type And Duration of Transmission-Based Precautions Recommended For Selected Infections and Conditions, reviewed/revised	F 603	* On 5/8/2019 the Director of Nursing (DON) referred to the McGreer Criteria for antibiotic use and isolation precautions. Notified the Nurse Practitioner (NP) and informed him of the residents status and current isolation precautions that were in place. After review of the medical record the NP discontinued Resident #85s contact isolation orders on 05/8/2019. The Activities Director reevaluated Resident #85s activity plan and updated her care plan to include out of room activities of	6/13/19

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F 603	Continued From page 4 07/2018, revealed: Infection/Condition: Multidrug-Resistant Organisms (MDROs) infection or colonization (i.e., VRE/Vancomycin Resistant Enterococci, VISA/Vancomycin Intermediate Staphylococcus Aureus, VRSA/Vancomycin Resistant Staphylococcus Aureus, ESBLs/Extended Spectrum Beta-lactamases, Resistant S. pneumonia). Precaution: Standard/Contact Isolation. Comments: Based on local, state, regional or national recommendations. Contact Precautions recommend in settings with evidence of ongoing transmission or in setting with increased risk for transmission or wounds that cannot be contained by dressings. Review of the facility's "Infection Control Standard-Transporting a Resident on Isolation policy, reviewed/revised 07/2018, revealed: It is our standard to take appropriate precautions to prevent transmission of infectious agents. Since able residents interact freely in this facility, and for most residents, this is their home, psychosocial needs will be balanced with infection control needs in an effort to counteract possible adverse effects on residents (i.e. anxiety, depression, stigma, reduced contact with clinical staff). An interview with Resident #85, on 05/7/19 at 9:20 AM, revealed the resident was upset with staff because she could come out of the room on Fridays to go to the activity room and participate in spiritual activities. Resident #85 stated she only came out of her room for Dialysis and appointments. An observation, on 05/8/19 at 9:23 AM, revealed Resident #85 in bed watching television.	F 603	choice. * On 5/8/2019 the DON reviewed for any residents that were on isolation precautions to ensure the isolation was warranted. No other residents identified on isolation precautions at this time. * Beginning the week of 5/8/2019 the Quality Assurance Nurse (QA) or DON will monitor weekly x 1 month then perform a monthly audit for current residents with isolation precautions, ensure that it is warranted and the appropriate protocols are in place. If any residents are identified the care plan will be reviewed to ensure in room activities are planned and out of room activities are included if allowed. * Beginning the week of 5/13/2019 the interdisciplinary team will discuss any resident on antibiotic therapy to ensure isolation precautions are warranted and the resident can participate in room or outside room activities as allowed. * All findings will be brought to the monthly Quality Assurance meeting by the DON to be addressed and the corrective action will be monitored and evaluated by the Committee for further recommendations as needed. The Quality Assurance committee consists of the Medical Director, DON, Nurse Educator, Unit Managers, MDS, Central Supply Aide, Dietary, Social Services and Maintenance.	

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F 603	Continued From page 5 An observation, on 05/8/19 at 4:24 PM, revealed Resident #85 in bed watching television. An observation, on 05/9/19 at 9:25 AM, revealed Resident #85 sitting in bed watching television. An observation, on 05/9/19 at 3:27 PM, revealed Resident #85 in bed watching television. During an interview, on 05/10/19 at 9:28 AM, Certified Nurse Assistant (CNA) #3 stated she had been taking care of Resident #85 since her admission. CNA #3 stated Resident #85 stayed in her room except during dialysis and doctors' appointments due to the resident being placed on contact isolation. CNA #3 did not know why the resident was placed on contact isolation. During an interview, on 05/10/19 at 9:43 AM, revealed Registered Nurse (RN) #3/Unit Manager revealed Resident #3 stays in her room because she's on contact isolation. RN #3 said she discussed this with the Nurse Practitioner (NP) three (3) weeks ago to taking the resident off isolation. RN #3 said the NP stated he would look into it, and see why Resident #85 was still on isolation and take care of it. RN #3 said she also talked to the Director of Nursing (DON) and Assistant Director of Nursing (ADON), and was not able to get information on why the resident was placed on contact isolation. RN #3 said the DON said the resident had been on contact isolation for a long time, and she did not know why. During an interview, on 05/10/19 at 9:46 AM, the DON revealed Resident #85 had been on contact isolation for multiple reasons; however, she did not know when the resident ended the antibiotics.	F 603		

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F 603	Continued From page 6 The DON confirmed Resident #85 should have been taken off contact isolation because there was no need for it. The DON stated she talked to the NP and he discontinued the contact isolation 5/8/2019. During an interview, on 05/10/19 at 9:50 AM, the Activity Director revealed Resident #85 received one (1) on one (1) activities because the resident was on contact isolation. The Activity Director stated she started working for the facility in February, and Resident #85 has been one on one and on contact isolation ever since she had been employed at this facility. During an interview, on 05/10/19 at 12:43 PM, the NP revealed he had talked to the Unit Manager last week to get the information on why Resident #85 was started on contact isolation. The NP stated he could not remember why the resident was placed on contact isolation. The NP stated the Unit Manager did not get back with him with the information. The NP said the DON called him this week and told him the resident has not been on antibiotics (ABTs) in the last two months. The DON asked for orders to remove Resident #85 off contact isolation. During an interview, on 05/10/19 at 1:38 PM, the Assistant Director of Nursing (ADON) stated she was the Infection Control Nurse and she monitors the infections in the building. The ADON also said she started working at this facility in February 2019. The ADON said Resident #85 was on contact isolation and was not taking antibiotics at that time. The ADON was told Resident #85 had been on contact isolation for a long time, and she did not need to worry about it.	F 603		

