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
	19ME	A. BUILDING: _____ B. WING _____	04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADVILLE CONVALESCENT HOME	300 HWY 556/ROUTE 2 BOX 66 MEADVILLE, MS 39653

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M 000	Initial Comments The State Agency (SA) conducted an annual recertification survey at the facility from 04/21/2024 through 04/24/2024. 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 cited M815, M1205 and M1570.	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	M 500		6/6/24

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M 500	Continued From page 1	M 500		

treatment, to not be limited in his/her choice of a 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

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M 500	Continued From page 2 in conformance with State law; 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	M 500		

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M 500	Continued From page 3 practitioner/physician assistant in his medical 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 observations, staff interviews, record review and facility policy review the facility failed to ensure a resident was free from a physical restraint offer as evidenced by failure to identify a seatbelt as a restraint for one (1) of 15 sampled residents. Resident #1	M 500	" The code status of RI# 7 & 41 was verified by Medical Records on 04/22/2024 and entered into all relevant locations within the Electronic Health Record. " All Residents have the potential to be affected. " The Social Worker Consultant and	

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M 500	Continued From page 4 Findings include: Record review of facility's policy titled, "Restraints," revised 11/28/17, revealed, "Policy: ... The use of restraint shall be based on comprehensive resident assessment that includes the physical assessment to identify medical conditions that may be causing behavior changes in resident. The assessment will also be performed to determine the safety and protective needs of the resident prior to the application of restraint ... Documentation: Documentation in the medical record should include: Restraint order, including the rationale for the restraint, the type of restraint ... the duration (timeframe) for the restraint application...Alternatives or less restrictive interventions attempted...The resident's medical conditions or symptoms that warranted the use of restraint, The resident's response to the restraint, including the rational for continued use of the intervention, Assessment and reassessments of the resident, Revision to the treatment plan, Unanticipated changes in residence condition, Condition/behavior required of the resident for release of restraints, The discussion with resident family regarding need for restraints ..." During an interview on 04/21/24 at 12:53 PM, with Licensed Practical Nurse (LPN) #6, she revealed Resident #1 has always worn the seatbelt. LPN #6 confirmed there was not an order in place for the seatbelt. LPN #6 also revealed that there was no restraint flow sheet in place. In an observation on 04/21/24 at 1:43 PM, Resident #1 was sitting in her wheelchair with a seatbelt intact and no one in the room with her. The resident was unable to demonstrate the	M 500	Director of Nursing In-Serviced the social worker and Minimum Data Set Nurses 05/14/2024 on ensuring the resident has executed an advanced directive on admission and upcoming MDS assessment schedule. A 100% audit was completed on all current residents to ensure their advance directives were accurate on 04/22/2024 by the Medical Records nurse. " For the next three months the Quality Assurance Nurse will perform weekly Audits beginning 05/16/2024 on all new admission and those residents on the MDS assessment Schedule for consistent documentation of the resident□s Advance Directive/code status throughout the electronic health record. After three months, the Quality Assurance Nurse will complete audits every other week on all new admissions and those residents on the MDS assessment Schedule for consistent documentation of the resident□s Advance Directive/code status throughout the electronic health record. Results of the audits will be discussed monthly with the QA committee beginning in June 06,2024 and will continue for 3 months or until such time it is determined that substantial compliance is maintained.	

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ability to open the seatbelt on her own.

During an interview on 04/22/24 at 12:53 PM, the Director of Nursing (DON) stated the seat belt on the wheelchair met the definition of a restraint, as defined by facility policy. The DON revealed the facility had recently conducted an audit of restraints and had somehow missed the seatbelt used by Resident #1. The DON stated the facility's interdisciplinary team is responsible for collaborating with other facility staff regarding this issue and a physician's order, consent with reassessment and monitoring tools should be in place for all restraints.

