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
	76GC	A. BUILDING: _____ B. WING _____	08/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY MANOR NURSING AND REHABILITAT	1935 NORTH THEOBOLD EXTENSION GREENVILLE, MS 38704

(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 a licensure survey from 8/12/19 to 8/15/18. During the survey the SA determined the facility was not in compliance with the Minimum Standards for The Institutions For The Aged And Infirm. The SA cited the state statutes M500 and M655. The census at the time of entrance was 58, and the facility was certified for 60 beds.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to	M 500		9/23/19

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M 500	Continued From page 1 participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this	M 500		

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M 500	Continued From page 2 responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as	M 500		

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M 500	Continued From page 3 documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level II Based on observation, staff interview, resident interview, record review and facility policy review, the facility failed to ensure the resident's right to receive appropriate medical care as evidenced by Resident #43 did not receive a skin treatment	M 500	*Resident #43 was assessed for adverse effects of the deficient practice on 9/4/19 by Licensed Practical Nurse#2 and no adverse effects were noted. Resident #43 had orders implemented for care and treatment of her skin condition on 8/14/19 by Medical Records Licensed Practical	

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M 500	Continued From page 4 as ordered by a physician for one (1) of three (3) resident skin observations, and Resident #36 did not receive arthriticmedication as ordered by the physician for one of two (1 of 2) residents reviewed for pain management. . Findings include: Record review of the facility's policy titled, " Prevention and Treatment of Skin Issues", dated 2/17, revealed it is the policy to properly identify and assess residents whose clinical conditions increase the risk for impaired skin integrity, and pressure ulcers; to implement preventative measures: and to provide appropriate treatment modalities for wounds according to industry standards of care. Record review of the facility's policy titled, "Pain Screen and Management", dated 9/18 revealed all residents who experience routine pain receive a comprehensive pain screening and a treatment plan until acceptable level of relief is achieved. Resident #43 On 08/12/19 at 12:33 PM, an observation revealed Resident #43 was sitting in the dining room at a table with noted swelling and blistered areas on her front lower extremities. Review of Resident #43's Physician's Order Details from the (Name of Hospital) Wound Healing Center, dated 8/1/19, revealed: Discharge from wound care clinic. Call for appointment if needed. May shower without dressing. Keep skin clean and well moisturized (with cream such as Aquaphor) daily. ACE 6X5 (Compression Bandage six inches by five feet) to Bilateral Lower Extremity (BLE) as needed	M 500	Nurse. * Seventeen of the fifty-six residents have the potential to be affected by the failure to implement orders for care and treatment of skin conditions. *An in-service was conducted on 8/21/19 by the Quality Improvement Nurse, Director of Nursing and/or Staff Development Nurse on the policy/procedure titled Prevention and Treatment of Skin Issues revised 2/17 with Nursing Staff. The in-service included implementing orders for the care and treatment of skin conditions. The Quality Assurance Committee, which includes the Administrator, Director of Nursing, Medical Director, and Department Heads, reviewed the policy on Prevention and Treatment of Skin Issues with revision date of 2/17 on 8/29/19 and did not recommend any changes. *Beginning 9/5/19 , performance will be monitored by Director of Nursing, Staff Development Nurse, Medical Records Nurse, Nurse Case Manager, and/or Nurse Supervisor to ensure compliance related to implementing orders for the care and treatment of skin conditions by reviewing skin reports and making observations to ensure all areas have care and treatment orders weekly for four weeks and then monthly for two months and findings recorded on the medical record audit form and maintained by the Director of Nursing. The Quality Assurance Committee will address concerns identified from the performance monitoring of ensuring skin conditions have care and treatment orders and evaluate the monitoring completed by the	

