STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255220	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sharkey-Issaquena Nursing Home	431 West Race Street Rolling Fork, MS 39159

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 47158 Based on observations, staff interviews, and facility policy review, the facility failed to conceal the urine collection bag for a resident's indwelling urinary catheter, thus failing to maintain the dignity of a resident, for one (1) of two (2) residents with urinary catheters. (Resident #51). Findings Include: A review of the facility's policy titled Resident Rights revealed, It is the policy of this facility to ensure that the rights of the residents residing at this facility are upheld in the highest regard . 2. Each resident has the right to a dignified existence . During observations on 10/01/24 at 10:50 AM and 1:28 PM, it was noted that Resident #51's door was open, and an indwelling catheter bag was visible hanging on the side of the bed, without a privacy cover. In a follow-up observation and interview on 10/01/24 at 1:29 PM, Registered Nurse (RN) #1 confirmed that the catheter bag had no privacy cover and agreed that it should have been covered to maintain the resident's dignity. During an interview on 10/01/24 at 1:31 PM, the Director of Nursing (DON) verified that Resident #51's catheter bag should have been covered and stated that leaving it uncovered could cause embarrassment for the resident. A record review of the Face Sheet revealed that the facility admitted Resident #51 on 9/11/24 with diagnoses including Neuromuscular dysfunction of bladder.

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.

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

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 47874 Based on record review, staff interviews and facility policy review, the facility failed to accurately complete and request a Preadmission Screening and Resident Review (PASARR) for a resident with a history of mental illness for one (1) of 12 residents reviewed. Resident #106 Findings Include: Record review of the facility policy titled, Pre-Admission Screening PAS/PASRR with a revision date of 6/13 revealed under, Level II PASRR . When Level 1 screening on the PAS (Preadmission Screening) indicates possible Mental Illness or Intellectual Disability/Developmental Disability and related conditions (RC) the DOM (Division of Medicaid) will notify Proper Name to review the case. Record review of the Level 1 PAS (Pre Admission Screening) for Resident #106, with a submission date of 9/30/24, revealed under, Referral Question #28. Does resident have any history of abusing alcohol or drugs? No was marked. #31. Does resident have any history of mental illness? No was marked. #32. Does resident take, or have a history of taking psychotropic medication(s)? No was marked. Record review of the Face Sheet revealed the facility admitted Resident #106 on 9/2/24 with medical diagnoses that included Schizophrenia, Unspecified psychosis, Alcohol use unspecified with intoxication delirium, and Major Depressive Disorder. Record review of the Physician Orders for Resident #106 revealed an order dated, 9/2/24, Cymbalta (antidepressant) 60 MG (milligrams) PO (by mouth) daily. An interview with Social Services (SS) #1 on 10/2/24 at 9:20 AM revealed, she was the person responsible for completing the PAS for residents. She confirmed that she made an error when completing Resident #106's level 1 screening and stated, I did not see that she had a Schizophrenia diagnosis. SS #1 revealed she was aware the resident took an antidepressant medication, but was not aware it was considered a psychotropic medication. She revealed the resident did have a history of alcohol abuse and agreed she did not answer the questions accurately. SS #1 confirmed, if the initial level 1 screen was not completed accurately, Resident #106 might not get the mental health services needed. An interview with the Administrator (ADM) on 10/2/24 at 9:25 AM revealed, it was her expectation for the PASARR's to be completed accurately, so Resident #106 gets any specialized services indicated.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47874 Based on observations, record review, interviews and facility policy review, the facility failed to provide adequate care and treatment to a pressure ulcer to improve healing for Resident #104, for one (1) of 1 resident reviewed for pressure ulcers. Findings Include: Review of the facility policy titled Wound Care with a revision date of 10/2/24 revealed under, Purpose: To provide standardized procedures for the prevention, identification, treatment, and ongoing management of wounds, ensuring the highest quality of care for all residents while maintaining compliance with local, state, and federal regulations . Also revealed under, a. Treatment Plan - A treatment plan will be developed by the wound care team and documented in the resident's medical record. This plan may include: - Cleansing and dressing the wound. - Use of appropriate topical medications or advanced wound care products . An interview with the Director of Nursing (DON) on 10/1/24 at 12:32 PM revealed, she was doing the wound care until the facility hired someone, and explained that Resident #104 came from home with an area like a skin tear on her bottom. She revealed the family told her the resident had the area for a while and thought it was from sitting in a chair for long periods of time. An observation of the sacral area for Resident #104, with the DON, on 10/2/24 at 12:30 PM revealed a broken area of skin that was open, round and located over a bony prominence between the upper aspects of the gluteal fold. The wound bed was 80 percent (%) red granulation tissue and 20 percent (%) white tissue (adherent slough). The wound edges were well-defined and rolled. No redness observed to the peri-wound and no sign of infection was noted. Record review of the Weekly Body Audit for Resident #104 revealed the following documentation: 9/4/24 -Superficial open area measures 1-inch mild