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
	72TC	A. BUILDING: _____ B. WING _____	06/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUNICA COUNTY HEALTH & REHAB, LLC	1024 HIGHWAY 61 SOUTH TUNICA, MS 38676

(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 at the facility from 6/17/24 through 6/19/24 .During the survey the SA determined the facility was not in compliance with the Minimum Standards of Operation for Institutions for the Aged or Infirm, state licensure requirements and deficiencies were cited at M 640 and M 655. The facility held a license for 60 beds, with a census of 48.	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: Based on staff interview, record review, and facility policy review, the facility failed to implement interventions to reduce the risk of accidents and hazards when staff transferred a resident in a mechanical lift with only one (1) staff assist, when the resident required the assistance of two (2) staff members for 1 of three (3) residents reviewed for accidents and hazards. (Resident # 1) Findings include: Review of the policy titled, "Lifting Machine, Using a Portable," revised February 2014, revealed two (2) nursing assistants are required to perform the procedure.	M 640	1. On 6/18/24 Administrator in-serviced all staff on shift on mechanical lifts, including types of lifts and number of people required to operate (minimum 2). 2. On 6/28/24 Administrator reviewed Lift Identification sheet and determined that 23 of 51 residents, currently in facility utilize a mechanical for transfers and have the potential to be affected by the same deficient practice. 3. All licensed and certified staff in-serviced by administrator on Types of Lifts, steps in procedure of using Lift Machines, number of staff required to perform procedure, how to identify transfer	7/30/24

Mississippi State Department of Health

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

Electronically Signed | 07/01/24

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M 640	Continued From page 1 Record review of the incident report dated 6/14/24 at 7:04 PM for Resident #1, revealed while Certified Nurse's Assistant (CNA) was transferring the resident with the lift, the resident became unstable due to being combative with care, and was assisted to the floor in an attempt to prevent a fall. The nurse assessed a small, reddened area noted to the left knee. Resident #1 was lifted from the floor via lift x (times) four (4) staff members and placed in a wheelchair. An interview with CNA #3 on 6/18/24 at 9:00 AM, revealed that there must be at least 2 staff present while using the mechanical lift because it reduces the risk of a resident getting hurt with staff support. Record review of the Lift/Transfer Evaluation for Resident #1 dated 4/30/24, revealed Mechanical floor lift required with transfer to and from: bed-to-chair, chair-to-toilet, and chair-to-chair. An interview with the Director of Nursing (DON) on 6/18/24 at 1:25 PM, revealed that all residents requiring a mechanical lift must have assistance of 2 staff unless otherwise care planned. She confirmed that during her investigation of the incident on 6/14/24 involving Resident #1, she found that CNA #2 did not use 2 staff assist to transfer Resident #1. She then revealed by not transferring Resident #1 with the appropriate staff required, would place the resident and staff at risk for injury, such as falls, skin tears, or fractures. An interview with CNA #2 on 6/18/24 at 1:58 PM, confirmed she did not have two staff present to transfer Resident #1 on 6/14/24 with a lift when he had to be lowered to the floor. She stated she knew at least two staff were required to transfer each resident, but stated it was the end of her	M 640	needs, and documentation of transfers. In-servicing began 6/20/24 and completed by 7/1/24. All licensed staff to perform demonstration of lifting procedure under observation of Administrator, Director of Nursing, Nursing Care Coordinator or CNA Coordinator referencing Vander Lift and Vera Lift Skills Observation Assessment. Check Off's began on 6/21/24 and completed by 7/1/24. on 7/1/24 the Quality Assurance committee reviewed the policies "Lifting Machine, Using a Portable" and "Accidents and Incidents" with no recommended changes to the policy. 4. On 7/2/24, the Director of Nursing, Resident Care Coordinator, Nursing Care Coordinator, CNA coordinator or MDS nurse will observe a minimum of 6 residents every week during transfer process times 4 weeks, then 3 residents weekly times 8 weeks until each resident requiring mechanical lift has been observed twice to ensure staff compliance with lifting policy. Quality Assurance meeting held 7/1/24 and Using a Portable Lifting Machine added to ongoing Quality Assurance monitoring and Quality Assurance committee will recommend changes as needed. Follow up Quality Assurance meeting to be held 7/29/24 and will be quarterly thereafter. 5. The corrective action will be completed by 7/30/24.	

