STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255327	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martha Coker Green House Home	2041 Grand Ave Yazoo City, MS 39194

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 47158 Based on record review, staff interviews, and facility policy review, the facility failed to accurately code the Minimum Data Set (MDS) assessment for discharge deposition for one (1) of 15 elder assessments reviewed. Elder #58 Findings included: Record review of Facility Policy titled, Conducting an Accurate Resident Assessment revealed, Policy: The purpose of this policy is to assure that all residents receive an accurate assessment . Record review of the Notice of Transfer/Discharge Notice dated 7/29/24, for Elder #58 revealed that the elder discharged to an alternative nursing home. Record review of Elder #58's Discharge return not anticipated MDS, with an Assessment Reference Date (ARD) of 7/29/24, revealed discharge status was coded as 04, indicating that the elder was discharged to a Short-Term General Hospital. During an interview with the MDS Coordinator on 9/25/24 at 10:47 AM, she confirmed that Elder #58 discharged to another long-term care facility and that the MDS was coded incorrectly. She stated it was a data entry error. She agreed that the importance of correctly coding the MDS accurately is to identify where the resident is located. An interview with the Administrator on 9/25/24 at 11:00 AM, revealed the MDS should have been coded correctly. Record review of the Admission Record revealed that facility admitted Elder #58 on 6/18/24 with a diagnosis of Diabetes Mellitus.

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 47158 Based on record reviews, staff interviews, and facility policy reviews, the facility failed to submit a correct Pre-Admission Screening and Resident Review (PASRR) for an Elder identified as having a mental illness. This issue involved one (1) of three (3) elders reviewed for PASRR. Elder #8. Findings Included: A review of the facility's policy titled Resident Assessment-Coordination with PASARR Program revealed: This facility coordinates assessments with the preadmission screening and resident review (PASARR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receive care and services in the most integrated setting appropriate to their needs. A record review of the PASRR, dated 12/27/23, for Elder #8 revealed that he had a diagnosis of Schizophrenia; however, question 31 was answered no, indicating that the Elder did not have a history of mental illness. Further review of the Pre-Admission Screening and Resident Review Determination (PASRR) for Elder #8 revealed the following outcome: Level 1 Outcome: Closed-Canceled/Withdrawn. Level 1 Outcome Comments: This PASRR will be canceled due to lack of documentation available to support the individual's diagnoses. A status change can be submitted upon retrieval of further information to support the individual's diagnoses. During an interview with Medical Records on 9/25/24 at 12:30 PM, confirmed that the PASRR had been completed incorrectly by indicating that Elder #8 did not have a mental illness. She also verified that there was no indication that a status change had been submitted to correct the error. In an interview with the Administrator on 9/25/24 at 1:16 PM, she agreed that a status change should have been submitted for Elder #8. She acknowledged that the purpose of a PASRR is to ensure the resident is properly placed and to make sure that the resident receives any additional interventions they may need. A review of the Admission Record revealed that the facility admitted Elder #8 on 12/19/23 with a diagnosis of Schizophrenia. Record review of the Minimum Data Set with an Assessment Reference Date of 9/13/24 Section I revealed a diagnosis of Schizophrenia.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 47874 Based on observation, elder and staff interview, record review, and facility policy review, the facility failed to implement a comprehensive care plan for nail care for two (2) of sixteen sampled elders. Elder #7 and #31 Findings Include: Review of the facility policy titled Comprehensive Care Plans date implemented 10/2022 revealed, Policy: 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 timeframe's to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. Resident #31 Record review of Elder #31's Care Plan with a revision date of 9/11/2024 revealed, Focus: Elder has an ADL (activities of daily living) self-care performance deficit r/t (related to) impaired balance, musculoskeletal impairment cervical disc disorder with myelopathy, paraplegia. Also, revealed under, Interventions: . Personal Hygiene . Elder is totally dependent on staff for personal hygiene . x (times) 1 staff assist q (every) shift. Keep nails clean and trimmed. On 9/24/24 at 11:25 AM, an observation and interview with Elder #31 revealed long jagged fingernails on both hands measuring approximately three-eighths (3/8) inch in length with a dark brown substance underneath. The elder revealed he would like his nails cut. An interview and observation, with Registered Nurse (RN) #1, on 9/24/24 at 11:32 AM confirmed Elder #31's nails were long and dirty. Record review of the Admission Record revealed the facility admitted Elder #31 on 1/05/24 with a medical diagnosis of Cervical Disc Disorder with Myelopathy. