MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04AC	A. BUILDING: _____ B. WING _____	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATTALA COUNTY NURSING CENTER	326 HIGHWAY 12 WEST KOSCIUSKO, MS 39090

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) conducted an annual re-certification survey and a complaint investigation (CI) MS #23326 at the facility from 11/6/23 to 11/8/23. During the survey, the SA determined that the facility was not in compliance with the Mississippi Regulations for Minimum Standards for Institutions for the Aged or Infirm and cited M650 and M1210 during the survey. The facility was found to be in compliance with CI MS #23326 related to call lights within reach of residents. The facility is licensed for 120 beds and at the time of the survey the census was 103.	M 000		
M 650	45.21.10 Hydration Hydration. Each resident shall be provided sufficient fluid intake to maintain proper hydration and health. This Statute is not met as evidenced by: Level II Based on observation, resident and staff interview, record review, and facility policy the facility failed to follow a physician prescribed fluid restriction for one (1) of five (5) residents on fluid restriction. Resident #72. Findings include: A review of the facility policy titled, "Fluid Restriction," revised 02/22, revealed Policy: "Fluids will be restricted as directed by physician's orders." An observation and interview with Resident #72 on 11/6/23 at 11:00 AM, revealed six (6) eight (8) ounce bottles of water and seven (7) eight-ounce	M 650	*On 11-09-23, the Director of Nursing assessed resident #72 with no negative findings noted. On 11-07-23, the Director of Nursing and Medical Records Nurse removed beverages from resident #72 room and Staff Development Nurse notified resident #72 Resident Representative of orders for fluid restriction and removal of beverages 11-07-23, and Director of Nursing notified Physician about resident #72 noncompliance with fluid restriction on 11-09-23. *Five of one hundred five residents have orders for fluid restrictions and have the potential to be affected by the deficient practice.	12/7/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04AC	A. BUILDING: _____ B. WING _____	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATTALA COUNTY NURSING CENTER	326 HIGHWAY 12 WEST KOSCIUSKO, MS 39090

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 650	Continued From page 1 Shasta cola's on the bedside table. Resident #72 stated she keeps the drinks left on her meal trays so she can drink them later. Resident #72 confirmed she was on Dialysis but was unsure if she was on a fluid restriction and stated, "I drink as much as I want because I don't pee very much and even drinking more, I still don't pee very much, I just don't know why." A review of the Physician's Telephone Order dated 8/02/23 for Resident #72 revealed, an order for "1500 ml (milliliter) Fluid Restriction: Dietary to provide 1080 ml with meals. Nursing allowed to provide 180 ml day shift, 120 ml in the evenings, and 120 ml on night shift." An observation and interview with Licensed Practical Nurse (LPN) #2 on 11/07/23 at 7:45 AM, she confirmed Resident #72 had several bottles of water and Shasta drinks on her bedside table and revealed that Resident #72 was on fluid restriction because she is on Dialysis and should not have all those drinks in her room. LPN #2 revealed it was possible for Resident #72 to consume over her recommended fluid restriction with all the drinks on her bedside table and staff would not know the total amount of fluids consumed and a potential concern would be fluid overload. An interview with Certified Nurse Assistant (CNA) #1 on 11/7/23 at 7:55 AM, she confirmed Resident #72 was on a fluid restriction and revealed she knew the drinks were in Resident #72's room because the resident likes to keep the drinks left on her meal trays. CNA #1 also revealed she did not remove the drinks from the room because the nurse did not tell her to. An interview with the Director of Nursing (DON)	M 650	*Beginning 11-09-23, Director of Nursing and Staff Development Nurse immediately initiated in-services with Registered Nurses and Licensed Practical Nurses in policies titled "Fluid Restriction" with a revision date of 02/22 and "Hydration Policy" with a revision date of 05/13, that included adhering to fluid restrictions as ordered. In-services will be ongoing until all Registered Nurses and Licensed Practical Nurses have been in-serviced. The facility Quality Assurance Committee meeting was held 11-09-23 with the committee consisting of Administrator, Director of Nursing, Medical Director, Infection Preventionist, MDS Nurse and CNA with policies titled "Fluid Restriction" with revision date of 02/22, and "Hydration Policy" with a revision date 05/13, with no changes made to the policies. *Beginning 11-13-23, Director of Nursing and/or Staff Development Nurse will monitor by observation on form titled "Fluid Restriction" to ensure no fluids left in resident rooms with orders for fluid restriction on three residents weekly for four weeks then monthly for three months. The Quality Assurance Committee will address concerns identified from the reviews monthly for four months and make recommendations or changes as needed. The Quality Assurance Committee will meet 11-09-23 and 12-04-23, and then monthly thereafter for four months to review monitoring of policies and procedures to ensure compliance achieved until resolved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04AC	A. BUILDING: _____ B. WING _____	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATTALA COUNTY NURSING CENTER	326 HIGHWAY 12 WEST KOSCIUSKO, MS 39090

