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
	47TM	A. BUILDING: _____ B. WING _____	01/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREAT OAKS REHABILITATION AND HEALTHCARE C	111 CHASE STREET BYHALIA, MS 38611

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M 000	Initial Comments The State Agency (SA) conducted an annual recertification survey and a complaint investigation (CI) MS#23601 and CI MS#23551 at the facility from 01/02/24 through 01/04/24 . During the survey, the SA determined the facility was not in compliance with Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements and deficiencies were cited at M610, M705, and M1570. The SA found the facility to not be in compliance related to CI MS #23601 and cited M610. The SA found the facility to be in compliance related to CI MS#23551 and no deficiency was cited. The census at the time of the survey was 51 and the facility was licensed for 60 beds	M 000		
M 610	45.21.2 Activities of daily living Activities of daily living. Each resident shall receive assistance as needed with activities of daily living to maintain the highest practicable well being. These shall include, but not be limited to: 1. Bath, dressing and grooming; 2. Transfer and ambulate; 3. Good nutrition, personal and oral hygiene; and 4. Toileting. This Statute is not met as evidenced by: Level II Based on observation, staff and family interview and facility policy review the facility failed to	M 610	Facility failed to provide timely incontinent care for resident #6 who had a bowel movement. On 1/02/2024 CNA #1 provided ADL care to resident #6. On 1/4/24 CNA #1 and #6 were inserviced by DON on answering the call lights timely	2/2/24

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M 610	Continued From page 1 provide timely incontinent care for a resident who had a bowel movement as evidenced by the resident waiting an hour and a half for incontinent care for one (1) of 18 Residents sampled. Resident #6 Findings include: Review of the facility policy titled, "Activities of Daily Living (ADL), Supporting" with a revision date of March 2018 revealed "Policy Statement ...Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene..." Review of the facility policy titled "Perineal Care" with a revision date of 7/21/18 revealed "Purpose ...The purposes of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition". An interview and observation of Resident #6 on 1/02/24 at 1:59 PM, revealed Resident #6 was lying in bed with eyes closed and a foul odor in the room. This observation revealed that the resident's son and daughter in law were sitting at the bedside and on interview stated they had called for someone to come change her, but it had been 10 minutes, and no one had come yet. The resident's son revealed they thought she had a bowel movement. An interview and observation on 1/2/24 at 3:40 PM, revealed Certified Nurse Assistant (CNA) #1 and CNA #2 were finishing up incontinent care for Resident #6. CNA #1 confirmed that Resident #6's family came to her and told her about an hour and half ago that the resident needed	M 610	and communicating with nursing staff if they are unable to answer the call light in a timely manner. All residents, 51, had the potential to be affected. 01/04/24 SSD interviewed residents with a BIMS of 12 and above to identify concerns regarding ADL care. No negative findings were noted. 1/4/24 SDC and DON initiated inservices with staff on ADL care and answering call lights timely. Beginning 1/8/24 SDC, Director of Nursing, Assistant Director of Nursing, or Nurse Manager will observe ADL care and answering call lights timely three times week for four weeks then two times a week for four weeks, then one time monthly thereafter until compliance is achieved. DON will bring results of the observations to monthly QA Committee for review times three months beginning 1/30/2024. The QA Committee will make recommendations based on findings.	

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M 610	Continued From page 2	M 610		

changing because they thought she had a bowel movement, but she was busy with other residents, so she was just now getting to change Resident #6. CNA #1 stated there is another CNA on the hall but he was busy and she did not notify the nurse she needed help. CNA #2 revealed she came into work at 2 PM to help with Activities but she came and helped change Resident #6.

An interview on 1/3/24 at 1:10 PM, with CNA #2 revealed that she had come in at 2:00PM yesterday 1/2/24 and about 3:20 PM she noticed that Resident #6's call light was on so she went to answer it. She stated that when she did the family told her that the resident had a bowel movement. She stated the resident could have had skin breakdown from laying in the bowel movement for an hour and a half.

An interview on 1/3/24 at 1:18 PM with the Director of Nurses (DON) confirmed that CNA #1 had come to tell her about the incident with Resident #6 waiting so long to be changed yesterday. She stated that the CNA should have had better time management and notified her nurse that she needed help if she was not able to get to the resident in time. She stated that every resident has to be checked every 2 hours but if you are aware that the resident needs assistance prior to that two-hour check then it needs to be done. She confirmed that a resident lying in a bowel movement for too long could lead to skin breakdown for the resident.

