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	36GR	A. BUILDING: _____ B. WING _____	C 08/13/2021

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OXFORD HEALTH & REHAB CENTER	1301 BELK BOULEVARD OXFORD, MS 38655

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M 000	Initial Comments The State Agency (SA) conducted complaint surveys CI MS #17955 and CI MS #17956, from 8/9/2021 to 8/13/2021. The SA determined during the survey the facility was not in compliance with the Mississippi Regulations for Minimum Standards for Institutions for Aged or Infirm. The complaints were substantiated for insufficient staffing.	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. c. Facilities of one-hundred eighty (180) beds or more shall have an assistant director of nursing services, who shall be a registered nurse.	M 225		

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M 225	Continued From page 1 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 observation, resident interviews, resident family interviews, staff interviews, facility policy review, and record review the facility failed to provide sufficient staff to resident ratio of 2.80 hours of direct nursing care on two (2) of 14 days reviewed. Findings include:	M 225		

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M 225	Continued From page 2 Review of facility policy titled, "Nursing Management and Staffing," dated 12/05/2014, revealed, "It is the policy of this facility to maintain adequate nursing staff in order to maintain the care, treatment and service needs of all residents." Record review of the Staffing Grid revealed that the staff to resident ratio on 7/31/21 was 2.4 and on 8/1/21 was 2.5. Interview on 8/9/2021 at 7:50 PM, with Certified Nursing Assistant (CNA) #1 revealed the staffing at the facility has been insufficient. She stated, "I just start at one end of the hall and work my way around. We do the best we can, but can't do everything." She stated, "We have one resident that has to go to the shower about 2 AM, so if I'm alone and take him then the hall is left with no aide." Interview on 8/9/2021 at 8:10 PM, with Licensed Practical Nurse (LPN) #1 revealed the facility has been short staffed. She stated, "We do the best we can. When I finish med pass, I hit the hall and help the aides." She stated she tries to do all needed tasks but not always possible when short staffed." She stated, "What I worry about is if we have a fire, how would we ever get all these residents out? What would we do? This is unfair to the residents". Interview on 8/9/2021 at 9 PM, with LPN #2, revealed the facility has been short staffed since they stopped allowing the agency staff into the facility. She stated the residents do not get the care they deserve. She stated when you are caring for 25 - 40 residents it is impossible to turn, change or bathe as often as needed.	M 225		

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M 225	Continued From page 3 Interview on 8/9/2021 at 9:15 PM, with LPN #3, revealed the facility was short staffed when the agency staff were not allowed to work and since they are back it has improved. Stated when they were working short handed, the residents "got the best care we could give them and I hope it was adequate." Interview on 8/9/2021 at 9:25 PM, with CNA #2 revealed the facility has been short staffed. She stated when it is short staffed she can only dry, turn, and get water for the residents if they ask, but some things like bathing would have to wait. She stated that this is not best, but she does what she can. Interview on 8/10/2021 at 11:00 AM, with CNA #3 revealed staffing on weekends is short. She stated they try to do the best they can do when short, but "it's impossible to do everything." Interview on 8/10/2021 at 2:30 PM, with the Executive Director revealed the facility had decided to cut back on agency staff since COVID-19 cases were increasing and for financial reasons. She stated the facility was short and there was one CNA per hall with 130 residents and 3 hallways. She confirmed this was not sufficient for resident care. Interview on 8/10/2021 at 2:30 PM, with the Administrator revealed the facility decided to not allow agency staff to work because she was concerned that the agency staff worked at other facilities so they were trying to rely on their own staff since the COVID-19 cases were increasing. Interview on 8/10/2021 at 5:15 PM, with the Staff Coordinator revealed the facility had decided to stop using agency staff due to "COVID-19 and	M 225		

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the budget". She stated the administration staff discussed this plan, but apparently it was not thought out well and the facility was left with insufficient staff coverage.

Interview on 8/11/2021 at 9:40 AM, with CNA #4 revealed weekends are extremely short staffed. She stated "We just don't have enough staff" and after 28 years of working in the facility, this is "the worse I have ever seen". She stated when the facility is short staffed, there is no possible way to complete all the needed tasks and that is not right for the residents.

Observation on 8/11/2021 at 1:00 PM on A-Hall of LPN #4 sitting at Nurses Station with three call lights lit on keyboard and alarming. No effort being made by LPN #4 to respond to the 3 call lights. LPN #5 entered the Nurses Station and told LPN #4 to check the lights.

Interview on 8/11/2021 at 1:50 PM, with LPN #4 revealed it is up to everyone to help answer call lights. She stated even though she was sitting next to the call light desk system, she is hard of hearing and she needed to pay closer attention and respond to the residents.

Interview on 8/11/2021 at 2:20 PM, with LPN #5 she stated when a call light goes off the staff "Is expected to get up and answer it." She stated LPN #4 should have answered the call light when it went off. If a staff is in the nurses station, they are expected to answer it and if they are in the hallway, they are expected to go in and answer it.

Observation on 8/10/2021 at 4:00 PM, of call light going off for approximately 9 minutes before staff went into resident's room.

