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
	45HH	A. BUILDING: _____ B. WING _____	06/20/2024

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HIGHLAND HOME	638 HIGHLAND COLONY PARKWAY RIDGELAND, MS 39157

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M 000	Initial Comments The State Agency (SA) conducted an annual recertification survey at the facility on 06/17/24 through 06/20/24. The SA determined that the facility was not in compliance with requirements for Mississippi Regulations for Minimum Standards for Institutions for the Aged or Infirm and cited M610, M655, M705, and M735. The census at the time of the survey was 112 with a license for 120 beds.	M 000		
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, staff and resident interviews, record review, and facility policy review, the facility failed to ensure a resident who required assistance with Activities of Daily Living (ADLs) was assisted with personal hygiene as evidenced by long, jagged nails with brown substance underneath nails and unshaven facial hair for one (1) of three (3) residents reviewed for ADLs. Resident #14	M 610	* Resident # 14 had his finger nails trimmed by the facility Registered Nurse Supervisor on June 19, 2024. Resident # 14 had his facial hair removed by Certified Nursing Assistant # 1 on June 19, 2024. * All residents have the potential to be affected by this deficient practice * The facility nursing staff were in serviced on SHAVING AND NAIL CARE on 6/20/24 by the facility Director of Nursing and Staff Development Nurse. The facility Medical	7/12/24

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M 610	Continued From page 1 Findings include: Record review of the facility policy titled, "Shaving" with a revision date of 01/24 revealed "Purpose: To provide hygiene in accordance with the resident's preferences and preferred self-image. To provide for the resident's comfort." Record review of the facility policy titled, "Nail Care" with the latest review date of 01/24, revealed "Purpose: To promote cleanliness, safety and a neat appearance." An observation and interview on 6/17/24 at 12:59 PM revealed Resident #14 sitting in his wheelchair, facial hair approximately one-half (1/2) inch to the sides of his cheeks, above his lip, and on his chin and neck. Resident #14's fingernails on bilateral hands were approximately ½ inch long and jagged with a brown substance under his nails. The resident revealed it's been a long time since he was shaved, and he would like to be shaved and his nails cut. An observation on 6/18/24 at 8:56 AM, and again at 1:00 PM, revealed Resident #14's appearance remained unchanged from the previous day. During an interview on 6/18/24 at 2:10 PM, Certified Nurse Aide (CNA) #1 revealed she is assigned to Resident #14 today and usually works the hall that he is on. She confirmed the resident gets his showers on Monday, Wednesday, and Fridays and gets a bed bath the other days. She revealed the showers and bed baths include shaving and nail care if the resident is not a diabetic. CNA #1 stated, "To be honest with you, I don't know if the resident is diabetic. I have never shaved him or done his nailcare."	M 610	Director reviewed the policy SHAVING and the policy NAIL CARE on July 10, 2024 with no recommended changes to the policy. The facility Quality Assessment and Assurance Committee met on July 10, 2024 to review the plan of correction. * Beginning, 6/21/24 the facility staff development nurse will observe 5 residents a week for nail trimming and facial hair. These observations will occur for 6 weeks and then monthly for two months. All findings or concerns will be reported to the QA committee for three months. The first QA meeting will be held on July 12, 2024.	

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M 610	Continued From page 2 An interview and observation on 6/18/24 at 2:35 PM, Licensed Practical Nurse (LPN) #1 revealed Resident #14 is not a diabetic and the CNAs are responsible for shaving him and doing his nail care. She confirmed the resident needed to be shaved and his nails were long and jagged. She confirmed with his long fingernails that he could scratch his skin and cause a skin tear. In an interview on 6/18/24 at 3:05 PM, the Assistant Director of Nurses (ADON) confirmed the male residents should be shaved and all residents' nails cleaned and trimmed. Record review of Resident #14's "Face Sheet" revealed the resident was admitted to the facility on 04/26/2024 with medical diagnoses that included Shortness of breath and Muscle Weakness.	M 610		
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: Level II Based on observation, resident and staff interview, record review, and facility policy review, the facility failed to label and store an aerosol	M 655	* The nebulizer mask of resident # 98 was replaced and dated on 6/18/24 by the facility Licensed Practical Nurse. Resident #98 had no adverse findings noted. On 6/25/24 all residents receiving oxygen were monitored and oxygen equipment	7/12/24