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F 603	Continued From page 7 A review of the Face Sheet revealed the facility admitted Resident #85, on 07/11/2018, with diagnoses, which included Heart Failure, Major Depressive Disorder, Psychosis, and Dementia. A review of Resident #85's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/28/2019, revealed Resident #85 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact.	F 603		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable	F 623		6/14/19

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F 623	Continued From page 8 before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with	F 623		

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F 623	Continued From page 9 developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to provide the resident/Resident Representative (RR) written notice of transfer to an acute care hospital for one (1) of four (4) residents reviewed for transfer/discharge, Resident #33. Findings include:	F 623	* On 5/9/2019 the Notice of Transfer and Discharge form was completed and sent to the responsible party (RP) designated for Resident #33 by the Business Office Manager. On 5/9/2019 the Administrator obtained the appropriate Notice of Transfer and Discharge form that will be used for any resident	

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F 623	Continued From page 10 Review of the facility's "Transfer and Discharge" policy, dated July 2018, revealed the facility's policy did not reference the Resident/Resident Representative written notification with the required information for the facility initiated transfer to an acute care hospital. Review of the Resident #33's "Progress Note", dated 01/29/2019, revealed Resident #33 was transported to the emergency room by ambulance. Review of Resident #33's "Progress Note", dated 02/01/2019, revealed the resident returned to the facility from the hospital. Review of Resident #33's record revealed a Discharge Minimum Data Set (MDS) dated 01/29/2019, and an Entry MDS dated 02/01/2019. The documents reflect they had been transmitted and accepted. An interview, on 05/09/19 at 9:35 AM, revealed the Administrator stated they call family at the time of the transfer, and the facility does the written notice for the 30 day discharge related to nonpayment or behaviors. The Administrator stated she had not had any of those types of discharges, so no written notices had to be sent out. An interview, on 05/09/19 9:40 AM, with the Business Office Manager (BOM) revealed she was responsible for completing the written notification for the bed holds, and she sends it to everyone at discharge. The BOM said she has not had to write any notifications of a 30 day discharge that would have to be signed by the	F 623	transferred/discharged out of the facility. * Any resident who have a discharge/transfer has the potential to be affected. On 5/13/2019 the Business Office Manager (BOM) audited any discharge/transfers for the past 3 months and made any correction as necessary. * Beginning 5/13/2019 the Business Office Manager will review any current transfers/discharges utilizing the 24 hour report and attendance record during the morning stand up meeting which is held at 9:30 am and send the Notice of Transfer and Discharge form to the resident/Responsible Party Monday through Friday. * On 5/13/2019 the Business Office Manager will perform weekly audits times 4 weeks then perform monthly audits to monitor the efficiency of discharge/transfer notices and ensure that the discharge/transfer notices are sent to the resident/RP. * All findings will be brought to the monthly Quality Assurance meeting by the Business Office Manager for evaluation and any further recommendations. The committee consists of the Medical Director, DON, Nurse Educator, Unit Managers, MDS, Central Supply Aide, Dietary, Social Services, Business office Manager, and Maintenance.	

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F 623	Continued From page 11 Administrator before she sent it to the family. During an interview, on 05/08/2019 at 12:10 PM, with the Social Services Director, (SSD), it was revealed she had not sent any written transfer notifications to a Resident Representative (RR). The SSD stated she had not been trained on the Notification of Resident Transfer Forms and policy, or about the responsibility doing the letter of notification until recently. The SSD stated she had started implementing the written notification of a transfer to the RR on 05/07/2019. The SSD stated she did not know if the previous SSD had been doing them, but she has not found anything to indicate that they did. During an interview, on 05/09/2019 at 1:50 PM, with the Director of Nursing (DON), it was revealed the facility had not been providing a written Notice of Transfer when a resident was sent out to the hospital. The DON stated the facility had made the decision to have the SSD send the written notification to the RR. Review of Resident #33's Face Sheet revealed the facility admitted the resident on 03/15/2018, with diagnoses to include Dementia without Behavioral Disturbances and Fistula of Stomach and Duodenum.	F 623		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide	F 655		6/14/19

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F 655	Continued From page 12 effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record	F 655	* On 5/9/2019 Resident #157's care plan	

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F 655	Continued From page 13 review, the facility failed to address oxygen use by the resident on the Admission Care Plan for one (1) of three (3) new Admission Care Plans reviewed, Resident #157. Findings include: A review of the facility's "Interim Care Plans" policy, no date, revealed: 1. Upon admission of a resident the admitting nurse will evaluate the resident's condition and develop an interim Care Plan (either using PPC or paper format) identifying "At Risk" concerns and relevant interventions. The Interim Care Plans are to be signed by the admitting nurse and communicated to the staff for implementation. 2. Within 24 hours, the RN (Registered Nurse) Unit Manager will validate the accuracy of the Interim Care Plan and add any further identified concerns/interventions and communicate to staff for implementation. Interim Care Plans are reviewed by the IDT (Interdisciplinary Team) to ensure resident care and safety (Morning Meeting, At Risk Meeting, etc...). 3. New admissions are to have an Interim Care Plan in place until the Comprehensive Care Plans are developed and implemented. "Comprehensive Care Plan Process" revealed assigned disciplines determine if a problem/concern exists and to have a care plan developed. A review of the Admission Care Plan and May 2019 physician's orders did not reveal a care plan or order for Resident #157's oxygen use. On 5/7/19 at 4:30 PM, an observation revealed Resident #157 was wearing a nasal cannula tube	F 655	was reviewed and updated with a oxygen care plan and a clarification order for oxygen use was obtained that day by the Director of Nursing (DON). * On 5/10/2019 current resident rooms were assessed to ensure residents currently receiving oxygen had appropriate orders in place and on the care plan, this was completed by the DON. Five residents were identified on oxygen who could be considered at risk, charts were reviewed, orders and care plan in place. * As of 5/10/2019 for new admission to the facility; the admission nurse will assess respiratory status and ensure if oxygen is needed she/he will obtain orders from the Medical Doctor or Nurse Practitioner (NP), the Baseline care plan will reflect oxygen needs. * The DON will perform weekly audits x 4 to ensure any new residents who are on oxygen have appropriate orders in place and the baseline care plan has Oxygen included. * All findings will be brought to the monthly Quality Assurance meeting by the DON for further recommendations as needed. The Quality Assurance Committee consists of the Medical Director, DON, Nurse Educator, Unit Managers, MDS, Central Supply Aide, Dietary, Social Services and Maintenance.	