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M 225	Continued From page 5 Observation on 8/11/2021 at 9:27 AM, of call light on C-Hall going off. At 9:31 a staff member walked past that room. At 9:32 AM, another staff member walked past that room. At 9:35 AM, CNA #6 walked down the hall where the call light was on and answered the call light. Interview on 8/11/2021 at 9:27 AM, with CNA #6, she stated all employees are responsible to check on resident when light is on. Interview on 8/13/2021 at 9:30 AM, with the Human Resource Director. She stated she knows the facility has some open positions, but she is unsure how many job openings the facility currently has. Interview on 8/13/2021 at 1:45 PM with the Administrator, revealed the facility use the facility assessment and for staffing they look at the census as well as the acquity of the residents. Interview on 8/10/2021 at 11:30 AM, with Resident #1. He stated he is scheduled to get a bath three times each week, but the facility has been short staffed and he is not getting his baths/showers. He stated, "I think it's been 7-9 days since I had a bath." Resident #1 stated his roommate often soils his bed and the staff will leave the soiled linen in the bathroom sink. He stated the smell is often so bad, he has to leave the room and can not even use his own bathroom. Record review of Face sheet revealed Resident #1 was admitted to the facility on 5/12/2021 with diagnoses of Metabolic Encephalopathy, Acute Respiratory Failure with Hypoxia, Sepsis, Pneumonia, Cryptosporidiosis, Thrombocytopenia, Anxiety Disorder.	M 225		

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M 225	Continued From page 6 Record review of Resident #1's Minimum Data Set (MDS) dated 5/19/2021 revealed a Brief Interivew for Mental Status (BIMS) of 15. Interview on 8/10/2021 at 11:30 AM, with Resident #2 stated the staff have him using the urinal and this is difficult for him and he often spills it and soils his bed. He stated it often takes the staff a long time to come into his room to change him, so he is left wet. Observation on 8/10/2021 at 11:30 AM of Resident #2's bathroom with a pile of dirty linen with a strong urine smell on the sink and his dirty pants on the floor at the foot of his bed. Interview on 8/13/2021 at 9:05 AM with Resident #2 revealed he had an irritated area on his penis and is receiving medication on it. He stated he is not able to wear Depends now so his wound can be open to air and not be irritated by something being against it. He stated it often takes a while to get the staff to come in when the call light is pressed, especially on nights and weekends when the staffing is shorter. He stated that often times his bed gets soiled because he can not get the needed help quick enough. He stated he often waits 20 minutes or longer for someone to come in to change him. Interview on 8/13/2021 at 1:10 PM with CNA #5 revealed Resident #2 has a wound on his penis and they are trying to keep it dry. She stated they have him use the urinal rather than having a brief or diaper on so the area will be open to air and there will not be anything putting pressure on the area. She stated Resident #2 has a weak right arm and limited movement. She stated he can use the urinal at times, but sometimes it spills	M 225		

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and his bed is soiled. She stated if he soils bed, he or his roommate will call the nurse's station and they will clean him up.

Record review of face sheet revealed Resident #2 was admitted to the facility on 6/24/2021 with diagnoses of Dementia without behavioral disturbance, Atrial Fibrillation, Local Infection of the Skin and Subcutaneous Tissue, History of TIA and Cerebral Infarction, Type 2 Diabetes Mellitus, Chronic Kidney Disease.

Record review of Resident #2's MDS dated 7/1/2021 revealed BIMS of 13.

Observation on 8/10/2021 at 5:30 PM of Resident #6 asleep in bed with heel protector boots in place. Resident #6's hair appears unwashed. Unable to interview resident due to resident being asleep and hard to awaken.

Interview on 8/11/2021 at 10:18 PM with Resident #6's wife. She stated there have been times when she has visited in the facility, and she will press the call light and it will take 45 minutes before a nurse responds. She stated her husband is not getting bathed or turned like he should be.

Record review of face sheet revealed Resident #6 was admitted to the facility on 7/8/2021 with diagnoses of Ischemic Cardiomyopathy, Metabolic Encephalopathy, Congestive Heart Failure, Dysphagia.

Record review of Resident #6's MDS dated 7/27/2021 revealed a BIMS of 12.

Interview on 8/10/2021 at 2:30 PM, with the Executive Director revealed the facility had

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decided to cut back on agency staff since COVID cases were increasing and for financial reasons. She stated the facility was very low on staff and there was one CNA per hall with 130 residents and 3 hallways. She confirmed this was not sufficient for the care the residents needed.

Interview on 8/10/2021 at 2:30 PM, with the Administrator revealed the facility decided to not allow agency staff to work because she was concerned that the agency staff worked at other facilities so they were trying to rely on their own staff since the COVID-19 cases were increasing.

Interview on 8/11/2021 at 6:30 PM, with the Administrator. She confirmed the facility had insufficient staff for the weekend of 7/30/2021 - 8/1/2021. She stated, "It wasn't enough, I know that it was bad. We are admitting that. It's the worst we have ever been. And we know some things were not done." She stated she and the Executive Director had a conference call with corporate and discussed the plan to get rid of agency staff. She stated they had "spent $160,000 on agency staff at that point and it's just better if you can have your own employees and we had to have a cut off day, so it was just decided for then."

Interview on 8/11/2021 at 6:30 PM, with the Executive Director. She confirmed the facility was left short staffed and there was no way the residents could have all their needs met and that could have led to negative outcomes.