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M 655	Continued From page 3 nebulizer mask in a manner that prevented possible contamination of the device for one (1) of 27 nebulizers in the facility. Resident #98 Findings Include: Record review of the facility policy titled "Infection Control Oxygen Equipment Cleaning" with a revision date of 8/2021 revealed when not in use, store the mask/cannula in a plastic bag clearly labeled with the resident's name and date. An observation and interview with Resident #98 on 6/17/2024 at 12:39 PM, revealed a nebulizer machine was sitting on the bedside dresser, with an unbagged and undated nebulizer mask and tubing lying on top of the machine. The resident revealed she did use the mask, but she was unsure how often. An observation on 6/18/2024 at 2:08 PM, of Resident #98's room, revealed a nebulizer machine sitting on the bedside dresser with an unbagged and undated nebulizer mask and tubing draped over the machine. Record review of Resident #98's June 2024 Medication Administration Record (MAR) revealed an order dated 2/1/2024, "Ipratropium 0.5 mg (milligram)-albuterol 3 mg (milligrams) (2.5 mg [milligram] base)/3 ml (milliliter) nebulization soln (solution): Give 3 milliliter(s) using nebulizer four times daily." An interview with Licensed Practical Nurse (LPN) #2 on 6/18/2024 at 2:16 PM, revealed Resident #98 did use the nebulizer machine daily. She revealed the nebulizer tubing and mask usually have a date on it. She confirmed she was responsible for ensuring the nebulizer mask was	M 655	replaced by facility Licensed Practical Nurse. * All residents receiving oxygen or nebulizers have the potential to be affected by this deficient practice. * Facility Nursing staff were in serviced on 6/21/24 by the facility Staff Development Nurse on INFECTION CONTROL OXYGEN EQUIPMENT CLEANING. The facility medical director reviewed the policy INFECTION CONTROL OXYGEN EQUIPMENT CLEANING on July 10,2024 with no recommended changes to the policy. The facility Quality Assessment and Assurance Committee met on July 10, 2024 to review the plan of correction. * Beginning June 21, 2024 the facility Staff Development Nurse will monitor three residents receiving oxygen equipment two days a week for 6 weeks and then monthly for two months. All findings and or concerns will be reported to the QA committee for three months. The first QA committee meeting will be held on July 12, 2024.	

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M 655	Continued From page 4 placed back in a bag and that the tubing was dated. An interview with the Director of Nursing (DON) on 6/18/2024 10:55 AM, confirmed the nebulizer mask should be dated. She stated they change out the mask and tubing every week on Tuesday and a date should be placed on the mask and tubing at that time. Record review of the "Face Sheet" revealed the facility admitted Resident #98 on 2/1/2024 with medical diagnoses which included Aftercare following joint replacement surgery and Unspecified Dementia.	M 655		
M 705	45.24.2 Policies and procedures Policies and procedures. Each facility shall have policies and procedures to assure the following: 1. Accurate acquiring; 2. Receiving; 3. Dispensing; 4. Storage; and 5. Administration of all drugs and biologicals. This Statute is not met as evidenced by: Level II Based on observation, staff interview, and facility policy review, the facility failed to store controlled substances in a permanently affixed locked compartment inside the refrigerator for one (1) of two (2) medication storage rooms observed.	M 705	* On 6/19/2024, the lock box was permanently affixed by the facility maintenance director. * all residents receiving controlled medication have the potential to be affected.	7/12/24

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M 705	Continued From page 5 Findings Include: Review of the facility policy titled "Controlled Drug Emergency Safe Protocol" with a revision date of 6/17 revealed, "Protocol: ... Refrigerated controlled substances will be kept in a refrigerator lock box with the key stored in the Controlled Drug Emergency Safe." An observation of medication storage room #1, on 6/19/2024 at 8:16 AM, revealed a small black refrigerator that contained a large tan lock box with four (4) boxes of liquid lorazepam concentrate. The refrigerator also held a small clear box that contained three (3) injectable vials of lorazepam, which was secured with a yellow sealed tab. Both boxes were not permanently affixed and could be picked up and removed from the refrigerator. An interview on 6/19/2024 at 8:19 AM, with Licensed Practical Nurse (LPN) #1, revealed the tan and clear lock boxes were for the storage of controlled drugs that must be refrigerated. She confirmed the boxes contained lorazepam and were not permanently affixed, which could result in someone removing the boxes. An interview with the Director of Nursing (DON) on 6/19/2024 at 9:20 AM, confirmed the lock boxes were not permanently affixed and acknowledged that it should be to ensure the safety of the controlled drugs.	M 705	* Facility nursing staff were in serviced on 6/21/24 by the facility staff development nurse regarding CONTROLLED DRUG EMERGENCY SAFE PROTOCOL. The facility medical director reviewed the policy CONTROLLED DRUG EMERGENCY SAFE PROTOCOL on 7/10/24 with no recommended changes to the policy. The facility Quality Assessment committee met on 7/10/24 to review the plan of correction. * Beginning 6/21/24, the facility Director of nursing will monitor both facility lock boxes to ensure permanent affixation weekly for six weeks and then monthly for two months. All findings and or concerns will be reported to the QA committee for three months. The first QA committee meeting will be held on 7/12/24.	
M 735	45.25.1 Medical Records Management Medical Records Management.	M 735		7/12/24

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M 735	Continued From page 6 1. A medical record shall be maintained in accordance with accepted professional standards and practices on all residents admitted to the facility. The medical records shall be completely and accurately documented, readily accessible, and systematically organized to facilitate retrieving and compiling information. 2. A sufficient number of personnel, competent to carry out the functions of the medical record service, shall be employed. 3. The facility shall safeguard medical record information against loss, destruction, or unauthorized use. 4. All medical records shall maintain the following information: identification data and consent form; assessments of the resident's needs by all disciplines involved in the care of the resident; medical history and admission physical exam; annual physical exams; physician or nurse practitioner/physician assistant orders; observation, report of treatment, clinical findings and progress notes; and discharge summary, including the final diagnosis. 5. All entries in the medical record shall be signed and dated by the person making the entry. Authentication may include signatures, written initials, or computer entry. A list of computer codes and written signatures must be readily available and maintained under adequate safeguards. 6. All clinical information pertaining to the residents stay shall be centralized in the resident's medical records.	M 735		

