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
	36GR	A. BUILDING: _____ B. WING _____	01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD HEALTH & REHAB CENTER	1301 BELK BOULEVARD OXFORD, MS 38655

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M 000	Initial Comments The State Agency (SA) conducted an annual re-certification survey from 01/20/2020 to 01/23/2020. During the survey, the SA determined the facility was not in compliance with the Minimum Standards of the Institutions for the Aged and Infirm. The SA cited the state statutes at M620 and M735. The facility was licensed for 180 beds, and had a census of 151, at the time of the survey.	M 000		
M 620	45.21.4 Urinary incontinence Urinary incontinence. Residents with urinary incontinence shall be assessed for need of bladder retraining program. An indwelling catheter will not be used unless the resident ' s clinical condition indicates that catheterization is necessary. These residents shall receive treatment and services to prevent urinary tract infections. Level II Based on observation, staff interview, and facility policy review, the facility failed to anchor the catheter during care to prevent trauma, for one (1) of six (6) catheter care observations, Resident #38. Findings include: Review of the facility's "Bladder and Bowel Habits, Urinary Incontinence and Catheter Care" policy, dated 05/29/2018, revealed catheter care shall be performed by nursing staff utilizing soap and water, and performed every shift or as needed. The policy did not address securing the catheter tube.	M 620	1. On 1/23/20 The Registered Nurse assessed resident #38 the catheter was patent and intact and the resident did not have any signs and symptoms of Infection 2. On 1/28/20 Licenses Practical Nurse (LPN) #4 Passed her skill check off on Catheter care. 3. All residents with an indwelling Foley Catheter have the potential to be affected. 4. Between 1/23/20 and 2/18/20 All Nurses Passed their Skill check off on Catheter Care with the Staff Educator to include demonstration properly securing the Foley Catheter with a leg Strap	3/9/20

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M 620	Continued From page 1 During an observation of Resident #38's catheter care, on 01/22/2020 at 10:35 AM, Licensed Practical Nurse (LPN) secured the catheter tubing approximately 10 inches away from the point of entrance into the penis. LPN #4 cleaned the tubing from the entrance of tubing into the penis, down to the point of where the catheter was secured. On 01/22/2020 at 10:50 AM, during an interview, LPN #4 confirmed she secured the catheter approximately 10 inches from the base of the catheter entering the penis, and cleaned the tubing from the entrance into the penis, out to the point of where she was secured the catheter. LPN #4 revealed by not securing the catheter tubing at the base, she could have possibly caused the tube to pull and hurt the resident. LPN #4 revealed she wasn't sure if she had an in-service on catheter care because they have had so many and she couldn't remember. During an interview, on 01/22/2020 at 2:45 PM, the Director of Nursing confirmed the catheter tube should be secured at the meatus to prevent possible harm. Review of the facility's procedure on providing catheter care, undated, revealed, to hold the catheter near the meatus to avoid tugging the catheter. Review of the facility's "Skills Fair" check off list, dated October 17-18, 2019, revealed LPN #4 signed and was checked off on 10/17/2019, for meeting the requirement skills for catheter care.	M 620	5. The staff educator will perform skill check off beginning 2/27/20 on five nurses weekly for four Weeks then five Nurses monthly for two months then Quarterly thereafter. Any discrepancies will be brought to Quality Assurance committee monthly or until substantial compliance has been met.	
M 735	45.25.1 Medical Records Management	M 735		3/9/20

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M 735	Continued From page 2 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		

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M 735	Continued From page 3 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 staff interview and record review, the facility failed to accurately code the discharge status for one (1) of eight (8) Minimum Data Set (MDS) assessments reviewed for discharge, Resident #146. Findings include: Review of the Centers for Medicare and Medicaid Services Long Term Care Resident Assessment Instrument (RAI) 3.0 User's Manual, dated October 2018, revealed: Chapter 1.3 (Completion of the RAI) - The RAI process requires the assessment to accurately reflect the resident's status. An accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations. A review of Resident # 146's Discharge Return Not Anticipated MDS assessment, with an Assessment Reference Date (ARD) of	M 735	1. Resident #146 Medical Data Set (MDS) was completed by the MDS on 1/23/20 2. All Discharged residents have the potential to be affected. 3. An Inservice was held 2/18/20 by the Director of Nursing (DON) and Staff Educator on the importance of coding the discharge status correctly under Section A2100 of the MDS. 4. The Risk Manager will audit section A2100 on all Discharge residents on Friday beginning 2/28/20 during the weekly Transmission meeting for six weeks and Monthly for three Months. 5. This Plan of Correction will be monitored by Quality Assurance Nurse (QA) monthly until such time consistent substantial compliance has been met.	

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M 735	Continued From page 4 12/20/2019, revealed Section A2100 (Discharge Status) was coded as discharged to an acute hospital. Record review of Resident #146's Physician Orders, dated 12/19/2019, revealed an order to discharge home on 12/20/19 with Home Health services. A review of the Departmental Notes for Resident #146, dated 12/20/2019, documented the resident was discharged home with wife. During an interview, on 01/23/2020 at 9:15 AM, Registered Nurse (RN) #2/MDS Coordinator confirmed she completed Resident #146's Discharge Assessment, dated 12/20/2019, and had coded Section A to indicate the resident was discharged to the hospital. RN #2 revealed the incorrect coding of Resident #146's discharge status was in error and that she would do a correction.	M 735		