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
	15PC	A. BUILDING: _____ B. WING _____	02/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE CREST GUEST HOME INC	133 PINE STREET HAZLEHURST, MS 39083

(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 Agency (SA) conducted an annual recertification from 02/10/2020 through 02/13/2020. The State Agency determined the facility was not in compliance with the Minimum Standards of Institutions for the Aged and Infirm. The SA cited the state statute at M735. At the time of survey, the facility had a census of 56, and was licensed 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 and progress notes; and discharge summary,	M 735		4/10/20

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M 735	Continued From page 1 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 observation, record review, staff interview, and facility policy review, the facility failed to accurately document a physician's order as prescribed, for one (1) of 20 resident records reviewed, Resident #24. Findings include: Review of the facility's "Medical Record, Medication, Discharge, Verbal and Written	M 735	On February 12, 2020 The medical records Licensed Practical Nurse updated Resident #24 Medication Administration Record. On February 28, 2020 all Physician orders were compared to each residents medication administration record by the Interdisciplinary Team. All residents have the potential to be affected.	

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M 735	Continued From page 2 Orders" policy, with a revision date of 11/28/2017, revealed, medical records of residents shall be maintained according to regulations and laws regarding proper documentation and privacy. A review of Resident #24's physician orders, dated 12/05/2019, revealed an order was written to discontinue Celexa 20 milligrams (mg) daily, and start Celexa 10 mg daily for Depression. Review of the "Note to Attending Physician/Prescriber", dated 12/05/2019, revealed the physician signed to reduce Resident #24's dosage of Celexa 20 mg daily to Celexa to 10 mg daily. Review of Resident #24's printed "Physician Orders" for February 2020, revealed an order for Celexa 20 mg daily, with a start date of 12/05/2019. On 02/12/2020 at 3:30 PM, during an interview, the Director of Nursing (DON) revealed the current physician orders for Resident #24 should match the MAR and medication card to ensure the resident was receiving the right medication and right dosage. The DON revealed Resident #24's current physician orders should have been changed to reflect the right dosage. On 02/12/2020 at 3:50 PM, during an observation and interview with Licensed Practical Nurse (LPN) #4, revealed Resident #24's medication card and Medication Administration Record (MAR) documented Celexa 10 mg. LPN #4 revealed the resident was currently receiving Celexa 10 mg.	M 735	On February 13, 2020 through March 5, 2020 nurses were in serviced by the Director of Nursing on receiving and reviewing the manifestation sheet from the pharmacy and comparing the medication card label to the physician orders, then to the medication administration record. The Medical Records Licensed Practical Nurse will audit new orders by comparing the physician orders to the Medication Administration Record for four residents weekly for six consecutive weeks to ensure compliance starting on March 30, 2020. Discrepancies will be promptly reported to the Director of Nursing. This plan of correction will be monitored at the Quality Assurance meeting until such time consistent substantial compliance has been met.	