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
	59AL	A. BUILDING: _____ B. WING _____	C 11/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LONGWOOD COMM LIVING CENTER	200 LONG STREET/P. O. BOX 326 BOONEVILLE, MS 38829

(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 and licensure survey along with a complaint survey, CI MS#16340, from 11/3/19 to 11/06/19. Concerns identified in the complaint were related to a facility reported incident of a resident's death after a fall. These concerns were not substantiated, and no deficiencies were cited related to the complaint. The SA determined the facility was not in compliance with State Licensure Regulations for the Aged or Infirm, and cited State Statutes at M635 and M705. The facility had a census of 43 at the time of the survey, with a license for 64 bed capacity.	M 000		
M 635	45.21.7 Gastric feeding Gastric feeding. Residents who are eating alone or with assistance are not fed by a gastric tube unless their clinical condition indicates that the use of a gastric feeding tube is unavoidable. The residents who are fed by a gastric tube receive the treatment and services to prevent complications or to restore if possible, normal eating skills. This Statute is not met as evidenced by: Level II Based on observation, staff interview, record review, and facility policy review, the facility failed to check for gastric contents to ensure proper placement and failed to flush water between each medication, to prevent complications, prior to medication administration via Percutaneous Endoscopic Gastrostomy (PEG) Tube. This affected one (1) of one (1) residents in the facility receiving medications via PEG tube. Resident #23.	M 635	Registered Nurse Supervisor performed a placement check for Resident number twenty-three (#23) Percutaneous Endoscopic Gastrostomy (PEG) tube on 11/4/19 11:03 am with correct placement confirmed per auscultation and presence of gastric contents. Resident number twenty-three (#23) was physically assessed on 11/4/19 11:03 am by the Registered Nurse Supervisor for any negative effects related to Licensed Practical Nurse number (#1) one not	11/29/19

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M 635	Continued From page 1 Findings include: Facility policy titled, "Enteral Tube Medication Administration," dated 08/09/13, revealed: Administer medication separately, flushing tube with five (5) milliliters (ml) of water after each dose. Equipment required: Medication Administration Record (MAR), prepare medications for administration as ordered. Review of Nursing Skills and Procedures, Perry and Potter, Eighth Edition, revealed on page 333 #11, to check for gastric residual volume (GRV) to ensure proper placement. On 11/04/19 at 8:48 AM, Licensed Practical Nurse (LPN) #1 failed to check gastric contents to ensure proper PEG tube placement, prior to medication administration, for Resident #23. LPN #1 administered Potassium liquid in a syringe followed by a liquid Multivitamin with minerals and allowed both medications to mix and flow by gravity through the syringe into the PEG tube. She then flushed with 15 cubic centimeter (cc) of water and continued with the rest of the resident's medications, which were administered appropriately. Review of a physician's order, dated 07/18/19, noted, referring to the PEG tube, "Check placement every shift and prior to medications." During an interview on 11/6/19 at 9:00 AM, in the hallway after leaving the resident's room, LPN #1 confirmed she failed to check the resident's PEG tube placement and stated, "I forgot my stethoscope. I should have checked her gastric contents, but I forgot." LPN #1 confirmed she was in-serviced to check PEG placement prior to	M 635	checking Percutaneous Endoscopic Gastrostomy (PEG) placement prior to medication administration and not flushing with water between medications with no negative findings noted. Licensed Practical Nurse number one (#1) was immediately in-serviced on 11/4/19 11:30 am by the Director of Nursing regarding checking Percutaneous Endoscopic Gastrostomy (PEG) placement by gastric residual and water flushes between medications. Gastric residual was checked on all residents in the facility with a Percutaneous Endoscopic Gastrostomy (PEG) tube, one (1) resident, revealed no concerns, by The Director of Nursing (DON) on 11/4/19 11:15 am. One (1) resident medication administration observed on 11/4/19 11:58 am by the Director of Nursing, revealed no concerns. Residents with Percutaneous Endoscopic Gastrostomy (PEG) tubes have the potential to be affected by this practice. An in-service for all nurses regarding checking gastric residual prior to administering any medications and/or enteral feedings and flushing with water between medications was initiated on 11/6/19 and completed on 11/11/19 by the Director of Nursing. The policy/procedure for checking gastric residual and medication administration per Percutaneous Endoscopic Gastrostomy (PEG) tube was reviewed on 11/8/19 8:00 am by The Regional Nurse Consultant for any needed revisions and/or updates with none noted. All nurses will follow the current policy for checking gastric residual	

