STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24DW	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PASS CHRISTIAN HEALTH AND REHABILIATION CEN	538 MENGE AVENUE PASS CHRISTIAN, MS 39571

(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 Survey Agency (SSA) conducted an annual recertification along with a complaint investigations (CI) MS #18611 and CI MS #18612 at the facility from 08/07/2022 to 08/10/2022. The SSA did not substantiate MS #18611 and MS #18612 for abuse and there were no citations related to the complaints. During the survey, the SSA determined the facility was not in compliance with the Mississippi Regulations for Minimum Standards for Institutions for the Aged or Infirm and cited M635.	M 000		
M 635 SS=D	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 interviews, record review, and facility policy review, the facility failed to ensure feeding tube placement was checked prior to flushing the tube for one (1) of two (2) residents observed with feeding tubes. Resident #15. Findings Include: Record review of the facility's "Policies and Procedures" with the "Subject: Medication-Administration Via Enteral Tube", and a revision date 3/6/2019, revealed, " ...Procedure	M 635	M-635 * On August 10, 2022, Resident #15 was assess by Director of Nursing, no adverse findings noted. On August 10, 2022, Resident # 15 was placed on monitoring for seventy-two hours to observe for any changes in condition, no adverse findings noted. * All residents have the potential to be affected. * On August 11, 2022, Registered Nurse #1 in-serviced on medication via enteral	9/20/22

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M 635	Continued From page 1 ...Checking for placement of enteral tube ...To confirm proper placement ...Aspirate by gently pulling back on plunger of syringe to check for stomach contents ..." On 8/8/22 at 12:03 PM, the State Agency (SA) observed Registered Nurse (RN) #1 flush Resident #15's enteral feeding tube. RN #1 used a syringe with the plunger removed to flush the enteral tube by gravity. She did not use the syringe to aspirate for stomach contents to ensure proper tube placement prior to flushing the tube. On 8/8/22 at 12:10 PM, in an interview with RN #1, she stated she should have checked for proper placement of the enteral tube by aspirating before flushing it. She normally checks for placement when flushing the tube. RN #1 stated that by not checking placement it could have caused the water from the flush to go into the wrong area. On 8/10/22 at 12:23 PM, in an interview with the Director of Nursing (DON), he stated RN #1 should have checked placement before flushing the enteral feeding tube. RN #1's actions could have caused the resident to have complications regarding feeding. Record review of Resident #15's "Admission Record" revealed the facility admitted her on 11/6/2020 with diagnoses including Dysphagia and Aphasia. Record review of Resident #15's "Order Summary Report" with "Active Orders As Of: 08/10/2022", revealed a Physician's Order with an order date of 7/1/22 for "Enteral Feed Order every shift check enteral tube placement via aspiration	M 635	tube, by Director of Nursing. On August 11, 2022, Director of Nursing began in-service training with all nurses, on medication administration via enteral tube. All residents with peg tubes, were monitored, by Unit Manager, beginning on August 11, 2022, to ensure tube placement check, via aspiration, prior to administering medications, feedings, or flushes. * Unit Manager will monitor two (2) nurses weekly x 4 weeks then monthly x 3 months, to ensure, proper placement of peg tube is checked, via aspiration, feeding, or flushes, beginning August 18, 2022. Findings will be brought to the Quality Assurance Performance Improvement Committee Meeting by Registered Nurse, monthly x 3 months and then quarterly x 3 quarters to determine the effectiveness and make any necessary changes as indicated. ADHOC Quality Assurance Committee Meeting was held on August 26, 2022 and is scheduled for September 20, 2022.	

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M 635	Continued From page 2 prior to medication administration, flushes, and feedings". Record review of the August 2022 electronic Medication Administration Record (eMAR) for Resident #15 revealed RN #1's initials on the first shift on 8/8/22 for "Enteral Feed Order every shift check enteral tube placement via aspiration prior to administration, flushes, and feedings". This indicated that RN #1 had documented that she had checked for proper placement of Resident #15's enteral feeding tube by aspiration prior to administering medications, flushes, or feedings.	M 635		