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
	24LA	A. BUILDING: _____ B. WING _____	C 02/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW NURSING CENTER	16411 ROBINSON ROAD GULFPORT, MS 39503

(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 two (2) Complaint Investigations (CI MS #24274 and CI MS #24301, at the facility from 2/26/24 through 2/28/24. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements. CI MS #24274 was a facility reported incident related to resident safety and M640 was cited. CI MS #24301 was investigated for pressure sores, inappropriate feeding assistance, resident left soiled, and notification of resident representative and there were no deficiencies cited related to the investigation.	M 000		
M 640	45.21.8 Accidents Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies. This Statute is not met as evidenced by: Level III Based on observation, interviews, record review, and facility policy review, the facility failed to provide a safe smoking environment when the facility staff did not remove an oxygen (O2) canister from Resident #1 prior to entering the smoking area and did not secure a cigarette lighter to prevent Resident #1 from lighting a cigarette. This failure resulted in Resident #1 receiving burns to his face. This was for one (1) of three (3) sampled residents reviewed for smoking.	M 640	*Brief summary of events: The facility failed to provide a safe smoking environment when the facility staff did not remove an oxygen (O2) canister and nasal cannula from resident #1 prior to entering the smoking area and did not secure a cigarette lighter to prevent resident #1 from lighting a cigarette. This failure resulted in resident #1 receiving burns to his face. On 2/21/24 License Practical Nurse (LPN) #1 promptly treated resident #1 and sent resident #1 to the hospital for evaluation and treatment.	3/15/24

Mississippi State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/08/24

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M 640	Continued From page 1 Findings Include: Review of the facility's policy, "Accidents and Supervision", dated 12/9/2020, revealed, "Policy: The resident environment will remain as free of accident hazards as is possible ...This includes ...3. Implementing interventions to reduce hazard(s) and risk(s) ... Policy Explanation and Compliance Guidelines ...3. Implementation of Interventions ...i. Resident-directed approaches may include ...supervising ...residents ..." Review of the facility's policy, "Resident Smoking, Smokeless Tobacco, and Vaping Policy," dated 3/29/22, revealed, " Policy: This facility provides a safe and healthy environment for residents, visitors, and employees, including safety as related to smoking ...Policy Explanation and Compliance Guidelines ...2. Safety measures for the designated smoking area will include ...e. Prohibition of oxygen use in the smoking area ...11. All safe smoking measures will be documented on each resident's care plan and communicated to all staff ...who will be responsible for supervising residents while smoking ...14. All smoking materials of residents will be maintained by nursing and/or activity staff ..." A record review of the facility's investigation, dated 2/23/24, revealed on 2/21/24, the Activities Director (AD) was assisting with the smoke breaks with her back turned, she heard a "popping/clicking" sound. Upon turning observed sparks coming from Resident #1 nasal cannula. She immediately removed the cannula and turned his oxygen off. Record review of the local hospital report, dated	M 640	**All residents who smoke have the potential to be affected by this deficient practice. ***Two staff members will be present at all designated smoke breaks. The cigarettes and lighter will remain in possession of a staff member at all times and all cigarettes will be lit by staff member only. Oxygen canisters will not be permitted in designated smoking area and will be removed by a staff nurse prior to entering smoking area. Director of Nursing (DON) began an inservice with all current staff on 2/21/24 on the revised smoking policy, abuse/neglect/exploitation policy and accidents and supervision policy. The inservices will be completed on 3/15/24. ****Beginning on 2/26/2024 Quality Assurance (QA) nurses will monitor all residents during three of three smoke breaks daily x five days. Then one smoke break biweekly x four weeks and monthly x three months. Findings will be brought to QA meeting beginning on 3/12/2024 x three months.	

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2/21/24, revealed "... Arrival Complaint FACIAL BURN Chief Complaint... Complaint of facial burns to bilateral nostrils after lighting a cigarette while wearing home O2...singed hair at nares ...Final diagnoses Second degree burn of nose. Partial thickness burns of face ..." Discharge Orders revealed Resident #1 received Keflex (antibiotic medication) and a Bacitracin Ointment (treatment order) upon discharge.

A record review of the "Face Sheet" revealed the facility admitted Resident #1 on 11/6/23 with current diagnoses including Chronic Obstructive Pulmonary Disease and Heart Failure.

Record review of the Admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/15/23 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated he was cognitively intact. Section J revealed Resident #1 currently uses tobacco. Section O revealed Resident #1 used oxygen therapy.

Record review of the "Physician Orders" for the month of February 2024 revealed Resident #1 had a physician's order, dated 11/9/23, for "Oxygen at 2 LPM (Liters per minute) via nasal cannula as needed ..."

A record review of the "Resident Safe Smoking Assessment", dated 11/13/23, revealed Resident #1 was able to verbalize the safety risks of smoking and was aware of smoking procedures.

On 2/26/24 at 3:45 PM, during an interview with Resident #1, he confirmed on 2/21/24, he went into the smoking area with an O2 canister on the back of his wheelchair and the O2 was being delivered through a nasal cannula. Resident #1

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expressed that it was his fault because he was rushing to make it to the smoke area and forgot to have his oxygen canister removed from his wheelchair. He said he was anxious about being late, so he got the lighter from the box that holds the smoking items and he lit his cigarette instead of waiting for staff to light it for him. He stated that the lighter sparked and he pulled the nasal cannula off. He said that it did not hurt him and he did not want to go to the hospital, but the facility insisted he get checked out.

On 2/26/24 at 4:00 PM, during an observation of the residents during the smoking break, the cigarettes and lighters were observed in a plastic container with the top not secured on a table in the smoking area. There were two (2) facility staff supervising and assisting the residents and were using the container to pass out cigarettes for the residents and then using a lighter to light the cigarettes.

On 2/27/24 at 10:21 AM, during an interview with the AD, she confirmed that on 2/21/24 at approximately 4:00 PM, she assisted Resident #1 during the smoke break. She confirmed that she did not remove his oxygen canister as she usually did before he entered the smoke area. The AD explained Resident #1 was late getting to the smoking area and while she was assisting another resident through the doorway, he got a lighter out of the box that was left on a table. She heard a "clicking/popping sound" and observed sparks coming from the nasal cannula. She assisted with removing the nasal cannula, turned the oxygen off, and got a nurse to assist.

On 2/27/24 at 10:50 AM, during an interview with License Practical Nurse (LPN) #1, she confirmed on 2/21/24, the AD called out for assistance in the

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M 640	Continued From page 4 smoking area. LPN #1 stated she observed Resident #1 having soot (ashes) on his nasal passages, bridge of his nose, and inside his nares, face, and right shoulder. She explained that the sparks had been put out before she went to the smoking area. She stated that she immediately notified the Director of Nursing (DON) and the Administrator. On 2/27/24 at 12:00 PM, during an interview with the DON, she confirmed that Resident #1 was brought to the smoking area while wearing O2 and had an O2 canister on the back of his wheelchair. The DON stated the AD failed to remove both the resident's oxygen and nasal cannula during his smoke break, which caused sparks. Resident #1 went to the hospital and was treated for a second degree burn of the nose and partial thickness burn of the face. During an interview with the Administrator on 2/27/24 at 2:33 PM, she confirmed that on 2/21/24, Resident #1 lit his cigarette before the AD checked or removed his O2. The Administrator stated safety is the utmost priority of the facility, and moving forward, the facility has placed more checks and balances to prevent further incidents or accidents.	M 640		