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F 655	Continued From page 14 that was attached to an oxygen concentrator with the oxygen flowing at two liters per minute (2L/M). Review of Resident #157's physician's orders, dated 5/9/19, revealed a clarification order as of 4/30/19 for Oxygen (O2) PER NC PRN (per nasal cannula as needed) for SOB (shortness of breath) every 8 hours. An interview, on 5/9/19 at 11:28 AM, with Registered Nurse (RN) #1/Unit Manager, revealed Resident #157 did use oxygen at 2 L/M. RN #1 reported she could not find an order for Resident #157's oxygen in her current physician's orders. RN #1 stated Resident #157 did not come from the hospital with oxygen orders, but she did have diagnoses of COPD (Chronic Obstructive Pulmonary Disease) and CHF (Congested Heart Failure), and did require oxygen. RN #1 stated she notified Resident #157's primary provider (Name of Physician) that day, and he said Resident #157 could have oxygen at 2 L/M. RN #1 said she must have forgot to write the order. An interview, on 05/09/19 at 10:35 AM, with Licensed Practical Nurse (LPN) #1/Minimum Data Nurse (MDS) Nurse, confirmed Resident #157 did not have an order or a care plan initiated on admission related to Resident #157's oxygen use. LPN #1 said the care plan would not address the oxygen if the orders or the assessment didn't trigger the care plan. LPN #1 also said the admission care plan should have addressed the oxygen use. An interview, on 05/09/19 at 2:27 PM, with the Director of Nursing (DON) revealed the nurse who took the order for Resident #157's oxygen from the doctor should have wrote the order as	F 655		

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F 655	Continued From page 15 soon as possible. She also confirmed the MDS nurses would not have known to adjust the care plan for oxygen because the order was not written.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for	F 656		6/14/19

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F 656	Continued From page 16 future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to follow the comprehensive care plan related to Suprapubic Catheter care for one (1) of 26 resident care plans reviewed, Resident #98. Findings include: A review of the facility's "Comprehensive Care Plan" policy, dated March 2019, revealed it is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. Review of Resident #98's comprehensive care plan revealed a Focus, with an initial date of 4/18/19, for a Suprapubic Catheter due to Obstructive Uropathy. The Goals stated there will be/remain free from catheter related trauma, and no signs and symptoms (s/s) of a Urinary Tract Infection (UTI). The Interventions/Tasks included: Changing the Suprapubic Catheter as needed for leakage/obstruction, keep the bag and tubing below the level of the bladder, check tubing for	F 656	* Resident #98 was observed by the Director of Nursing (DON) and no infection identified. Resident 98 did not have any irritation around suprapubic catheter site. * Any resident with suprapubic catheters would be at risk. The facility had one other resident with a suprapubic catheter and no issues noted with following the care plan. * On 5/9/2019 nursing staff were provided with an in-service by the Nursing Educator regarding catheter care per care plan, infection control practices to include glove technique, and hand washing. Certified Nursing Assistant (CNAs) were in-serviced by the Nurse Educator regarding how to care for a resident with a catheter per care plan, hand washing, and glove technique. Both nursing staff and Certified Nursing Assistant (CNA) staff were in-serviced by the Nurse Educator on how to follow the care plan during the 5/9/2019 in-service. The Assistant Director of Nursing (ADON) in-serviced Nursing staff and CNA staff 5/9/2019	

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F 656	Continued From page 17 kinks 2-3 times during the shift, monitor for s/s pain/discomfort due to the catheter, and notify the physician of s/s of UTI. On 3/7/19 at 11:22 AM, an observation of suprapubic catheter care for Resident #98 performed by Registered Nurse (RN) #2 and assisted by Certified Nursing Assistant (CNA) #2 revealed, RN #2 and CNA #2 washed their hands and applied clean gloves. RN #2 removed the resident's dressing from around the suprapubic catheter area, washed her hands and applied clean gloves. She then cleaned around the resident's catheter site using a back and forth motion six times. RN #2 washed her hands, applied gloves, and applied a clean dressing to the catheter area. RN #2 and CNA #2 positioned the resident on his back and covered him up with the catheter tubing observed to be underneath the resident's right leg. Review of the most recent comprehensive Minimum Data Set (MDS), assessment with an Assessment Reference Date (ARD) of 4/30/19, revealed the MDS section for Urinary Continence was coded for an indwelling urinary catheter and not rated, resident had a catheter (indwelling, condom) urinary ostomy, or no urine output the entire seven (7) days. Review of the physician's orders for May 2019 revealed an order for a Suprapubic Catheter 18 French (Fr) with 10 milliliter (ML) balloon to gravity drainage. Change suprapubic catheter prn (as needed) due to leakage/obstruction. Clean suprapubic catheter with betadine and apply drainage sponge every day, diagnosis of Chronic Obstructive Uropathy. Suprapubic catheter output every shift.	F 656	through 5/10/2019 on proper hand washing which included a return demonstration by nurses and CNA's. * On 5/13/2019 the Nurse Educator began performing random staff observations of proper performance of catheter care per care plan weekly times 4 weeks and will continue to perform this monthly for CNA's and Nursing staff each month. * All findings will be brought to the monthly Quality Assurance meeting by the Nurse Educator and/or DON to be evaluated and for recommendations as needed. The Quality Assurance Committee consists of the Medical Director, DON, Nurse Educator, Unit Managers, MDS, Central Supply Aide, Dietary, Social Services and Maintenance.	

