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
	09FD	A. BUILDING: _____ B. WING _____	12/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLOY DYER NH	1000 EAST MADISON HOUSTON, MS 38851

(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) determined during an annual recertification/licensure survey, conducted from 12/15/19 to 12/17/19, the facility was not in compliance with the Mississippi Regulations for Minimum Standards for Institutions for Aged or Infirm, with deficiencies cited at M490, M515, M690, and M870. The Census at the time of the survey was 64, with a bed capacity of 66.	M 000		
M 490	45.17 RESIDENTS RIGHTS RESIDENTS RIGHTS This Statute is not met as evidenced by: Level II Based on observation, staff interview, and facility policy review, the facility failed to preserve the resident's dignity as evidenced by failure to transport the resident to the shower with proper coverage for one (1) of 16 sampled residents, Resident #11. Findings include: Review of the facility's "Promoting/Maintaining Resident Dignity" policy, undated, revealed: It is the practice of this facility to protect and promote resident's rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances the resident's quality of life by recognizing each resident's individuality. The compliance guidelines reveal all staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights.	M 490	This Plan of Correction is being submitted in response to alleged deficiencies. The submission of this Plan of Correction is not an acknowledgement of the accuracy of these alleged deficiencies. On December 16, the Certified Nurses Aide (CNA) Supervisor provided one-on-one training to CNA #4 on resident dignity, related to moving residents though the hall to the shower room. This included the requirement that residents must be covered while being transported to and from the shower room. Resident #11 was dressed, with any bare skin covered, after the completion of the shower on December 16. Resident #11 was fully covered while being transported from the shower room on December 16. Resident #11 will have any bare skin covered by a sheet or blanket while being moved through the hall to or from the shower room.	1/6/20

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M 490	Continued From page 1 An observation, on 12/16/19 at 8:45 AM, revealed Certified Nursing Assistant (CNA) #4 pushing Resident #11 in a wheelchair in the hallway. The resident had on a short top that covered only the upper one fourth of her thighs. Resident #11's feet were bare and she was holding a brief in her hands. CNA #4 pushed the resident to the linen cart and retrieved a sheet to cover her. An interview, on 12/16/19 at 8:46 AM, with Licensed Practical Nurse (LPN) #2, revealed she saw Resident #11 being pushed in the hallway exposed. LPN #2 stated that was why she made a shocked face when she saw it. LPN #2 stated she told CNA #4 the resident should be covered. LPN #2 stated Resident #11 could have been seen by a visitor, another resident, or someone of the opposite sex. An interview, on 12/16/19 at 10:30 AM, with CNA #4, confirmed she pushed Resident #11 in a wheelchair down the hallway to the linen cart. She stated the resident was coming out of her room and all she thought was to go to the linen cart and get a sheet. She confirmed she did not think to keep the resident in her room and ask for assistance from staff in the hallway. An interview, on 12/16/19 at 10:45 AM, with Registered Nurse (RN) #1, confirmed residents should not be brought into the hallway exposed. RN #1 stated that was a dignity issue. An interview, on 12/17/19 at 10:15 AM, with the Director of Nursing (DON), revealed she felt CNA #4 got nervous and did not do what she should have. The DON stated this was a dignity issue and CNA #4 should have had Resident #11 covered, before allowing her to be in the hallway.	M 490	Any resident has the potential to be affected by this allegedly deficient practice. On December 30 the Certified Nurses□ Aide (CNA) Supervisor reeducated CNA #4 on resident dignity, related to moving residents though the hall to the shower room. This included the requirement that residents must be covered while being transported to and from the shower room. On December 30 the CNA Supervisor educated the other Shower Aide on resident dignity, related to moving resident through the hall to the shower room. This included the requirement that residents must be covered while being transported to and from the shower room. On December 30, December 31, January 2, and January 3, the CNA Supervisor will educate the CNAs on duty on resident dignity, related to moving residents through the hall to the shower room. This included the requirement that residents must be covered while being transported to and from the shower room. Beginning January 6, this dignity education will be included in new employee orientation. This education will include the requirement that residents must be covered while being transported to and from the shower room. Beginning January 6, the CNA Supervisor will monitor staff moving residents through the hall to and from the shower room daily, Monday through Friday, for two weeks. Beginning January 6, the CNA Supervisor will interview three residents per shower day, Monday through Friday, for two	