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/02/24 revealed, under section C, a BIMS summary score of 15, which indicated Elder #31 was cognitively intact. Resident #7 Record review of Elder #7's Care Plans revealed Focus: Elder has an ADL (activities of daily living) self-care performance deficit r/t (related to) Alzheimer's, confusion, dementia, limited mobility, bilateral contractures lower ext (extremities). Also, revealed under, Interventions: . Personal Hygiene . Elder is totally dependent on (2) staff for personal hygiene Provide nail care, keep clean and trimmed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation and interview, on 9/24/24 at 11:40 AM, with Elder #7 revealed long fingernails observed on both hands, measuring approximately one-half (1/2) inch in length. The elder voiced it had been a while since her nails had been cut and revealed she would like it done. On 9/25/24 at 7:40 AM, an interview with RN #1 confirmed Elder #7's nails were long and needed to be cut. Record review of the Admission Record revealed the facility admitted Elder #7 on 11/02/21 with a medical diagnosis of Alzheimer's Disease. Record review of the MDS with an ARD of 8/5/24 revealed, under section C, a Brief Interview for Mental Status (BIMS) summary score of 10, which indicated Elder #7 was moderately cognitively impaired. In an interview with the MDS Nurse on 9/25/24 at 2:32 PM, she stated the care plan provides the guided care the staff were supposed to follow. She confirmed the care plan was not followed, related to nail care for Elder's #7 and #31.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 47874 Based on observation, elder and staff interview, and facility policy review, the facility failed to provide the necessary nail care for an elder dependent on staff for assistance with Activities of Daily Living (ADL) for two (2) of sixteen sampled elders. Elder #7 and #31 Findings Include: Review of the facility policy titled, Nail Care dated 10/2022 revealed, Policy: The purpose of this procedure is to provide guidelines for the provision of care to a resident's nails for good grooming and health . 3. Routine cleaning and inspection of nails will be provided during ADL care on an ongoing basis Resident #31 During an observation and interview on 9/24/24 at 11:25 AM, with Elder #31 revealed long jagged fingernails on both hands measuring approximately three-eighths (3/8) inch in length with a dark brown substance underneath. The elder revealed he would like his nails cut. On 9/24/24 at 11:32 AM, an interview and observation with Registered Nurse (RN) #1 revealed the Shahbaz's were responsible for cutting the elder's nails that were not diabetic. She explained that if an elder was a diabetic, the nails must be cut by a RN and diabetic nails were usually cut monthly. RN #1 revealed Elder #31 was a diabetic and confirmed his nails were long and dirty, which could result in skin injury and infection. Record review of the Admission Record revealed the facility admitted Elder #31 on 1/05/24 with a medical diagnosis of Cervical Disc Disorder with Myelopathy. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/02/24 revealed, under section C, a BIMS summary score of 15, which indicated Elder #31 was cognitively intact. Resident #7 During an observation and interview, on 9/24/24 at 11:40 AM, with Elder #7 revealed long fingernails observed on both hands, measuring approximately one-half (1/2) inch in length. The elder voiced it had been a while since her nails had been cut and revealed she would like it done. An interview with RN #1 on 9/25/24 at 7:40 AM, confirmed Elder #7's nails were long and revealed she could easily scratch herself. Record review of the Admission Record revealed the facility admitted Elder #7 on 11/02/21 with a medical diagnosis of Alzheimer's Disease. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the MDS with an ARD of 8/5/24 revealed, under section C, a Brief Interview for Mental Status (BIMS) summary score of 10, which indicated Elder #7 was moderately cognitively impaired. An interview with the Administrator (ADM) on 9/25/24 at 1:48 PM, revealed, it was her expectation for nail care to be done daily. She explained that nail care was part of personal hygiene and should be looked at during bathing and done when needed.