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 |
|---|---|---|---|
| | 73RR | A. BUILDING: _____ B. WING _____ | 06/25/2025 |

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| NEW ALBANY HEALTH & REHAB CENTER | 118 SOUTH GLENFIELD ROAD NEW ALBANY, MS 38652 |

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| M 000 | Initial Comments<br><br>The State Agency (SA) conducted an annual recertification survey and a complaint investigation (CI) MS #29057 at the facility from 6/23/25 through 6/25/25. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements and deficiencies were cited at M610, M640, and M1570. The SA investigated CI MS #29057 with no deficiencies cited.<br><br>The facility held a license for 114 beds at the time of the survey, and the facility census was 90. | M 000 | | |
| M 610 | 45.21.2 Activities of daily living<br><br>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:<br><br>1. Bath, dressing and grooming;<br><br>2. Transfer and ambulate;<br><br>3. Good nutrition, personal and oral hygiene; and<br><br>4. Toileting.<br><br>This Statute is not met as evidenced by:<br>Level II<br><br>Based on observation, staff and resident interviews, record review and facility policy review the facility failed to ensure resident's requiring assistance with Activities of Daily Living (ADL) were given care as they needed to maintain hygiene for two (2) of 18 sampled residents. | M 610 | | 7/28/25 |

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| M 610 | Continued From page 1<br>Resident #57 and #62<br><br>Findings include<br><br>Review of the facility's policy titled, "Activities of Daily Living (ADL)" with a revision date of 9/15/2022, revealed under "Policy: Based on the resident's comprehensive assessment and consistent with the resident's needs and choices, the facility will ensure a resident's abilities in ADL's do not deteriorate unless deterioration is unavoidable. Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming, and oral care ...Policy Explanation and Compliance Guidelines ...3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene ..."<br><br>Resident #57<br><br>On 06/23/25 at 11:15 AM an observation of Resident #57 revealed facial hair on his chin, above his upper lip and on his bilateral cheeks. Resident #57's hair was greasy and there was a mild body odor. His facial hair was approximately one-eighth to one-fourth inch long.<br><br>On 06/24/25 at 8:05 AM an observation and interview with Resident #57 revealed he had facial hair to his chin, above his top lip and scattered on his bilateral cheeks. His hair was greasy and there was a mild body odor. He stated that his bath days were Tuesdays, Thursdays, and Saturdays and they forgot about him some days. Resident #57 revealed that he did not get a bath this past Saturday and that no one came in and offered him a bath. He revealed that he had not had a bath since Thursday, four days ago, | M 610 | | |

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| M 610 | Continued From page 2 | M 610 | | |

and he felt dirty. Resident #57 revealed that getting a good bath always made him feel better and stated, "I don't feel clean when I miss my bath." He also revealed that he didn't like to have facial hair and wanted it shaved.

On 06/24/25 at 8:25 AM an observation and interview with Licensed Practical Nurse (LPN) #1, revealed that the hospice aid came in on Tuesdays and Thursdays to give him his baths. During this observation, Resident #57 told LPN #1 that he had not gotten his bath on Saturday. LPN #1 confirmed the facial hair, mild body odor and stated that this was a concern. She stated, "I definitely wouldn't want to go without a bath since Thursday" and revealed that she would make sure he got his bath today.

On 06/24/25 at 10:40 AM an observation and interview with Certified Nursing Assistant (CNA) Supervisor, revealed that Resident #57's scheduled bath days were Tuesdays, Thursdays and Saturdays. She revealed that he was on hospice and that their CNAs came in on Tuesdays and Thursdays and that the facility CNAs were responsible for his baths on all other days. During this observation, Resident #57 told CNA Supervisor that he did not get his bath on Saturday and that no one had offered him a bath or shower. He also told the CNA Supervisor that he used to get his baths on Tuesdays, Thursdays, and Saturdays but he hadn't been getting them on Saturdays lately. CNA Supervisor revealed that Resident #57 was cognitively intact and if he said he hadn't been getting his showers on Saturdays lately, he hadn't.