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M 490	Continued From page 2 She stated Resident #11 should have had socks on her feet and a sheet or blanket covering her lower body.	M 490	weeks, then by then two residents a days for two weeks, and one resident a day for two weeks. The CNA Supervisor will report the findings of these resident interviews to the Quality Assurance Committee monthly for three months to ensure ongoing compliance. The Quality Assurance Committee will make recommendations for performance improvement plans as necessary to ensure ongoing compliance.	
M 515	45.18.2 In-service Training In-service Training. Appropriate in-service education programs shall be provided to all employees on an on-going basis. This Statute is not met as evidenced by: Level II Based on staff interview, record review, and policy review, the facility failed to provide staff education, related to Dementia care, for 40 of 40 Certified Nursing Assistants (CNAs) providing care to residents. Findings include: Review of the facility's "Care of Residents with Dementia" policy, dated 6/20/19, revealed: It is the policy of this facility for staff to be trained on dementia care of the resident. Approaches will be in accordance with dementia care principles. On 12/16/19 at 3:00 PM, an interview with the Administrator, revealed the last Dementia training was done in 3/2018. The Administrator stated	M 515	On December 17, the facility arranged for dementia training for all staff on duty. This training was completed by those staff on duty on December 18. On January 3, the facility will begin dementia training utilizing the hand-in-hand training videos. Any resident has the potential to be affected by this alleged deficient practice. On January 3, the facility will begin dementia training with existing employees, utilizing the hand-in-hand training videos. Training will continue weekly until all modules are completed. Staff failing to attend will not be allowed to work until modules are caught up. New employees will be trained as a part of orientation prior to the first shift of independent work.	1/6/20

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M 515	Continued From page 3 dementia training is not done upon hire or routinely. He stated hospice staff has done some training related specifically to their residents, but doesn't recall any in-services directly related to dementia care. The Administrator stated the Hand in Hand videos needed to be implemented. Review of an in-service log, dated 3/2018, revealed the last dementia care in-service provided by the facility. On 12/17/19 at 7:16 AM, an interview with Certified Nursing Assistant (CNA) #1, revealed she received dementia training last year, but can't recall exactly when. CNA #1 stated when a resident is admitted, they are given report and told if the resident has any behaviors. On 12/17/19 at 7:28 AM, an interview with CNA #2, revealed she was hired September 2019, and had not received any training related to dementia care. CNA #2 stated she had been trained in the past, to allow the resident time to calm down before trying to provide care. On 12/17/19 at 8:02 AM, an interview with CNA #3, revealed she was hired in April 2019, and has not had any training related to dementia care. On 12/17/19 at 9:53 AM, an interview with the Director of Nursing (DON) confirmed the facility provided care to residents with dementia. The DON stated she started here September 30, 2019, and is responsible for training, related to dementia. The DON stated she feels training needs to be done upon hire and at least annually, or as needed, throughout the year. On 12/17/19 at 2:30 PM, an interview with Licensed Practical Nurse (LPN) #1, revealed it	M 515	The Administrator will report on attendance at these training sessions, the number of employees suspended due to lack of attendance, and any new employees beginning, within, or completing the training to the Quality Assurance Committee monthly for three months to ensure ongoing compliance. The Quality Assurance Committee will make recommendations for performance improvement plans as necessary to ensure ongoing compliance.	

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M 515	Continued From page 4 has been a year or so since she attended in-service training on dementia. She stated the CNAs will come to her when a resident is combative or demonstrating behaviors. On 12/17/19 at 2:54 PM, an interview with LPN #2, revealed she last received training on dementia care greater than a year ago.	M 515		
M 690	45.23.1 Rehabilitative services Rehabilitative services. Residents shall be provided rehabilitative services as needed upon the written orders of an attending physician or nurse practitioner/physician assistant. 1. The therapies shall be provided by a qualified therapist. 2. Appropriate equipment and supplies shall be provided. 3. Each resident ' s medical record shall contain written evidence that services are provided in accordance with the written orders of an attending physician or nurse practitioner/physician assistant. This Statute is not met as evidenced by: Level II Based on resident interview, staff interview, record review, and policy review, the facility failed to provide Rehabilitation services to a resident who had orders for Restorative Nursing, for one (1) of one (1) residents reviewed with orders for rehab services, Resident #21. Findings include:	M 690	On December 12, the Restorative Nursing Coordinator (RNC) evaluated Resident #21 for the restorative nursing program. On December 16, Resident #21 began the restorative nursing program. Any resident with a potential need for inclusion in the restorative nursing program has the potential to be affected by this alleged deficient practice.	1/6/20

