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 |
|---|---|---|---|
| | 33JD | A. BUILDING: _____ B. WING _____ | 09/19/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| JEFFERSON DAVIS COMMUNITY HOSPITAL E( | 1320 WINFIELD STREET PRENTISS, MS 39474 |

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| M 000 | Initial Comments<br><br>The State agency (SA) conducted an annual survey from 9/16/19 through 9/19/19. During the survey, 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.<br><br>The facility was licensed for 55 beds and had a census of 51 at the time of survey. | 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 and progress notes; and discharge summary, | M 735 | | 10/18/19 |

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| M 735 | Continued From page 1<br>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>Level II<br><br>Based on observation, record review, staff interview and facility policy review, the facility failed to ensure accuracy of the medical record, related to a soft wrist splint and an indwelling urinary catheter, for two (2) of 18 resident medical records reviewed, Resident #3 and Resident #38.<br><br>Findings include:<br><br>A review of the facility's policy titled" Medication | M 735 | 1. Resident #3 was assessed by the Director of Nursing on 10/04/2019 with no negative findings. Resident #38 was assessed by the Director of Nursing on 9/17/2019 with no negative findings. A Clarification Order was obtained for Resident #3 on 10/04/2019 and Resident #38 on 09/17/2019 by the Minimum Data Set Nurse to accurately reflect the Residents status.<br>2. All Residents have the potential to be affected by this deficient practice. | |

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| M 735 | Continued From page 2<br>Orders" with a revision date of November 2014, revealed a current list of orders must be maintained in the clinical record of each resident.<br><br>A review of the facility's documented statement, signed by the Director of Nursing (DON), not dated, revealed the facility does not have a policy and procedure that specifically addresses the input of orders after a hospital return.<br><br>Resident #38<br>A record review of the physician's orders for September 2019, revealed there was no order for Resident #38's indwelling urinary catheter. The most recent Discharge-Return Anticipated Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 8/27/19, was coded to include an indwelling urinary catheter. The resident had a catheter for entire seven (7) day look-back period.<br><br>On 9/17/19 at 9:15 AM, an observation revealed Resident #38 lying in bed with his eyes open. Resident #38 was observed with an indwelling urinary catheter.<br><br>On 9/17/19 at 11:00 AM, an interview, with the Director of Nurses (DON), confirmed the medical record was inaccurate related to no physician's order for the indwelling urinary catheter for Resident #38. She also stated the physician orders did not reflect the resident's current status regarding the indwelling urinary catheter. The DON stated Resident #38 had the catheter upon his hospital return (8/19/19).<br><br>On 9/18/19 at 8:54 AM, an interview, with Registered Nurse (RN) #3, revealed the resident returned from the hospital with the catheter, had poor kidney function, and is unable to urinate on | M 735 | 3. An in-service was conducted on 10/03/2019 by the Nurse Consultant for The Director of Nurses, Staff Development Nurse, Charge Nurses, Licensed Practical Nurses, Minimum Data Set Nurse, Social Service Designee, regarding the importance of accuracy of medical records including transcription of Physicians Orders.<br>4. The Director of Nursing and Staff Development Nurse will conduct a review of all Physicians Orders for accuracy and report daily to the Morning Staff Meeting. Any deficient practice will be corrected immediately. Findings will be reviewed in the weekly Quality Assurance Performance Improvement meeting and recommendations will be made as needed. | |

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| M 735 | Continued From page 3<br>his own. She also stated she would have to look at the chart to make sure of the diagnoses. She stated the resident had not had any complications from the urinary catheter that she is aware of.<br><br>Resident #3<br>Review of Physician orders for August 2019, revealed no Physician's order for a soft wrist splint to Resident #3's right wrist on 8/13/19.<br><br>Review of an incident report timeline, provided by the facility, documented on 8/13/19, revealed Resident #3 received a right soft wrist splint, placed per Primary Care Provider, due to a nondisplaced distal radial fracture.<br><br>An observation on 09/16/19 at 8:53 AM, revealed a soft wrist splint noted on Resident #3's right wrist.<br><br>An interview on 09/18/19 at 11:00 AM, with the facility Medical Director, revealed he applied the soft splint to Resident #3's wrist in the Emergency Room on 8/13/19.<br><br>An interview on 09/18/19 at 11:07 AM, with the Director of Nursing (DON), revealed there should have been an order written for Resident #3's splint when she returned from the hospital. The DON confirmed the medical record was inaccurate because there was no order written for the wrist splint.<br><br>An interview on 09/18/19 at 1:37 PM, with the DON, revealed the RN Supervisor or the LPN who checks a resident back in after an appointment are supposed to write any orders that return with the resident. She stated whoever writes the order, is supposed to create or update the care plan, specific to the order. The DON | M 735 | | |

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| M 735 | Continued From page 4<br>confirmed there was no Physician's order written for Resident #3's splint, nor a care plan updated with written interventions for the soft right wrist splint. | M 735 | | |