Record review of Resident #57's "Admission Record" revealed an admission date of 06/19/23 and that he had diagnoses that included Chronic

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| M 610 | Continued From page 3<br>Obstructive Pulmonary Disease, Unspecified Heart Failure, and Need for Assistance with Personal Care.<br><br>Record review of Resident #57's Quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 04/30/25 under Section C revealed a Brief Interview for Mental Status (BIMS) score of 14 which indicated that he was cognitively intact.<br><br>Resident #62<br><br>On 6/24/25 at 9:15 AM, an observation and interview with Resident #62, revealed Resident #62 had not received a bath this week. She stated, "The aide on night shift told me that they no longer give baths on night shift. I always take my baths on Monday, Wednesday, and Friday nights."<br><br>During an interview with CNA #2 on 6/24/25 at 9:17 AM, she stated Resident #62 did not have a bath on night shift, and she usually gets her baths on Monday, Wednesday, and Fridays nights, and has for as long as she can remember.<br><br>Record review of the chart did not reveal any notes or documentation of Resident #62 refusing a bath.<br><br>During an interview on 6/24/25 at 11:15 AM, with the Infection Preventionist, she stated, "Resident #62 gets her baths at nights because she is private and doesn't want to get her bath during the day. She has been getting her baths at night for a long time."<br><br>During an interview with on 6/24/25 at 2:00 PM with the Director of Nursing, she confirmed | M 610 | | |

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| M 610 | Continued From page 4<br><br>Resident #62 did not have a bath on Monday night. She stated, "(Proper Name of Resident #62) gets a bath at night on Mondays, Wednesdays, and Fridays. I do not know of any reason why she has not received a bath if she wanted one."<br><br>Record review of Resident #62 "Admission Record" revealed the resident was admitted 10/18/2022 with diagnosis of Polyneuropathy.<br><br>Record review of Resident #62's MDS, Section C, with an ARD of 6/15/25, revealed a BIMS score of 15, indicating Resident #62 is cognitively intact. | M 610 | | |
| M 640 | 45.21.8 Accidents<br><br>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.<br><br>This Statute is not met as evidenced by:<br>Level II<br><br>Based on observation, resident and staff interview, record review and facility policy review the facility failed to ensure an environment that is free from accident hazards and the safety of a resident during care for one (1) of 18 sampled residents. Resident #31<br><br>Findings Include:<br><br>Review of the facility policy titled, "INCIDENT | M 640 | | 7/28/25 |

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| M 640 | Continued From page 5<br>AND ACCIDENT REPORTING", with a revised date of 9/05/2023, states "It is the policy of this facility that everything possible should be done to avoid accidents or incidents involving patients ...Proper reporting helps correct the current incident and prevent future incidents like it ..."<br><br>An observation and interview on 06/23/25 at 10:30 AM with Resident #31, revealed a bandage on her right arm. Resident stated, "The aide scratched me with her nails when she was giving me care."<br><br>During an interview with Resident #31's daughter on 6/23/25 at 10:35 AM at the facility, her daughter stated that she noticed the bandage on her arm last week and stated her mother told her someone scratched her and she saw the bandage to her right arm.<br><br>Record review 6/23/25 3:21 PM, revealed no order or note regarding skin tear to right arm.<br><br>Record review of the facility skin assessment dated 06/24/25 revealed, "Right antecubital; Right forearm; Skin tear identified. New orders noted. Resident noted with skin tear to right forearm. Resident states, An aid was turning me and her nails scratched me. Treated with Xeroform gauze daily and as needed (PRN). Oriented to place. Oriented to time."<br><br>During an interview on 6/24/25 at 11:38 AM, with the Wound Care Nurse, she confirmed that she was unaware of the skin tear on Resident #31's right arm until this morning, but that she had assessed the area and new orders were given for care of the area.<br><br>During an interview on 6/24/25 at 3:08 PM, with | M 640 | | |

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| M 640 | Continued From page 6<br>the Director of Nursing, she confirmed that the incident was not reported to her but that she had spoken with the wound nurse and that new orders were given for care of the skin tear/scratch area to the resident's forearm. She stated, "We are investigating this, I am not aware of how this incident occurred and who placed a bandage on her right arm," but confirmed that there was an injury to the resident's forearm.<br><br>Record review of Resident #31's "Admission Record" revealed the resident was admitted 12/10/2024 with diagnoses that included Parkinson's Disease.<br><br>Record review of Resident #31's Minimum Data Set (MDS), Section C, with an Assessment Reference Date (ARD) of 4/24/2025, revealed a Brief Interview for Mental Status (BIMS) score of 13, indicating the resident is cognitively intact. | M 640 | | |
| M1570 | 48.58.1 Infection Control<br><br>The following infection control standards shall be met:<br><br>1. The facility must maintain and document an effective infection control program that protects patients, families, visitors, and facility personnel by preventing and controlling infections and communicable diseases.<br><br>2. The facility must have an active surveillance program that includes specific measures for prevention, early detection, control, education, and investigation of infections and communicable diseases in the facility. There must be a mechanism to evaluate the effectiveness of the program(s) and take corrective action when | M1570 | | 7/28/25 |