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 650	Continued From page 2 on 11/07/23 at 9:29 AM, she confirmed Resident #72 was on a fluid restriction and should not have fluids left in her room and a possible concern would be the resident could drink extra fluids leading to fluid overload related to her End-stage Renal Disease. Record review of the Facesheet revealed that the facility admitted Resident #72 to the facility on 8/02/23 with diagnoses that included End Stage Renal Disease and Heat Failure. Record review of the open quarterly Minimum Data Set (MDS) Section C with an Assessment Reference Date (ARD) on 11/03/23, revealed that Resident #72 had a Brief Interview for Mental Status (BIMS) score of 13 which indicated that she was cognitively intact. A record review of the admission MDS Section O dated 8/09/23, revealed Resident #72 received dialysis while a resident at the facility.	M 650		
M1210	45.40.7 Walls and Ceilings Walls and Ceilings. All walls and ceilings shall be of sound construction with an acceptable surface and shall be maintained in good repair. Generally the walls and ceilings should be painted a light color. This Statute is not met as evidenced by: Level II Based on observation, staff and resident interview, and facility policy review the facility failed to maintain a safe environment as	M1210	*Resident #70 was assessed by the Director of Nursing on 11-09-23 and no adverse effects noted. An in-service was conducted with the Maintenance Supervisor by the Administrator on policy titled, "Maintenance and Repairs" on 11-09-23. On 11-06-23 the Maintenance	12/7/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04AC	A. BUILDING: _____ B. WING _____	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATTALA COUNTY NURSING CENTER	326 HIGHWAY 12 WEST KOSCIUSKO, MS 39090

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M1210	Continued From page 3 evidenced by a splintered chair rail molding for one (1) of 62 resident rooms observed. Resident #70. Findings include: Record review of the facility policy titled, "Maintenance and Repairs", with a revision date of 12/22, revealed "Purpose, To reduce risks and vulnerabilities..." An observation on 11/7/23 at 8: 20 AM, revealed an 18 inch section of wooden chair rail molding, located on the wall beside the residents bed that was splintered, jagged and sticking out toward the foot of Resident #70's bed. During an interview with Licensed Practical Nurse (LPN) #1 on 11/7/23 at 8:22 AM, she stated that if there was something broken in a residents room, they put the information on the log at the nurses station for Maintenance Staff #1. She stated he has to check and sign it daily. During an interview with Resident #70 on 11/7/23 at 8:30 AM, she stated that she did not know how long the wood had been splintered. During an observation and interview with LPN #1 on 11/7/23 at 8:32 AM, she confirmed the wooden chair rail molding was splintered and sticking out. She stated that she was not aware it was broken and stated that it could cause resident injury. A record review of the facility's "Maintenance and Repair Log" for 9/6/2023 through 11/7/2023 revealed no documentation that the chair rail molding in Resident #70's room was in disrepair. During an interview with Maintenance Staff #1 on	M1210	Supervisor removed the jagged molding from the wall. *All one hundred five residents have the potential to be affected by the deficient practice. *Staff consisting of maintenance, housekeeping, laundry, licensed practical nurses, registered nurses, and certified nurse assistants were in-serviced by the Director of Nursing and/or Staff Development Nurse on the policy titled, "Maintenance and Repairs", beginning on 11-09-23. The Facility Quality Assurance committee was held on 11-09-23, with the committee consisting of Administrator, Director of Nursing, Medical Director, Infection Preventionist, Minimum Data Set Nurse, and Certified Nurse Aide, with policy titled, "Maintenance and Repairs" with no changes made to the policy. *Beginning 11-13-23, the Administrator and/or Administrative Assistant will monitor the Maintenance and Repairs checklist, located at Desk One and Desk Two Nurse's Station on bulletin boards, weekly for four weeks then monthly for three months. Beginning 11-13-23, the Administrator and/or Administrative Assistant will monitor five rooms per day, weekly for four weeks and monthly for three months. The Quality Assurance committee will address concerns identified from the checklist monthly for four months and make recommendations or changes as needed. The Quality Assurance committee will meet 12-04-23 and then monthly thereafter for four months to review monitoring of procedures to ensure compliance achieved until resolved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04AC	A. BUILDING: _____ B. WING _____	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATTALA COUNTY NURSING CENTER	326 HIGHWAY 12 WEST KOSCIUSKO, MS 39090

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M1210	Continued From page 4 11/7/23 at 8:38 AM, he stated he was not aware that the wooden chair rail molding was in disrepair. During an interview on 11/7/23 at 12:46 PM, the Administrator stated that the facility makes periodic safety rounds in rooms, but missed the splintered chair rail molding in Resident #70's room. A record review of the facility's most recent "Safety Checklist", dated 10/27/23, for Resident #70's room revealed no documentation that the chair rail molding was in disrepair. During an interview on 11/7/23 at 1:43 PM, with the Administrator revealed that the splintered wood on the chair rail molding could cause an injury to the resident. Record review of Resident #70's Facesheet revealed that she was admitted to the facility on 10/16/2023, with diagnoses of Cerebral Infarction and Diabetes Mellitus. Record review of Resident #70's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/25/23 revealed a Brief Interview for Mental Status (BIMS) score of 14, indicating the resident is cognitively intact.	M1210		