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M 640	Continued From page 2 shift and Resident #1 was wet, and she would rather not leave him wet, so she went ahead and transferred him. Record review of the Face Sheet revealed the facility admitted Resident #1 on 1/17/19 with a diagnosis of Unspecified Dementia and Cerebral infarction. Level II Based on staff interview, record review, and facility policy review, the facility failed to implement interventions to reduce the risk of accidents and hazards when staff transferred a resident in a mechanical lift with only one (1) staff assist, when the resident required the assistance of two (2) staff members for 1 of three (3) residents reviewed for accidents and hazards. (Resident # 1) Findings include: Review of the policy titled, "Lifting Machine, Using a Portable," revised February 2014, revealed two	M 640		

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M 640	Continued From page 3 (2) nursing assistants are required to perform the procedure. Record review of the incident report dated 6/14/24 at 7:04 PM for Resident #1, revealed while Certified Nurse's Assistant (CNA) was transferring the resident with the lift, the resident became unstable due to being combative with care, and was assisted to the floor in an attempt to prevent a fall. The nurse assessed a small, reddened area noted to the left knee. Resident #1 was lifted from the floor via lift x (times) four (4) staff members and placed in a wheelchair. An interview with CNA #3 on 6/18/24 at 9:00 AM, revealed that there must be at least 2 staff present while using the mechanical lift because it reduces the risk of a resident getting hurt with staff support. Record review of the Lift/Transfer Evaluation for Resident #1 dated 4/30/24, revealed Mechanical floor lift required with transfer to and from: bed-to-chair, chair-to-toilet, and chair-to-chair. An interview with the Director of Nursing (DON) on 6/18/24 at 1:25 PM, revealed that all residents requiring a mechanical lift must have assistance of 2 staff unless otherwise care planned. She confirmed that during her investigation of the incident on 6/14/24 involving Resident #1, she found that CNA #2 did not use 2 staff assist to transfer Resident #1. She then revealed by not transferring Resident #1 with the appropriate staff required, would place the resident and staff at risk for injury, such as falls, skin tears, or fractures. An interview with CNA #2 on 6/18/24 at 1:58 PM, confirmed she did not have two staff present to transfer Resident #1 on 6/14/24 with a lift when	M 640		

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M 640	Continued From page 4 he had to be lowered to the floor. She stated she knew at least two staff were required to transfer each resident, but stated it was the end of her shift and Resident #1 was wet, and she would rather not leave him wet, so she went ahead and transferred him. Record review of the Face Sheet revealed the facility admitted Resident #1 on 1/17/19 with a diagnosis of Unspecified Dementia and Cerebral infarction.	M 640		
M 655	45.21.11 Special needs Special needs. Each resident with special needs shall receive proper treatment and care. These special needs shall include, but are not limited to injections; parenteral and enteral fluids; colostomy, ureterostomy, ileostomy care; tracheostomy care; tracheal suction; respiratory care; foot care; and prostheses. This Statute is not met as evidenced by: Based on resident and staff interview, record review, and facility policy review the facility failed to communicate pertinent resident information with a contracted End-Stage Renal Disease (ESRD) facility, when a dialysis resident had refused medications two (2) or more consecutive times for one (1) of three (3) dialysis residents reviewed. Resident #46 Findings include: Cross reference F580 Review of the policy titled , End-Stage Renal Disease, Care of a Resident with," revealed	M 655	1. On 6/18/24, Director of Nursing contacted MD at the dialysis center and notified him of resident # 46's refusal of medications. Administrator held in-service with all staff on shift on documentation along with Notification of Status Changes. 2. On 6/20/24 Director of Nursing verified that the 3 residents in our facility that receive dialysis services could be affected by the same deficient practice. 3. Administrator in-serviced all licensed and certified staff on "Care of Resident with ESRD" and communication with	7/30/24