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| M1570 | Continued From page 7<br>necessary. The program must include implementation of nationally recognized systems of infection control guidelines to avoid sources and transmission of infections and communicable diseases.<br><br>3. The facility must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions.<br><br>This Statute is not met as evidenced by:<br>Based on observation, staff and resident interviews, record review and facility policy review the facility failed to utilize Personal Protective Equipment (PPE) for a resident (Resident #188) in contact isolation for one (1) of three (3) survey days.<br><br>Findings Include:<br><br>Review of the facility policy "Infection Prevention and Control" with revision date of 02/17/25 revealed, "This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines..."<br><br>An observation on 06/23/25 at 9:36 AM, revealed Certified Nursing Assistant (CNA) #1 enter Resident #188's room to answer her call light without utilizing Personal Protective Equipment (PPE). There was "Contact Precaution" signage on her door and a three-drawer cart outside of her room in the hall with gowns, gloves, masks and shoe covers inside. | M1570 | | |

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| M1570 | Continued From page 8<br><br>An interview on 06/23/25 at 9:40 AM with CNA #1, revealed that she went into Resident #188's room to answer her call light and did not provide care. She revealed that they did not have to wear gowns and gloves if they did not provide care. CNA #1 confirmed that Resident #188 was on contact precautions for Clostridium Difficile (C-Diff) and confirmed the contact precautions signage on the door. She revealed that the purpose of wearing gowns and gloves with a resident on contact precautions was to prevent the spread of infection and agreed that she should have worn gloves and a gown prior to entering her room. CNA #1 confirmed that she confused Enhanced Barrier Precautions (EBP) with Contact Precautions and stated, "It's a little different when they are on contact precautions." She revealed that when a resident was on EBP, they could answer the call lights without having to dress out in PPE but with contact precautions, they were supposed to dress in appropriate PPE before entering the room.<br><br>An interview on 06/23/25 at 9:45 AM with Registered Nurse (RN) #1, revealed that Resident #188 was on contact precautions for C-Diff. She revealed that she came from the hospital with this and had been in isolation since admission. She revealed that there was a small cart outside of her door and staff were supposed to put on gloves and gowns before entering her room to prevent the spread of infection. RN #1 revealed that Resident #1 had completed her antibiotics and was supposed to be out of isolation, but they extended it due to her continued diarrhea.<br><br>An interview on 06/23/25 at 2:05 PM with Resident #188 revealed that she spent nine days in the hospital with C-Diff prior to coming to the | M1570 | | |

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| M1570 | Continued From page 9 | M1570 | | |

facility. She revealed that she still had diarrhea, but it had slowed down. Resident #188 revealed that most staff members wore gowns and gloves when they came into her room but some of them did not.

An interview on 06/24/25 at 01:35 PM with Infection Preventionist (IP), revealed that Resident #188 had C-Diff and was on contact precautions. She revealed that there was a small cart placed outside of her room and staff were supposed to wear gowns and gloves before entering the room. She revealed that C-DIFF was contagious and by not wearing the proper PPE, the staff could cause the spread of infection.

Record review of Resident #188's "Admission Record" revealed an admission date of 06/10/25 and that she had diagnoses that included Enterocolitis due to Clostridium Difficile, Retention of Urine, and Unsteadiness on Feet.

Record review of Resident #188's Admission Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 06/17/25 under Section C revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated that she was cognitively intact.

Record review of Resident #188's "Order Summary Report" revealed orders for Contact Precautions related to Enterocolitis Due To Clostridium Difficile.

Record review of Resident #188's "Care Plan Report" initiated on 06/11/25 revealed that she had C. Difficile with interventions that included "Contact Precautions."