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
	14GI	A. BUILDING: _____ B. WING _____	10/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENBOUGH HEALTH AND REHABILITATIOI	340 DESOTO AVE EXTENDED CLARKSDALE, MS 38614

(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 at the facility from 9/30/19 to 10/3/19. During the survey, the SA determined the facility was not in compliance with Minimum Standards for the Aged or Infirm requirements of participation. The SA cited the regulatory deficiencies M735. At the time of the survey, the census was 55, 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. 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		10/31/19

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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: Based on record review, staff interview, and facility policy review, the facility failed to ensure that a Discharge Minimum Data Set (MDS) Assessment was completed accurately for one (1) of 18 MDS reviewed, Resident #52, as evidenced by the MDS was coded for discharge to the hospital and the resident was discharged home. Findings include:	M 735	M735: 1. Resident #52's discharge Minimum Data Set (MDS) assessment was corrected and transmitted on 10/2/2019 by the MDS nurse. 2. On 10/4/19, the MDS nurse completed a 100% audit of residents on the discharge/tracking roster to determine any other residents with the potential for this	

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M 735	Continued From page 2 Review of the Resident Assessment Instrument (RAI) for MDS coding, used by the facility for their policy, revealed to review the medical record, including the discharge plan and discharge orders, for documentation of the discharge location. Review of the discharge Minimum Data Set (MDS) for Resident #52, with an Assessment Reference Date (ARD) of 7/2/19, revealed in section A2100 the discharge status was to an Acute Hospital. Review of the physician's orders, dated 7/2/19, revealed Resident #52 was to be discharged home with Home Health for follow-up care. On 10/1/19 at 4:54 PM, an interview with the Director of Nursing (DON) confirmed Resident #52's discharge MDS with the Assessment Reference Date (ARD) of 7/2/19, was coded for discharge to an acute hospital and the resident was discharged home. The DON stated she remembered the resident went home with Home Health. On 10/2/19 at 3:28 PM, an interview with Licensed Practical Nurse (LPN) #1/MDS Coordinator, confirmed the discharge MDS for Resident #52, on 7/2/19, was coded as being discharged to the acute hospital and he was discharged home with Home Health. LPN #1 revealed she does not know how it got coded wrong.	M 735	same accuracy issue of the discharge location. There were no other residents identified. 3. On 10/4/19, the MDS nurse, Director of Nursing (DON), and Assistance Director of Nursing/Registered Nurse Assessor were in-serviced on accuracy of the MDS and coding per the RAI guidelines by the Nursing Home Administrator (NHA). 4. Starting 10/14/19, all discharges will be discussed in the weekday morning meeting among the Interdisciplinary Team (IDT) members to verify discharge location. The MDS nurse will verify discharge location with the business office manager, physician orders, and RN MDS assessor prior to coding the MDS. Starting 10/21/19, the DON and/or NHA nurse will audit discharged resident records weekly to ensure accuracy of the discharge location of the MDS assessments. 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.	