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F 656	Continued From page 18 On 5/9/19 at 1:51 PM, an interview, with the Director of Nursing (DON), revealed she would expect the staff to follow the comprehensive care plan. On 5/09/19 at 1:52 PM, an interview with the Minimum Data Set (MDS) Nurse ,revealed she would expect the staff to read the care plan and take care of the resident.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the	F 657		6/14/19

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F 657	Continued From page 19 comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to revise the comprehensive care plan related to infection for one (1) of 26 resident care plans reviewed, Resident #89. Findings include: A review of the facility's "Comprehensive Care Planning Process" policy, not dated, revealed care plans are updated as resident condition changes. An observation, on 5/7/19 at 9:39 AM, revealed Personal Protective Equipment (PPE) was hanging on Resident #89's door. A review of Resident #89's physician's orders revealed an order, dated 4/29/19, for contact precautions for Clostridium difficile (C. diff) infection. A review of Resident # 89's current physician's orders revealed the resident had orders, dated 4/23/19, for Vancomycin (antibiotic medication) for the treatment of C. diff. A review of the current comprehensive care plan, for Resident #89, revealed the care plan was not updated to address the resident's C. diff infection and contact precautions. An interview, on 5/7/19 at 10:00 AM, with the Director of Nursing (DON), confirmed Resident #89 was on contact precautions related to a C.	F 657	* On 5/7/2019 resident #89s care plan was updated by the Director of Nursing to reflect infection of C-Diff and isolation precautions. * Any residents identified for infection/isolation needs are at risk. On 5/13/2019 the Assistant Director of Nursing (ADON) reviewed current residents with infection/antibiotic and/or isolation needs and none were identified to ensure the care plan was updated. * On 5/13/2019 the Minimum Data System (MDS) coordinator is running an order recap report for the previous 24 hour period to bring to stand up every AM. Each order is discussed by the interdisciplinary team and care planning completed as needed including infection/isolation needs. * On 5/13/2019 the Quality Assurance nurse began auditing every resident with antibiotic/infection and or isolation weekly x 4 weeks then monthly to ensure appropriate orders and care plans are up to date. * All findings will be brought to the monthly Quality Assurance meeting by the Director of Nursing for further recommendations if needed. The Quality Assurance Committee consists of the Medical Director, DON, Nurse Educator,	

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F 657	Continued From page 20 diff diagnosis, and was still in treatment. An interview, on 05/09/19 at 10:29 AM, with Licensed Practical Nurse (LPN) #1/Minimum Data Set (MDS) Nurse, confirmed Resident #89's care plan had not been updated to address the C. diff infection and contact precautions. LPN #1 said the responsibility was with the nurses in the MDS office, but they don't always receive the orders in a timely manner. LPN #1 also said the physician orders were how they became aware of the changes for residents. An interview, on 05/09/19 at 2:22 PM, revealed the DON said it was "very important" for Resident #89's contact precautions, C. diff diagnosis, and medication to be care planned. The DON confirmed the MDS nurses were the only ones to update the care plan.	F 657	Unit Managers, MDS, Central Supply Aide, Dietary, Social Services and Maintenance.	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that	F 690		6/14/19

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F 690	Continued From page 21 catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, review of the Perry and Potter Eighth Edition, and facility policy review, the facility failed to have a diagnosis to justify Resident #94's catheter, and to provide Resident #98's catheter care in a manner to prevent the possibility of infection. These concerns were identified for two (2) of five (5) catheter care observations. Findings include: A review of facility's "Incontinence Management" policy, reviewed/revised 2013, revealed the use of an indwelling catheter is not justified unless the resident's clinical condition demonstrated the catheterization was necessary. The policy also revealed if the indwelling catheter is not medically justified, it will be discontinued as soon as	F 690	* On 5/9/2019 an order was obtained by the Wound Care nurse to discontinue Resident 94s foley catheter and diagnosis for wound healing. On 5/9/2019 the wound care nurse removed the foley catheter and assessed and no adverse affects noted. * Any residents with catheters are considered at risk, On 5/9/2019 the Director of Nursing reviewed the six residents with catheters, orders, diagnosis, and care plan were in place and no adverse affects noted to the residents. * On 5/9/2019 and 5/10/2019 nurses and Certified Nursing Assistants (CNA's) were	