During an interview with the Administrator on 04/24/24 at 1:07 PM, confirmed a physician's order, consent with reassessment, as well as a monitoring tool should be in place for all restraints.

Record review of the "Order Summary Report," with active orders as of 4/23/24, revealed there was no physician order for the use of a seat belt as a restraint. Further review of the medical record revealed there was no documentation of an assessment regarding the use of a seat belt or the use of any type of least restrictive device, nor was there a restraint flowsheet in place for use.

Record review of the "Admission Record" revealed Resident #1 readmitted on 7/24/23 with diagnoses that included Intracranial Injury with Loss of consciousness, status unknown and Other developmental disorders of speech and language.

Record review of the Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 2/16/24, revealed the resident had a

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M 500	Continued From page 6 Brief Interview for Mental Status (BIMS) score of 02, which indicated the resident had severe cognitive impairment. Further review of the MDS revealed the resident was dependent on staff for assistance with all her activities of daily living.	M 500		
M 815	45.29.1 Safe Food Handling Procedures Safe Food Handling Procedures. Food shall be prepared, held, and served according to current Mississippi State Department of Health Food Code Regulations. This Statute is not met as evidenced by: Level II Based on observation, interviews, record review, and facility policy review, the facility failed to monitor and record freezer and refrigerator temperatures daily and discard expired foods for one (1) of four (4) kitchen observations. This has the potential to affect 48 of the 52 residents that reside in the facility. Findings include: Review of facility's policy titled, "Food Safety Requirements," dated 10/12/22, revealed Policy: ...Food will also be stored, prepared, disturbed, and served in accordance with professional standards for food service safety ... Policy Explanation and Compliance Guidelines: 1. Food safety practices shall be followed throughout the facility's entire food handling process ... Elements of the process include the following: b. Storage of food in a manner that helps prevent deterioration or contamination of the food including from growth of microorganisms ... 3 ...	M 815	" Dietary Manager was in serviced by the Administrator 05/15/2024 on monitoring and recording the freezer and refrigerator temperature daily and discarding expired food. The expired food was discarded was discarded 04/21/2024 " The facility has determined that all residents have the potential to be affected. " All Dietary Staff will be in serviced by the administrator 05/15/2024 on the importance of recording temperatures daily and discarded expired food to ensure compliance. " Temperature logs will be audited weekly for 8 weeks beginning 05/16/2024 by the Quality Assurance Nurse and Staff educator. Audits will be reviewed by the Quality Assurance Committee on June 06,2024 then monthly for 3 months or until such time consistent substantial	6/6/24

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M 815	Continued From page 7 c. Refrigerated storage ... c ... Practices to maintain safe refrigerated storage include: i. Monitoring food temperatures and functioning of the refrigeration equipment daily and at routine intervals during all hours of operation... iv. Labeling, dating, and monitoring refrigerated food, including but not limited to leftovers, so it is used by its use-by-date or frozen (where applicable) discarded; and v. Keeping foods covered or in tight containers ..." On 04/21/24 at 11:35 AM, the initial tour of the kitchen with the Dietary Cook (DC), revealed seven (7) 32-ounce bottles of a browning and seasoning sauce, with an expiration date of 4/1/22. One of these bottles was opened and in the kitchen area. The was also a 32-ounce carton of opened liquid eggs, without a legible opened date. On 04/21/24 at 11:47 AM, while continuing the kitchen tour with the Dietary Manager (DM), review of the refrigerator/freezer/temperature logs, revealed the logs were pre-filled with temperatures for the entire month of April 2024 for three (3) of the six (6) units that required temperature checks. The logs for the additional three (3) units revealed no record of daily temperature checks. Review of the March 2024 refrigerator/freezer temperature logs revealed only five (5) of the six (6) units were monitored. On 04/21/24 at 11:58 AM, in an interview the DM, she stated "staff know better." She confirmed all expired items are to be pulled on their expiration date. She stated Dietary Aid (DA) #1 is responsible for removing expired items from the storage. She stated staff should check the temperature on all units daily and record, as that lets staff know that the units are functioning	M 815	compliance has been achieved as determined by the committee.	