Record review of Resident #6's "Admission Record" revealed the resident was admitted to the facility on 11/22/23 with medical diagnoses that included Metabolic Encephalopathy.

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M 610	Continued From page 3 Record review of Resident #6's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/29/23 revealed in Section C a Brief Interview for Mental Status (BIMS) score of 11, which indicates the resident is moderately cognitively impaired and in Section GG that the resident needed substantial to maximal assistance with toileting hygiene.	M 610		
M 705	45.24.2 Policies and procedures Policies and procedures. Each facility shall have policies and procedures to assure the following: 1. Accurate acquiring; 2. Receiving; 3. Dispensing; 4. Storage; and 5. Administration of all drugs and biologicals. This Statute is not met as evidenced by: Level II Based on observation, staff interview, record review, and policy review the facility failed to ensure medications were secured when a medication cart was left unlocked and unattended with medications left on top of the cart for (1) one of (5) five medication administration observations. Findings include: Review of the facility policy titled, "Storage of Medications, revised April 2019, revealed, Policy Statement: "The facility stores all drugs and	M 705	Facility failed to ensure medications were secured when a medication cart was unlocked and unattended with medications on top of the cart. On 1/3/24, Registered Nurse (RN) #1 was inserviced by DON on storing all drugs and biologicals in a safe, secure, and orderly manner. All carts must be locked and medications secured when leaving the cart unattended. All residents, 51, have the potential to be affected due to the deficient practice. On 1/3/24 observations were made by DON and Administrator that carts were locked	2/2/24

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M 705	Continued From page 4 biologicals in a safe, secure, and orderly manner." ... Policy Interpretation and Implementation: 9.) Unlocked carts are not left unattended..." An observation of Registered Nurse (RN) #1 during medication administration on 1/03/2024 at 8:00 AM, revealed RN #1 left the medication cart to go get supplies. She stated "I will be right back" and walked towards the nurse's station leaving the medication cart unlocked and a cup with an inhaler in it on the top of the cart. An interview with RN #1 on 1/03/24 at 8:04 AM she confirmed she left her medication cart unlocked and left the Albuterol inhaler for Resident #13 on the top of the cart unattended. A continued medication administration observation revealed RN #1 prepared medications for Resident #13 locked her cart and entered the resident's room and administered the medications with observation of Tiotropium inhaler box with inhalation powder capsules left on top of the medication cart in the hallway unattended. After completion of medication administration RN #1 left the room and confirmed she left the box of Tiotropium inhaler inhalation powder capsules with 16 capsules on the top of the medication cart unattended. She confirmed the medication should have been placed back in the cart before entering the room. RN #1 then confirmed that leaving the medication cart unsecure and medications on top of the cart unattended could have resulted in adverse reaction to a resident if taken. An interview with the Director of Nursing (DON) on 1/03/24 at 1:00 PM, confirmed medications should never be left on top of the medication cart and the cart should always be locked when left	M 705	and medications were stored correctly and no other negative findings were noted. On 1/8/24 Staffing Development Coordinator (SDC) and DON initiated inservices on proper medication storage with Licensed Practical Nurses (LPN) and RNs. Beginning 1/8/24 SDC, Director of Nursing, Assistant Director of Nursing, or Nurse Manager will observe proper medication storage and that carts are not left unattended and unlocked three times week for four weeks then two times a week for four weeks, then one time monthly thereafter until compliance is achieved. DON will bring results of the observations to monthly QA Committee for review times three months beginning 1/30/2024. The QA Committee will make recommendations based on findings.	

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M 705	Continued From page 5 unattended and revealed that someone could have taken the medications off the cart and placed others at risk for harm or adverse reactions. Record review of the Admission Record revealed that the facility admitted Resident #13 to the facility on 04/04/22 with diagnoses that included Chronic Obstructive Pulmonary Disease and Emphysema.	M 705		
M1570	48.58.1 Infection Control The following infection control standards shall be met: 1. The facility must maintain and document an effective infection control program that protects patients, families, visitors, and facility personnel by preventing and controlling infections and communicable diseases. 2. The facility must have an active surveillance program that includes specific measures for prevention, early detection, control, education, and investigation of infections and communicable diseases in the facility. There must be a mechanism to evaluate the effectiveness of the program(s) and take corrective action when necessary. The program must include implementation of nationally recognized systems of infection control guidelines to avoid sources and transmission of infections and communicable diseases. 3. The facility must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions.	M1570		2/2/24

