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
	06OG	A. BUILDING: _____ B. WING _____	02/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK GROVE RETIREMENT HOME	209 OAK CIRCLE/P. O. BOX 198 DUNCAN, MS 38740

(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 survey from 2/21/19 to 2/23/19. During the survey, the SA determined the facility was not in compliance with the Mississippi Regulations for Minimum Standards for Institutions for the Aged or Infirm with deficiencies cited at M655. The facility held a license for 60 beds, and had a census of 57 at the time of entrance.	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, and staff interview, the facility failed to store oxygen tubing and a nebulizer mask in a manner to prevent contamination and likelihood of infection, for one (1) of 23 sampled residents; Resident #35. Findings include: An observation, on 02/21/19 at 10:38 AM, revealed Resident #35's nebulizer mask and oxygen cannula tubing lying on the bedside table and not stored in a bag.	M 655	"Preparation an/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement is prepared and/or executed solely because it is required by provision of Federal and State Law." M 655 45.21.11 Special Needs Bullet 1. Corrective action accomplished for alleged deficient practice. A. On 2/22/2019 Resident #35 was	4/10/19

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M 655	Continued From page 1 On 02/21/19 at 1:07 PM, an interview with Resident #35, revealed the staff does not put his oxygen tubing or nebulizer mask in a bag when not in use. Resident #35 stated, they do wash the nebulizer mask after he uses it. An observation, on 02/22/19 at 01:05 PM, revealed Resident #35's oxygen tubing and nebulizer mask in a plastic bag. An interview, on 02/22/19 at 01:15 PM, with Registered Nurse (RN) #2, confirmed Resident #35's oxygen tubing and nebulizer mask were not in a bag. She stated, she put it in a bag this morning. RN #2 confirmed, the oxygen tubing and nebulizer mask should be stored in a plastic bag and dated. She further stated, this was an infection control issue because bacteria could get on it. An interview, on 02/22/19 at 01:58 PM, with the Director of Nursing (DON), confirmed the oxygen tubing and nebulizer masks should be stored in plastic bag, that is dated. She stated, they should be changed every three (3) days.	M 655	assessed by Registered Nurse(RN) and no ill effects noted. Nebulizer mask and tubing was cleaned, dated and stored in a bag. The bag per policy will be replaced every three days. B. On 4/08/2019 Resident #35 was assessed by the Director of Nurses(DON) for potential harm due to infection control issues due to Nebulizer mask and tubing. DON determined that Resident #35 suffered no ill effects at this time due to storage issues with Nebulizer mask and tubing. Bullet 2. All residents have the potential to be affected by this deficient practice. A. On 2/22/2019 all residents that utilize Nebulizer and oxygen supplies was assessed by RN with no ill effect found. Bullet 3. Measures put in place to ensure the alleged deficient practice does not reoccur: A. On 4/09/2019, DON and Nursing Staff were in-serviced by a local Administrator and DON/RN on infection prevention an control with the use of Nebulizer mask and tubing. B. On 4/09/2019, Pharmacy Consultant in-serviced DON and Nursing Staff on infection prevention and control with the use of Nebulizer, Nebulizer mask and tubing. C. On 4/08/2019, DON in-serviced by the Administrator as to the importance of	

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M 655	Continued From page 2	M 655	Infection prevention and control as it relates to Nebulizer supplies and storage of equipment. D. The DON will ensure compliance by making walking rounds and visual observations daily. Bullet 4. DON is responsible to ensure compliance. DON will monitor Nebulizer supplies (mask and tubing) 1 X a week for 4 weeks and then monthly to ensure proper storage and infection prevention methods are followed per facility policy. Findings will be reported to Quality Assurance (QA) Committee on a monthly basis by the DON. The QA Committee will review and evaluate findings for potential concerns and address changes as the needs develops.	

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	06OG	A. BUILDING: **01 - MAIN BUILDING 01** B. WING _____	**02/21/2019**

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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 observations, the facility failed to maintain a complete manual fire alarm system as directed by NFPA 72 Chapter 10, and NFPA 101 section 9.6. The deficient practice affected all smoke compartments and all 57 residents in facility on the day of survey. Findings include: On 2/21/19 at 10:20 AM, observation revealed a "trouble signal" on the fire alarm system panel in the facility. The Maintenance Supervisor was unable to reset the fire alarm panel to "normal" mode. The finding was acknowledged by the Administrator and Maintenance Supervisor verified this observation during the exit interview on 2/21/19.	M1245	"Preparation an/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement is prepared and/or executed solely because it is required by provision of Federal and State Law." M 1245 - 45.41.1 Date of Construction & Life Safety Bullet 1. Corrective action accomplished for alleged deficient practice: A. Fire Alarm Panel vendor on 2/25/2019 serviced the Fire Panel and returned to "normal" mode. B. Fire Alarm Panel vendor on 3/25/2019 serviced The Sprinkler System and noted that Fire Panel was all clear. C. Photographs of Alarm Panel in "normal" mode were taken on 3/13/2019	4/10/19

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	06OG	A. BUILDING: **01 - MAIN BUILDING 01** B. WING _____	**02/21/2019**

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M1245	Continued From page 1	M1245	and 4/05/2019. Bullet 2. All residents have the potential to be affected by this deficient practice. Bullet 3. Measures put in place to ensure the alleged deficient practice does not reoccur: A. Administrator and Maintenance Staff were in-serviced by a local Administrator on 4/08/2019 about the importance of maintaining the Fire Panel in a "normal" mode. B. Administrator and Maintenance staff will monitor the Fire Panel on a regular work day basis to ensure Panel is in a "normal" mode. Bullet 4. Administrator will monitor this deficient practice monthly for six months. Administrator will report finding to the QA committee on a quarterly basis. Administrator is responsible to ensure compliance with Fire Alarm regulations.	

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	25E115	A. BUILDING _____ B. WING _____	02/21/2019

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E 000	Initial Comments Initial certification survey conducted 2/21/19 revealed the above facility does not meet all applicable Federal, State and local emergency preparedness requirements. Deficiencies were identified.	E 000		
E 004 SS=E	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) [The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.] * [For hospitals at §482.15 and CAHs at §485.625(a):] The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements:] (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that	E 004		4/10/19

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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E 004	Continued From page 1 must be [evaluated], and updated at least annually. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed provide update the emergency preparedness (EP) plan per requirements of 42 CFR §483.73(a). Findings include: On 2/21/19 at 11:41 AM, the facility failed to provide updated (2019 or 2018) the emergency preparedness (EP) plan. Documentation review revealed the facility provided an EP plan dated from the year of 2017. The finding was acknowledged by the Administrator and Maintenance Supervisor verified this observation during the exit interview on 2/21/19.	E 004	"Preparation an/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement is prepared and/or executed solely because it is required by provision of Federal and State Law." E004 Develop EP Plan, Review and Update Annually CFRC(s); 483.73(a) Bullet 1. Correction actions accomplished for alleged deficient practice: A. On 4/5/2019, a community wide emergency plan exercise was held by facility in the Town of Duncan, MS. A Mississippi River Flood exercise event was done. B. On 4/08/2019, a table top exercise was held by the facility. A tornado disaster exercise table top event was done. Bullet 2. All residents have the potential to be affected by this deficient practice. Bullet 3. Measures put in place to ensure the alleged deficient practice does not reoccur:	