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
	26LM	A. BUILDING: _____ B. WING _____	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON MANOR SENIOR CARE, LLC	56 ROCKPORT ROAD LEXINGTON, MS 39095

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M 000	Initial Comments The State Agency (SA) conducted an annual recertification survey at the facility from 10/15/24 through 10/17/24. During the survey, the SA determined that the facility was not in compliance with the requirements of Minimum Standards of Operation for Institutions for the Aged or Infirm, state licensure requirements and deficiencies were cited at M 225 and M 640. The facility held a license for 60 beds, with a census of 58.	M 000		
M 225	45.4.1 Nursing Facility Nursing Facility. To be classified as a facility, the institution shall comply with the following staffing requirements: 1. Minimum requirements for nursing staff shall be based on the ratio of two and eight-tenths (2.80) hours of direct nursing care per resident per twenty-four (24) hours. Staffing requirements are based upon resident census. Based upon the physical layout of the nursing facility, the licensing agency may increase the nursing care per resident ratio. 2. Each facility shall have the following licensed personnel as a minimum: a. Seven (7) day coverage on the day shift by a registered nurse. b. A registered nurse designated as the Director of Nursing Services, who shall be employed on a full time (five [5] days per week) basis on the day shift and be responsible for all nursing services in the facility.	M 225		11/13/24

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M 225	Continued From page 1 c. Facilities of one-hundred eighty (180) beds or more shall have an assistant director of nursing services, who shall be a registered nurse. d. A registered nurse or licensed practical nurse shall serve as a charge nurse and be responsible for supervision of the total nursing activities in the facility during the 7:00 a.m. to 3:00 p.m. and 3:00 p.m. to 11:00 p.m. shift. The nurse assigned to the unit for the 11:00 p.m. to 7:00 a.m. shift may serve as both the charge nurse and medication/treatment nurse. A medication/treatment nurse for each nurses' station shall be required on all shifts. This shall be a registered nurse or licensed practical nurse. e. In facilities with sixty (60) beds or less, the director of nursing services may serve as charge nurse. f. In facilities with more than sixty (60) beds, the charge nurse may not be the director of nursing services or the medication/treatment nurse. 3. Non-Licensed Staff. The non-licensed staff shall be added to the total licensed staff, to complete the required staffing requirements. 4. There shall be at least two (2) employees in the facility at all times in the event of an emergency. This Statute is not met as evidenced by: Level II Based on record review and interviews the facility failed to maintain a state minimum of two and eight-tenths (2.80) hours of direct nursing care staffing per resident for five (5) of 24 days reviewed in the fiscal year third quarter of 2024.	M 225	1) On 6/30/2024, the Director of Nursing conducted an audit. The audit revealed that the facility had an adequate number of employees on the weekends, but not all were working their entire shifts. The Staff Development Nurse and Director of Nursing conducted an education on	

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M 225	Continued From page 2 Findings Include: A review of the facility policy titled, "Nursing Services and Sufficient Staff," revised 6/2017, revealed, Policy Explanation and Compliance Guidelines: 1.) "The facility will supply services by sufficient numbers of each of the following personnel types on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans and always meeting the state guidelines of 2.8 at a minimal." ... Review of the PBJ (Payroll-Based Journal) Staffing Data Report the facility triggered for excessively low weekend staffing for Fiscal Year Quarter 3 2024 (April 1-June 30). Review of the staffing grid for the weekends for Quarter 3 2024 revealed the facility failed to meet 2.80 minimum state direct care staffing requirements for five (5) days. In an interview with the Staff Develop Coordinator on 10/17/24 at 8:37 AM, she revealed that she was aware that there were concerns with low staffing numbers during April-June 2024. She revealed she found that staff were not clocked in for the 12 full scheduled hours and the total hours dropped below the minimum staffing requirement below 2.80. In an interview with the (AIT) Administrator in Training on 10/17/24 at 8:44 AM, she revealed the staffing coordinator did notify her of the staff not staying clocked in for 12 hours scheduled which dropped the staffing numbers. She revealed a potential problem with staff not staying their scheduled hours is it could affect resident care and would drop the total minimal staffing hours that were required.	M 225	7/8/2024, reviewing staffing hour requirements, focusing on staffing assignments, and working their total scheduled shift. On 7/10/2024 Interdisciplinary team met to discuss and develop a process for checking staffing and managing issues when they arise. Beginning on 7/15/2024, the Staff Development Nurse is responsible for initial staffing checks and providing the staffing ratio and reports any deficient staffing numbers during daily huddles implemented to the facility's daily process of communication. The director of Nursing conducts a follow-up review of the staffing ratio with findings reported to the administrator daily for the following four (4) months ending 11/18/2024 Regular reporting ensures that staffing deficiencies are addressed promptly to ensure compliance and regulations are adhered to. 2) On 7/8/2024, the Administrator, Administrator in Training, and Director of Nursing reviewed the facility policy, Nursing services, and Sufficient staff and determined that all residents have the potential to be affected 3) Staffing ratios for the weekends are sent every Monday beginning 10/21/2024 to the Corporate Compliance Officer by the Staff Development Nurse weekly for 4 months. 4) On 11/11/2024, the monitoring results will be taken to the Quality Assurance Committee for three (3) months (including 11/11/2024) to evaluate the process and effectiveness and make changes as	