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M 815	Continued From page 8 properly. On 04/21/24 at 12:15 PM, in an interview with DA #1, stated she is responsible for checking all the freezer and refrigerator temperature logs. She admitted she pre-filled the refrigerator/freezer temperature logs due to trying to catch up on the logs, because there are times when she does not check them. On 04/22/24 at 10:50 AM, in an interview with the DM, stated all the unit's refrigerator/freezer temperature logs should be checked daily and revealed that it is her responsibility to check the logs. She confirmed that they did not have documentation of all the units being checked daily. On 04/24/24 1:00 PM in an interview with Administrator stated he expects DM and staff to know and understand the regulations and requirements and follow them.	M 815		
M1205	45.40.6 Floors Floors. All floors shall be smooth and free from defects such as cracks and be finished so that they can be easily cleaned. This Statute is not met as evidenced by: Level II Based on observations and staff interviews the facility failed to ensure tiles in the resident shower area were free from black grime and broken tiles were repaired and floors in three (3) common areas were free from cracked tiles and gaps in the floor for one (1) of four (4) days of survey.	M1205	" The Director of Plant Operations will ensure that the floor of the resident shower will be repaired, and the inside of the shower will be cleaned to ensure the area is safe for residents usage. The shower was cleaned 04/24/2024 by an outside cleaning service. " All residents have the potential to be affected.	6/6/24

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M1205	Continued From page 9 Findings include: During an observation and interview on 4/24/24 at 9:06 AM, of the resident shower, the floor was noted to have buckling floor tile near the entrance of the shower. Inside the shower, dark black grime was noted in the corners. An interview with Certified Nursing Aide (CNA) #1 revealed she was the shower aide. She explained that the floor tile has been buckling for a while and the tile near the toilet has been broken for a long time. She stated she had made previous maintenance staff aware of the tile, but it had not been repaired yet. She confirmed the black grime in the corners of the resident shower. During an observation on 4/24/24 at 9:51 AM, of the resident shower and facility hallways with the Maintenance Director, he revealed that he was aware of the numerous cracked tiles and gaps in the floor throughout the facility in high traffic areas. He explained that he had been patching, as best he could. He revealed every time he replaced some of the tiles, more tiles became cracked and at this point, it's a "no-win" situation. The Maintenance Director stated he was not aware that the shower room had tile coming up and buckling. He confirmed that some of the cracks in the tile could be considered trip hazards and could cause injury to residents and employees, as they were large enough to cause an uneven surface. On 4/24/24 at 10:51 AM, during an observation and interview with the Administrator revealed that he was aware of the numerous cracked tiles and gaps in the floor throughout the facility. He explained that the maintenance staff have been patching the broken tile as best they could, however the facility was old and needed updating	M1205	" Temporary repairs were completed using internal resources. The external resources for repairs will be completed within 120 days of survey exit, August 24, 2024 Ownership, Director of Plant Operations and the Administrator are soliciting quotes to repair flooring in all communal areas within the facility. Once the quotes have been obtained and vendor chosen, renovations will begin based on scheduling with external vendor. Quotes began being obtained 05/10/2024. Period for completion will be based on logistical barriers of vendor. Part and partial to choose will be vendors availability. Specific to the communal areas noted in the 2567, The Director of Plant Operations, in collaboration with Administration will ensure that the areas are repaired, ensuring resident and staff safety, within 120 days of survey exit, August 24, 2024 " The QA nurse will perform weekly audits of the shower room to monitor for cleanliness and make sure no further tiles are in need of repair beginning 05/16/2024 and will be done weekly for 8 weeks. Results of the audits will be discussed by the Quality Assurance Committee monthly beginning 06/06/2024 and then for 3 months or until substantial compliance is maintained as determined by the committee.	