redness around area - Lantiseptic applied signed by the DON. 9/11/24 - No redness with no change in open area Lantiseptic applied signed by the DON. 9/16/24 - No change in open area Lantiseptic applied signed by the DON. 9/24/24 - Lantiseptic applied - open area is the same and redness Duoderm ordered per Medical Director signed by the DON. Record review of the Weekly Wound Assessment for Resident #104 revealed the following documentation: Date 9/4/24, Stage 1 & (and) 2, Size .55 inch, Tissue Appearance red, Wound Edge Appearance round intact, Drainage none, Wound Pain Yes sore, Response to Treatment applied Lantiseptic signed by the DON. Date 9/9/24, Stage 1 & (and) 2, Size .55 inch Tissue Appearance red, Wound Edge Appearance round intact, Drainage none, Wound pain sore, Response to Treatment no change signed by the DON. Date 9/24/24, Stage 1 &(and) 2 Size .5-inch x 3/4 (three-fourths) inch, Tissue Appearance, red/white, Wound Appearance red and white, Wound Edges intact, Drainage none, Wound Pain sore Response to Treatment Duoderm q (every) 72 hours signed by the DON. Record review of Resident #104's Medication Administration Record (MAR) for September 2024 revealed an order dated 9/9/24, Lantiseptic Skin Protectant PRN (as needed) not initialed as administered for the month of September. Also revealed an order dated 9/24/24, Duoderm CGF (controlled gel formula) 2.5-inch x 2. 5-inch dressing change every 72 hours, begin 9/24/24. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the DON on 10/2/24 at 12:38 PM revealed Resident #104 admitted to the facility on [DATE] with the area of broken skin to her sacral area. She revealed that she thought the wound was a skin tear or a shearing and was not pressure related. She revealed she called the Medical Director (MD) the day the resident admitted , and he gave an order for Lantiseptic to be applied as needed. The DON acknowledged, I might not have described the wound correctly. She confirmed they had been applying Lantiseptic (barrier ointment) to the open wound from admit until 9/24/24. The DON explained that the MD assessed the wound on 9/23/24 and changed the order to Duoderm for debridement. She confirmed that Lantiseptic was not an appropriate treatment to assist with healing for an open pressure wound and confirmed this could cause deterioration in the wound. She confirmed that her documentation lacked the total area (length x width x depth) of the wound, which was needed to determine if the wound was healing or getting larger. A telephone interview with the Medical Director (MD) on 10/2/24 at 2:12 PM revealed, the first time he assessed Resident #104's sacral wound was on 9/23/24. He revealed that he did not give the wound a number (stage) and described the wound as, Red and had a white film on it. He revealed that the information that was relayed to him when the resident admitted was the wound was a stage 1 and that was why he ordered Lantiseptic. The MD explained that Lantiseptic was a barrier and reduced friction and would be beneficial for a stage 1 wound. He confirmed, after assessing the wound, he determined the wound was not a stage 1, stopped the Lantiseptic and ordered Duoderm. An interview with the Administrator (ADM) on 10/2/24 at 2:30 PM revealed she was not aware that the resident had a pressure wound. She revealed she was told the resident had something like a bite that was being treated. She confirmed Lantiseptic was not an appropriate treatment to promote healing of a pressure wound. The ADM confirmed the wound needed weekly assessments and measurements to track the status to determine if the wound was responding to the treatment or deteriorating. Record review of the Face Sheet revealed the facility admitted Resident #104 on 9/4/24 with a medical diagnosis that included Unspecified dementia.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 47874 Based on staff interview, record review, and facility policy review, the facility failed to ensure a resident receiving an as needed (PRN) psychotropic medication had a stop date for one (1) of two (2) medication reviews. Resident #108 Findings Include: Review of the facility policy titled Psychotropic Medications for PRN (as needed) Use and Gradual Dose Reduction (GDR) Reviews undated, revealed under, Policy: . PRN use of psychotropic medications will be strictly regulated and monitored to comply with CMS (Centers for Medicare and Medicaid Services) regulations and ensure resident safety .Time Limitation: PRN orders for psychotropic medications must be limited to 14 days. After 14 days, the attending physician must review the resident's condition before extending the PRN order for continued use. This review must include a clinical evaluation to determine if continued PRN use is necessary. Record review of the September 2024 Medication Administration Record (MAR) for Resident #108, revealed an order dated 9/3/24, Lorazepam 1 MG (milligram) tablet administer 1 mg (milligram) q (every) 12 hours as needed for anxiety or agitation with no stop date. Documentation revealed the resident received doses on 9/5/24, 9/6/24, 9/11/24, and 9/20/24. An interview with the Administrator (ADM) on 10/2/24 at 9:36 AM confirmed, Resident #108's lorazepam order did not have a stop date. She confirmed the medication should have had a stop date after 14 days to ensure the resident got the least amount of medication required to control her symptoms and re-evaluated by the physician to ensure the continued need. Record review of the Face Sheet revealed the facility admitted Resident #108 on 9/2/24 with a medical diagnosis of Hemiplegia following unspecified cerebrovascular disease affecting the right dominant side.