| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 255251 | A. BUILDING _____ B. WING _____ | 05/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| MS CARE CENTER OF DEKALB | 220 WILLOW AVENUE DE KALB, MS 39328 |

| (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) COMPLETION DATE |
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| F 000 | INITIAL COMMENTS<br><br>The State Agency (SA) conducted an annual recertification at the facility from 5/6/24 through 5/8/24. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F558, F689 and F757.<br><br>The facility held a license for 60 beds, with a census of 53. | F 000 | | |
| F 558 SS=D | Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3)<br><br>§483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, resident and staff interview, and facility policy review, the facility failed to provide an appropriately sized wheelchair for one (1) of fifty-three residents residing in the facility during the survey. Resident #37<br><br>Findings Include:<br><br>Review of the facility policy titled "Resident Rights Policy" with a revision date of 9/2022 revealed under, "Reasonable Accommodations of Needs/Preferences: The resident has the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents." | F 558 | 1. Upon being made aware of Resident #37s complaint, the Director of Nursing (DON)/Assistant Director of Nursing (ADON) And Occupational Therapist (OT) assessed the resident and a larger wheelchair was located and care planned for resident. A customized wheelchair was ordered 5/22/2024 for Resident #37.<br>2. Facility determined that there are 46 residents in wheelchairs that could be affected of which 20 are customized chairs.<br>3. DON/OT Assessed 46 residents in wheelchairs (5/9/24)to ensure wheelchairs are appropriately sized for the residents occupying those wheelchairs. Quarterly assessment of residents having a Minimal | 6/3/24 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 05/31/2024

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| F 558 | Continued From page 1<br><br>An observation and interview with Resident #37 on 5/6/2024 at 10:57 AM, revealed she was sitting in a wheelchair and slightly slouched forward. There was not enough seating space and the residents' hips, and outer thighs were tight against the edges of the wheelchair. The resident voiced that her wheelchair was too small.<br><br>An observation and interview with the Director of Nursing (DON) on 5/7/2024 at 10:54 AM, confirmed Resident #37's wheelchair was too small. She revealed the family brought the wheelchair into the facility on admission, but the resident had gained weight and the wheelchair no longer fit the resident's size. She confirmed the resident should have an appropriately sized chair to ensure comfort and prevent skin concerns.<br><br>Record review of the "Facesheet" revealed the facility admitted Resident #37 on 10/3/2023 with medical diagnoses that included Morbid obesity, Chronic pain, and Unspecified dementia. | F 558 | Data Set (MDS) review will have wheelchairs assessed to make sure wheelchairs are properly fitting conducive to the individual's need by DON/OT. Resident counsel was apprised of findings of Survey 5/28/24.<br>4. Residents are evaluated at least quarterly to include an evaluation of proper fitting wheelchair by DON/OT ---or sooner if excessive weight gain/loss or change of condition is warranted. The Quality Assurance Performance Improvement (QAPI) Team will monitor weekly/monthly beginning 5/9/2024 x 3 week excessive weight gain/loss of all residents. DON/OT will be involved in assessing any resident that is in a wheelchair to ensure proper fitting and, with Social Services, discuss with family and resident the need to either have family replace their personal wheelchair or have a wheelchair purchased that will ensure adequate and appropriate care. Beginning 5/9/2024 QAPI findings are reviewed by Quality Assurance (QA) Team monthly x 3 weeks to ensure compliance.<br>5. QA meeting June 3, 2024 to discuss findings and ensure compliance. | |
| F 689 SS=D | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent | F 689 | | 6/3/24 |

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| F 689 | Continued From page 2<br>accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, and facility policy review the facility failed to provide residents with a safe environment, as evidenced by various spray bottles and cans of chemical disinfectant, cleaning, and insecticide sprays, found unsecured on two hanging shelves on the B hallway for one (1) of three (3) days of survey.<br><br>Findings include:<br><br>Review of the facility policy titled, "Storage of Chemicals", undated, revealed, "Policy: The facility ensures the quality and safety of our residents through accepted storage practices. Procedure: 1. Chemicals are stored in a storage area, designated only for chemicals that can be locked. 2. Chemicals are safely stored for the protection of others by placing in locked carts while on halls during housekeeping procedures ..."<br><br>On 5/06/24 at 10:40 AM, observation during the initial tour revealed on the B-Hall two (2) wooden shelves hanging approximately six (6) feet up on the right side of the wall. Shelf #1 had three chemical spray bottles: Cleaner/ Disinfectant, deodorizer, and fungicide. A label with "HALT Danger" on the bottles was noted. Shelf #2 revealed a can of chemical crawling insecticide spray and four chemical sprays labeled with "HALT Danger."<br><br>An interview on 5/06/24 at 10:50 AM, Housekeeper #1 confirmed the items were used to sanitize and clean and one was also an insecticide spray. She revealed we used those | F 689 | 1. Chemicals were immediately removed (5/6/2024) from high shelf on A-Hall and B-Hall and placed in a locked closet to prevent harm to 53 residents.<br>2. Facility determined that 53 (All) Residents have potential to be affected by the deficient practice.<br>3. Quality Assurance Performance Improvement (QAPI)/Safety Director reviewed and updated Storage of Chemical/Equipment policy discussed the removal of the chemicals from the hallways and completed in-service 5/20-21/2024 with all staff to ensure their awareness of the necessity of use and where chemicals are now stored. Resident Council was apprised of Survey findings 5/28/24.<br>4. Environmental Manager and Safety Manager began hall monitoring 5/9/2024 and will walk the halls daily to ensure chemicals are properly stored. Managers will then report findings x 3 Weeks to Quality Assurance (QA) Team (6/3/2024) to enforce the need to keep chemicals locked away from residents. Safety Meeting, Environmental QAPI will continue their monitoring indefinitely. QA Team will review findings as presented by Safety Committee for 3 weeks on 6/3/2024 to ensure compliance. | |

