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
	47TM	A. BUILDING: _____ B. WING _____	11/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREAT OAKS REHABILITATION AND HEALTHCARE C	111 CHASE STREET BYHALIA, MS 38611

(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 at the facility from 11/14/22 to 11/16/22 along with a complaint investigation (CI) MS19720 related to accidents hazards. The SA determined that the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm. The SA substantiated CI MS 19720 for accidents and cited M640. The SA also cited M655 during the survey. Census at the time of survey was 46 and the facility was licensed for 60 beds.	M 000		
M 640 SS=D	45.21.8 Accidents Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies. This Statute is not met as evidenced by: Based on record review, resident and staff interviews, and facility policy review, the facility failed to ensure a resident was free of accidents/hazards during transfer from a wheelchair to bed when a two (2) person mechanical lift was operated by one (1) staff and the sling broke causing the resident to fall back into the wheelchair for 1 or four (4) residents reviewed for accidents, Resident #10. Findings include: The facility policy and procedure titled "Lifting Machine, using a Mechanical" dated 2001 and	M 640	1. CNA #1 on 10/19/22 and used a lift against company policy alone. On 10/21/22, CNA #1 was immediately suspended pending a full investigation. CNA #1 was terminated on 10/24/22 for violating policy regarding mechanical lifts and abuse and neglect. The Assistant Director of Nursing conducted an in service with all employees regarding Mandatory 2 person lift usage, proper notification of faulty equipment and lockout/tagout procedure. These were completed 10/21 through 10/22/22. On 10/24, the administrators did interviews	12/29/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 12/05/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	47TM	A. BUILDING: _____ B. WING _____	11/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREAT OAKS REHABILITATION AND HEALTHCARE C	111 CHASE STREET BYHALIA, MS 38611

(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 640	Continued From page 1 revised July 2017 revealed: At least two (2) nursing assistants are needed to safely move a resident with a mechanical lift. On 11/15/22 at 10:50 AM, an interview with Registered Nurse (RN) #1 revealed on 10/19/22 Certified Nurse Aide (CNA) #1 came out of the resident's room and into the hallway and said she needed help with Resident #10. She had tried to lift her with the Hoyer lift and the left side of the bottom of the sling broke. RN#1 confirmed that CNA #1 had attempted to transfer the resident by herself, and that Resident #10 was to be transferred by two staff members when utilizing the Hoyer lift. Interview by telephone on 11/15/22 at 1:05 PM, with CNA #1 confirmed that she had received an in-service before the incident on having two people when transferring a resident in the Hoyer lift and confirmed that she did not use a second person to help her. She confirmed that on 10/19/22 that she had gone into the room of Resident #10 to put her back to bed after lunch and stated, "I hooked her (Resident #10) onto the lift and started raising her up out of her wheelchair and had her up about a foot or two out of her wheelchair seat when the left bottom side of the mesh pad broke. I heard it rip and I quickly lowered her back into her wheelchair and went for help." She stated that when she stepped out of the room, she was able to get four other staff members to come and help her immediately and she knew she should have had a second person but failed to go get anyone and stated, "I just didn't ask anyone to help me." During an interview on 11/15/22 at 1:10 PM, the Director of Nursing (DON) revealed that she first had knowledge of the incident on 10/21/22 when	M 640	regarding CNA #1 regarding lift usage and abuse and neglect with no findings during Brief Interview for Mental Status 12 and above. For residents with Brief Interview Mental Status below 11, body audits were performed on 10/24. The routine monthly inspection of mechanical lifts was performed on 10/21/22 with no issues. Resident #10 is mandatory 2-person lift, therefore no one is allowed to enter the room with a lift without a second person present. 2. Currently 21 residents require the use of mechanical lifts have the potential to be affected. 3. The Staff Development Coordinator inserviced staff on 10/24/22 and will in service all staff monthly on proper lift usage, reporting of faulty lifts, and lockout/tagout once a month for 4 months beginning 12/2/22 for all employees. The Maintenance Director will perform weekly mechanical lift inspections beginning 12/2/22 for 4 months and then twice per month for 8 additional months. The facility ordered upgraded sling pads for the mechanical lifts on 11/02/22. 4. The Staff Development Coordinator is responsible for auditing proper lift usage 3 times a week for 4 weeks then 2 times a week for 4 weeks then monthly thereafter. This will be done by visual and recorded auditing proper lift usage and instant inservicing on any technique done	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	47TM	A. BUILDING: _____ B. WING _____	11/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREAT OAKS REHABILITATION AND HEALTHCARE C	111 CHASE STREET BYHALIA, MS 38611

