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
	06ZG	A. BUILDING: _____ B. WING _____	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF SHELBY	1108 CHURCH STREET SHELBY, MS 38774

(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 and a Compliant Investigation (CI) with one (1) complaint, CI MS # 24203 at the facility from 5/19/24 through 5/22/24. The SA found the facility was in compliance related to misappropriation of property for CI MS #24203. No citations were written related to the CI. During the recertification 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 cited M635.	M 000		
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, staff interview, and record review and facility document review, the facility failed to ensure a resident who received enteral nutrition received appropriate treatment and services, as evidenced by, the facility's failure to administer an enteral feeding according to the physician's order for one (1) of 11 residents with a feeding tube. Resident #1 Findings Include: Record review of a typed document on facility	M 635	M635 1. Resident # 1 was immediately assessed by the Director of Nursing on 05/21/2024. 2. All Residents in the center who receives Enteral tube feedings are at risk for the deficient practice. 3. The Director of Clinical Education educated nurses on 05/24/2024 on following Medical Director orders, administering enteral feedings as ordered	6/27/24

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M 635	Continued From page 1 letterhead, dated 5/21/24 and signed by the Licensed Nursing Home Administrator revealed, "Standards of Practice: The expectation set forth by (Proper Name of the facility) is that nurses comply with current standards of practice in terms of following physician's orders. This includes following orders for medication and enteral feedings." An observation on 5/19/2024 at 12:25 PM, revealed Resident #1 with his eyes closed lying in bed.. A bottle of Jevity 1.5 was hanging via pump, which was turned off. An observation on 5/19/2024 at 3:15 PM, revealed Resident #1 lying in bed with his eyes closed. A bottle of Jevity 1.5 was hanging via pump, which was turned off. An interview with Licensed Practical Nurse (LPN) #2 on 5/19/2024 at 3:55 PM, confirmed Resident #1's enteral feeding was turned off. Record review of the May 2024 MAR for Resident #1 revealed an order dated 3/12/2024, "Enteral feed one time a day turn feeding pump off" scheduled for 7:00 AM, signed as administered on the MAR, which indicated the resident was receiving this order. An additional order dated 3/12/2024 revealed, "Enteral Feed Order one time a day turn feeding pump on" scheduled for 1500 (3:00 PM) signed off as administered on the MAR, which indicated the resident was receiving this order. Record review of the May 2024 Medication Administration Record (MAR) for Resident #1 revealed an order dated 5/7/2024, "Enteral feed order every shift Jevity 1.5 @ 65 ml/hr (milliliters per hour) x (times) 22 hours, 2145 kcal	M 635	with emphasis placed on the importance of not signing orders that are questionable. If any doubt or questions about an enteral order or any other orders, please notify MD for correct orders. Do no just click on the Medication Administration Record. 4. All new orders related to enteral feed will be reviewed by the Interdisciplinary team daily in the stand-up meeting to discuss enteral feeding orders and ensure the correct orders are documented and all feeding orders discontinued. This audit will be done daily for two weeks effective 6/05/2024, weekly X 4 weeks, then monthly X 3 months. The results of the audit will be submitted to Quality Assurance Performance Improvement committee on 6/26/2024, then monthly for the next 3 months.	

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M 635	Continued From page 2	M 635		

(kilocalories); 90g (grams) protein; 2330 ml (milliliter) total fluid" which was signed off on the MAR as administered, which indicated the resident was receiving this order.

During an interview with the Director of Nursing (DON) on 5/20/2024 at 8:45 AM revealed several weeks ago Resident #1 began not eating meals, and they increased his tube feeding. She revealed he was supposed to be receiving Jevity1.5 at 65 ML/HR (milliliters per hour) x (times) 22 hours. She confirmed the Jevity was not supposed to be off between the hours of 7:00 AM to 3:00 PM and stated the order should have been discontinued. The DON revealed an error was made by not removing the order from the resident's MAR. She revealed she took responsibility for the error because she put the new feeding order into the medical record and did not take out the other discontinued order. She confirmed weight loss could be a concern.

An interview with Registered Nurse (RN) #1 on 5/21/2024 at 9:02 AM, confirmed he was aware Resident #1 had two enteral feeding orders on the MAR. He revealed there was a problem with communication and the old order was not discontinued. He stated he had been turning the resident's feeding pump off at 7:00 AM and re-starting it at 3:00 PM daily, and confirmed he was signing both orders. RN #1 revealed he should have questioned the order and called the doctor for clarification and confirmed he should not sign a physician's order on the medical record that was not given. He revealed that the resident was at risk for dehydration, weight loss and malnutrition by not getting the appropriate enteral feeding.

An interview with the Administrator (ADM) on

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M 635	Continued From page 3 5/21/2024 at 9:48 AM, revealed the nurses should have questioned two different enteral feeding orders on the MAR. She revealed they should not have signed both orders as administered, and confirmed this was a standard of practice issue. She acknowledged Resident #1 was at risk for weight loss by not getting the correct enteral feeding order. During a telephone interview with the Registered Dietician (RD) on 5/21/2024 at 10:22 AM, confirmed Resident #1 was at risk for weight loss if he did not get the prescribed enteral feeding. Record review of the "Admission Record" revealed the facility admitted Resident #1 on 9/8/2019 with current medical diagnoses that included Alzheimer's Disease, Dysphagia, and Gastrostomy status.	M 635		