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
	34HH	A. BUILDING: _____ B. WING _____	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE CENTER OF LAUREL	935 WEST DR LAUREL, MS 39440

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M 000	Initial Comments The State Agency (SA) conducted an Annual Recertification Survey at the facility from 3/19/21 through 3/21/24. 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 requirement and cited M500, M610, M620, and M635.	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 participate in the planning of his medical treatment, to not be limited in his/her choice of a	M 500		4/23/24

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M 500	Continued From page 1 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 responsibility to the facility for any period of time in conformance with State law;	M 500		

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M 500	Continued From page 2 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 documented by his physician or nurse practitioner/physician assistant in his medical	M 500		

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M 500	Continued From page 3 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, interviews, record review, and facility policy review the facility failed to promote the dignity of residents by requiring the residents to use a bedside commode (BSC) in their room instead of a designated restroom when toileting for two (2) of (19) sampled residents. (Resident #29 and Resident #51)	M 500	1) Root Cause Analysis was conducted by the Interdisciplinary Team (IDT) on 03/22/2024 and based on findings the facility failed to promote the dignity of residents by requiring the residents to use a bedside commode in their room instead of a designated restroom for toileting for Resident #29 and Resident #51, and staff not notifying the Administrator and/or	

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M 500	Continued From page 4 Findings Include: Review of the facility's policy, " Dignity and Respect", revised 7/22, revealed, "A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life ...The facility shall protect and promote the rights of the resident ...2. Each resident of the facility has the right to a dignified existence ..." Review of the facility's "Resident Rights Policy", revised 12/23, revealed, "Every resident in this facility has the right to ...12. Be treated ...with the fullest measure of dignity...17. Be treated with consideration and respect for their personal privacy including but not limited to toileting ..." During an observation and interview on 3/19/24 at 11:00 AM, with Resident #29 and Resident #51, the residents revealed the toilet in their bathroom did not work. Resident #29 stated the sewage backed up and had overflow issues, so they had been instructed by the facility to use BSCs provided by the facility. The toilet had been in disrepair since January of this year (2024) and both residents expressed they did not feel comfortable using the BSCs because of the odors and the lack of privacy. The staff made sure the curtains were pulled for privacy, but they had to call staff to empty the BSCs after each use. There were two BSCs noted in the residents' room. One BSC was located on each side of the room. During an interview on 3/19/24 at 11:15 AM, with Certified Nursing Aide (CNA) #7, she confirmed the toilet had not worked properly in Resident #29	M 500	Maintenance Director of a toilet not functioning properly. The toilet for Resident #29 and Resident #51 was replaced on 03/21/2024 by the Maintenance Director to promote dignity of residents in their room by having a toilet to function properly. Resident #29 and Resident #51 was assessed on 03/22/2024 by the Director of Nurses (DON) to ensure no adverse effects to each resident related to failing to promote dignity of resident by requiring the residents to use a bedside commode in their room instead of a designated restroom for toileting. Resident #29□s bedside commode was removed from the room by the Maintenance Director on 03/22/2024. Resident #51 did choose to keep her bedside commode even though the toilet is in working order, and the care plan was revised. 2) Residents□ requiring the use of a toilet that functions properly have the potential to be affected by this deficient practice. 3) On 03/22/2024, an audit was conducted by the Administrator and Maintenance Director to ensure residents□ toilets functions properly. On 03/22/2024, the Maintenance Director was educated by the Administrator on ensuring toilets function properly. Beginning on 03/28/2024, the licensed nurses, CNAs, and housekeeping staff were educated by the DON and/or Staffing Nurse on ensuring residents□ toilets functions properly and to notify the Administrator	

