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
	17LD	A. BUILDING: _____ B. WING _____	09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK OF DESOTO	3068 NAIL ROAD WEST HORN LAKE, MS 38637

(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 Survey Agency (SA) conducted an annual recertification survey along with complaints MS #16062, MS #16149, and Facility Reported Incident MS #15946, from 9/15/19 to 9/17/19. The SA did not substantiate MS #16062 for Quality of Care/Injury of Unknown Origin. The SA did not substantiate MS #16149 for Quality of Care/Treatment. The SA did not substantiate Facility Reported Incident MS #15946 for Abuse. No deficiencies were cited related to the complaint survey, however, the SA determined the facility was not in compliance with the Mississippi Regulations for Minimum Standards for Institutions for Aged or Infirm with deficiencies cited at M735. At the time of the survey, the census was 57, and the facility held a license for 60 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.	M 735		10/14/19

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M 735	Continued From page 1 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 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, staff interview, and	M 735	1. The Trazadone was discontinued from the Medication Administration Record and the Medical Doctor was notified by the	

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M 735	Continued From page 2 facility policy review, the facility failed to ensure that the medical records were accurate for a discontinued medication for one (1) of five (5) residents reviewed for unnecessary medications, Resident #49. Findings include: Review of the facility's "Medical Records" policy, revealed, "This facility maintains a separate resident record on each resident in accordance with regulations and accepted professional standards and practices that are complete, accurate, readily accessible, and systematically organized. Review of the physician's order, dated 7/26/19, revealed a hand written order to discontinue (D/C) Trazodone, signed by the Medical Doctor. Review of nurse's notes, dated 7/26/19, at 03:14 PM, revealed the (Medical Doctor) was here in the AM and visited with the resident. A new order noted to Discontinue Trazodone. Faxed to pharmacy. Signed by Licensed Practical Nurse #2. Review of the July 2019 Physician's Orders revealed that there were two (2) separate orders for Trazadone. An order dated 9/12/18, read "Trazodone 50 mg tablet - take one half (1/2) tablet by mouth daily at 5 PM". The second order dated 12/27/18, read "Trazodone (Desyrel) 50 mg tablet - give one (1) tablet by mouth every bedtime (qhs)...". Review of the August 2019 and September 2019 Physician's Orders revealed that the 12/27/18 order remained on the physician's orders.	M 735	Director of Nursing for Resident #49 on 9/16/19. 2. All residents have the potential to be affected by the deficient practice. All physicians orders were audited on 9/16/19 by Registered Nurses and Licensed Practical Nurses to check orders for non-compliance and no problems were noted. The medication carts were audited on 9/16/19, by the Medical Records Nurse for any discontinued meds and no problems were noted. 3. All nurses were in serviced by the Director of Nursing on 9/21/19, regarding transcription of Physicians orders to the computer, follow-up to the appropriate tasks and documentation of medications with appropriate administration of medications. Policies reviewed were Drug Administration and Documentation and Administration of Medications. All facility nurses who documented giving the medication were educated and given a disciplinary action by the Director of Nursing and Administrator. All facility nurses and agency nurses, who documented giving the medication, will have a Monitoring Medication Pass review done with Director of Nurses by 10/14/19. 4. All medication orders will be reviewed daily by the Medical Records department to ensure that orders are transcribed correctly and discontinued medications are removed from the medication cart. Any negative findings will be reported to the Director of Nurses and Administrator by the Medical Records Nurse during daily Stand- up Meeting. Negative findings will be reported to the Quality Assurance Committee immediately and quarterly by	

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M 735	Continued From page 3 Interview with the Pharmacist on 9/16/19 at 5:42 PM, revealed that the pharmacy received an order to discontinue Trazodone for Resident #49 on 7/26/19. She stated that Trazodone was last filled by the pharmacy on 7/22/19, for a 14 day supply with 21 tablets. She stated that both doses were on one (1) card and there were 28 bubbles. Review of the Prescription Drug Inventory for Destruction revealed 25 Trazodone tablets were destroyed by Pillverizer on 7/29/19. On 09/16/19, at 5:00 PM, in an interview with the Director of Nursing (DON), she stated that Trazodone was taken off the cart and destroyed and Resident #49 did not receive any Trazodone after 7/25/19; but, confirmed the order was still in the record. Interview with Registered Nurse (RN) #1, on 09/17/19 09:14 AM, revealed she worked the evening shift on 8/30/19, and she recalled the Trazodone not being on the cart or in the med room. She stated that she went back to the cart to document Trazodone not administered and the computer died. She took it to the nurse's station to charge and when it came back up she documented administered. She stated, "It was just so much going on I didn't think to go back to it". On 09/17/19, 09:40 AM, an interview with LPN #1/Medical Records, revealed nurses on the floor are responsible for taking the medications out of the cart. LPN #1/Medical Records confirmed the order for Trazodone was still in the medical record and should have been removed. On 09/17/19 at 10:05 AM, interview with LPN #2 confirmed she took the order for D/C Trazodone	M 735	the Medical Records Nurse to ensure ongoing compliance. The Quality Assurance Committee will address concerns and update the corrective action plan when needed. 5. Completion Date 10/14/19	

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M 735	Continued From page 4 on 7/26/19, faxed it to the pharmacy, pulled the med off the cart so nobody would have given it accidentally, and entered the order in the computer. She stated she discontinued the Trazodone in the computer, but sometimes the computer glitches and jumps. She stated she doesn't work the night shift so she wasn't aware of the two (2) separate Trazodone orders. She stated she removes any discontinued medications from the med cart.	M 735		