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M 500	Continued From page 5 (PRN). Compression/Edema Control: Single Layer Compression Wrap to affected Leg(s). Apply compression wrap from mid-foot to knee, covering heel. Apply in the morning. Remove at bedtime. Keep legs elevated. - ACE 6x5 to BLE PRN. Elevate leg(s) above the level of the heart when sitting - Monitor fluid intake. Further review of the (Name of Hospital) Wound Healing Center revealed Physician Orders Details dated 7/18/19 and 7/25/19. Both orders stated: Return appointment in one week. Wound Cleansing & Dressings: Dressing/wrap to be changed in seven (7) days, by nurse, upon arrival to the wound healing center. Do not get wrap wet. Xerofoam to wound covered with ABD pads, triamcinolone cream, viscopaste, and ACE 6x5 (Compression bandage six inches by five feet) to RLE (Right Lower Extremity). Compression and Edema Control: Multi Layer Wrap to affected leg(s) - Do not get leg(s) with wrap wet. If wraps are too tight, elevate leg(s) and the call the wound center. Remove wrap if discomfort continues. ABD pads, triamcinolone cream, viscopaste, and ACE 6x5 to RLE. Elevate the leg(s) above the level of the heart when sitting - Monitor fluid intake. Physician Review: Discussed Plan of Care at bedside with patient/caregiver. Orders sent to the nursing home, as they provide care for the patient. On 8/12/19 at 3:00 PM, an interview with Resident #43 revealed the nurses do not do any treatments to her legs. On 08/14/19 at 10:15 AM, an interview with Registered Nurse (RN) #2/Treatment Nurse confirmed there were no orders for treatment to Resident #43's lower legs. After review of the orders on 8/1/19, RN #2 confirmed she was not aware of the orders from the wound clinic, dated	M 500	Director of Nursing, Staff Development Nurse, Medical Records Nurse, Nurse Case Manager, and/or Nurse Supervisor monthly for three months and make any recommendations or changes needed. *Resident #36 was assessed for adverse effects of the deficient practice on 9/4/19 by Licensed Practical Nurse #2 and no adverse effects were noted. Resident #36 received her arthritis injection on 8/14/19 by Licensed Practical Nurse #4 and received her Norco as needed for complaints of pain. *Thirty-nine of the fifty-six residents have the potential to be affected by the failure to administer pain medications. *An in-service was conducted on 8/21/19 by the Quality Improvement Nurse, Director of Nursing and/or Staff Development Nurse on the policy/procedure titled Pain Screen and Management revised 9/18 with Nursing Staff. The in-service included administration of pain meds as ordered . The Quality Assurance Committee, which includes the Administrator, Director of Nursing, Medical Director, and Department Heads, reviewed the policy on Pain Screen and Management with revision date of 9/18 on 8/29/19 and did not recommend any changes. *Beginning 9/5/19 , performance will be monitored by Director of Nursing, Staff Development Nurse, Medical Records Nurse, Nurse Case Manager, and/or Nurse Supervisor to ensure compliance related to administration of pain meds weekly for four weeks and then monthly	

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M 500	Continued From page 6 8/1/19, for Resident #43 to apply a single layer compression wrap to affected legs, apply compression wrap from mid-foot to knee, covering heel. Apply in the morning. Remove at bedtime. Keep legs elevated. RN #2 confirmed the order from the wound clinic was not being implemented. On 8/15/19 at 11:32 AM, an interview with the Director of Nursing (DON) confirmed the order from the Physician at the wound clinic, on 8/1/19, after Resident #43 was treated there, did not get processed or implemented after she returned to the facility. Record review of Resident #43's August 2019 Physician's Orders revealed an order noted on 6/21/9 and discontinued on 7/11/19 to clean the right leg with normal saline pat dry, apply Vit. D ointment twice daily and monitor leg for drainage, open wounds or bleeding. Further review of the orders revealed no orders for treatment to Resident #43's lower legs were written until 8/14/19, after the surveyor brought the absence of orders for the resident's lower leg treatment. Review of the Face Sheet revealed Resident #43 was admitted by the facility, on 7/16/15, and readmitted on 8/26/15, with included diagnoses . Dementia, Cellulitis, Nicotine Dependence, Edema, Diabetes Mellitus Type I with Hyperglycemia, and Convulsions Resident #36 On 08/12/19 at 04:07 PM an interview with Resident #36 revealed she had arthritis and pain in her hands and wrist, and she was supposed to receive a shot on Saturday for her arthritis, but	M 500	for two months and findings recorded on the medical record audit form and maintained by the Director of Nursing. The Quality Assurance Committee will address concerns identified from the performance monitoring of administration of pain meds and evaluate the monitoring completed by the Director of Nursing, Staff Development Nurse, Medical Records Nurse, Nurse Case Manager, and/or Nurse Supervisor monthly for three months and make any recommendations or changes needed.	

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M 500	Continued From page 7 she did not. Resident #36 revealed she was told by the nurse she did not have any, and she would take care of it on Monday. Record review of Resident #36's Medication Administration record revealed on Saturday, August 10th 2019 the medication Actemra was not administered. Record review of Resident #36's Physician Orders for August 2019 revealed an order dated 5/8/19 for Actemra 162 mg/0.9 ML syringe give subcutaneous injection every week. On 8/15/19 at 11:45 AM, a phone interview with Licensed Practical Nurse (LPN) #1 confirmed she did not give Resident #36 her ordered and scheduled Actemra injection on Saturday at 9:00 AM due to there was none in the facility. LPN #1 revealed she checked in the medication storage room refrigerator, where it was kept, and it was not there. LPN #1 revealed she attempted to call Resident #36's physician but was unable to get him, and she called the pharmacy and was told they did not have the medication in stock and would have to order it and it should be delivered on Monday. LPN #1 confirmed she did not document she attempted to call the physician, that she called the pharmacy and did not document being out of the medication on the 24 hour report. On 08/12/19 at 4:36 PM, an interview with the Director of Nursing (DON) confirmed Resident #36's Electronic Medication Administration Record (EMAR) for Saturday August 10th revealed an N was documented for the medication of Actemra 162 milligrams (MG)/0.9 millimeters (ML) syringe give subcutaneous injection every week was not given. The DON	M 500		