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47158 Based on observations, staff interviews, record reviews, and facility policy review, the facility failed to check and record food temperatures before serving all meals for the last 30 of 30 days. Findings Included: A review of the facility's policy titled Monitoring Temperatures of Cooked Foods revealed, Policy: The temperature of potentially hazardous cooked foods will be monitored to ensure that the foods are not in the danger zone (above 41 degrees F (Fahrenheit) and below 135 degrees F) for more than six hours . Cooking, holding, and storage temperatures should be recorded on a Food Temperature Monitoring Log. These logs should be maintained for at least three (3) months. During an observation of the kitchen on 10/2/24 at 11:35 AM, it was noted that kitchen staff were serving lunch to the dining room residents from the steam table. A record review of the meal temperature logbook revealed there was no documentation for breakfast, lunch, or dinner since 9/2/24. In an interview with the Dietary Manager (DM) on 10/2/24 at 11:40 AM, she stated that the kitchen staff had not been checking or recording the meal temperatures because they did not have a logbook. She admitted that she hadn't considered using a piece of paper to log the temperatures and the logbook had just arrived the previous Friday. She stated that she had instructed the kitchen staff to begin recording meal temperatures before serving food and confirmed that no temperatures had been documented. In an interview with the Dietary [NAME] on 10/2/24 at 11:45 AM, she revealed that food temperatures had not been checked because they did not have a thermometer and stated that they had a thermometer the previous day, but it could not be calibrated. She acknowledged that temperatures were not being taken and recognized that this could pose a health risk to the residents. During a follow-up interview with the Dietary Manager on 10/2/24 at 11:52 AM, she confirmed that the thermometer from the previous day was not working and that she needed to purchase a new one. She stated that she had ordered food thermometers for the kitchen, but they had not yet arrived. She admitted that it did not occur to her to obtain a thermometer from another source. She also verified that failing to check food temperatures could result in foodborne illnesses. In an interview with the Administrator (ADM) on 10/2/24 at 11:58 AM, she confirmed that she was unaware the kitchen did not have a food thermometer and did not check food temperatures at each meal. She emphasized that the purpose of checking food temperatures is to prevent burns to the residents and to reduce the risk of foodborne illness if the food is not maintained at a certain temperature.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47158 Based on record reviews, staff interviews, and facility policy review, the facility failed to establish and maintain an infection prevention and control program designed to prevent the transmission of communicable diseases and infections. This failure was evidenced by the facility's failure to administer a second-step tuberculin (TB) skin test to one (1) of 17 residents (Resident #104) and 34 of 37 employees, who had no documentation of a negative TB skin test within the last 12 months. Findings Include: A review of the facility's policy titled TB Testing MS, with a revision date of 4/14, stated: Resident Testing for Tuberculosis .Residents .shall have a baseline Tuberculin Skin Test (TST) performed with the initial step of a two-step Mantoux TST placed within 30 days prior to the day of admission. The second step shall be administered, read, and documented within 10-21 days of the first step . Employee Testing for Tuberculosis . Employees with a negative tuberculin skin test and a negative symptom assessment shall have the second step of the two-step Mantoux tuberculin skin test administered, read, and documented in the employee's personnel record within fourteen (14) days of employment. Resident #104 A record review of Medication Details for Resident #104 revealed that she received a TB skin test prior to being admitted to the facility on [DATE]. This test was read on 8/30/24 and the result was negative. There was no documentation present indicating that Resident #104 received a second-step TB skin test. In an interview with the DON on 10/3/24 at 10:02 AM, she verified that Resident #104 did not have a second-step TB skin test. Record review of the Face Sheet revealed the facility admitted Resident #104 on 9/4/24 with a diagnosis of Essential Hypertension. Employee Testing A review of the facility's TB Skin Test Placement documentation for new hires revealed that 34 of 37 employees had no documentation of a second-step TB skin test or proof of a negative TB skin test within the last 12 months prior to hire. There was no evidence that any of these employees were offered or received a second-step TB skin test. In an interview with the Business Office Manager on 10/3/24 at 9:15 AM, she stated that she was responsible for coordinating and ensuring that new employees receive TB skin tests. She admitted that she was not aware that employees were required to have a two-step TB skin test if they did not have proof of a negative TB skin test within the last 12 months. During an interview with the Administrator (ADM) and Director of Nursing (DON) on 10/3/24 at 10:00 AM, they both stated that they had never heard that a two-step TB skin test was required for staff or residents and confirmed that the facility had always only performed one TB skin test. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview with the Social Worker (SW) on 10/3/24 at 10:10 AM, she explained that she is responsible for coordinating admissions and ensuring that residents have the required paperwork before admission. She stated that the first step of the TB skin test is required before admission, and one of the TB Certified Registered Nurses (RN's) is responsible for following up and completing the second-step TB skin test. The SW added that the facility used to perform a two-step TB skin test but had stopped doing so, and she was unsure why. In a follow-up interview with the ADM, on 10/3/24 at 10:15 AM, she agreed that a second-step TB skin test should have been performed on the 34 employees and Resident #104. She acknowledged that not administering a TB skin test to staff or residents could potentially spread TB within the facility.