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| F 689 | Continued From page 3<br>when we had COVID-19 and they have always stayed up on the wall in the hallway.<br><br>During an observation and interview on 5/06/24 at 11:00 AM, the Environmental Manager revealed we keep the supplies up there so the staff can spray the equipment off. He confirmed that the chemical supplies were accessible to anyone and that residents could access the shelf with the chemicals on it.<br><br>Observation and interview on 5/06/24 at 11:05 AM, the Administrator (ADM) confirmed the unsecured chemicals could be an accident hazard and should be kept locked up and away from the residents and visitors.<br><br>Record review of the accident and incident log for the last year revealed there were no incidents related to chemicals being left unsecure. | F 689 | | |
| F 757 SS=D | Drug Regimen is Free from Unnecessary Drugs<br>CFR(s): 483.45(d)(1)-(6)<br><br>§483.45(d) Unnecessary Drugs-General.<br>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-<br><br>§483.45(d)(1) In excessive dose (including duplicate drug therapy); or<br><br>§483.45(d)(2) For excessive duration; or<br><br>§483.45(d)(3) Without adequate monitoring; or<br><br>§483.45(d)(4) Without adequate indications for its use; or | F 757 | | 6/3/24 |

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| F 757 | Continued From page 4<br>§483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or<br><br>§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, record review and facility policy review, the facility failed to monitor a resident receiving anticoagulant medication for signs of bruising and bleeding for one (1) of five (5) residents reviewed for unnecessary medication. Resident #27<br><br>Findings Include:<br><br>Record review of the facility policy titled "Medication Monitoring" with a revision date of 8/13/2023 revealed under, "Policy: This facility takes a collaborative, systematic approach to medication management, including the monitoring of medications for efficacy and adverse consequences."<br>Record review of the May 2024 "Physician Orders" for Resident #27 revealed an order dated 12/16/2020, "Eliquis (blood thinner) 2.5 MG (milligrams) by mouth twice a day R/T (related to) circulation".<br><br>Record review of the "Physician Orders" and the "Medication Administration Record" (MAR) revealed there was not a monitoring tool for staff to monitor for signs of bruising and bleeding with the anticoagulant (blood thinner) medication Eliquis.<br><br>An interview with Licensed Practical Nurse (LPN) | F 757 | 1. Resident #27 showed monitoring on a medication that was not being documented. Immediately, Director of Nursing (DON) corrected this error by including on the facility American Healthtech (AHT) system a mandatory monitoring on all medications requiring monitoring, per facility policy. Corrected 5/8/2024.<br>2. Facility determined that all residents (53) have the potential to be affected by the same deficient practice.<br>3. The policy related to Medication Monitoring and Use of Anti-Coagulant Drugs outlining proper monitoring of Resident(s) for anticoagulants/psychotropic Drugs medications was reviewed and approved on 5/8/2024 by Quality Assurance (QA) team. Medical Records, DON immediately reviewed all medications requiring monitoring, added in the system controls for monitoring completed 5/8/24. Resident Council apprised of Survey findings 5/28/24.<br>4. Beginning 5/9/2024 QA team will review the Minimum Data Systems (MDS) Coordinator data related to all related audits and/or in-services x 3 weeks. QA will determine the necessity of corrective | |

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| F 757 | Continued From page 5<br>#1 on 5/7/2024 at 1:40 PM revealed she considered anticoagulant medication to be a high-risk drug that should be monitored for adverse outcomes. She confirmed the facility did not have a monitoring task implemented on the Medication Administration Record (MAR) for Resident #27 for bruising or signs of bleeding.<br><br>An interview with the Assistant Director of Nursing (ADON) on 5/7/2024 at 2:02 PM confirmed the facility did not have a system in place to trigger the nurses to monitor for the potential outcomes associated with the use of blood thinners.<br><br>Record review of the "Face Sheet" revealed the facility admitted Resident #27 on 12/16/2020 with medical diagnoses that included schizophrenia and unspecified dementia. | F 757 | measures as well as the continued frequency of relevant audits and/or training or in-services needed based upon results achieved and to ensure compliance.<br>The MDS Coordinator began monitoring side effect audits of anticoagulant medications 5/9/2024 for all residents receiving anticoagulant medications per policy with the same to be conducted for at least five (5) residents weekly x 3 weeks to present to QA Team on 6/3/2024. | |