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47874 Based on observation, staff interview, record review, and facility policy review, the facility failed to maintain a clean and sanitary refrigerator, label, and date open items in the refrigerator and freezer for one (1) of six (6) houses and failed to check and record food temperatures before serving meals for four (4) of six (6) houses reviewed during survey. Findings Include: House #5 Review of the facility policy titled, Cleaning of Food and Nonfood Contact Surfaces with a revision date of 1/24, revealed under, Food Contact Surfaces . To prevent cross -contamination, kitchenware and food-contact surfaces of equipment shall be washed, rinsed, and sanitized after each use and following any interruption of operations during which time contamination may have occurred. Also revealed, Food Contact Surfaces (meaning: those surfaces of equipment and utensils which food normally comes in contact, and those surfaces from which food may drain, drip, or splash back onto food or surfaces normally in contact with food.) Review of the facility policy titled Dating and labeling of Food in Production undated, revealed under, Standard: All foods, including prepared items, bulk foods, frozen foods, and ingredients present in a (Proper Name) facility must be labeled at all times. Foods requiring a date mark shall be labeled with the common name, preparation date, discard date, and associate initials. Initial tour of the kitchen at House # 5 on 9/24/24 at 11:55 AM, revealed a white refrigerator in the pantry area contained an empty, brown, cardboard egg crate in the bottom of the refrigerator that was observed to be wet with a white substance. The shelf above held two (2) containers of milk that were not stored in an upright position which resulted in milk leaking into the bottom of the refrigerator and on the egg carton. An observation on 9/24/24 at 12:06 PM, of the refrigerator in the kitchen area of the House #5 revealed a dark red liquid that covered the interior bottom of the refrigerator pull out crisper drawer. The top crisper drawer contained a large package [5 pounds (lbs.)] of sliced cheese with a torn blue wrapper that was undated and was dried out and hard around the edges. The freezer side of the refrigerator held a large clear plastic bag of tater tots that had been opened and was unlabeled and undated. An interview with Shahbaz #3 on 9/24/24 at 12:11 PM, revealed that anyone could clean out the refrigerators when they were dirty and needed cleaning. She explained the red substance in the kitchen refrigerator crisper drawer was blood from raw ground beef that had been stored until it was cooked for lunch today. She stated, It must have leaked out of the bag. Shahbaz #3 confirmed the sliced cheese was not any good and should be thrown away. She revealed the cheese, and the tater tots had been opened and were not labeled and dated but should have been. She confirmed the pantry refrigerator had spilled milk that had saturated the lower refrigerator. Shahbaz #3 revealed all the issues identified could make the Elder's sick. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	House #1, #2, #4, and #6 Temperature Logs Review of the facility policy titled, Food Handling Guidelines (HACCP) Hazard analysis and critical control points, with a revision date of 1/24, revealed Minimum Safe Internal Temperatures: Hot food temperatures must be checked before the cooking process is ended. Hot Holding Temperatures: Foods should be held hot for service at a temperature of 135 degrees or higher. Cold Holding Temperatures: Foods should be held cold for service at a temperature of 41 degrees or less. Record review of the September 2024 Food Temperature Logs for House # 1 revealed the breakfast and lunch meal temperatures were not logged for the dates of 9/2, 9/9, 9/10, 9/16, and 9/23. The facility was unable to account for the meal temperature logs for the dates of 9/3, 9/4, 9/5, 9/6, 9/7, 9/8, 9/11, 9/12, 9/13, 9/14, 9/15, 9/17, 9/18, 9/19, 9/20, 9/21, 9/22, 9/24, and 9/25. Record review of the September 2024 Food Temperature Logs for House # 2 revealed the lunch and dinner temperatures were not logged for 9/1, 9/2, 9/7, and 9/8. The dinner temperatures were not logged for the following dates 9/3, 9/4, 9/5, 9/9, 9/10, 9/11, 9/12, 9/13, 9/14, 9/15, 9/16, 9/17, 9/18, 9/19, 9/20, 9/21, 9/22, 9/23, and 9/24. Record review of the August 2024 Food Temperature Logs for House #4 revealed the breakfast and lunch meal temperatures were not logged for the dates of 8/14, 8/15, 8/16, 8/17, 8/18, 8/19, 8/20, and 8/21. The facility was unable to account for the meal temperature logs from 8/22/24 until 9/25/24. On 9/24/24 at 12:00 PM, at House #4 an interview with Shahbaz #2 revealed she did not check the food temperatures for the lunch meal today. She revealed that she was sure she was trained to check the temperatures but confirmed she had not been checking them for any meal she had cooked in a long time. Record review of the September 2024 Food Temperature Logs for House #6 revealed the Dinner temperatures were not logged for