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M 500	Continued From page 5 and Resident #51's bathroom since January 2024. CNA #7 stated the residents used the BSCs that were lined with a clear bag and after use of the BSC, the CNAs removed and disposed of the bags. In an interview on 3/20/24 at 11:00 AM, with the Maintenance Director, he explained that he had installed a new toilet in Resident #29 and Resident #51's room about a week and a half ago and he was unaware the residents were still having problems with the toilet. The Maintenance Director stated that no one had completed a maintenance form indicating the toilet needed to be repaired. During an interview on 3/21/24 at 10:00 AM, with the Director of Nursing (DON), she stated that she did not know the residents were having issues with the toilet. The DON said she understood why using BSCs rather than the toilet would be upsetting to the residents. During an interview on 3/21/24 at 10:15 AM, with the Administrator, she stated that she was aware the toilet was not working properly for Resident #29 and Resident #51, but thought it was repaired when the Maintenance Director installed a new toilet in the residents' room. The Administrator was unaware the residents were currently using BSCs and confirmed this could be a dignity issue for the residents. She reported that she would work to have the toilet flushing issue repaired immediately. Resident #29 A record review of the "Face Sheet" revealed the facility admitted Resident #29 on 10/11/18 and she had current diagnoses including Hemiplegia,	M 500	and/or Maintenance Director if a toilet is not functioning properly, and education will be completed by 04/19/2024. New hires will be educated upon hire on ensuring residents□ toilets function properly and to notify the Administrator and/or Maintenance Director if a toilet is not functioning properly. 4) Beginning on 03/25/2024, the Administrator and/or Maintenance Director will conduct an audit on a resident bathroom to ensure the toilet functions properly on 5 resident bathrooms 5 times a week for 4 weeks and then 5 resident bathrooms monthly for 3 months. Areas of concern will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee for review. The QAPI Committee will convene on 04/22/2024 to discuss further recommendations as needed and once a month for 3 months. Additional training and/or disciplinary action will be considered as warranted.	

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M 500	Continued From page 6 Hypertension, and Anxiety. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/13/23 revealed Resident #29 had a Brief Interview of Mental Status (BIMS) score of 12, which indicated her cognition was moderately impaired. Resident #51 A record review of the "Face Sheet" revealed the facility admitted Resident #51 on 12/7/23 and she had current diagnoses including Heart Failure, Renal Disease, and Diabetes Mellitus. A record review of the Admission MDS with an ARD of 12/15/23 revealed a BIMS score of 15, which indicated she was cognitively intact.	M 500		
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 observations interviews, record review, and facility policy review, the facility failed to	M 610	1) Root Cause Analysis was conducted by the Interdisciplinary Team (IDT) on 03/22/2024 and based on findings the	4/23/24

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M 610	Continued From page 7 clean, cut, and file fingernails for a resident who required assistance with Activities of Daily Livings (ADLs) for personal hygiene for one (1) of 19 sampled residents. Resident #55 Findings include: A review of the facility's policy "Nail Care", revised 01/24, revealed "Purpose ...To promote cleanliness, safety and a neat appearance ..." On 03/19/24 at 10:22 AM, Resident #55 was lying in bed and had long fingernails on both hands. The resident was able to respond to questions and answered "yes" when asked if she would like to have her nails trimmed. On 03/20/24 at 10:05 AM, during an observation of Resident #55 and an interview with Certified Nurse Aide (CNA) #3, she confirmed Resident #55 had long nails that were dirty. CNA #3 explained Resident #55 had a diagnosis of Diabetes and CNAs were not allowed to trim her nails. At 10: 15 AM on 03/20/24, during an observation of Resident #55 and an interview with Licensed Practical Nurse (LPN) #2, she explained LPNs were not allowed to clip Resident #55's nails because she had a diagnosis of Diabetes, and a Registered Nurse (RN) clipped the resident's nails on weekends and as needed. LPN #2 observed Resident #55's fingernails and confirmed the resident's fingernails were long, jagged, and dirty and asked Resident #55 if a nurse could trim her nails, and the resident replied "yes". LPN #2 reported that the resident's nails had not been clipped recently. On 03/20/24 at 03:35 PM, during an interview	M 610	facility failed to clean, cut, and file fingernails for a resident who required assistance with Activities of Daily Livings (ADLs) for personal hygiene for Resident #55. Resident #55□s fingernails were cut, trimmed, and filed on 03/22/2024 by the Director of Nurses (DON). 2) Residents who require assistance with ADL for nail care have the potential to be affected by this deficient practice. 3) On 03/22/2024, an audit was conducted by the DON to ensure ADL nail care was provided to residents and nail care performed if needed. Beginning on 03/28/2024, the licensed nurses and CNAs were educated by the DON and/or Staffing Nurse on ensuring ADL nail care is provided to residents and nail care performed if needed. Education will be completed by 04/19/2024. New hires will be educated upon hire on ensuring ADL nail care is provided to residents and nail care performed if needed. 4) Beginning on 03/25/2024, the DON and/or Nurse Supervisor will audit to ensure ADL nail is provided on 5 residents 5 times a week for 4 weeks and then 5 residents monthly for 3 months. Areas of concern will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee for review. The QAPI Committee will convene on 04/22/2024 to	