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M1205	Continued From page 10 throughout. The Administrator revealed he was not aware that the shower room had tile coming up and buckling throughout and confirmed that this could be a hazard that could cause injury to residents and staff.	M1205		
M1570	48.58.1 Infection Control The following infection control standards shall be met: 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, interviews, record reviews,	M1570	" Resident #11 Continuous Positive Airway Pressure Mask was cleaned and placed in a storage bag by the Staff	6/6/24

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M1570	Continued From page 11 and facility policy review, the facility failed to ensure that a resident's CPAP (Continuous positive airway pressure) mask was properly stored, when not in use, for one (1) of (1) residents reviewed that required respiratory care. Resident #11 Findings include: Review of facility's policy titled, "Oxygen, Nebulizer, CPAP/BIPAP (Bilevel positive airway pressure)," with a revision date of 6/14/23, revealed, "It is the policy of this facility to clean, disinfect, label and store supplies, nebulizer supplies, CPAP and BIPAP supplies appropriately ... 3.vi. While not in use, store oxygen tubing, mask/cannula, nebulizer mask and tubing, and CPAP/BIPAP mask and tubing in a labeled (date) storage bag ..." On 04/21/24 at 1:08 PM, during an interview and observation with Resident #11, a CPAP mask was lying on table by the resident's bed. It was not in a labeled storage bag. Resident #11 stated "it is never put in a bag." On 04/21/24 at 1:30 PM, in an interview with Licensed Practical Nurse (LPN) #1/Charge Nurse confirmed Resident #11's CPAP mask should be in a bag to keep it clean, as the bag will prevent germs from getting in it. On 04/24/24 10:26 AM, in an interview with LPN #3/IP (Infection Preventionist) stated when not in use, Resident #11's CPAP mask should be in a bag to prevent bacteria from getting on the mask and causing infection. She IP confirmed the staff should make sure this is done. On 4/24/24 at 12:56 PM, in an interview the	M1570	Development Nurse on 04/21/2024 and labeled with initial and date. " The facility has determined that all residents that use a Continuous Positive Airway Pressure Machine have the potential to be affected. " All Nurses and Certified Nursing will be in-serviced on the facility□s Policy titled Oxygen, Nebulizer, Continuous Positive Air Way Pressure Machine/ Bilevel Positive Airway Pressure Machine by the Staff Educator on 05/15/2024 All Nurses and nursing assistants will be in-serviced by the Staff Educator 05/15/2024 to ensure all residents with a Continuous Positive Air Way Pressure mask are properly stored when not in use. " The Quality Assurance nurse will audit all resident that have a Continuous Positive Pressure Airway Machine, weekly for 8 consecutive weeks starting 05/16/2024. The Quality Assurance nurse will make weekly rounds to monitor for proper cleaning/storage of Continuous Positive Airway Pressure Masks beginning 05/16/2024. The audits will be reviewed by the Quality Assurance Committee monthly starting on June,6, 2024 and will continue fpr 3 months or until such time consistent substantial compliance has been achieved as determined by the committee.	

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MEADVILLE CONVALESCENT HOME	300 HWY 556/ROUTE 2 BOX 66 MEADVILLE, MS 39653

(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
M1570	Continued From page 12 Administrator stated he certainly expected staff to have knowledge of CPAP care and staff to monitor usage and follow protocol for safe storage when not in use. Record review of the "Order Summary Report," with active orders as of 4/24/24 revealed an order dated 3/7/24 "Wear CPAP @ (at) night ... related to Sleep Apnea, Unspecified." Record review of the "Admission Record" for Resident #11 revealed the facility admitted the resident on 5/23/13 .Current diagnoses included sleep apnea. Review of the Minimum Data Set (MDS), for Resident #11, with an Assessment Reference Date (ARD) of 4/4/24, revealed a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident is cognitively intact.	M1570		