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
	25WP	A. BUILDING: _____ B. WING _____	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT HILLS COM LIV CENTER	1600 RAYMOND RD JACKSON, MS 39204

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M 000	Initial Comments The State Agency (SA) conducted an annual recertification survey and Complaint Investigations (CIs), at the facility from 7/8/24 through 7/11/24. The SA investigated CI MS #25528 and CI MS #25529 related to nursing services, CI MS # 25530 related to misappropriation of Property, CI MS #25348 related to facility staffing and resident rights, CI MS #25737 related to an allegation of a resident elopement, and CI MS #25777 related to an allegation of resident left wet and neglect. There were no citations related to the CIs. 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 requirement and cited M620, M635, and M640.	M 000		
M 620	45.21.4 Urinary incontinence Urinary incontinence. Residents with urinary incontinence shall be assessed for need of bladder retraining program. An indwelling catheter will not be used unless the resident ' s clinical condition indicates that catheterization is necessary. These residents shall receive treatment and services to prevent urinary tract infections. This Statute is not met as evidenced by: Level II Based on observation, interviews, record review, and facility policy review, the facility failed to ensure indwelling catheter tubing was secured to prevent complications for one (1) of one (1) resident reviewed with an indwelling catheter. Resident # 3	M 620	The facility failed to ensure indwelling catheter leg tubing was secured to prevent complications for one (1) of one (1) resident reviewed with an indwelling catheter. Resident #3 was assessed on 7/11/2024 by the Assistant Director of Nursing (ADON) with no issues identified. The Assistant Director of Nursing ensured	8/6/24

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M 620	Continued From page 1 Findings include: A review of the facility's policy "Catheter Care, Urinary" dated 8/25/14, revealed, " ...The purpose of this procedure is to prevent catheter-associated urinary tract infections ... 17. Secure catheter utilizing a leg band ..." On 7/11/24 at 8:30 AM, during an interview and observation of catheter care with Certified Nurse Aide (CNA) #1 and Licensed Practical Nurse (LPN) #1 revealed Resident #3 had an indwelling catheter but there was no leg strap to secure the tubing. CNA #1 and LPN #1 confirmed the resident did not have a leg strap in place. LPN #1 stated she would get one for the resident and explained a leg strap was used to secure the catheter tubing to prevent the tubing from pulling or becoming dislodged. Record review of the "Order Summary Report" with active orders as of 7/12/24 revealed Resident # 3 had a Physician's Order, dated 1/19/24, to "Check urinary catheter leg strap every shift and replace as needed ..." On 7/11/24 at 10:30 AM, during an interview with the Administrator and the Director of Nursing (DON), the DON explained that all residents with an indwelling catheter should have a leg strap to secure the tubing. The Administrator reported that she expected the staff to provide quality care to the residents. A record review of the "Admission Record" revealed the admitted Resident # 3 on 12/28/23 with current diagnoses including Neuromuscular Dysfunction of Bladder.	M 620	Resident #3 had their catheter strap in place and adjusted per Catheter care and Urinary policy with no issues identified. All residents who reside in the facility with an indwelling catheter have the potential to be affected. On 7/12/2024 the Assistant Director of Nursing and the Register Nurse Supervisor completed a 100% audit on all residents with indwelling catheters to ensure that each one had a proper leg strap in place. All residents are found to be in compliance with the Catheter Care and Urinary policy. On 7/12/2024 the Medical Records Nurse audited and updated all task administration check offs for residents with catheter care to include checking for leg strap intact; with 100% accuracy. On 7/11/2024 the RN Supervisor and all other nursing staff were in-serviced by the DON and ADON on urinary catheter care procedures, to include proper leg strap placement. The Quality Assurance Performance Improvement Team (QAPI) met on 7/12/2024 to discuss policy and procedures related to urinary catheter care and proper placement of leg straps with no revisions needed. Effective 7/13/2024 the Registered Nurse Supervisor will make daily rounds on residents with catheter care needs and complete a daily sign off on the daily task to ensure accuracy of proper leg strap and report to the Assistant Director of Nursing any adverse findings ending 10/7/2024. Effective 10/8/2024 the Registered Nurse	