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M1570	Continued From page 6 This Statute is not met as evidenced by: Level II Based on observation, staff interview, record review, and facility policy review the facility failed to prevent the potential spread of infection when staff failed to sanitize hands between a respiratory treatment and peg (percutaneous endoscopic gastrostomy) tube medication administration and failed to clean and properly store a respiratory mask and peg tube syringe for (1) one of (8) resident care observations. Resident #15 Findings include: Review of the facility policy titled, "Administering Medication, revised April 2019, revealed "Policy heading: Medications are administered in a safe and timely manner, and as prescribed... Policy Interpretation and Implementation: 25.) Staff follows established facility infection control procedures (e.g. (for example) handwashing, antiseptic technique, and gloves) for the administration of medications, as applicable..." Review of the facility policy titled, "Infection Prevention and Control Program," reviewed January 2023, revealed "Policy Statement: An infection prevention and control program is established and maintained to provide a safe, sanitary, and comfortable environment and help to prevent the development and transmission of communicable disease and infections..." A medication administration observation of Licensed Practical Nurse (LPN) #1 on 1/03/24 at 8:35 AM revealed she prepared medication for Resident #15, locked her cart and entered room to administer the medications. LPN #1 sanitized	M1570	Facility failed to prevent the potential spread of infection by not sanitizing hands between a respiratory treatment and a PEG tube administration and failed to properly clean and store a respiratory mask and PEG tube syringe for Resident #15. Resident #15 was assessed by Director of Nursing (DON), 1/3/24, and no negative findings were noted. On 1/4/24 LPN #1 was inserviced by DON on following established facility infection control procedures when administering medications per PEG, respiratory treatments, storing respiratory masks, PEG tube syringes and sanitizing hands. All residents, 51, had the potential to be affected by the deficient practice. Staffing Development Coordinator and DON initiated inservices 1/8/24 to LPNs and RNs on following established facility infection control procedures when administering medications per PEG, respiratory treatments, storing respiratory masks, PEG tube syringes, and sanitizing hands. DON, SDC, or Nurse Manager will observe medication administration and handwashing between respiratory treatments, cleaning and storage of respiratory masks and PEG tube syringes three nurses per week for four weeks, then two nurses per week for two weeks then one nurse monthly thereafter until compliance is achieved beginning 1/8/24. DON will bring results of the observations	

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M1570	Continued From page 7 and donned gloves started the Brovana Nebulizer treatment via face mask and then began to administer peg tub medications. After giving half of the medications via the peg tube she stated, "The nebulizer is completed" and took the nebulizer mask off Resident #15 and placed it in the clean storage bag with no observation of doffing gloves, sanitizing hands prior to removing the nebulizer mask or sanitizing the mask before placing it in the clean bag. LPN #1 then began to finish the peg tube medications wearing the same gloves she applied upon entering the resident's room. Once the peg medications were finished LPN #1 placed the peg tube syringe in the clean storage bag with no observation of sanitizing the syringe. LPN #1 then took her gloves off sanitized hands at the door and left the room. During an interview with LPN #1 she confirmed she failed to remove her gloves and sanitize prior to taking the resident's nebulizer mask off and did not sanitize the mask prior to putting it in the bag and then revealed she knew she should have done that and knew that could cause possible cross contamination of bacteria and lead to increased risk of infections. LPN #1 then confirmed she failed to clean the peg tube syringe after use and revealed she should have sanitized her hands, cleaned the syringe, dried, and stored in the bag to reduce the risk of bacteria growth. An interview with the Director of Nursing (DON) on 1/03/24 at 1:00 PM, confirmed staff should have sanitized their hands between administering the peg tube medications and the nebulizer treatment and should always sanitize the nebulizer and peg tube syringe after each use. She stated that by failing to do so placed the resident at risk for cross contamination and increased risk of infection.	M1570	to monthly QA Committee for review times three months beginning 1/30/2024. The QA Committee will make recommendations based on findings.	

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M1570	Continued From page 8 An interview with Registered Nurse (RN) #1 on 1/04/24 at 10:40 AM revealed that breathing treatment masks and peg syringes should be cleansed and stored in a clean dry bag after each use and confirmed if a staff failed to do so the oncoming nurse would assume the items were clean and may use them. Record review of the Admission Record revealed that the facility admitted Resident #15 to the facility on 10/12/23 with diagnoses that included Chronic Obstructive Pulmonary disease.	M1570		