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M 225	Continued From page 3	M 225	necessary to ensure substantial compliance.	
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 Pattern Based on observation, staff interview, record review, and facility policy review, the facility failed to promote an environment as free of accident hazards as possible, when the facility failed to provide a resident a smoking protection assistive device to prevent accidents for one (1) of three (3) residents reviewed for accidents and hazards. (Resident #44) Findings include: A review of the facility policy titled, Smoking/Tobacco Use Policy, last review 2024 revealed, "Procedure: 5.) Smoking aprons will be provided for residents who are evaluated to need them by the smoking safety assessment. Wearing of the apron will be assisted by staff during smoking times for those residents who require them..." An observation of Resident #44 on 10/15/24 at 12:52 PM, revealed small cigarette burn holes on	M 640	1) On 10/16/2024, the Director of Nursing immediately placed a protective smoking apron on resident #44, and then the Director of Nursing and Treatment nurse performed a body audit on resident # 44 to assess for injury. No injury was noted. Resident Brief Interview for Mental Status Score of 12, Moderate impairment Cognition. He denied any past or current injuries to his skin/self while smoking. Also, on 10/16/2024, the Administrator in Training and Social Service Director performed one-on-one with housekeeper #1 regarding the importance of a smoking apron and that resident # 44 requires a smoking apron prior to lighting a cigarette. 2) On 10/16/2024, the Administrator in Training, Social Service Director, and Minimum Data Set nurse reviewed the current smoking list of residents and performed an audit reviewing each resident's smoking assessment and care plan. Twelve residents smoke cigarettes, and two chew tobacco. Six of the twelve	11/13/24

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M 640	Continued From page 4 the blanket covering his legs. A record review of a Smoking Safety Screen for Resident #44 dated 5/28/24, revealed the resident needed adaptive equipment during smoking with a smoking apron and supervision. ... Notes on safety from Interdisciplinary team: Staff noted that Resident #44 fell asleep while holding a lit cigarette. Due to the risk of injury, Resident #44 will be required to wear an apron while smoking. Review of the Smoking Safety Screen for Resident #44 dated 10/14/24 revealed resident need for adaptive equipment needed was a smoking apron and supervision. ... Notes on safety from the Interdisciplinary team: Resident #44 has a history of dropping ashes on clothing. Resident requires supervision and an apron. Record review of the Smoking and Tobacco/Snuff list of residents revealed Resident #44 was listed but did not have two (2) asterisks next to his name to indicate he required a smoking apron. On 10/16/24 at 10:00 AM, an observation revealed Resident #44 smoking with the supervision of Housekeeper #1 and it was observed that Resident #44 was not wearing a smoking apron while he was smoking a lit cigarette. It was observed that there were two small burn holes on the blanket covering Resident #44's legs. Interview with Housekeeper #1 on 10/16/24 at 10:04 AM, revealed the Social Service Director lets him know who requires a smoking vest, and confirmed he was unaware that Resident #44 needed a smoking vest. He then revealed he was unaware of a smoking list that reflected which	M 640	residents require a smoking apron. In the review of the smoking list, resident #44 was on the list but was not listed as requiring an apron. The list had not been revised, indicating resident #44 required an apron. All other eleven residents on the list were accurate and current. On 10/16/2024, the Social Service Director revised and updated the Smoking List and placed it in the smoking box, nurse supervisor's office, first nurses' station, and second nurses' station. 3) On 10/16/2024, the Administrator in Training and Director of Nursing performed in-service with all employees responsible for taking residents to smoke regarding the updated smoking list and facility Smoking policy. Residents on the smoking list with two asterisks next to their name require a smoking apron. This practice is in place to ensure accurate communication so that staff adheres to the care plan. The Quality Assurance Performance Improvement Committee reviewed the smoking policy and procedure on 10/18/2024, and no recommendations for changes were made. 4) Beginning 10/21/2024, the Director of Nursing or Administrator in Training will observe residents' smoking three (3) days a week for four (4) weeks, following weekly observations beginning 11/18/2024 for four (4) weeks, then monthly beginning on 12/16/2024 for three (3) months to ensure safety for those residents who require the use of a smoking apron and staff competency and knowledge of the	

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M 640	Continued From page 5 residents required a smoking vest. In an interview with the Social Service Director on 10/16/24 at 10:10 AM, she confirmed Resident #44 was to wear a smoking vest and stated the housekeeper was unaware that the resident required a smoking vest. She confirmed that she updated the smoking list as changes occurred. In a review of the smoking list with the Social Service Director, she confirmed the smoking list did not reflect that Resident# 44 required a smoking vest. She then revealed that by not applying the smoking apron, the staff placed Resident #44 at risk for burning himself. An interview with the Minimum Data Set (MDS) Coordinator on 10/16/24 at 10:53 AM she revealed after review of the Smoking Assessment for Resident # 44 he should have been wearing a smoking apron and stated the smoking list should have been updated by the Social Service Director. Review of the "Admission Record" revealed the facility admitted Resident # 44 on 12/02/22 with a diagnosis of Nicotine Dependence. Record review of Resident # 44's Section C of the Annual MDS with an Assessment Reference Date of 10/14/24 revealed a Brief Interview for Mental Status (BIMS) score was 12, indicating the resident was moderately cognitively impaired.	M 640	requirements of the comprehensive care plan. 10/21/2024 The Minimum Data Set Coordinator or Social Service Director will begin reviewing the assessments and care plans of residents who smoke quarterly, annually, and as needed to ensure compliance. On 11/11/2024, the monitoring results will be taken to the Quality Assurance Committee for three (3) months (including 11/11/2024) to evaluate the process and effectiveness and make changes as necessary to ensure substantial compliance.	