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M 620	Continued From page 2 A record review of Section H of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/18/24, revealed Resident # 3 was coded for an indwelling catheter.	M 620	Supervisor will make rounds on residents with catheter care needs three times a week to ensure continuity of care and accuracy of proper leg strap and report to the Assistant Director of Nursing any adverse findings ending 12/6/2024. The Assistant Director of Nursing will monitor the daily task charting beginning 7/13/2024 and ending 12/6/2024. Any identified concerns will be addressed immediately and reported to the Administrator and brought to the monthly QAPI meeting beginning 8/5/2024 and then monthly for 5 months thereafter ending 12/6/2024.	
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, interviews, and facility policy review, the facility failed to label and date enteral feeding bags for three (3) of four (4) observations for a resident with enteral feedings. Resident # 24 Findings include: Review of the facility's policy "Enteral Feeding Via	M 635	The facility failed to properly label and date enteral feeding bags for resident #24. Resident #24 was assessed by the Assistant Director of Nursing (ADON) on 7/11/2024 with no issues identified. The ADON verified the orders for enteral feeding for resident #24 for accuracy then dated the eternal feeding bag with correct date on 7/11/2024. This deficient practice of not properly	8/6/24

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M 635	Continued From page 3 Continuous Pump", dated 8/25/2014, revealed, "The purpose of this procedure is to provide nourishment to the resident who is unable to obtain nourishment orally ...Steps in the Procedure ...Initiate Feeding ...5. On the formula label document initials, date and time the formula was hung/administered, and initial that the label was checked against the order ..." During an observation on 7/8/24 at 11:42 AM, Resident #24 had a feeding tube bag hanging from a pole in her room. The bag was not labeled to indicate the name of the formula or the date and time of when the bag was hung. During an observation, on 7/9/24 at 8:44 AM, Resident #24's tube feeding bag was not labeled and dated to indicate the time the bag was hung, or the name of the substance in the bag. During an observation, on 7/10/24 at 9:46 AM, Resident # 24's tube feeding bag was not labeled to indicate the type of formula and there was no date to indicate the time the bag was hung. During an interview and observation, on 7/10/24 11:23 AM, with Licensed Practical Nurse (LPN) #1, she confirmed the feeding bag was not labeled with the type of feeding or the date it was hung. She stated she checked the residents' rooms every morning to verify the rate on the feeding pumps were accurate because the previous shift was responsible for changing and labeling the tube feeding bag, the tubing, and the feedings. She explained she did not notice the feeding tube bag was not labeled. During an interview on 7/10/24 at 2:43 PM, with the Director of Nursing (DON), she explained it was the night nurses' responsibility to label the	M 635	labeling and dating enteral feeding bags can affect all residents within the facility who rely on feeding bags for enteral feedings. On 7/11/2024 the ADON completed a 100% audit on all enteral feeding bags to ensure proper compliance with the Enteral Feeding via continuous pump policy with no additional adverse findings or changes needed. The Assistant Director of Nursing was directly in-serviced on 7/11/2024 by the Director of Nursing and the Regional Nurse Consultant on Enteral Feeding via Continuous Pump policy and procedures. All nursing staff were in-serviced by the DON on 7/11/2024 on Enteral Feeding via continuous pump policy and procedures. The Quality Assurance Performance Improvement (QAPI) team met on 7/12/2024 and discussed the policy and procedures related to enteral Feedings via continuous pump for all residents with no revisions needed. Effective 7/15/2024 the Register Nurse Supervisor will complete a shift check off on enteral feeding bags for proper labeling and dating daily for 4 weeks ending 8/12/2024. Effective 8/13/2024 the Registered Nurse Supervisor will complete a shift check off on enteral feeding bags two (2) times a week for four (4) weeks ending 9/9/2024 to ensure proper labeling and dating of enteral feeding bags. Effective 7/15/2024 the ADON will verify the shift check off has been completed daily; this information will be brought to the daily stand-up meetings. Any identified concerns will be addressed immediately and reported to the	