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M 690	Continued From page 5 Review of the facility's, "Restorative Nursing Programs" policy, dated 5/15/19, revealed: It is the policy of this facility to provide maintenance and restorative services designed to maintain or improve a resident's abilities to the highest practicable level. On 12/15/19 at 10:22 AM, an interview with Resident #21, revealed her therapy ended about two (2) weeks ago, and was told she would get started with Restorative therapy, but has not at this point. Resident #21 stated she didn't want to lose the progress she had gained thus far. Review of the Physician's orders, dated 11/26/19, revealed Occupational Therapy (OT) discharged Resident #21 on 11/26/19, with an order for the resident to receive Restorative Nursing six (6) to seven (7) times weekly, in order to maintain progress achieved throughout intervention. On 12/17/19 at 8:48 AM, an interview with Registered Nurse (RN) #1, revealed the resident was discharged from therapy on 11/26/19, and Restorative Nursing should have started at that time, but did not. RN #1 stated the facility failed to note the order off, and Restorative Nursing was not started. RN #1 stated chart check is performed nightly, but the order was missed during chart check also. On 12/17/19 at 9:11 AM, an interview with the Occupational Therapist revealed she discharged Resident #21 on 11/26/19, and gave the Restorative Nurse a copy of the treatment plan on that date. She stated she would have expected therapy to start within 24-48 hours. On 12/17/19 at 9:14 AM, an interview with	M 690	Resident #21 began the restorative nursing program on December 16. Beginning January 6, a resident discharging from therapy services that has a continued need for rehabilitation and will remain a resident of the facility will be discharged with a plan for restorative nursing. The Physical Therapist, Occupational Therapist, or Speech Therapist will develop this plan prior to discharge. Beginning January 6, the Director of Therapy (DOT) will report to the Director of Nursing (DON) any resident discharging from therapy with a recommendation for continuation of services through the restorative nursing program weekly for four weeks, then every other week for four weeks, and monthly for one month. Beginning January 6, the RNC will report any new or changing restorative nursing programs to the DON weekly for four weeks, then every other week for four weeks, and monthly for one month. The DON will report on these therapy discharges and new or changing restorative plans to the Quality Assurance Committee monthly for three months to ensure ongoing compliance. The Quality Assurance Committee will make recommendations for performance improvement plans as necessary to ensure ongoing compliance.	

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M 690	Continued From page 6 Licensed Practical Nurse (LPN)/Restorative Nurse, revealed she received the treatment plan for Restorative Nursing from the Occupational Therapist on 11/26/19. LPN #3 confirmed therapy was not initiated timely. The Restorative Nurse stated she spoke with the resident yesterday, and plans to get therapy started today. On 12/17/19 at 9:53 AM, an interview with the Director of Nursing (DON), revealed Restorative should have been initiated within 72 hrs of orders being written by therapy.	M 690		
M 870	45.31 PHYSICAL FACILITIES PHYSICAL FACILITIES This Statute is not met as evidenced by: Level II Based on observation, staff interview, record review, policy review, and preventative maintenance documentation review, the facility failed to ensure a clean and safe environment, as evidenced by dust and lint buildup on wiring to heating and cooling units, for 42 of 50 resident rooms, and oxygen cylinder tanks in resident rooms not properly secured, for two (2) of 18 residents receiving oxygen therapy, Resident #56 and #19. Findings include: Review of the facility's "Therapeutic Gases" policy, dated 11/14/18, revealed: Oxygen tanks are to be stored in a designated area and the areas are labeled as partial, full, or empty. Oxygen tanks are transported by a secured rolling cart.	M 870	On December 16, the Director of Nursing removed and secured the hospice-provided oxygen tanks from the rooms of Residents #19 and #56. On December 17, a 6-tank storage rack was ordered. The rack arrived and placed in a Medication Room on December 18. Oxygen tanks supplied by hospice providers will be stored in this rack. On December 16, Maintenance Employee (ME) #1 began cleaning the in-room blower units throughout the facility. ME #1 completed this task on December 19. Any resident requiring oxygen and on hospice has the potential to be affected by this alleged deficient practice. Any resident using an in-room blower unit has the potential to be affected by this alleged deficient practice.	1/6/20