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M 500	Continued From page 8 revealed the last injection was given August 3, 2019, and should have been reordered at that time but was not. On 8/15/19 at 11:32 AM, an interview with the DON confirmed Resident #36 did not receive her Actemra on Saturday as ordered. The DON revealed the nurse that gave the last injection should have ordered another injection for the next week. The DON revealed Resident #36's physician was notified on 8/13/19. mg/0.9 ml scheduled for 8/10/19 was not administered Record review of Resident #36's Nurses Notes, dated 8/10/19 at 10:15 AM, revealed LPN #1 documented the Actemra 162 .	M 500		
M 655	45.21.11 Special needs Special needs. Each resident with special needs shall receive proper treatment and care. These special needs shall include, but are not limited to injections; parenteral and enteral fluids; colostomy, ureterostomy, ileostomy care; tracheostomy care; tracheal suction; respiratory care; foot care; and prostheses. This Statute is not met as evidenced by: Level II Based on observation, staff interview, facility policy review and record review the facility failed to change the oxygen tubing every seven (7) days for 1 of five (5) residents reviewed with oxygen. Resident # 25 Findings include:	M 655	*Resident #25 was assessed for adverse effects of the deficient practice on 9/4/19 by Licensed Practical Nurse #1 and no adverse effects were noted. Resident #25 had his oxygen tubing changed on 8/19/19 by Licensed Practical Nurse #3. * Twelve of the fifty-six residents have the potential to be affected by the failure to change oxygen tubing per policy. *An in-service was conducted on 8/21/19	9/23/19

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M 655	Continued From page 9 Review of the facility's policy titled, "Infection Control Oxygen Equipment Cleaning", latest revision of 03/18, revealed: "Use disposable tubing, masks, and cannulas for patients receiving oxygen therapy. This equipment is to be discarded as this procedure dictates: 7. Tubing should be replaced every 7 (seven) days". An observation, on 08/12/19 at 4:51 PM, revealed Resident #25's oxygen (O2) tubing was attached to an O2 concentrator by his bed. The O2 tubing had not date to indicate the date it was connected to the O2 concentrator. There was a piece of torn white tape wrapped around the O2 tubing at the connection to the humidifier bottle. On 08/13/19 at 11:08 AM, an observation revealed the same O2 tubing with the torn tape around the tubing at the connection to the humidifier bottle remained attached to the concentrator. Record review of the August 2019 Physician's Orders revealed an order with a start date of 12/21/18, for "Humidified Oxygen at two (2) liters per minute continuously for Dyspnea". On 08/13/19 at 11:10 AM, during an interview with Licensed Practical Nurse (LPN) #2 revealed she confirmed the tape looked as if it had been torn off, and that there was no date on the oxygen tubing. LPN #2 stated the whole system is usually changed every Sunday on the 11/7 shift. She stated it was important to change the tubing weekly because we want to be sure they are getting proper air flow. If it has been on too long they may not get the proper air they need, sometimes it will make their nose dry out, and also for sanitary issues, it may cause an infection.	M 655	by the Quality Improvement Nurse, Director of Nursing and/or Staff Development Nurse on the policy/procedure titled Infection Control Oxygen Equipment Cleaning revised 3/18 with Nursing Staff. The in-service included changing oxygen tubing weekly. The Quality Assurance Committee, which includes the Administrator, Director of Nursing, Medical Director, and Department Heads, reviewed the policy on Infection Control Oxygen Equipment Cleaning with revision date of 3/18 on 8/29/19 and did not recommend any changes. *Beginning 9/5/19 , performance will be monitored by Director of Nursing, Staff Development Nurse, Medical Records Nurse, Nurse Case Manager, and/or Nurse Supervisor to ensure compliance related to changing oxygen tubing weekly for four weeks and then monthly for two months and findings recorded on the medical record audit form and maintained by the Director of Nursing. The Quality Assurance Committee will address concerns identified from the performance monitoring of changing oxygen tubing and evaluate the monitoring completed by the Director of Nursing, Staff Development Nurse, Medical Records Nurse, Nurse Case Manager, and/or Nurse Supervisor monthly for three months and make any recommendations or changes needed.	

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M 655	Continued From page 10 LPN #2 confirmed that there would be no way of knowing how long the tubing had been in use without a date. On 08/13/19 at 1:53 PM, in an interview with the Director of Nursing (DON), she stated that the oxygen tubing should be changed weekly on the 11/7 shift, and it should be dated on a piece of tape. The DON stated that it's important to have clean tubing. Record review of Resident #25's Face Sheet revealed the resident was admitted by the facility, on 3/7/14, with a diagnosis of Toxic Encephalopathy. Record review of the Minimum Data Set (MDS) Quarterly Assessment, with an Assessment Reference Date (ARD) of 5/24/19, Section C, revealed that a staff assessment for mental status was conducted and the resident had severely impaired cognitive skills for daily decision making.	M 655		