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
	15PC	A. BUILDING: _____ B. WING _____	04/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE CREST GUEST HOME INC	133 PINE STREET HAZLEHURST, MS 39083

(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 a State Licensure survey from 04/02/19 through 04/04/19. During the survey the SA determined the facility did not meet the licensure requirements for the State Minimum Standards for the Aged and Infirm. The SA cited M500 and M655. The facility was licensed for 90 beds and had a census of 59 at the time of survey.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his	M 500		5/6/19

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
	15PC	A. BUILDING: _____ B. WING _____	04/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE CREST GUEST HOME INC	133 PINE STREET HAZLEHURST, MS 39083

(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 500	Continued From page 1 medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15PC	A. BUILDING: _____ B. WING _____	04/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE CREST GUEST HOME INC	133 PINE STREET HAZLEHURST, MS 39083

(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 500	Continued From page 2 facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15PC	A. BUILDING: _____ B. WING _____	04/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE CREST GUEST HOME INC	133 PINE STREET HAZLEHURST, MS 39083

(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 500	Continued From page 3 unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level II Based on observation, record review, facility policy review, and staff interview, the facility failed to provide privacy during the personal care for one (1) of seven (7) residents observed for a	M 500	On 04/18/19, Resident #42 was assessed by Director of Nursing and found to be alert and lying in bed. Respirations even and unlabored. Skin warm and dry. Meal intakes adequate. Resident attends activities and has a pleasant demeanor.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15PC	A. BUILDING: _____ B. WING _____	04/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE CREST GUEST HOME INC	133 PINE STREET HAZLEHURST, MS 39083

(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 500	Continued From page 4 personal care task, Resident #42. Findings include: A review of the facility policy titled, "Privacy and Confidentiality Policy," no date, revealed that it is the policy of this facility that the resident has the right to personal privacy. The facility policy noted that personal privacy included personal care. The facility policy noted, as a reminder, that the cubicle curtain, window curtains or blinds, and the door should always be closed before rendering treatment or care. During an observation, on 04/02/2019 at 7:10 PM, of the personal care task for Resident #42, Certified Nursing Assistant (CNA) #1 failed to close the door to Resident #42's room when providing personal care to the resident. Resident #42 was exposed from her waist to her feet while CNA #1 was changing her brief. The privacy curtain was not in use and Resident #42 could be seen from the hallway. During an interview, on 04/02/2019 at 7:20 PM, Registered Nurse (RN) #1 stated that CNA #1 should have closed the door to Resident #42's room before starting care, to provide Resident #42 with privacy. During an interview, on 04/02/2019 at 7:35 PM, the Director of Nursing (DON) stated that closing the resident's door should always be done before providing resident care. During an interview, on 04/02/2019 at 7:55 PM, CNA #1 confirmed that she did not close the door of Resident #42's room prior to providing personal care to the resident. CNA #1 stated that she should have closed the door before she	M 500	Resident had no adverse affects or psychosocial harm regarding failure to provide privacy. On 04/19/19, Director of Nursing did disciplinary action with Certified Nursing Assistant #1 regarding Resident Rights and their right to privacy. On 04/18/19, 100% of all residents that are incontinent were audited by the MDS Nurse to ensure residents that are incontinent had an incontinent care plan and appropriate interventions in place to include provide privacy. All residents that are incontinent have the potential to be affected by this deficient practice. On 04/15/19-04/21/19, inservices on "Residents Rights" were conducted by the Quality Assurance Nurse with Certified Nursing Assistant #1 and all Nurses and Certified Nursing Assistants regarding Resident's Right to privacy and closing the door and privacy curtains when providing care were discussed. All new hires will be inserviced on Resident's Rights before providing care. Staff Development Nurse will monitor Certified Nursing Assistants beginning on 04/16/19, for maintaining privacy and dignity during incontinent care check-offs for two achieved pass rates in two months, then quarterly check-offs thereafter until substantial compliance is achieved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15PC	A. BUILDING: _____ B. WING _____	04/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE CREST GUEST HOME INC	133 PINE STREET HAZLEHURST, MS 39083