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F 690	Continued From page 22 clinically warranted. A review of the facility's "Perineal Care Standard" policy, with a revision date of May 2014, revealed wash and rinse area in a circular motion, using clean surface of washcloth for each stroke; or wet wipes if used. Backward and forward movement can introduce contaminants into the urinary tract. A review of Perry and Potter Eighth Edition, page 545 revealed clean skin around insertion site in circular motion, starting near insertion site and continuing in outward widening circles for approximately 5 centimeter (cm). Secure catheter to lateral abdomen with tape or Velcro multipurpose tube holder. Resident #94 An observation, on 05/07/19 at 9:26 AM, revealed Resident #94's catheter was draped over his bed's side rail at the head of the bed. Resident #94 was lying sideways in his bed, and had not called for help or used the call light. Registered Nurse (RN) #2 walked in the room and assisted Resident #94 to reposition himself in bed. RN #2 said the resident had done this before, and would not call for help. Resident #94 stated he was comfortable, but readily repositioned without any distress. An observation, on 5/8/19 at 4:39 PM, revealed Certified Nursing Assistant (CNA) #1 provided Resident #94's catheter without any concerns related to the catheter care technique or infection control measures. An interview with RN #2/Treatment Nurse, on 5/7/29 at 9:30 AM, revealed Resident # 94's	F 690	in-serviced regarding the facility protocol for catheter care, hand washing, and infection control measures by the Nurse Educator. The Nurse Educator performed random observations beginning 5/13/2019 of 6 staff members per week x 4 weeks and will continue to perform random observations for minimum 6 staff per month to ensure proper catheter care is provided. Beginning 5/13/2019 the order recap report is printed every AM and reviewed at the morning stand up meeting by the interdisciplinary team to ensure all catheter orders have appropriate diagnosis and are care planned by the Minimum Data System Nurse. Beginning 5/13/2019 the Quality Assurance nurse and DON review residents with catheters in the weekly High Risk meeting to ensure catheter orders, diagnosis, and care plans are in place. * All findings will be brought to the monthly Quality Assurance meeting by the DON to be evaluated and for recommendations as needed. The Quality Assurance Committee consists of the Medical Director, DON, Nurse Educator, Unit Managers, MDS, Central Supply Aide, Dietary, Social Services and Maintenance.	

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	255326	A. BUILDING _____ B. WING _____	05/10/2019

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F 690	Continued From page 23 Stage III ulcer had healed on his sacrum. A review of Resident #94's physician's orders revealed an order for a Foley catheter noted on 3/28/19 with a diagnosis of sacral wound. An interview, on 05/08/19 at 4:50 PM, with RN #1/Charge Nurse confirmed the orders for a Foley catheter was for the diagnosis of his sacral wound. She said the Treatment Nurse would have to give specifics on the wound healing. An interview, on 05/08/19 at 4:55 PM, with RN #2/Treatment Nurse, confirmed the sacral wound on Resident #94's sacrum was healed. Review of the "Weekly Wound Evaluation" notes, dated 4/10/19, revealed the sacral wound was healed on 4/10/19. An interview, on 05/09/19 at 11:24 AM, with RN #1/Unit Manager, confirmed Resident # 94's catheter was inserted after admission related to a Stage III pressure area on his sacral area. RN #1 said if the wound was healed the catheter needed to be removed. RN #1 also said she would confirm Resident # 94's diagnosis for the catheter. RN #1 said if Resident #94 did not have a diagnosis to continue his catheter use, he needed the catheter to be removed today. An interview, on 05/09/19 at 2:33 PM, revealed the Director of Nursing (DON) said the policy of the facility was to discontinue the Foley catheter when it was no longer needed. She said Resident #94's risk of injury or infections increased with a Foley catheter. She said Resident # 94's Foley catheter should have been discontinued when the	F 690		

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F 690	Continued From page 24	F 690		

wound was healed if he didn't have another diagnosis to justify the use of a catheter.

Review of Resident #94's Admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 4/2/19, 14 Day MDS with an ARD of 4/9/19, and 30 Day MDS with an ARD of 4/21/19, revealed the resident was coded for the use of an indwelling catheter (suprapubic or nephrostomy tube).

Resident #98

On 3/7/19 at 11:22 AM, an observation of suprapubic catheter care for Resident #98 performed by Registered Nurse (RN) #2 and assisted by Certified Nursing Assistant (CNA) #2, revealed RN #2 and CNA #2 washed their hands and applied clean gloves. RN #2 removed the resident's dressing from around the suprapubic catheter area, and washed her hands and applied clean gloves. She then cleaned around the resident's catheter site using a back and forth motion six times. RN #2 washed her hands, applied gloves, and applied a clean dressing to the catheter area. RN #2 and CNA #2 positioned the resident on his back, and covered him up with the catheter tubing observed to be underneath the resident's right leg.

A review of the most recent comprehensive Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 4/30/19, revealed Resident #98's urinary continence was coded for an indwelling urinary catheter and not rated due to the resident had a catheter.

Review of the physician's orders, for May 2019,

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F 690	Continued From page 25 revealed an order for a suprapubic catheter 18 French (Fr) with 10 milliliter (ML) balloon to gravity drainage. Change suprapubic catheter prn (as needed) due to leakage/obstruction. Clean suprapubic catheter with betadine and apply drainage sponge every day, diagnosis of Chronic Obstructive Uropathy. Suprapubic catheter output every shift. On 5/9/19 at 10:52 AM, an interview with RN #1, revealed Resident #98 was admitted with the suprapubic catheter and she has not had to change it yet. She stated the resident's wife said it had just been changed prior to his admission. She also stated the resident is being followed up by a Urologist, and the suprapubic catheter site looks good and has not had any acute changes noted. She then stated "well, yes ma'am there is a problem with the nurse cleaning the catheter area in a back and forth motion," and that RN #2 should have swabbed once in a circular motion and gotten a clean swab to swab again verses swabbing in a back and forth motion. RN #1 also stated she will do a one on one with RN #2. On 5/9/19 at 2:00 PM, an interview with RN #4/Staff Educator, revealed RN #2 should have cleaned the area once and threw the swab away. She stated the facility does training upon hire, annually, and as needed to ensure nurse competency. RN #4 also stated the company provides an in-service calendar and it lets her know when to perform in-services to the staff.	F 690		
F 695 SS=D	Gloria Daughtry Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)	F 695		6/14/19