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M 635	Continued From page 2 medication administration. LPN #1 confirmed she failed to give the liquid potassium separate from the liquid multivitamin; she should have given it separately and used a five (5) cubic centimeter (cc) water flush between the two (2) medications. On 11/06/19 at 9:45 AM, the Director of Nursing (DON) confirmed, per interview, that the nurses are in-serviced to check gastric contents prior to administering medications via PEG tube. The DON confirmed the nurses are in-serviced not to mix medications; they should give medications separately with five (5) cc of water between each medication. Record review revealed LPN #1 had been provided an in-service, dated 05/07/19, titled, "Medication Administration Technique," and the in-service noted, "Tube checked for placement."	M 635	and flushing with water between medications. All nurses will follow the current policy for checking gastric residual. All nurses will be educated on the medication administration policy and Enteral tube policy upon hire and prior to working with any residents by the Registered Nurse Supervisor. The Director of Nursing, or Registered Nurse Supervisor, or Licensed Practical Nurse Supervisor, will monitor medication administration per Percutaneous Endoscopic Gastrostomy (PEG) tube five (5) times per week for (2) two weeks, then three (3) for two (2) weeks, then one (1) for (2) two weeks to ensure Percutaneous Endoscopic Gastrostomy (PEG) placement is checked prior to medication administration and flushes are performed between medications. Findings will be reported to the Quality Assurance and Performance Committee monthly and as needed for review, revision, and/or resolution.	
M 705	45.24.2 Policies and procedures Policies and procedures. Each facility shall have policies and procedures to assure the following: 1. Accurate acquiring; 2. Receiving; 3. Dispensing; 4. Storage; and	M 705		11/29/19

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M 705	Continued From page 3 5. Administration of all drugs and biologicals. 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 ensure medications were administered per proper procedure via Percutaneous Endoscopic Gastrostomy (PEG) tube, and correct dosage of an inhaler per physician's orders, for Resident #23, one (1) of seven (7) residents observed during medication pass. Findings include: Facility policy titled, "Enternal Tube Medication Administration," dated 08/09/13, revealed: Administer medication separately, flushing tube with five (5) milliliters (ml) of water after each dose. Equipment required: Medication Administration Record (MAR), prepare medications for administration as ordered. Observation on 11/04/19 at 8:48 AM, revealed Licensed Practical Nurse (LPN) #1 administered medications to Resident #23 through a PEG tube. She placed Potassium liquid in a syringe followed by a liquid Multivitamin with minerals and allowed both medications to mix and flow by gravity through the syringe. She then flushed with 15 cubic centimeter (cc) of water and continued with the rest of the resident's medications. LPN #1 administered Flonase nasal spray to Resident #23 and gave one (1) puff to each nare. Review of a physician's order, dated 06/11/19, revealed: Flonase Suspension two (2) puffs in each nostril one (1) time a day.	M 705	Resident number twenty-three (#23) was physically assessed on 11/4/19 11:03 am by the Registered Nurse Supervisor for any negative effects related to Licensed Practical Nurse number one (#1) not flushing with water between medications and not administering the full dose of a nasal spray with no negative findings noted. Licensed Practical Nurse number (#1) one was immediately in-serviced on 11/4/19 11:30 am by The Director of Nursing (DON) regarding administering water flushes between medications and administering all medications as ordered. An in-service for all nurses regarding medication administration and following physician orders was initiated on 11/6/19 by the Director of Nursing and completed on 11/11/19. The Facility Pharmacy Consultant performed medication administration education on 11/22/2019, 9 am for nurses. All nurses will follow the current medication administration policy. All nurses will be educated on the medication administration policy upon hire and prior to working with any residents by the Registered Nurse Supervisor. One (1) resident medication administration per Percutaneous Endoscopic Gastrostomy (PEG) tube observed on 11/4/19 11:15 am by the Director of Nursing, revealed no concerns. Medication administration observed for (6) six residents on 11/07/2019 by the Director of Nursing, revealed no concerns. Residents with medications administered	

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M 705	Continued From page 4 Interview with LPN #1 at 9:00 AM, in the hallway after leaving the resident's room, confirmed she failed to give the liquid potassium separate from the liquid multivitamin; she should have used a five (5) cubic centimeter (cc) water flush between the two (2) medications. LPN #1 confirmed she administered one (1) puff of Flonase nasal spray to each nare of Resident #23 instead of two (2) puffs per the physician's order. LPN #1 stated, "I always give her just one (1) puff, she doesn't want two (2) puffs." LPN #1 confirmed she had not notified the doctor to have the medication dosage re-evaluated or changed. Interview with the Director of Nursing (DON) on 11/06/19 at 9:45 AM, confirmed the nurses are in-serviced and they are not to mix medications; they should give medications separately with five (5) cc of water between each medication.	M 705	by the facility nursing staff have the potential to be affected by this practice. An in-service for all nurses regarding medication administration and following physician orders was initiated on 11/6/19 by the Director of Nursing and completed on 11/11/19. The Facility Pharmacy Consultant performed medication administration education on 11/22/2019, 9 am for nurses. All nurses will follow the current medication administration policy. All nurses will be educated on the medication administration policy upon hire and prior to working with any residents by the Registered Nurse Supervisor. The Director of Nursing, or Registered Nurse Supervisor, or Licensed Practical Nurse Supervisor will monitor medications administration five (5) times per week for two (2) weeks, then three (3) times for two (2) weeks, then one (1) time for two (2) weeks to ensure proper medications administration as ordered. Findings will be reported to the Quality Assurance and Performance Committee monthly and as needed for review, revision, and/or resolution.	