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M 655	Continued From page 5 agreements between this facility and the contracted ESRD facility include all aspects of how the resident's care will be managed, including the facility will share pertinent information with the dialysis unit on residents per communication. Review of the E-Medication Administration Record (EMAR) from June 4th -June 17th for Resident #46, revealed Cosopt eye drops: instill one drop to both eyes twice daily for Glaucoma-(6) six refused doses. ... Docusate Sodium 100 (mg) milligram twice daily for prevention of constipation-12 refused doses. ... Pepcid 20 mg one tablet twice daily for GERD (Gastroesophageal Reflux Disease) -(5) five refused doses. ... Aspirin 81 mg one tablet daily for history of CVA (Cerebral Vascular Accident)-5 refused doses. ... Plavix 75 mg 1 tablet daily for Peripheral Vascular Disease--5 refused doses. ... Vitamin C 500 mg daily to promote wound healing--5 refused doses. ... Zinc 50 mg daily to promote wound healing--5 refused doses. ...MTV (multivitamin) with minerals one tablet daily to promote wound healing--5 refused doses. ...Rena-vite one tablet daily for ESRD (End Stage Renal Disease) --5 refused doses. ...Norvasc 10 mg one tablet daily on Tuesday/Thursday/Saturday /Sunday-(4) four refused doses. ... Sodium Bicarb 650 mg 2 tablets twice daily for ESRD-10 refused doses. ... Pro-stat 30 (ml) milliliters twice daily to promote wound healing- 22 refused doses. ...Arginaid 1 packet twice daily to promote wound healing-22 refused doses. ...Velphoro 500 mg 1 tablet three times daily for ESRD- 20 refused doses. Review of the June Dialysis Transfer forms for Resident #46, revealed no documentation of resident refusing medications on multiple days.	M 655	dialysis. In-servicing began on 6/20/24 and completed by 7/1/24. Dialysis communication form updated to reflect a section for "Status Changes Specific to Resident" that will go with resident to each dialysis visit. On 7/1/24 Quality Assurance committee reviewed the policy "Care of Resident with ESRD" with no recommended changes to policy. 4.Beginning 7/1/24, the Director of Nursing, Medical Records Nurse or Ward Clerk will audit Dialysis Communication forms against Nurses Notes, MAR and Acute Book 3 times weekly times 4 weeks then once weekly times 4 weeks, then monthly. Quality Assurance meeting held on 7/1/24 and Dialysis Communication added to ongoing Quality Assurance monitoring. Follow up Quality Assurance meeting to be held 7/29/24 and will be quarterly thereafter. 5. The corrective action will be completed by 7/30/24.	

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M 655	Continued From page 6 An interview with Resident #46 on 6/19/24 at 9:00 AM, revealed she knows she does not take all her medications but takes them when she is feeling up to it. She knows she needs to take them. An interview with the Director of Nursing (DON) on 6/18/24 at 10:00 AM, she verbalized after review of the June 2024 Dialysis Transfer Forms for Resident #46 she was unable to find any documentation that the dialysis clinic was ever notified of the resident's refusal of medications and supplements. She then stated the Dialysis Provider should have been notified of Resident #46's continued refusal of medications and failure to do so put the resident at risk for decompensation, organ failure, or acute illness. A phone interview with the Dialysis Registered Nurse (RN) #1 on 6/19/24 at 5:45 AM, verbalized Resident #46 was a patient at the clinic and she is assigned to her. She verbalized she was not aware that Resident #46 had not been taking her medications and supplements, and that information was not on any of the communication forms sent from the nursing facility. She stated Resident #46's treatment plan was discussed on the morning of 6/18/24 with the Nephrologist and care team and the refusal of medications should have been discussed for needed changes. She went on to say that she will immediately ensure the provider and care team are aware because the provider may need to make changes to Resident 46's treatment plan. She went on to reveal that the refusal of the medications and supplements could definitely affect Resident #46's lab values and overall health condition. An interview with Licensed Practical Nurse (LPN) #2 on 6/19/24 at 8:10 AM, she verbalized she	M 655		

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M 655	Continued From page 7 was aware that Resident #46 had been refusing her medications and verbalized that Resident #46 was continuing to refuse her medications and vitamin supplements. LPN #2 confirmed she had not communicated to dialysis that the resident was continuing to refuse her medications and confirmed she should have. Review of the Face Sheet revealed the facility admitted Resident #46 on 4/30/24 with a diagnosis of End Stage Renal Disease and Orthopedic aftercare following a surgical amputation. Record review of the Admission Minimum Data Set (MDS) Section C with an Assessment Reference Date) ARD of 5/07/24, revealed Resident #46 had a Brief Interview for Mental Status (BIMS) score of 12 which indicated she was moderately cognitively impaired. Level II Based on resident and staff interview, record	M 655		