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M 635	Continued From page 4 feeding tube bags with the type of feeding, date, time and initial the time the feeding was hung or administered. A record review of the "Medication Administration Record" for 7/1/24 through 7/31/24 revealed Resident #24 had a Physician's Order, with a start date of 3/12/24, for " ...Isosource 1.5- 40 ml/hr (milliliters per hour) x (times) 22 hrs ..." A record review of the "Clinical" record revealed the facility admitted Resident #24 on 9/20/23. A record review of the of the Quarterly Minimum Data Set (MDS), dated 05/01/2024, revealed Resident # 24 received nutrition via a feeding tube.	M 635	Administrator and brought to the monthly QAPI meeting effective 8/5/2024 and then monthly for 5 months thereafter ending 12/6/2024.	
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: Level II Based on interviews, record review, and facility policy review, the facility failed to conduct a safety smoking assessment for a resident to safeguard against the potential hazards for burns and/or fires. This concern was identified for one (1) of three (3) residents reviewed for accidents and hazards. Resident #1	M 640	The facility failed to conduct a safety smoking assessment for resident #1to safeguard against the potential hazards for burns and/or fires. On 7/11/2024 the Director of Nursing (DON) performed a smoking assessment on resident #1 and identified no issues. All residents that smoke have the potential	8/6/24

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M 640	Continued From page 5 Findings include: Review of the facility's policy, "Smoking", undated, revealed, " ...It is the policy of this facility to provide a safe environment for residents who smoke ...Additional precautions may apply to some residents due to safety awareness concerns or medical conditions ...Procedure for Resident safety during smoking 1) Residents with known history of smoking ...will be evaluated on admission, quarterly, and as needed for safety awareness and any physical limitations related to smoking safety ..." On 7/9/24 at 9:55 AM, in an interview with Resident # 1, she explained she smoked at the designated times and had always smoked since she was admitted to the facility several years ago. Record review of the medical record revealed a "Smoking and Tobacco Evaluation", dated 7/6/2021. Resident #1 did not have a current smoking safety evaluation completed. A record review of the "Admission Record" revealed the facility initially admitted Resident #1 on 9/10/2013 and she had current diagnoses including End Stage Renal Disease. A record review of the Comprehensive Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/29/23 revealed Resident #1 currently used tobacco. On 7/11/24 9:21 AM, in an interview with the Licensed Practical Nurse (LPN) #2/MDS nurse, she confirmed Resident #1 had not been assessed for smoking since 2021. She stated Resident #1 had been a resident at the facility for	M 640	to be affected. On 7/11/2024 the DON completed a 100% audit on all residents who smoke to ensure all smoking assessments were completed and up to date per policy and procedures. All residents are found to be in compliance with the smoking policy. The DON, Assistant Director of Nursing (ADON) and Administrator were directly in-serviced on 7/10/2024 by the Regional Nurse Consultant (RNC) on proper completion of the safety smoking assessments on all residents in the facility. All nursing staff were in-serviced by the DON on 7/10/2024 on proper completion of the safety smoking assessments of all residents which reside in the facility. The Quality Assurance Performance Improvement Team (QAPI) met on 7/12/2024 and discussed policy and procedures related to proper completion of the smoking assessment for all residents with no revisions needed. Effective 7/15/2024 and ongoing indefinitely all quarterly assessments will be reviewed during the daily stand-up meetings by the DON or Administrator, discussed with the Interdisciplinary Team and reviewed in the weekly Persons at Risk meeting to ensure proper compliance with the smoking assessment are followed. Effective 7/15/2024 and ending 12/6/2024 the RN supervisor will sign off on all Quarterly Smoking and Tobacco Evaluations on the sign off sheet for each Nurse station. This sign off sheet will be reviewed by the DON and the MDS nurse daily for accuracy in the daily stand-up meeting. Effective	

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M 640	Continued From page 6 a long time and had always smoked. She explained that smoking assessments are completed for residents quarterly and not assessing residents for safe smoking could put them at risk for burns. LPN #2 explained it was the responsibility of the nursing supervisors to complete the assessment form per the facility's policy. On 7/11/24 at 10:21 AM, in an interview with the Director of Nurses (DON), she confirmed that not having a smoking assessment puts residents at risk for burns. The DON stated the staff should use information from the smoking assessment to ensure a safe smoking environment for Resident #1. She revealed the smoking evaluation form should be completed by the nursing supervisors and Resident #1's "must have gotten missed." A record review of the Quarterly MDS with an ARD of 5/7/24 revealed Resident #1 had a Brief Interview for Mental Status score of 15, which indicated she was cognitively intact.	M 640	7/15/2024, the RN Supervisor on duty is assigned by the DON to complete the smoking evaluations due to be reviewed quarterly. The MDS Nurse will verify any assessments due to ensure completion and accuracy and then report it in the daily stand-up meeting. Any identified concerns will be addressed immediately and reported to the Administrator and brought to the monthly QAPI meeting beginning 8/5/2024 and then monthly for 5 months thereafter ending 12/6/2024.	