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
	61MS	A. BUILDING: _____ B. WING _____	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METHODIST SPECIALTY CARE CENTER	1 LAYFAIR DRIVE SUITE 500 FLOWOOD, MS 39232

(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 recertification survey at the facility from 4/09/24 through 4/11/24. 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 and deficiencies were cited at M640 and M1570. The facility held a license for 60 beds at the time of the survey, and the facility census was 58.	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 II Based on observation, resident and staff interviews, and facility policy review, the facility failed to secure smoking materials in a safe manner for one (1) of two (2) smokers in the facility. Resident #15 Findings Include: Review of facility policy titled "Smoking Program" with a revision date of 3/10/2023 revealed under, "Procedure... Residents should have smoking materials labeled and locked in the medication room. Residents should not have smoking, vaping, lighters or other smoking devices or material in their possession or in their room."	M 640	This Plan of Correction is being submitted in accordance with specific regulatory requirements. It should not be construed as an admission of any deficiency cited. 1. On 04/10/24, Resident # 15 was noted by the surveyor with a pack of cigarettes in his lap and stated he had a lighter hidden in the side pocket of his wheelchair cushion. Smoking paraphernalia was confiscated from resident and resident was educated to the policy of not having smoking materials in his room or on his person. 2. One resident, #15, had the potential to be affected by the cited deficient practice.	5/11/24

Mississippi State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/19/24

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M 640	Continued From page 1 An observation and interview on 4/10/2024 at 9:15 AM, with Resident #15 revealed he was sitting in a motorized wheelchair in his room. A small green box that was labeled "(proper name of cigarette brand)" was lying on his lap. The contents of the box contained 10 cigarettes and the resident acknowledged that he had a cigarette lighter in his possession as well. An observation and interview on 4/10/2024 at 9:20 AM, with Registered Nurse (RN) #1, confirmed Resident #15 had a pack of cigarettes and a lighter in his possession, which was a fire hazard for the facility. She revealed smoking materials were to be kept locked at the nurse's desk and never in the possession of the resident. An interview with the Director of Nursing (DON) on 4/10/2024 at 4:50 PM, confirmed smoking materials were to be stored in the medication room due to potential accident hazards. Record review of Resident #15's "Safe Smoking Assessment" dated 3/11/2024 revealed "... Resident Observation...Does resident attempt to keep smoking paraphernalia on self or in room? No" was answered. Record review of Resident #15's "Face Sheet" revealed the facility admitted the resident on 11/06/2008 with medical diagnoses that included Quadriplegia and Tobacco use.	M 640	Although no other residents were affected by the cited deficient practice, the facility had determined that one other resident had the potential to be affected. 3. A complete and comprehensive review of the Smoking Program and the Smoking Policy was conducted on 04/10/24 by the Facility Administrator, the Director of Nursing and The Quality Assurance Nurse. Revisions to policies were made to reflect all current safety interventions. Resident #15 was educated to the content of both policies and voiced understanding. On 4/18/24 the other resident identified was educated as to the content of both policies, including revisions; the resident voiced understanding of policies and procedures and was left copies of both policies On 4/10/24 a complete and comprehensive review of Resident #15's Tobacco Use care plan was conducted by the Facility Administrator, Director of Nursing and MDS Nurse, to ensure appropriate interventions have been put into place. On 04/18/24, an intervention was added to Resident #15 plan of care stating resident will be asked on each shift if resident has any type of smoking materials on their person or in their room. Intervention will be placed residents' treatment record to ensure continued compliance. Resident #15 was informed and educated on new care plan intervention and a copy was left in resident's room. On 04/18/24 a complete and comprehensive review of the other	

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M 640	Continued From page 2	M 640	resident identified was conducted by the Facility Administrator, the Director of Nursing and the Minimum Data Set Nurse to ensure that appropriate interventions have been put into place. An intervention was added to the care plan stating resident will be asked on each shift if resident has any type of smoking materials on their person or in their room. Resident was educated to new plan of care. Resident voiced understanding a copy was left with resident. Intervention will be placed on resident's treatment record to ensure continued compliance. 4. The Director of Nursing, the Quality Assurance Nurse and Minimum Data Set Nurse will conduct weekly chart audits of interventions 3 x weekly for 3 weeks, then monthly x 2 to begin on 04/22/24. The Director of Nursing, the Nursing Supervisor or the Quality Assurance Nurse will educate all nursing staff on new interventions for both identified residents including documentation on treatment record. Training will begin on 04/18/24 to be completed by 05/06/24. Findings of observations will be brought to the Quality Assurance Committee by the Director of Nursing, the Nursing Supervisor, the Quality Assurance Nurse or the Minimum Data Set Nurse beginning on May 10th 2024 times 3 months to ensure compliance.	
M1570	48.58.1 Infection Control The following infection control standards shall be met:	M1570		5/11/24

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M1570	Continued From page 3 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. This Statute is not met as evidenced by: Level II Based on observation, staff interviews, record review, and facility policy review, the facility failed to prevent the possible spread of infection as evidenced by lack of a biohazard container in one (1) of three (3) residents on transmission-based precautions on initial entrance to the facility. Resident #25 Findings include: Record review of facility policy titled, "Tracheostomy Care" revised 4/11/24, revealed, "	M1570	This plan of correction is being submitted in accordance with specific regulatory compliance. It should not be construed as an admission of any deficiency cited. 1. Trach inner cannula was changed for resident #25 on 04/10/24 during observation by survey staff. The Respiratory Therapist was immediately educated on the proper procedure for disposal of inner cannula for residents with a Multi-Drug Resistant Organism and a red biohazard can was placed in resident's room. Nursing staff will monitor and	

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M1570	Continued From page 4 Procedure: Remove and throw away inner cannula... i. If resident is on MDRO (multi-drug resistant organism) isolation, dispose of in biohazard bag." Record review of facility policy titled, "Isolation - Categories of Transmission-Based Precautions", dated 4/1/24, revealed, " ...Policy Interpretation and Implementation: 1. Transmission-Based Precautions will be used whenever measures more stringent than Standard Precautions are needed to prevent or control the spread of infection." An observation and interview on 04/09/24 at 10:40 AM, revealed signage on Resident #25's door for droplet isolation. An interview with the Respiratory Therapy (RT) Supervisor revealed the resident had bacteria in his sputum that required droplet isolation and gowns, gloves, masks, and goggles were needed when entering room. Record review of lab results of the sputum culture dated 3/15/24, revealed result of "Carbapenem-resistant pseudomonas aeruginosa Heavy growth". Record review of the April 2024 "Physician Orders" revealed an order dated 2/17/24 for Droplet isolation due to carbapenem-resistant pseudomonas aeruginosa in sputum. An observation and interview on 4/10/24 at 10:45 AM, with Licensed Practical Nurse (LPN) #1 revealed there was not a biohazard container for trash in the resident's room and the personal protective equipment (PPE) was being discarded in a regular trash can with a white plastic liner. LPN #1 revealed this resident was in droplet	M1570	document for signs and symptoms of infection for 3 days, to be reviewed by the Director of Nursing and/or Infection Preventionist. 2. One resident, #25 had the potential to be affected by the cited deficient practice. Although no other residents were affected by the cited deficient practice, the facility has determined that all residents have the potential to be affected. 3. A complete and comprehensive review of the Trach Change Policy was conducted on 04/10/24 and 04/11/2024 by the Facility Administrator, the Director of Nursing, the Respiratory Therapy Supervisor and the Infection Preventionist. Revisions to the policy were made on 04/11/24 to reflect all current infection control guidelines. A complete and comprehensive review of the Infection Control Transmission based Precautions Policy was conducted on 04/10/24 and 04/11/24 by the Facility Administrator, the Director of Nursing, and the Infection Preventionist. Revisions were made to reflect all current infection control guidelines. All Respiratory staff will be in-serviced on the Trach Change Policy updates beginning on 04/11/24 to be completed by 05/06/24. All staff will be in-serviced on Transmission-Based Precautions policy updates beginning on 04/11/24 to be completed by 05/06/24 to ensure continued compliance. 4. Observation of inner cannula change and placement of biohazard container will be completed by the Respiratory Therapy	

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M1570	Continued From page 5 isolation and the infection control staff determined what to use for disposal of items in the isolation rooms and she was unsure why a red biohazard container was not used. An interview with the Infection Preventionist on 4/10/24 at 10:55 AM, revealed only residents in isolation for clostridium difficile colitis (C-diff) used a red biohazard trash system. She revealed Resident #25 tested positive for carbapenem-resistant pseudomonas aeruginosa in his sputum and for that bacteria, the staff contained the trash in a regular trash bag and it was disposed of with the regular trash. During an interview on 4/10/24 at 3:30 PM, the Director of Nursing revealed she thought items from a resident positive for carbapenem-resistant pseudomonas aeruginosa could be disposed of in the regular trash if there was not a large amount of bodily fluid on the items. She confirmed that the inner trachea cannula of Resident #25 contained sputum fluid from the trachea and had the potential to spread infection. She stated the regular trash bag had no identifying information that would alert others of the infectious waste. She confirmed that by not disposing of infectious material properly, the potential for the spread of infection could increase. Record review of "Face Sheet" revealed the resident was admitted to the facility on 8/8/17 with the diagnoses of Hemiplegia, dependence on respirator ventilator status, and Tracheostomy status.	M1570	Supervisor and/or the Infection Preventionist 3 x weekly x 3 weeks, then monthly x 2 months to ensure continued compliance, to begin on 04/22/24. Findings of observations will be brought to the Quality Assurance Committee by the Respiratory Therapy Supervisor, the Infection Preventionist or the Director of Nursing beginning on 05/10/24 times 3 months to ensure compliance.	