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F 695	Continued From page 26 § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: . Based on observation, staff interview, resident interview, and facility policy review, the facility failed to ensure oxygen tanks were secured for two (2) of five (5) observations in Resident #157's room, and a physician's order was obtained for Resident #157's oxygen use. This concern was identified for for one (1) of 26 residents reviewed. Findings include: Review of the facility's "Oxygen, Administration - Nasal Cannula/Mask" policy, reviewed/revised 11/2017, revealed the resident's clinical record is checked for a physician's order/obtain a physician's order. Oxygen is a drug and as such, there should be a physician's order for its use. An oxygen sign must be visibly posted. A review of the facility's "Oxygen E-Tanks" policy, revised 11/2017, revealed oxygen cylinders must be secured in racks or by chains. A review of Resident #157's physician's orders for May 2019, revealed the resident did not have a physician's order for oxygen. The facility provided a clarification order as of 4/30/19, on	F 695	* On 5/7/2019 Resident #157's physician was notified by the Director of Nursing (DON) and appropriate Oxygen orders implemented. Oxygen cylinders were removed and secured in the proper storage location within the facility by the Director of Nursing (DON) and Central Supply Aide. * Any resident with oxygen use are at risk. On 5/9/2019 current resident rooms were checked for oxygen by the DON and Assistant Director of Nursing (ADON). The DON and ADON confirmed the 6 residents with oxygen in use have orders and appropriate storage in place. * Beginning 5/9/2019 any new admit will have the respiratory status assessed by the admitting Registered Nurse (RN). Staff to obtain the appropriate orders for use of Oxygen from the Medical Doctor. Oxygen cylinders will be used for activities outside of room to include meals, therapy, and recreational purposes and will be properly stored in the designated area. On 5/20/2019 the Nurse Educator	

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F 695	Continued From page 27 5/9/19, for oxygen two (2) liters per min (minute) as needed. An observation, on 05/07/19 at 9:47 AM, revealed two (2) small oxygen tanks, unsecured, in Resident #157's room by a television stand. Resident #157 did not have an oxygen in use sign on the door. Resident #157 was observed at the same time walking down the hallway assisted by one person with oxygen tubing attached to a small oxygen tank. An observation, on 05/07/19 at 10:49 AM, revealed Resident #157 still had the unsecured oxygen tanks in her room. An observation, on 05/07/19 at 4:30 PM, revealed Resident #157 was wearing a nasal cannula tube that was attached to an oxygen concentrator running at 2L (liters) per minute. An interview, on 05/07/19 4:25 PM, revealed the Director of Nursing (DON) said the facility policy for oxygen was to have a sign on the door, and to secure the oxygen tanks in the appropriate storage area in a box that secures the tanks. The DON confirmed the tanks in the room with Resident #157 were not secured, and she would have them removed immediately. The DON also confirmed the sign was missing on the door, and she would have one placed by the Charge Nurse. An interview, on 5/7/19 at 4:30 PM, revealed Resident #157 said she had been using oxygen at home, and she had her daughter bring the oxygen tanks for her to use while she was in the facility. Resident #157 confirmed that the tanks in the room were hers. The DON, who was present at this time, said they would provide oxygen while	F 695	in-serviced nursing staff and CNA's regarding proper storage, documentation, and monitoring for oxygen. The Nurse Educator also educated the nursing staff on assessing respiratory status and obtaining physician orders for all oxygen residents. Beginning 5/13/2019 the Interdisciplinary team members will discuss any new resident with oxygen in use during the weekly high risk meeting to ensure orders in place. Beginning 5/13/2019 the DON will perform weekly audits for any resident on oxygen to ensure orders and oxygen is stored securely. * All findings will be brought to the monthly QAPI meeting to be evaluated and recommendations as needed. The Quality Assurance Committee consists of the Medical Director, DON, Nurse Educator, Unit Managers, MDS, Central Supply Aide, Dietary, Social Services and Maintenance.	

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F 695	Continued From page 28 she was in the facility, and her daughter could pick her private use tanks up. An interview, on 05/09/19 at 11:28 AM, with Registered Nurse (RN) #1/Unit Manager, confirmed Resident #157 used oxygen. RN #1 confirmed she did not see an order for oxygen when she reviewed Resident #157's current physician's orders. She said Resident #157 did not come from the hospital with physician's orders for oxygen, and said the resident had her family bring her oxygen from home. RN #1 said Resident #157 had a diagnosis of Chronic Obstructive Pulmonary Disorder (COPD) and Congestive Heart Failure (CHF), and did require oxygen. RN #1 said she notified Resident #157's primary provider on the day of admission, and he said Resident #157 could have oxygen. RN #1 said she must have just forgot to write the order. An interview, on 05/09/19 at 10:35 AM, with Licensed Practical Nurse (LPN) #1/Minimum Data Nurse (MDS) Nurse, confirmed Resident #157 did not have an order or a care plan initiated on admission related to the Resident #157's oxygen use. An interview, on 05/09/19 at 2:27 PM, revealed the Director of Nursing (DON) stated the nurse who took the order for Resident #157's oxygen from the doctor should have wrote the order as soon as possible.	F 695		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		6/14/19

