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
	78EH	A. BUILDING: _____ B. WING _____	03/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF EUPORA	156 E WALNUT AVE EUPORA, MS 39744

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M 000	Initial Comments The State Agency (SA) conducted an annual re-certification survey, at the facility, from 03/02/2020 to 03/05/2020. During the survey, the SA determined that the facility was not in compliance with the Minimum Standards of Operation for Institutions for the Aged or Infirm. The SA cited the state statute at M655. At the time of the survey, the facility had a census of 115, and held a license for 119 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: Level II Based on observation, resident interview, staff interview, and policy review, the facility failed to store respiratory equipment in a manner to prevent contamination, for six (6) of seven (7) residents reviewed for respiratory care; Resident #3, Resident #27, Resident #53, Resident #72, Resident #87 and Resident #103. Findings include: Review of the facility's "Policies and Practices-Infection Control" policy, dated, November 1, 2017, revealed, "This center's infection control policies and practices are	M 655	1. Registered Nurse (RN) changed the tubing on affected residents. 100% audit was completed by the Director of Nursing (DNS) and the Assistant Director of Nursing (ADNS)on 3/5/2020 to ensure no other tubing was improperly stored. The 20 residents who were on oxygen were assessed for respiratory issues by the RN charge nurse on each unit on 3/5/2020. No adverse signs and symptoms were noted. 2. The 20 residents who were on oxygen were assessed for respiratory issues by the RN charge nurse on each unit on 3/5/2020. No adverse signs and	4/13/20

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M 655	Continued From page 1 intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections." Resident #3 During an observation, on 03/02/2020 at 12:24 PM, Resident #3's oxygen tubing revealed, the tubing was not dated or labeled. Resident #3's oxygen tubing was draped across his oxygen concentrator and dangling. There was no evidence of a protective covering for the oxygen tubing in the room. On 03/03/2020 at 9:20 AM, an observation of Resident #3's oxygen tubing, revealed it was draped across his oxygen concentrator and continued to be undated and labeled. Resident #3's oxygen tubing was not in a protective covering. On 03/04/2020 at 11:10 AM, Resident #3's oxygen tubing was noted to be laying across his oxygen concentrator and not in a bag. During an interview, on 03/04/2020 at 11:17 AM, Licensed Practical Nurse (LPN) #1 stated the night shift nurse is responsible for changing out the water, tubing, labeling items and placing them in a plastic bag weekly. LPN #1 confirmed Resident #3's tubing was not dated or in a plastic bag. She stated the oxygen tubing should be placed in a bag for infection control purposes, and that you wouldn't want the tubing touching any contaminated surfaces. Resident #53 On 03/02/20 at 2:54 PM, during an observation, Resident #53's oxygen tubing was noted to be wrapped around her bed rail frame and not in a	M 655	symptoms were noted. Education was conducted by Director of Clinical Education for all direct care team members regarding storage of oxygen tubing when not in use and was completed 3/13/2020. 3. Room rounds, which include observation of oxygen tube storage, were conducted by department leaders. The Administrator or DNS followed up on these room rounds daily x two (2) weeks and then weekly x four (4) weeks. This was completed 4/13/2020. 4. Room round findings will be shared at Daily Connect Meetings. Any adverse oxygen tubing storage findings will be brought by the Administrator monthly to the Centers Quality Assessment Performance Improvement (QAPI) Committee for follow up. This committee consists of the Medical Director, Administrator, DNS and at least three other department managers. This committee will review the audits for additional monitoring and continued improvement and make recommendations as needed.	

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M 655	Continued From page 2 protective covering. On 03/03/20 at 3:54 PM, an observation of Resident #53's oxygen tubing, revealed it was wrapped around the bed rail frame and uncovered. Resident #103 During an interview and observation, on 03/02/2020 at 10:33 AM, Resident #103's oxygen tubing revealed, the tubing was hooked through the water pitcher handle. Resident #103 stated that she had put it there, so it would stay off the floor. Resident #103 stated, at times, she draped it over her oxygen concentrator. On 03/03/2020 at 9:00 AM, during an observation, Resident #103's oxygen tubing was observed lying across the oxygen concentrator and was not in a protective cover. During an interview, on 03/04/2020 at 11:17 AM, LPN #1 stated the night shift nurse was responsible for changing out the water, tubing, labeling items, and placing them in a plastic bag weekly. LPN #1 stated the oxygen tubing should be placed in a bag for infection control, and that you wouldn't want the tubing touching any contaminated surfaces. On 03/04/2020 at 12:07 PM, an interview with the Director of Nursing (DON), revealed, she stated the facility does not have a policy specific to oxygen tubing and proper storage, but that all tubing and humidified bottles of water are changed weekly on the 11 AM to 7 AM shift and should be dated and labeled. The DON stated the tubing should be stored in a plastic bag for infection control purposes and for safety.	M 655		

