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 |
|---|---|---|---|
| | 06ZG | A. BUILDING: _____ B. WING _____ | 10/11/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| SHELBY HEALTH AND REHABILITATION CENT | 1108 CHURCH STREET SHELBY, MS 38774 |

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| M 000 | Initial Comments<br><br>The State Agency (SA) conducted an annual recertification from 10/7/2019 to 10/11/2019. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in the Minimum Standards for the Aged of Infirm. The SA cited M735, during the recertification survey.<br><br>The facility held a license for 60 beds, with a census of 52. | M 000 | | |
| M 735 | 45.25.1 Medical Records Management<br><br>Medical Records Management.<br><br>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.<br><br>2. A sufficient number of personnel, competent to carry out the functions of the medical record service, shall be employed.<br><br>3. The facility shall safeguard medical record information against loss, destruction, or unauthorized use.<br><br>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 | M 735 | | 11/8/19 |

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| M 735 | Continued From page 1<br>and progress notes; and discharge summary, including the final diagnosis.<br><br>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.<br><br>6. All clinical information pertaining to the residents stay shall be centralized in the resident's medical records.<br><br>7. Medical records of discharged residents shall be completed within sixty (60) days following discharge.<br><br>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.<br><br>9. A resident index, including the resident's full name and birth date, shall be maintained.<br><br>This Statute is not met as evidenced by:<br>Based on record review, observation, staff interview, and facility policy review, the facility failed to accurately code the Minimum Data Set (MDS) for four (4) of 22 MDS assessments reviewed as evidenced by inaccurate coding for: one (1) resident discharged to home (Resident #56), two (2) residents with a gastrostomy tube (Resident #51 and Resident #35), one (1) resident with Insulin injections (Resident #51), two (2)residents with pressure ulcers (Resident #51 and Resident #35), and two (2) residents | M 735 | M735:<br><br>1. The following Minimum Data Set (MDS) assessments were corrected by the MDS Nurse:<br>Residents #35 - corrected on 10/12/19 and transmitted 10/31/19.<br>Resident #51 - corrected and transmitted 10/31/19.<br>Resident #56 - corrected and transmitted 9/13/19. | |

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| M 735 | Continued From page 2<br>without an anticoagulant ordered (Resident #51 and Resident #35).<br><br>Findings include:<br><br>Review of a statement on facility letterhead, signed by the Administrator, and dated 10/10/19, revealed: All MDS assessments are completed by the direction of the Resident Assessment Instrument (RAI) manual.<br><br>Resident #56<br>Record review of Resident #56's Discharge MDS, with an Assessment Reference Date (ARD) of 9/6/19, revealed "Acute Hospital" was chosen as the Discharge Status.<br><br>Record review of Resident #56's Physician's Orders, dated 9/6/19, revealed: Discharge home with Home Health, with front wheel walker, standard wheelchair, and a bedside commode.<br><br>During an interview on 10/10/19 at 4:43 PM, Registered Nurse (RN) #1/MDS Nurse/Care Plan Coordinator, confirmed she did enter the wrong information about the discharge status of Resident #56 on the MDS, with an ARD of 9/6/19. She stated, "I was under the impression that she was discharged to another facility, a hospital". RN #1 stated she was in orientation at the time and input information into the MDS according to what the Director of Nursing (DON) told her. She stated, "I've never done MDS". She stated she is scheduled to go to the State MDS training this month.<br><br>Resident # 51<br>Review of Resident #51's MDS, with ARD of 9/18/2019, was inaccurately coded with the following: Section K0510B was not coded for a | M 735 | Resident #43 - corrected and transmitted 10/31/19.<br><br>2. On 10/31/19 and 11/1/19, the MDS Nurse and the Registered Nurse Consultant completed a 100% audit of MDS assessments to determine anyone else with the potential for this same issue for the past 6 months for discharge location, gastrostomy tubes, insulin injections, pressure ulcers, and anticoagulants. Four assessments needed to be corrected to be in compliance. They were corrected and submitted 11/1/2019.<br><br>3. On 10/31/19, the MDS nurse, was in-serviced on accuracy of the MDS and coding per the Resident Assessment Instrument (RAI) guidelines by the Registered Nurse Consultant.<br><br>4. Starting 11/1/19, MDS nurse will audit each MDS prior to completion. Starting 11/1/19, the Director of Nursing (DON) or the Nursing Home Administrator (NHA) nurse will randomly audit five MDS assessments weekly to review accuracy of the MDS assessments. If accuracy issues are discovered, the MDS will be corrected by the MDS nurse. Results of these audits will be brought by the DON/NHA to the Quality Assurance Performance Improvement (QAPI) meeting monthly with recommendations as needed to ensure continued compliance. | |

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gastrostomy tube, K0710A and B were not coded for the amount of nutrition received via gastrostomy tube, M0100A and B was not coded for pressure ulcer, M0210 was coded "0" for number of stage 2 pressure ulcers, N0300 was coded "0" for injections received, N0350A was blank for insulin injections, N0410E was coded "7" for days of anticoagulant therapy.

Review of the physician's orders, Medication Administration Record (MAR), Treatment Administration Record (TAR), Weekly Skin Assessments, and Care Plan, for Resident #51, all initiated on 9/6/19, revealed the resident had a gastrostomy tube and received medications and enteral feedings via this route, resident had a stage 2 pressure ulcer, resident received seven (7) days of insulin injections, and there was not an anticoagulant ordered or received during the seven (7) day look back period.

Resident #35
Review of Resident #35's MDS with an ARD of 8/25/2019, revealed Section N0410E was coded "7" for days receiving an Anticoagulant.

Record review of the August 2019 MAR and Physician's Orders revealed an anticoagulant was not ordered or received by Resident #35.

Resident #43
Review of Resident #43's Annual MDS, with an ARD of 9/5/2019, revealed section K0510B was not coded for a gastrostomy tube, K0710A was not coded for fluid intake, and M0300B was not coded for pressure ulcers.

Review of the September 2019 physician's orders, MAR, TAR, care plan, and weekly skin assessments, revealed Resident #43 had a

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| M 735 | Continued From page 4<br>gastrostomy tube, received flushes per tube every shift, and had two (2) facility acquired Stage 2 pressure ulcers.<br><br>Interview with RN #2, on 10/8/19 at 10:24 AM, revealed Resident #43 had two (2) Stage 2 pressure ulcers that are being treated on a daily basis.<br><br>Interview with RN #1 on 10/10/19 at 4:43 PM, revealed she was in orientation at the time and input information into the MDS according to what the Director of Nursing told her. She stated, "I've never done MDS". She stated she is scheduled to go to the State MDS training this month. She stated she is still in training and was completing the MDS, with guidance from the previous Director of Nursing. She confirmed the MDS assessments for Residents #56, #43, #35, and #51 were coded in error. | M 735 | | |