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F 812	Continued From page 29 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, record review, and facility policy review, the facility failed to sanitize dishes and pots to prevent the possibility of food borne illnesses for one (1) of three (3) kitchen observations. Findings include: Review of the facility's "Machine Warewashing" policy, not dated, revealed: Standard: All dishes and utensils will be washed and sanitized after each use. Procedure: 2. Set up the dish machine. Check to see of the machine is clean. a. Place scrap trays, wash arm and curtains in proper positions. b. Check detergent supply. Refill or replace containers as necessary. c. Close drain valve tightly. Open fill valves. Fill all tanks to proper level, and then tightly shut all fill valves. d. Turn on heaters. All tank heaters and final rinse. If gas heaters are used, check to be sure they are lit. f. Chlorine test papers are used to test the	F 812	* No one resident was identified. On 5/9/2019 the Director of Nursing (DON) reviewed all residents and no outbreak of foodborne illness identified. * All residents in the facility have the potential to be affected. * On 5/9/2019 the Dietary Manager contacted the vendor for dishwashing services and a representative came on 5/9/2019 and provided an in-service with dietary staff regarding proper use of the dishwashing machine and the sanitation process. Beginning 5/9/2019 the Dietary Manager and/or assistant Dietary Manager will monitor the temperature log every day to ensure the sanitation is maintained per manufacture recommendation of the dishwasher.	

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F 812	Continued From page 30 proper chlorine concentration of the rinse water for each meal. Review of the facility's "Manual Warewashing" policy, not dated, revealed: Standard: Dining service pots and pans that cannot fit in a dish machine are cleaned and sanitized in a three-compartment sink. 3. Wash items in the first sink in a detergent solution of 110 degrees Fahrenheit (F). Replace detergent when suds are gone and water is dirty. 4. Immerse or spray items in the second sink with water at 110 degrees F. Replace rinse water when it becomes cloudy or dirty. 5. Immerse items in the third sink in hot water or chemical sanitizing solution. If hot water immersion is used, the water must be a minimum of 171 degrees F, and items must be immersed for 30 seconds. If chemical sanitizing is used, the sanitizer must be mixed to the proper concentration and the water temperature must be 75 degrees F. 6. The concentration of the sanitizing solution is checked with a test kit. 9. Employees using the three compartment sink documents the chemical strength on the Pot and Pan Chemical Log. The Guidelines for Chemical Sanitizers Chart revealed the Minimum Concentration for Chlorine was 50 PPM (Parts Per Million). Review of the (Name of Dish Machine)'s Operations Guide, no date, revealed: 4. Push and hold the Fill button until the water level in the dishmachine reaches the center notch of the baffle. Press Start button to cycle machine. Verify that chemical is properly dispensed. Machine is not ready to use. 5. Check product supply containers and verify levels are adequate. Replace empty containers as necessary. Verify Chemical delivery for all three chemicals regularly	F 812	* All findings will be brought to the monthly Quality Assurance meeting to be evaluated by the Dietary Manager and for further recommendations as needed. The Quality Assurance Committee consists of the Medical Director, DON, Nurse Educator, Unit Managers, MDS, Central Supply Aide, Dietary Manager, Social Services and Maintenance.	

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F 812	Continued From page 31	F 812		

by watching chemicals drop into funnel of sump. If chemical is not being properly delivered check chemical supply container levels and tubing connections. Replace empty container or secure connections. Contact your service representative if chemical still does not dispense properly. Verify sanitizer levels regularly. Use test strip to ensure sanitizer level is at least 50 PPM and not more than 200 PPM. If the test strip does not indicate proper dosage, check sanitizer supply container levels and tubing connections. Replace empty container or secure connections. Repeat test.

An observation, on 05/09/2019 at 11:24 AM, revealed the Dish Washer/Dietary Staff #1 washed three racks of dishes in the dish machine without soap in the container. Dietary #1 tested the sanitizer level in the dish machine three (3) times, with a different test strip each time, and was unable to get a reading. Then the Dietary Manager got some test strips out of her office and tested the sanitizer level in the dish machine. The machine tested at 50 PPMs. Further observations revealed Dietary Staff #2 washed pots in the three compartment sink without sanitizing them. Dietary Staff #2 tested the soapy water sink and the rinse water sink with the test strips, which did not measure the sanitizer level. During this time the Cook took two large pots from the three compartment sink area and placed them on the stove to use. The Dietary Manager came over and turned on the three compartment sanitizer solution. Then the Cook came over and tested the three compartment sink sanitizer level. The test strip registered at 100 PPM.

During an interview, on 05/09/19 at 11:47 AM, Dietary Staff #1 revealed she forgot to fill the

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F 812	Continued From page 32 soap container before starting the dish machine. Dietary #1 said the other Dietary Manager checked the sanitizer test strips, and changed the chemicals out prior to their shift for the 22 years that she has worked in the kitchen. Dietary Staff #1 also stated she will learn to remember to test the strips and change the chemicals prior to her shift. During an interview, on 05/9/19 at 11:47 AM, Dietary Staff #2 revealed she had not been trained to sanitize the pots. Dietary Staff #2 said she depended on the Cook to put in the sanitizer solution. During an interview, on 05/09/19 at 11:51 AM, the Registered Dietician (RD) revealed if the staff does not wash the dishes with soap, and the pots are not sanitized it could cause bacteria to build up and food borne illnesses. During an interview, on 05/10/19 at 11:54 AM, the Dietary Manager confirmed the dishwasher washed three (3) racks of dishes without soap, and also confirmed the Dietary Staff #2/Cooks' Helper was unable to check the sanitizer levels for the pots. The Dietary Manager revealed the staff was in-serviced by (Name of Dish Machine Company) by the (Name of Dish Machine Company) Supervisor on How to sanitize dishes and pots appropriately.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and	F 880		6/14/19