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M 610	Continued From page 8 with the Director of Nursing (DON), she explained the weekend RNs are to assess resident nails weekly and they only checked the condition of the nail and cleaned and clipped as needed. She explained she was not sure if Resident #55 refused nail care but if so, it would be documented in the medical chart. She stated she expected staff to adequately complete ADL care for all residents, which included clipping and cleaning their fingernails. At 4:00 PM on 03/20/24, during a phone interview with RN#2, she explained she worked at the facility on the weekend on a part-time basis. She explained that she looked at the at the nails for residents with Diabetes, but she did not clip all the resident's nails in the facility every week and rotated nail care from week to week. She confirmed that she did not clip Resident #55's nails this month, but she did observe them to ensure they were clean. She was unable to recall if Resident #55 ever refused to have her nails clipped. Record review of the "Face Sheet" revealed the facility admitted Resident #55 on 12/15/21, and she had current diagnoses including Type 2 Diabetes Mellitus. Record review of the Quarterly Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 01/08/24 revealed Resident #55 had a Brief Interview for Mental Status (BIMS) score of six (6), which indicated her cognition was severely impaired. Further review revealed she required moderate assistance with personal hygiene.	M 610	discuss further recommendations as needed and once a month for 3 months. Additional training and/or disciplinary action will be considered as warranted.	

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M 620	Continued From page 9	M 620		
M 620	45.21.4 Urinary incontinence Urinary incontinence. Residents with urinary incontinence shall be assessed for need of bladder retraining program. An indwelling catheter will not be used unless the resident ' s clinical condition indicates that catheterization is necessary. These residents shall receive treatment and services to prevent urinary tract infections. This Statute is not met as evidenced by: Level II Based on observation, interviews, record review, and facility policy review, the facility failed to provide incontinent care in a manner to prevent complications for one (1) of two (2) residents reviewed for care. (Resident #26) Findings Include: Review of the facility's policy, "Perineal Care", revised 1/24, revealed, " ...Purpose ...To prevent irritation or infection ...Male-Without Catheter ...4. Hold the shaft of the penis with on hand. 5. Using the other hand gently cleanse from the tip to the base of the penis ..." On 03/20/24 at 11:00 AM, Certified Nurse Aide (CNA) #9 provided incontinent care for Resident #26 after he had an incontinent episode and had a soiled brief. During the care, the CNA did not clean the resident's penis. In an interview on 03/20/24 at 11:30 AM with CNA #9, she confirmed she failed to cleanse the resident's penis during care. She explained that she had forgotten and confirmed that not cleansing the penis after an incontinent episode	M 620	1) Root Cause Analysis was conducted by the Interdisciplinary Team (IDT) on 03/22/2024 and based on findings the facility failed to provide incontinent care in a manner to prevent complications for Resident #26. Certified Nursing Assistant (CNA)#9 was educated on 03/22/2024 by the Director of Nurses (DON) to ensure perineal care is provided correctly to male residents to prevent complications. Resident #26 was assessed on 03/22/2024 by the DON with no adverse findings. 2) Male residents who require incontinent care have the potential to be affected by this deficient practice. 3) On 03/22/2024, an audit was conducted by the DON to ensure incontinent care is provided in a manner to prevent complications. Beginning on 03/28/2024, the licensed nurses and CNAs were educated by the DON and/or Staffing Nurse on ensuring incontinent care is	4/23/24

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M 620	Continued From page 10 could have caused the resident to acquire an infection. During an interview on 3/21/24 at 10:00 AM, with the Director of Nursing (DON), she stated she expected the staff to follow the standards of practice while providing incontinent care and she reported the staff received training regarding how to appropriately provide care, including cleaning the penis. A record review of the "Face Sheet" revealed the facility admitted Resident #26 on 5/23/23 and he had current diagnoses including Cerebral Infraction, Aphasia, and Dysphagia. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/10/24 revealed Resident #26 had a Brief Interview for Mental Status (BIMS) score of 00, which indicated the resident was severely cognitively impaired.	M 620	provided in a manner to prevent complications. Education will be completed by 04/19/2024. New hires will be educated upon hire on ensuring incontinent care is provided in a manner to prevent complications. 4) Beginning on 03/25/2024, the DON and/or Staffing Nurse will audit to ensure incontinent care is provided in a manner to prevent complications on 5 residents 5 times a week for 4 weeks and then 5 residents monthly for 3 months. Areas of concern will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee for review. The QAPI Committee will convene on 04/22/2024 to discuss further recommendations as needed and once a month for 3 months. Additional training and/or disciplinary action will be considered as warranted.	
M 635	45.21.7 Gastric feeding Gastric feeding. Residents who are eating alone or with assistance are not fed by a gastric tube unless their clinical condition indicates that the use of a gastric feeding tube is unavoidable. The residents who are fed by a gastric tube receive the treatment and services to prevent complications or to restore if possible, normal eating skills. This Statute is not met as evidenced by: Level II Based on observation, interviews, record review and facility policy review, the facility failed to	M 635	1) Root Cause Analysis was conducted by the Interdisciplinary Team (IDT) on 03/22/2024 and based on findings the facility failed to ensure the head of the bed	4/23/24