(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 500	Continued From page 5 changed Resident #42's brief and pad, so that the resident had privacy. A review of the facility document titled, "CNA Orientation Checklist," dated 02/02/2019, revealed that Certified Nursing Assistant (CNA) #1 was checked off as having completed the Orientation Training for Privacy Reinforcement (ex. Knock before Entering, Pulling Privacy Curtains and Etc.), as was indicated by the initials of the Orientation Staff Member and CNA #1. Review of the Face Sheet revealed Resident # 42 was admitted by the facility on 05/21/2015, with diagnoses to include Cerebral Infarction and Non-Alzheimer's Dementia. Review of the Annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/27/2019, revealed that Resident #42 had a Brief Interview of Mental Status (BIMS) score of 6, indicating severely impaired cognition.	M 500	Quality Assurance Nurse will make rounds auditing incontinent care plan interventions beginning 04/18/19, on all incontinent residents weekly for four weeks, monthly times two months, then quarterly thereafter until substantial compliance is achieved. The Quality Assurance Nurse will bring any discrepancies to the Director of Nursing. Director of Nursing will bring discrepancies to monthly Quality Assurance Meeting for review and any corrective action to be taken.	
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 observation, staff interview, record review, and facility policy review, the facility failed to	M 655	On 04/02/19, Resident #16 was assessed by Director of Nursing. Resident was without complaints. Respirations even and unlabored. Skin warm and dry. Resident	5/6/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15PC	A. BUILDING: _____ B. WING _____	04/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE CREST GUEST HOME INC	133 PINE STREET HAZLEHURST, MS 39083

(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 655	Continued From page 6 follow the manufacturer's guidelines regarding inhalers for (1) of (27) medication administration opportunities. Resident #16. Findings include: A review of Symbicort Inhaler Manufacture's Pharmacy Guide revealed, "After inhalation, the patient should rinse the mouth with water without swallowing." Swallowing and not rinsing the Symbicort can cause Candida Albicans Infection of the oral cavity. A review of the facility's Physicians order, dated 01/22/2018, revealed orders for Symbicort aerosol 160-4.5 mcg (microgram)/AER(Budesonide-Formoterol Fumarate) two (2) puffs, inhale orally two (2) times a day, related to Chronic Obstructive Pulmonary Disease. Rinse mouth with water after use. A review of the facility's policy titled, "Administering Medication", not dated, revealed medication must be administered in accordance with the orders, including required time frame. A review of Resident #16's Medication Administration Record (MAR) revealed documentation to administer the Symbicort and rinse mouth with water after use. During an observation on 4/2/2019 at 09:00 AM, of the facility's morning Medication Pass, License Practical Nurse (LPN) #1 gave Resident #16 two (2) puffs from the Symbicort Inhaler. LPN #1 offered Resident #16 water to rinse his mouth out after inhaling the medication. Resident #16 swallowed the water after each puff. LPN #1 failed to educate Resident #16 on the importance	M 655	able to make needs known. Alert and oriented times three. On 04/18/19, Resident #16 was assessed by Director of Nursing. Resident alert and oriented times three. Respirations even and unlabored. Proper use of administration of Inhaler and resident's ability to follow instructions were observed by Director of Nursing. Resident's skin warm and dry. Mucous membranes pink and moist. No indication of thrush, tongue or gum problems. No adverse affects from failure to follow manufacturer's recommendations. On 04/02/19, Licensed Practical Nurse #1 was provided one on one inservice by the Director of Nursing on proper use of inhaler including for the resident to rinse and spit after treatment is complete. On 04/23/19, all residents that use corticosteroid inhalers were audited by the Director of Nursing for medication orders to include for the resident to rinse and spit after use. All residents who use an inhaler have the potential to be affected by this deficient practice. On 04/16/2019 - 04/21/2019, medication check-offs were conducted with all Nurses by the Director Of Nursing and Quality Assurance Nurse to include proper use of inhalers and for the resident to rinse and spit after treatment is complete. All new hired nurses will complete medication administration check-offs to include proper use of inhalers for the resident to rinse	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15PC	A. BUILDING: _____ B. WING _____	04/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE CREST GUEST HOME INC	133 PINE STREET HAZLEHURST, MS 39083

(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 655	Continued From page 7 of not swallowing the water. During an interview on 4/2/2019 at 03:00 PM, LPN #1 said she did not know the resident should spit the water out. LPN #1 said she knew the resident should rinse with water because of the medication, but didn't know why. During an interview on 4/3/2019 at 1:50 PM, The Director of Nursing (DON) confirmed that the facility failed to follow the Manufacturer's Prescribing Guidelines by allowing Resident #16 to swallow the water mouth after inhaling the Symbicort. Review of Physician orders revealed the facility admitted Resident #16 on 08/24/2017, with diagnoses, which included Chronic Obstructive Pulmonary Disease, Hypertension and Atrial Fibrillation. A review of Resident #16's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 1/22/2019 , revealed Resident #16 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident is cognitively intact.	M 655	and spit after treatment is complete, before administering medications. Quality Assurance Nurse will begin on 04/21/19, to monitor administration of two residents using inhalers weekly for four weeks, monthly for two months, then quarterly thereafter until substantial compliance is achieved. Quality Assurance Nurse will bring any discrepancies to the Director of Nursing. Director of Nursing will bring discrepancies to the Quality Assurance Committee Meeting monthly for further review or corrective actions to be taken.	