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
	45HH	A. BUILDING: _____ B. WING _____	12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND HOME	638 HIGHLAND COLONY PARKWAY RIDGELAND, MS 39157

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) conducted an annual recertification survey at the facility from 12/11/18 to 12/14/18. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for the Aged and Infirm requirements for participation. The SA cited the regulatory deficiencies M735. At the time of survey, the census was 111, and the facility held a license for 120 beds.	M 000		
M 735	45.25.1 Medical Records Management Medical Records Management. 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. 2. A sufficient number of personnel, competent to carry out the functions of the medical record service, shall be employed. 3. The facility shall safeguard medical record information against loss, destruction, or unauthorized use. 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		1/11/19

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M 735	Continued From page 1 and progress notes; and discharge summary, including the final diagnosis. 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. 6. All clinical information pertaining to the residents stay shall be centralized in the resident's medical records. 7. Medical records of discharged residents shall be completed within sixty (60) days following discharge. 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. 9. A resident index, including the resident's full name and birth date, shall be maintained. This Statute is not met as evidenced by: Level II Based on record review, Resident Representative (RR) interview, staff interview and facility policy review, the facility failed to have complete and accurate medical records as evidenced by the failure to develop a Baseline Care Plan to address a catheter for a newly admitted resident, for one (1) of four (4) new admissions reviewed; Resident #259.	M 735	M 735 * On 12/14/2018, Resident #259 was assessed by facility's Registered Nurse Supervisor with no concerns noted. Resident #259's baseline careplan was updated on 12/14/2018 by the Director of Nurses to include a Suprapubic Catheter. * All newly admitted residents, especially residents with Suprapubic catheters have	

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M 735	Continued From page 2 Findings include: Review of the facility's policy titled, "Care Plan Process", dated 08/17, revealed the facility shall develop and implement a Baseline Care Plan and Summary for each resident that includes the instructions need to provide effective and person-centered care of the resident that meets professional standards of quality care. The baseline care plan shall be developed within 48 hours of a resident's admission, include the minimum health care information necessary to properly care for a resident immediately upon their admission. An interview, with the RR, on 12/13/18 at 3:02 PM, revealed she stated Resident #259 was admitted to the facility from the hospital with a Urinary Tract Infection, and has a Suprapubic Catheter. Review of the Physician Orders for Resident #259, revealed an order dated 12/5/18 for a Suprapubic Catheter 16 French 10 cubic centimeters (cc) bulb for Bladder Disorder. Review of the Baseline Care Plan revealed there was no documentation to address the resident's catheter. An interview, on 12/14/18 at 10:27 AM, with the Director of Nursing (DON), revealed the resident was admitted with a Foley catheter. Upon review of the Baseline Care Plan, the DON confirmed it did not address his catheter. The DON stated, "He came in with it and it should have been on the care plan." On 12/14/18 at 10:35 AM, an interview with Registered Nurse (RN)/Minimum Data Set (MDS)	M 735	the potential to be affected. On 1/8/2019, the facility's Director of Nurses reviewed the care plans of residents with Suprapubic Catheters. No new concerns identified. * On 1/8/2019, the facility's Director of Nurses inserviced the facility's assessment nurses on the facility's policy related to the CARE PLAN PROCESS which includes the development of the Baseline Care Plan. The information was well recieved from the assessment nurses. On 1/9/2019, the Quality Assurance Committee reviewed the policy, "CARE PLAN PROCESS" with no recommended changes to the policy. * The facility's Director of Nurses will review the care plan of all newly admitted residents, especially residents with Suprapubic Catheters three days a week for five weeks to ensure the Care Plan Process is sustained. The Director of Nurses will report any adverse findings to the Quality Assurance Committee monthly for three months. The Quality Assurance Committee will make recommendations as needed to ensure compliance.	

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M 735	Continued From page 3 Nurse, confirmed the Baseline Care Plan did not address the catheter. The RN/MDS Nurse stated, "It should have been checked." A review of the Face Sheet revealed, Resident #259 was admitted by the facility on 12/5/18, with diagnoses which included Urinary Tract Infection.	M 735		