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 _____	C 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

(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 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 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	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 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	2/2/24

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M 610	Continued From page 1 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 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.	M 610	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 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. 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		