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M 655	Continued From page 8 review, and facility policy review the facility failed to communicate pertinent resident information with a contracted End-Stage Renal Disease (ESRD) facility, when a dialysis resident had refused medications two (2) or more consecutive times for one (1) of three (3) dialysis residents reviewed. Resident #46 Findings include: Review of the policy titled , End-Stage Renal Disease, Care of a Resident with," revealed agreements between this facility and the contracted ESRD facility include all aspects of how the resident's care will be managed, including the facility will share pertinent information with the dialysis unit on residents per communication. Review of the E-Medication Administration Record (EMAR) from June 4th -June 17th for Resident #46, revealed Cosopt eye drops: instill one drop to both eyes twice daily for Glaucoma-(6) six refused doses. ... Docusate Sodium 100 (mg) milligram twice daily for prevention of constipation-12 refused doses. ... Pepcid 20 mg one tablet twice daily for GERD (Gastroesophageal Reflux Disease) -(5) five refused doses. ... Aspirin 81 mg one tablet daily for history of CVA (Cerebral Vascular Accident)-5 refused doses. ... Plavix 75 mg 1 tablet daily for Peripheral Vascular Disease--5 refused doses. ... Vitamin C 500 mg daily to promote wound healing--5 refused doses. ... Zinc 50 mg daily to promote wound healing--5 refused doses. ...MTV (multivitamin) with minerals one tablet daily to promote wound healing--5 refused doses. ...Rena-vite one tablet daily for ESRD (End Stage Renal Disease) --5 refused doses. ...Norvasc 10 mg one tablet daily on	M 655		

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M 655	Continued From page 9 Tuesday/Thursday/Saturday /Sunday-(4) four refused doses. ... Sodium Bicarb 650 mg 2 tablets twice daily for ESRD-10 refused doses. ... Pro-stat 30 (ml) milliliters twice daily to promote wound healing- 22 refused doses. ...Arginaid 1 packet twice daily to promote wound healing-22 refused doses. ...Velphoro 500 mg 1 tablet three times daily for ESRD- 20 refused doses. Review of the June Dialysis Transfer forms for Resident #46, revealed no documentation of resident refusing medications on multiple days. An interview with Resident #46 on 6/19/24 at 9:00 AM, revealed she knows she does not take all her medications but takes them when she is feeling up to it. She knows she needs to take them. An interview with the Director of Nursing (DON) on 6/18/24 at 10:00 AM, she verbalized after review of the June 2024 Dialysis Transfer Forms for Resident #46 she was unable to find any documentation that the dialysis clinic was ever notified of the resident's refusal of medications and supplements. She then stated the Dialysis Provider should have been notified of Resident #46's continued refusal of medications and failure to do so put the resident at risk for decompensation, organ failure, or acute illness. A phone interview with the Dialysis Registered Nurse (RN) #1 on 6/19/24 at 5:45 AM, verbalized Resident #46 was a patient at the clinic and she is assigned to her. She verbalized she was not aware that Resident #46 had not been taking her medications and supplements, and that information was not on any of the communication forms sent from the nursing facility. She stated Resident #46's treatment plan was discussed on the morning of 6/18/24 with the Nephrologist and	M 655		

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M 655	Continued From page 10	M 655		

care team and the refusal of medications should have been discussed for needed changes. She went on to say that she will immediately ensure the provider and care team are aware because the provider may need to make changes to Resident 46's treatment plan. She went on to reveal that the refusal of the medications and supplements could definitely affect Resident #46's lab values and overall health condition.

An interview with Licensed Practical Nurse (LPN) #2 on 6/19/24 at 8:10 AM, she verbalized she was aware that Resident #46 had been refusing her medications and verbalized that Resident #46 was continuing to refuse her medications and vitamin supplements. LPN #2 confirmed she had not communicated to dialysis that the resident was continuing to refuse her medications and confirmed she should have.

Review of the Face Sheet revealed the facility admitted Resident #46 on 4/30/24 with a diagnosis of End Stage Renal Disease and Orthopedic aftercare following a surgical amputation.

Record review of the Admission Minimum Data Set (MDS) Section C with an Assessment Reference Date) ARD of 5/07/24, revealed Resident #46 had a Brief Interview for Mental Status (BIMS) score of 12 which indicated she was moderately cognitively impaired.