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M 735	Continued From page 7 7. Medical records of discharged residents shall be completed within sixty (60) days following discharge. 8. Medical records are to be retained for five (5) years from the date of discharge or, in the case of a minor, until the resident reaches the age of twenty-one (21), plus an additional three (3) years. 9. A resident index, including the resident's full name and birth date, shall be maintained. This Statute is not met as evidenced by: Level II Based on staff interview, record review, and facility policy review, the facility failed to accurately document the administration of the prn (as needed) pain medication in the electronic medication system for one (1) of three (3) residents reviewed for pain. Resident #53 Findings include: Record review of facility policy titled, "Drug Administration and Documentation", dated 12/23, revealed, "The complete act of administration entails removing an individual dose from a previously dispensed, properly labeled container (including a unit dose container), verifying it with the physician's orders, giving the individual dose to the proper resident, and promptly recording the time and dose given". The policy also revealed, "Chart each resident's medications on the MAR (Medication Administration Record) immediately after it is administered, as well as any administration special requirements as they are obtained, and any refused or withheld medication. PRN (as needed) medications will be	M 735	* Resident #53 was seen by the facility Nurse Practitioner on 5/29/2024 with no adverse findings noted. On 5/30/24 a new order was obtained for resident #53 pain management. On 7/10/2024, the DON audited PRN orders of pain medications to ensure adequate supply of medication. On 7/10/2024, the DON audited PRN meds to compare the Narcotic sign out sheet to the eMAR. * All residents receiving prn medication have the potential to be affected by this deficient practice. * facility Nursing staff were in serviced on 6/21/24 by the facility Director of Nursing related to DRUG ADMINISTRATION AND DOCUMENTAITON. The facility Medical Director reviewed the policy DRUG ADMINISTRATION AND DOCUMENTATION on 7/10/24 with no recommended changes to the policy. The facility Quality and Assessment committee met on 7/10/24 to review the plan of correction.	

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M 735	Continued From page 8 documented on the MAR and the reason for giving as well as the result/response for each dose given will be noted in the clinical record". Record review of facility policy titled, "Pain Screen and Management", dated 12/23, revealed, "When the resident is medicated with prescribed medication or treated as ordered, documentation of medication or treatment is done on the electronic Medication Administration Record (eMAR) or the electronic Treatment Administration Record (eTAR)". The policy also revealed, "The eMar will reflect resident usage of medication as a treatment modality and screening is completed on admission/readmission and in the observation period of each MDS. Documentation requirements for chronic pain management focus on the following: eMAR documentation, use of as needed (PRN) medication, review and revision of care plan as appropriate." Record review of Resident #53's "Individual Resident Narcotic Record" from 4/25/24 - 6/18/24 revealed 98 doses of his prescription pain medications were used from his medication supply cards received from pharmacy. Record review and comparison of the "eMAR" and the "Individual Resident Narcotic Record" for Resident #53 revealed 47 of these 98 doses were not documented in his eMAR. During an interview with the Director of Nursing (DON) and the Administrator on 6/19/24 at 9:10 AM, the DON revealed the "Electronic Medication Administration Record" (eMAR) did not accurately reflect the medications Resident #53 received according to the "Individual Resident Narcotic Record". She confirmed the narcotic record revealed the resident received his narcotic pain	M 735	* Beginning 6/21/24, the facility Director of Nursing will monitor electronic documentation of PRN pain medication as well as narcotic sign out sheets of three residents weekly for 6 weeks and then monthly for two months. All finding and or concerns will be reported to the QA committee for three months. The first QA meeting will be held on 7/12/24.	

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M 735	Continued From page 9	M 735		

medication two times a day, but the EMAR did not reflect this. The Administrator confirmed that it was unacceptable that out of approximately 98 doses of narcotic medication given to Resident #53 that was signed out on the narcotic sheet, 47 of these doses were not documented on the eMAR. The DON confirmed the eMAR should provide accurate information of the medications the resident had taken for appropriate treatment and management of the resident's care, and the inaccurate documentation on this resident's eMAR did not meet that standard. She stated the eMAR revealed the resident often went days without pain medications, when in reality, he received it two times a day. The DON confirmed the facility failed to accurately document the administration of the resident's pain medication into the eMAR system and that could lead to medication errors and inaccurate treatment plans.

Record review of "Physician Orders" revealed orders dated 4/24/24 for "Hydrocodone 5 mg (milligrams) - Acetaminophen 325 mg tablet: Give one tablet orally every 8 hours as needed" and "Acetaminophen 325 mg tablet: Give 2 tablets orally (650 mg total dose) every 6 hours as needed".

Record review of Resident #53's "Face Sheet" revealed he was admitted to the facility on 4/24/24 with diagnoses including Pain.

Record review of Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 4/30/24, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact.