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 _____	10/31/2019

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 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 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	M 735		11/14/19

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M 735	Continued From page 1 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 accurately code the Minimum Data Set (MDS) for Hospice, for two (2) of 21 residents reviewed, Resident #30 and Resident #44. Findings include: Record review of the facility's "Resident MDS Assessment" policy, dated 9/19, revealed The Registered Nurse is responsible for verifying the completion of the assessment. The completed assessment guide the staff in identifying key information about the resident and serves as a a basis for identifying resident specific issues and objectives in order to develop a care plan. The assessment will describe the resident's physical and mental deficits, strengths and the requirements of assistance to meet their needs. The assessment will also identify risk factors associated with possible functional decline and describe the resident's objectives for maintaining or improving their functional abilities.	M 735	By submitting the enclosed materials we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceeding and submit these responses pursuant to our regulatory obligations. * On 10/31/2019, Resident #30 s Quarterly Minimum Data Set (MDS) was modified to correct Section O related to Hospice Services by the Assessment Nurse. Resident #44 s Quarterly and Significant Change MDS assessments were modified and corrected by the Assessment Nurse on 11/1/2019 to reflect resident s hospice status. * On 11/13/2019, the Administrator reviewed the current MDS assessments of residents receiving hospice care to ensure accuracy of MDS, with no other issues identified. * On 10/30/2019, the Quality Improvement Nurse in-serviced the facilitiys MDS	

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M 735	Continued From page 2 Resident #44 Review of Resident #44's Significant Change MDS with an Assessment Reference Date (ARD) of 6/11/19, revealed Hospice was not marked. Record review of the Quarterly MDS with an ARD of 9/6/19, revealed Dialysis was not marked. On 10/29/19 at 4:10 PM, during an interview, Licensed Practical Nurse (LPN) #1/MDS Nurse confirmed Resident # 44 had an order to be admitted to Hospice on 6/5/19. The MDS Nurse stated the significant change MDS on 6/11/19, and the quarterly MDS on 9/6/19, did not have Hospice coded. LPN #1 stated Hospice should have been coded and they will have to do a modification. On 10/29/19 at 4:20 PM an interview with LPN #2 confirmed she completed the MDS with an Assessment Reference Date (ARD) of 6/11/19 and 9/6/19. LPN # 2 confirmed that she did not code Resident #44 was receiving treatment by Hospice. LPN #2 revealed she did the significant change MDS on 6/11/19, because Resident #44 was admitted to Hospice, but did not mark Hospice in section "O". LPN #2 revealed she gets her information for the MDS from the resident's chart and reviewing the orders, and must have just missed that section. Review of the current physician's orders, for Resident #44, revealed an order noted on 6/5/19, to admit to Hospice with a diagnosis of Heart Disease. Resident #30 Review of Resident #30's Quarterly MDS, with an ARD of 9/5/19, revealed Hospice was not marked.	M 735	nurses related to accuracy of resident Minimum Data Sets according to the facility s policy and the Resident Assessment Instrument (RAI) Manual. On 11/14/2019, the Quality Assurance Committee reviewed the policy, Resident MDS Assessment with no recommended changes to the facility. * The Director of Nurses (DON) will assess three (3) residents most current MDS assessment for accuracy weekly for five (5) weeks through the facility s Utilization review meeting. The Quality Assurance (QA) Committee will evaluate the DON assessments two (2) times a month for 2 months and make recommendations and/or changes needed to ensure ongoing compliance.	

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M 735	Continued From page 3 On 10/30/19 at 1:05 PM, during an interview, Licensed Practical Nurse (LPN) #3/Minimum Data Set (MDS) Nurse confirmed she completed the MDS, with an ARD of 9/5/2019. LPN #3 confirmed she did not code the MDS to reflect Resident #30 was receiving treatment by Hospice. LPN #3 stated " I just missed it". She stated Hospice should have been marked. Review of the current physician's orders revealed an order noted on 6/5/19, to admit Resident #30 to Hospice with a diagnosis of Hypertensive Heart Disease with Heart Failure.	M 735		