the following dates 9/14, 9/16, 9/18, and 9/20. On 9/15 and 9/17 the temperatures were not logged for breakfast, lunch, or dinner. On 9/19 the temperatures were not logged for lunch and dinner. The facility was unable to account for the meal log for the dates of 9/1-9/13, 9/21, 9/22, and 9/23. An interview with Shahbaz #4 on 9/25/24 at 10:38 AM, in House # 6 revealed the food temperatures were to be checked before serving each meal and logged. She confirmed there was missing documentation in the logbook to prove that the temperatures were being checked with each meal. She explained that staff do the temperatures out of habit and then forget to log it down because they get busy and forget. Shahbaz #4 confirmed, if it is not logged, there would be no way to ensure that it was done. An Interview with Shahbaz #1 on 9/24/24 at 12:05 PM, revealed she was not safe certified and had no knowledge of checking the holding food temperatures. She voiced that she was not trained in that. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the Registered Dietician (RD) on 9/25/24 at 12:51 PM, revealed that the Shahbaz's were trained upon hire on the duties in the kitchen including taking and logging holding food temperatures, cleaning and the storage of food products. He revealed this was part of their job responsibilities. He revealed each house has a safe serve certified Shahbaz that does the cooking. The RD confirmed that the food holding temperatures should be checked before serving every meal. He revealed all Shahbaz's were trained, and they have also had in-services on ensuring foods were labeled and dated when they opened. He revealed the blood left in the refrigerator crisper tray was not acceptable and should have been cleaned at the point it was observed. The RD confirmed these things discussed could make the elders sick. He stated, It could cause food poisoning, at the very least some upset stomachs. He then revealed he was unable to find any food temperature logs for the Month of September 2024 for House #4 and found blanks in the temperature logs for Houses #1, #2, and #6. In a follow-up interview with the RD on 9/25/24 at 3:05 PM, revealed the facility does not have any forms that the house's document the cleaning of the refrigerators. He revealed he audits the houses at least monthly for cleanliness, storage of items, items labeled and dated, and the problems were reported to the Administrator and the Shahbaz Coordinator. An interview with the Administrator (ADM) on 9/25/24 at 1:48 PM, revealed that they were making audits on the houses weekly to ensure the food temperatures were being done and logged but had since changed to monthly. She revealed the Shahbaz's knew that when things were opened, they must be labeled and dated and voiced they all had been in-serviced on this. She confirmed that when the refrigerator needed cleaning because of a spill, it should be cleaned and not left for someone else. The ADM explained that they go over all these things and the kitchen responsibilities monthly in the Shahbaz meeting. She confirmed that these issues discussed could cause spoilage of food or an infection for the Elders.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 47874 Based on observation, staff interview, record review, and facility policy review, the facility failed to use hand hygiene during wound care to prevent the possibility of the spread of infection for one (1) of four (4) care observations. Elder #44 Findings Include: Review of the facility policy titled Clean Dressing Change with no revision date revealed under, Policy: It is the policy of this facility to provide wound care in a manner to decrease potential for infection and/or cross-contamination. Record review of Elder #44's Treatment Administration Record (TAR) for September 2024, revealed an order dated 9/24/24, Apply collagen powder to wound bed. May dampen collagen powder with normal saline before application. Apply sureprep to peri area around wound, cover with bordered dressing daily until healed. every day shift for sacral wound. An observation of sacral wound care for Elder #44, with Licensed Practical Nurse (LPN) #1 on 9/25/24 at 11:40 AM, revealed she removed the soiled dressing from the sacrum and continued the treatment to the wound without performing hand hygiene and applying a new pair of gloves. An interview with LPN #1 on 9/25/24 at 11:47 AM, confirmed she did not wash her hands after removing Elder #44's soiled dressing. LPN #1 revealed she should have washed her hands to ensure the wound did not get infected. An interview with the Infection Control Nurse on 9/25/24 at 3:36 PM, confirmed improper hand hygiene during wound care was an infection control concern and could cause a wound infection. Record review of the Admission Record revealed the facility admitted Elder #44 on 2/09/21 with medical diagnoses that included Unspecified Dementia and Pressure Ulcer of Sacral region stage 3.