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F 880	Continued From page 33 comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the	F 880		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE FOREST HEALTH AND REHABILITATION	1116 FOREST AVENUE JACKSON, MS 39206

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 34 circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, record review, and facility policy review, the facility failed to prevent the possible spread of infection for one (1) of one (1) subcutaneous (SQ) injections observed out of 25 medication administration opportunities observed during med pass, Resident #17. Findings include: A review of the facility's "Medication Administration Guidelines--Subcutaneous Medication Administration" policy, revealed to apply gloves before selecting an appropriate site for injection.	F 880	* The Director of Nursing (DON) assessed Resident #17 on 5/7/2019 for adverse effects and none identified. The completion of 1:1 annual competencies were completed with LPN #2 by the Nurse Educator on 5/9/2019. * Any resident who receives injections would be a potential risk. The DON reviewed records for infections on 5/9/19 and noted no adverse outcomes related to injections. * On 5/9/2019 the Nurse Educator performed in-services related to Glove usage, accu-check protocol,	

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F 880	Continued From page 35 A review of the facility's "Infection Control Standard" policy, revealed to wear gloves when it can be reasonably anticipated that contact with blood or other potentially infectious material. A review of Resident #17's physician's orders, for May 2019, revealed an order dated 5/2/19, for Novolog Insulin 100 units per milliliter, inject per sliding scale. An observation, on 05/07/19 at 11:35 AM, revealed Resident #17 received Novolog Insulin 2 (two) Units given SQ by Licensed Practical Nurse (LPN) #2, who did not wear gloves while giving the injection. LPN #2 said she would normally wear gloves when giving intramuscularly (IM) injections, but not with SQ injections. LPN #2 said the IM injection had the risk of blood exposure. When asked if the injection she just administered to Resident #17 exposed her to any body fluids, LPN #2 then confirmed there was a risk of exposure when given SQ injections. An interview, on 05/08/19 at 3:02 PM, revealed the Director of Nursing (DON) stated the policy for the facility was to always use gloves during injections regardless of sites. The DON said it was an "infection control issue." An interview, on 05/09/19 at 2:01 PM, revealed the DON said LPN #2 did have a skills check list, and training on medication administration. An interview, on 05/09/19 2:17 PM, revealed Registered Nurse (RN) #3/Education Nurse confirmed the facility did do a skills check list that included blood glucose monitoring and subcutaneous injections. She said the skills would include using gloves when performing any	F 880	subcutaneous injections (SQ) and blood borne pathogens with staff. The Assistant Director of Nursing (ADON) conducted a PowerPoint presentation, 5/9/2019 and 5/10/2019, on hand washing technique with a return demonstration from nursing staff and CNA staff. Beginning 5/13/2019 Nurse Educator and/or DON will observe residents who receive SQ injections weekly times four weeks then monthly to include a minimum 6 staff members to ensure proper procedure related to infection control. Beginning 5/13/2019 Nurse Educator and/or DON will perform random staff observation of proper glove technique for direct care staff. * All findings will be brought to the monthly Quality Assurance meeting to be addressed by the DON for evaluation and recommendations as needed. The Quality Assurance Committee consists of the Medical Director, DON, Nurse Educator, Unit Managers, MDS, Central Supply Aide, Dietary, Social Services and Maintenance.	

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	255326	A. BUILDING _____ B. WING _____	05/10/2019

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F 880	Continued From page 36 injection. A review LPN #2 skills checks list titled, "Orientation Checklist", provided by the facility was dated 5/31/17, and revealed LPN #2 skills check list included accu-check skills, and gloves. The facility did not provide a more current skills check list to review.	F 880		

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	255326	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/07/2019**

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PINE FOREST HEALTH AND REHABILITATION	**1116 FOREST AVENUE** **JACKSON, MS 39206**

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

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

Electronically Signed | 06/18/2019

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.

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E 000	Initial Comments *EMERGENCY PREPAREDNESS* Survey conducted on 5/7/19 reveals the above facility does not meet all applicable Federal, State and local emergency preparedness requirements. Deficiencies were identified.	E 000		
E 039 SS=E	EP Testing Requirements CFR(s): 483.73(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based.	E 039		6/14/19

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

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E 039	Continued From page 1 (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on document review and interviews, the facility failed to conduct Emergency Prep Testing Requirements Annually of the 'Tabletop Exercise' and 'Community-Based Exercise' for current annual emergency preparedness (EP) plan requirements of 42 CFR §483.73(a). Findings Include:	E 039	1.No resident was specifically identified. 2. All residents could have the potential to be affected 3.Pine Forest Health and Rehabilitation has been in operation since October 1, 2018. The annual exercise for our emergency operation plan is actually not due until the end of September, 2019, however, in the spirit of cooperation we	

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E 039	Continued From page 2 On 5/7/19 at 1:15 PM, the facility failed to provide all portions of the annual emergency preparedness (EP) requirements. Documentation review revealed the 'Tabletop Exercise' and 'Community-Based Exercise' were not conducted and documented within the last calendar year for EP plan.	E 039	contacted Robert Martin a licensed safety consultant with Ameritech Consulting LLC and the exercise will be done before July 8, 2019. The EOP will be reviewed at least annually by the Maintenance Director to assure table top exercise is done. 9/30/2019	