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
	19ME	A. BUILDING: _____ B. WING _____	12/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADVILLE CONVALESCENT HOME	300 HWY 556/ROUTE 2 BOX 66 MEADVILLE, MS 39653

(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) determined during an annual recertification/licensure survey, conducted from 12/3/19 to 12/5/19, the facility was not in compliance with the Minimum Standards of Operation for Institutions for the Aged or Infirm, state licensure requirements and cited M655. The census at time of survey was 58, with a license for 60 beds.	M 000		
M 655	45.21.11 Special needs Special needs. Each resident with special needs shall receive proper treatment and care. These special needs shall include, but are not limited to injections; parenteral and enteral fluids; colostomy, ureterostomy, ileostomy care; tracheostomy care; tracheal suction; respiratory care; foot care; and prostheses. This Statute is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure residents were administered oxygen therapy, per physician's order, for two (2) of three (3) residents reviewed for respiratory care, Resident #30 and Resident #31. Findings Include: Review of the facility's "Oxygen Policy", dated 06/23/17, revealed oxygen would be used with specific physician's orders and should never be above three (3) liters (L), without special physician's orders. The Medication Administration Record (MAR) is used to document continuous oxygen usage. The Oxygen Flow Sheet is used	M 655	Tag 0655 1.Corrective action for resident #30 was done on 12/04/19 by placing a sign for Oxygen in Use on the door by the charge nurse Licensed Practical Nurse (LPN). The care plan was updated to reflect the use of oxygen. The nurses were in-serviced by the Staff Educator Registered Nurse (RN) on observation of oxygen use to ensure ordered liter was in use and document accordingly. The smoking equipment is locked in the medication room and only nurses have access. The resident is brought to the nurses desk before and after smoking to ensure a nurse removes and replaces the oxygen tank and the proper rate is	12/30/19

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M 655	Continued From page 1 for PRN (as needed) oxygen usage. Resident #30 A review of Resident #30's December 2019 physician's orders, revealed an order dated 02/15/19, for Oxygen (O2) at two (2) Liters (L) via nasal cannula (NC) as needed (PRN), related to shortness of breath (SOB). Observations of Resident #30, on 12/03/19 at 10:13 AM, 11:55 AM, 2:50 PM, and 3:39 PM; and on 12/04/19 at 8:51 AM, revealed Resident #30 was lying in bed with oxygen being administered via nasal cannula to both nostrils at 3.5 liters (L) per minute from an oxygen concentrator. There was no "Oxygen in Use" sign (no smoking) on the door or posted in the room. In an interview, on 12/03/19 at 11:55 AM, Resident #30's daughter stated the resident had been on O2 for some time and she was unsure what the setting was supposed to be on. The resident's daughter stated she never adjusted the oxygen concentrator; only nurses do. During an interview, on 12/04/19 at 11:45 AM, the DON revealed she expected nurses to monitor oxygen periodically throughout the day, to ensure it was being administered at the correct rate. The DON stated she would expect the nurses to observe and document every shift, the O2 saturation level for the resident, and the rate of administration, accurately on the Medication Administration Record (MAR) or the oxygen flow chart. The DON stated there should have been an "Oxygen in Use" sign on the resident's door. In an interview, on 12/04/19 at 4:01 PM, LPN #4 stated she completed Resident #30's MAR for O2 use. LPN #4 stated she marks the MAR after	M 655	administered. Corrective action for resident #31 was done on 12/04/19 by in-servicing nurses to remove oxygen tanks from her wheelchair and not allow daughter to turn off or turn on. When resident returns from smoking the nurse is to set the rate of oxygen use. The daughter was educated on 12/04/19 by the Director of Nursing (DON) to allow the nurses at the desk to remove and replace the oxygen tanks and to set the rate. 2. All residents using oxygen have the potential to be affected by this practice. 3. The nurses were in-serviced by the Staff Educator Registered Nurse (RN) on 12/04/19 to observe and document oxygen use to ensure the correct rate is being used and also to replace oxygen tank after resident smokes to ensure daughter doesn't change rate. The nurses keep the portable oxygen tanks in the medication room during smoking times to ensure only nurses remove and replace them. 4. The Quality assurance nurse will observe the documentation of oxygen use to ensure the correct dose ordered is being administered and checked every shift on a weekly basis for six months. The medication nurse will document every shift on the oxygen observation log in the medical administration record. The QA nurse will bring her weekly observation check list to all Quality Assurance meetings for the committee to review for	