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M 655	Continued From page 3 Resident #27 An observation, on 03/02/2020 at 11:32 AM, revealed Resident #27's nebulizer mask was not bagged, and lying on top of the nebulizer machine. No bag or other protective cover was observed in room. During an observation, on 03/03/2020 at 10:49 AM, Resident #27's nebulizer mask was lying on top of her nebulizer machine and not stored in a bag. An observation, on 03/04/2020 at 10:05 AM, revealed, Resident #27's nebulizer mask remained on top of the nebulizer machine and not in a protective cover. During an observation and interview, on 03/04/2020 at 11:48 AM, with Registered Nurse (RN) #1, she confirmed Resident #27's nebulizer mask was lying on top of the nebulizer machine uncovered. RN #1 revealed, she knew oxygen tubing was supposed to be in a bag, but she didn't know about nebulizers. RN #1 stated she realized this was an infection control issue, because the tubes could end up in the floor. On 03/04/2020 at 11:53 AM, during an interview, LPN #2 confirmed that all respiratory equipment should be in bags. Resident #72 An observation, on 03/02/2020 at 11:37 AM, revealed, Resident #72's oxygen (O2) cannula and tubing was on the floor behind her wheelchair. Resident #72's nebulizer mask was not stored in a container to prevent contamination. During an observation, on 03/03/2020 3:24 PM,	M 655		

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M 655	Continued From page 4 Resident #72's oxygen cannula was draped over the back of her wheelchair, with the cannula lying on her wheelchair seat cushion. Resident #72's nebulizer machine and nebulizer mask was sitting on the overbed table and was not in a bag. On 03/04/2020 at 11:48 PM, during an observation, with RN #1 and LPN #2, Resident #72's oxygen tubing was noted to be draped over the back of her wheelchair, and her handheld nebulizer was on her nebulizer machine uncovered. During an interview, on 03/04/2020 at 11:52 AM, RN #1 revealed she knew oxygen tubing was supposed to be in a bag, but she didn't know about nebulizers. RN #1 stated she realized this was an infection control issue, because the tubes could end up in the floor. During an interview, on 03/04/2020 at 11:53 AM, LPN #2 confirmed that all respiratory equipment should be in bags. Resident #87 During an observation of Resident #87's room, on 03/02/2020 at 10:40 AM, the resident's oxygen cannula and tubing were lying on the bed without being in a storage bag. Resident #87 was not in the room. During an interview and observation, on 03/02/2020 at 12:33 PM, Resident #87, stated that he used oxygen most of the time when he was in his room, but does not use it when he leaves his room. Resident #87 stated when he leaves the room, he takes his oxygen off, and places the cannula on the bed. Resident #87 stated he had storage bags in the past, but not lately. Resident #87's oxygen cannula and tubing	M 655		

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M 655	Continued From page 5 were observed on the bed, until the resident picked it up to put on. An observation, on 03/03/2020 at 10:00 AM, revealed Resident #87 ' s oxygen cannula was on bed and no storage bag available. Resident #87 was not present in the room. During an observation on, 03/04/2020 at 8:33 AM, Resident #87 was in the room wearing oxygen. There was no bag for storage at Resident #87's bedside. During an observation and interview with LPN #2, on 03/04/2020 at 11:30 AM, revealed, Resident #87's oxygen tubing was lying on the bed and no storage bag was noted. Resident #87 was not present in the room. LPN #2 stated the oxygen tubing should be stored in a plastic bag to keep it clean when not in use, and staff should date these bags. LPN #2 confirmed a storage bag was not in the resident's room for use.	M 655		