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M 870	Continued From page 7 On 12/16/19 at 2:30 PM, an observation of the enclosed heating and cooling unit, with the Administrator in room 447, revealed the wiring leading to the thermostat was covered in a thick coating of dust and lint. The Administrator stated he felt this could be a fire hazard and was in need of cleaning. The Administrator stated the hospital maintenance staff was responsible for the preventative maintenance of heating and cooling units. He stated he was not sure when they had been cleaned, but it was obvious it had been quite a while. On 12/17/19 at 10:30 AM, an environmental tour, with Maintenance Employee #1, revealed 42 of the 50 rooms in the facility had dust and lint build up on the wires leading to the thermostat. Maintenance Employee #1 stated quarterly preventative maintenance was performed on the heating and cooling units, and vacuuming and cleaning the unit's housing was a part of the preventative maintenance. Maintenance Employee #1 stated he did not know when they were last cleaned. He stated the employee who most often takes care of the nursing home has been off on medical leave. Maintenance Employee #1 confirmed the units were in need of cleaning. He stated they have a wet/dry vacuum they use to vacuum the dust and lint particles. Review of the quarterly maintenance records, with Maintenance Employee #1, did not indicate the heating and cooling units had been cleaned. Resident #19 An observation, on 12/15/19 at 10:49 AM, revealed an "E" oxygen cylinder laying on its side against the wall inside Resident #19's room. The oxygen cylinder was not secured.	M 870	Beginning December 19, oxygen tanks supplied by hospice providers will be stored in the 6-tank storage rack placed in a Medication Room. Beginning December 30, the Administrator will observe for proper storage of oxygen tanks daily, Monday through Friday, for two weeks, then three days a week for two weeks, and two days a week for two weeks. Beginning December 30, hospice providers will store oxygen cylinders in this storage rack. As of December 23, cleaning the wiring and open spaces in the in-room blower units has been added to the preventive maintenance schedule. Beginning December 30, the Administrator will insure cleanliness by inspecting four units a day, Monday through Friday, for two weeks, then two units a day for two weeks, and one unit a day for two weeks. Beginning December 30, the Maintenance Department will clean the wiring and open spaces in the in-room blower units as a part of the quarterly preventive maintenance schedule. The Administrator will report on these observations and inspections to the Quality Assurance Committee monthly for three months to ensure ongoing compliance. The Quality Assurance Committee will make recommendations for performance improvement plans as necessary to ensure ongoing compliance.	

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M 870	Continued From page 8 An observation and interview with Registered Nurse (RN) #1, on 12/16/19 at 8:50 AM, revealed the oxygen cylinder remained on the floor in Resident #19's room, unsecured. RN #1 determined the oxygen cylinder tank was full. She stated the tanks were brought in by hospice and needed to be secured, because the tank could blow up. An interview, on 12/16/19 at 9:05 AM, with the Director of Respiratory Therapy (DRT), revealed the oxygen tanks were brought in by hospice, but they should be secured. The DRT confirmed the oxygen tank was full cylinder of oxygen and should have been secured in a container. She stated the Respiratory Therapy staff is responsible for, and monitors all oxygen in the facility. She stated they make rounds twice a day and should have noticed the cylinder laying on the floor. She stated the cylinder could have gotten moved or bumped and busted. An interview, on 12/17/19 at 10:10 AM, with the Director of Nursing (DON), confirmed oxygen cylinders should be secured. The DON stated the cylinder could roll, causing a tripping or fall risk, and is combustible. Resident #56 An observation of Resident #56's room, on 12/15/19 at 10:30 AM, revealed two (2) oxygen E-cylinder canisters at bedside. One (1) canister was noted in the canister holder, and the other canister was lying on the floor by the canister holder. During an observation on 12/16/19 at 2:15 PM, the oxygen canister remained on the floor. At	M 870		

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M 870	Continued From page 9 that time, the Respiratory Therapist (RT) came into Resident #56's room. The RT stated Hospice left an extra E-cylinder in resident's room, in case it was needed. The RT stated she recognized the danger in leaving an oxygen cylinder lying on the floor. She stated it could be a fall hazard and since it is compressed gas, it could be dangerous if dropped. The RT stated the E-cylinder should be stored in a secure location. The RT took the extra cylinder tank from the resident's room.	M 870		

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M1245	45.41.1 Date of Construction & Life Safety... Date of Construction and Life Safety Code Compliance. 1. Buildings constructed after the effective date of these regulations shall comply with the edition of the Life Safety Code (NFPA 101) effective on the date of construction. 2. Buildings constructed prior to the effective date of these regulations shall comply with Chapter 13 of the Life Safety Code (NFPA 101), 1985 edition. This Statute is not met as evidenced by: Based on observation and testing, the facility failed to properly arrange exit discharge in accordance to NFPA 101 sections 19.2.7 & 7.7.1. These deficiencies practice affected one (1) of four (4) exits in the facility. Findings include: On 12-19-19 at 11:05 AM, observation revealed all the four (4) exit doors in the facility re-engage to lock position when the fire alarm system was put into silence mode. This locked mode of all the exit doors obstructed/ blocked the exit discharge from mean of egress in the facility. The finding was acknowledged by the Administrator and Maintenance Supervisor verified this observation during the exit interview on 12-19-19.	M1245	This Plan of Correction is being submitted in response to alleged deficiencies. The submission of this Plan of Correction is not an acknowledgement of the accuracy of these alleged deficiencies. On December 19, the Maintenance Director completed a temporary troubleshoot of the alarm and egress door magnets. Any resident has the potential to be affected by this alleged deficient practice. On January 3, Maintenance Department employees completed a repair of the alarm and egress door magnets. The Maintenance Director will perform a test of each egress points 3 times a week for 2 weeks, then 2 times a week for weeks, and once a week for 2 weeks. The Administrator will report to the QA Committee monthly for 3 months.	1/6/20

Mississippi State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/06/20