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M 635	Continued From page 11 ensure the head of the bed (HOB) was properly elevated for a resident who required enteral feedings and was at high risk for aspiration for one (1) of nine (9) residents observed who received nutrition by a feeding tube. Resident #26 Findings include: Record review of the facility's policy, "Tube Feedings" revised 12/15, revealed, " ...4. A resident who is fed by nasogastric, jejunostomy or gastrostomy tubes will receive appropriate treatment and services to prevent aspiration pneumonia ..." During an interview on 03/19/24 at 01:07 PM, a family member for Resident #26 stated the staff provided care to the resident by laying him flat, even though he had a high risk for aspiration. She stated the feeding tube was not infusing while staff provided care, but the resident could not tolerate lying flat at any time and the HOB must be kept elevated. During an observation on 03/20/24 at 11:00 AM, Certified Nursing Assistant (CNA) #9 lowered the HOB until Resident #26 was lying flat. CNA #9 completed incontinent care and the HOB was not elevated during the care. During an interview on 03/20/24 at 11:30 AM, with CNA #9, she confirmed she had lowered the HOB and Resident #26 was lying flat while she provided care. CNA #9 said that she was aware Resident #26 had a high risk for aspiration and explained that it was difficult to turn the resident without assistance if the HOB was elevated. CNA #9 confirmed that she had not asked any other staff to assist with providing care to Resident #26.	M 635	(HOB) was properly elevated for a resident who required enteral feedings for Resident #26. Certified Nursing Assistant (CNA)#9 was educated on 03/22/2024 to ensure the HOB is properly elevated for a resident who requires enteral feedings by the Director of Nurses (DON). Resident #26 was assessed on 03/22/2024 by the DON with no adverse findings. 2) Residents who receive tube feeding have the potential to be affected by this deficient practice. 3) On 03/22/2024, an audit was conducted by the DON to ensure the HOB is properly elevated for a resident who requires enteral feedings. Beginning on 03/28/2024, licensed nurses and CNAs were educated by the DON and/or Staffing Nurse on ensuring the HOB is properly elevated for a resident who requires enteral feedings. Education will be completed by 04/19/2024. New hires will be educated upon hire on ensuring the HOB is properly elevated for a resident who requires enteral feedings. 4) Beginning on 03/25/2024, the DON and/or Nurse Supervisor will audit to ensure the HOB is properly elevated for a resident who requires enteral feedings on 5 residents 5 times a week for 4 weeks and then 5 residents monthly for 3 months. Areas of concern will be reported to the Quality Assurance and Performance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34HH	A. BUILDING: _____ B. WING _____	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE CENTER OF LAUREL	935 WEST DR LAUREL, MS 39440

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M 635	Continued From page 12 During an interview on 3/21/24 at 10:00 AM, with the Director of Nursing (DON), she said she expected the staff to follow the standards of practice while providing care to residents. The DON confirmed the CNA should have kept the Resident #26's HOB elevated at least 30 degrees and stated "she should have asked for assistance rather than lying the resident flat." A record review of the "Face Sheet" revealed the facility re-admitted Resident #26 on 5/23/23 and he had current diagnoses including Cerebral Infraction, Aphasia, and Dysphagia. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/10/24 revealed Resident #26 had a Brief Interview for Mental Status (BIMS) score of 00, which indicated the resident was severely cognitively impaired.	M 635	Improvement (QAPI) Committee for review. The QAPI Committee will convene on 04/22/2024 to discuss further recommendations as needed and once a month for 3 months. Additional training and/or disciplinary action will be considered as warranted.	