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M 655	Continued From page 2 checking O2 saturation levels for each resident. LPN #4 stated she did not check to see that the O2 was set at 2L per minute, for Resident #30, but she should have. Resident #31 Review of the physician's orders, dated 10/29/18, revealed Resident #31 had an order for O2 sats every (Q) shift, and if below 90 percent (%), place O2 at 2L via NC. An observation, on 12/03/19 at 10:32 AM, revealed Resident #31 in hallway, at the door to her room, with O2 being administered via nasal cannulas at 2L per minute, with a portable oxygen tank attached to the back of her wheelchair. At 10:34 AM, on 12/3/19, Resident # 31 was observed to go outside on the back patio area with visitors to smoke; she had no oxygen being administered. An observation on 12/03/19 at 11:12 AM, of Resident #31 in the dining room, revealed O2 being administered via bilateral NC at 3L per minute from a portable O2 tank. An observation on 12/03/19 at 2:46 PM, revealed Resident #31 in the dining room, during an activity, with O2 being administered via bilateral NC at 3L per minute from a portable O2 tank. An observation on 12/03/19 at 3:36 PM, revealed O2 being administered to Resident #31 at 2L per minute, via bilateral NC, from a portable tank on her wheelchair. An observation and interview, in Resident #31's room, on 12/04/19 at 8:39 AM, revealed the resident was being administered O2 at 2L per	M 655	six months.	

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M 655	Continued From page 3 minute, via bilateral NC, from an oxygen concentrator. The resident stated she has been on oxygen continuously for several months and had been on 2L of oxygen since she had been using it. The resident stated her daughter turned off her oxygen, prior to her smoking yesterday, and back on after she finished, once she was inside. The resident stated her daughter was an Emergency Medical Technician (EMT) and had training on the use of oxygen. The resident stated she was unaware her O2 was being administered at 3L per minute for a period of time yesterday, but it should have been 2L. The resident stated the nurses check her oxygen level two (2) or three (3) times a day. The resident suggested a Certified Nursing Assistant (CNA) may have put her oxygen level on 3L, after she smoked yesterday, she was unsure, because they sometimes turn the oxygen on/off before and after smoke breaks. During an observation of Resident #31, and interview with LPN #2, on 12/04/19 at 11:30 AM, revealed Resident #31 lying in bed with O2 being administered via NC at 3.5 L per minute, via the oxygen concentrator. LPN #2 stated the O2 should be at 2L and adjusted to the rate to 2L. LPN #2 stated she had not checked the resident's oxygen, prior to this observation; she didn't normally work this hall. During an interview on, 12/04/19 at 11:35 PM, RN #1 revealed Resident #31 and all residents were monitored by staff when smoking, however, Resident #31's daughter did come and take her out to smoke on occasion. RN #1 stated sometimes staff were not aware when the resident's daughter visited, but she was an EMT and knew how to turn off oxygen. RN #1 stated staff should check periodically, to make sure the	M 655		

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M 655	Continued From page 4 O2 level was correct, and it was possible the resident's daughter turned the O2 on and put it at 3L per minute. An interview on 12/04/19 at 11:45 AM, with the DON, confirmed Resident #31's daughter (an EMT) visits and takes the resident out to smoke. She indicated the daughter might manipulate the oxygen administration. The DON stated she would expect the nurses to check O2 administration for residents, to make sure it is being administered at the correct rate.	M 655		

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	19ME	A. BUILDING: **01 - MAIN BUILDING 01** B. WING _____	**12/10/2019**

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M1245	45.41.1 Date of Construction & Life Safety... Date of Construction and Life Safety Code Compliance. 1. Buildings constructed after the effective date of these regulations shall comply with the edition of the Life Safety Code (NFPA 101) effective on the date of construction. 2. Buildings constructed prior to the effective date of these regulations shall comply with Chapter 13 of the Life Safety Code (NFPA 101), 1985 edition. This Statute is not met as evidenced by: Based on document review, the facility failed to properly test the emergency generator as per NFPA 110 section 8.4.2. The deficient practice affected the entire facility on day of survey. Findings include: During document review on 12/10/19 at 10:00 AM, the facility could not provide documentation showing the weekly inspections of the generator from 4/15/19 to 9/23/19, and the monthly load tests of the generator from 3/18/19 to 12/10/19 (day of survey).	M1245	Plan of Correction 1. Tag M1245 Corrective action was taken for this deficiency by the administrator training the new maintenance supervisor on appropriate documentation of generator inspections. This was done upon hire and the deficiency occurred before this date. 2. All residents of the facility have the potential to be affected by this practice. 3. The maintenance supervisor will do generator inspections every Monday and document appropriately. 4. The Maintenance supervisor will bring generator documentation logs to all Quality Assurance meetings for approval by the Quality Assurance Committee. 5. This corrective action will be completed by December 28, 2019.	12/30/19

Mississippi State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/02/20