(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 640	Continued From page 2 Registered Nurse #1 came to her and told her that they needed to get an x-ray on Resident #10 and I asked her why and she said because there was an incident the other day and her lift sling tore while CNA #1 was lifting her for a transfer and now, she was complaining of pain in her left arm. "I asked who was helping the CNA (CNA#1) and she (RN#1) said that the CNA was in the room by herself utilizing the Hoyer lift. I immediately began to investigate the situation and suspended the CNA." An interview on 11/15/22 at 1:15 PM, with CNA #2 confirmed that she was working the other hall on the day of the incident but was immediately called over to assist and help transfer the resident back to bed. She confirmed that when she went into the room that the resident was sitting in her wheelchair and that the resident had fallen back into her wheelchair when the sling pad started to tear. Record review of Resident #10's care plan revealed, the resident has an Activities of Daily Living (ADL) self-care performance deficit. Under Transfer: The resident requires total assistance of two staff with transfers with the use of mechanical lift transfer. Record review of Resident #10's Admission Record revealed that she was admitted to the facility on 12/06/2019 with diagnoses of Rheumatoid Arthritis, Age Related Osteoporosis, Cerebral Infarction, and Need for Assistance with Personal Care. Record review of the Minimum Data Set (MDS) revealed that Resident #10 had a Brief Interview of Mental Status (BIMS) score of 08 which indicated that she has moderate cognitive	M 640	incorrectly. Staff Development will report the findings to the Quality Assurance and Performance Improvement committee beinning with the 12/15/22 regular meeting. The Maintenance Director will conduct visual and performance lift inspection audits weekly and report findings to the Quality Assurance and Performance Improvement committee monthly. These actions were approved by the Quality Assurance and Performance Improvement Committee on 12/6/22 and will be reviewed monthly at the Quality Assurance and Performance Improvement Committee on 12/15/22 which is our regular meeting and monthly for 12 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	47TM	A. BUILDING: _____ B. WING _____	11/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREAT OAKS REHABILITATION AND HEALTHCARE C	111 CHASE STREET BYHALIA, MS 38611

(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 640	Continued From page 3 impairment. Level II Based on record review, resident and staff interviews, and facility policy review, the facility failed to ensure a resident was free of accidents/hazards during transfer from a wheelchair to bed when a two (2) person mechanical lift was operated by one (1) staff and the sling broke causing the resident to fall back into the wheelchair for 1 or four (4) residents reviewed for accidents, Resident #10. Findings include: The facility policy and procedure titled "Lifting Machine, using a Mechanical" dated 2001 and revised July 2017 revealed: At least two (2) nursing assistants are needed to safely move a resident with a mechanical lift.	M 640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	47TM	A. BUILDING: _____ B. WING _____	11/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREAT OAKS REHABILITATION AND HEALTHCARE C	111 CHASE STREET BYHALIA, MS 38611

(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 640	Continued From page 4 On 11/15/22 at 10:50 AM, an interview with Registered Nurse (RN) #1 revealed on 10/19/22 Certified Nurse Aide (CNA) #1 came out of the resident's room and into the hallway and said she needed help with Resident #10. She had tried to lift her with the Hoyer lift and the left side of the bottom of the sling broke. RN#1 confirmed that CNA #1 had attempted to transfer the resident by herself, and that Resident #10 was to be transferred by two staff members when utilizing the Hoyer lift. Interview by telephone on 11/15/22 at 1:05 PM, with CNA #1 confirmed that she had received an in-service before the incident on having two people when transferring a resident in the Hoyer lift and confirmed that she did not use a second person to help her. She confirmed that on 10/19/22 that she had gone into the room of Resident #10 to put her back to bed after lunch and stated, "I hooked her (Resident #10) onto the lift and started raising her up out of her wheelchair and had her up about a foot or two out of her wheelchair seat when the left bottom side of the mesh pad broke. I heard it rip and I quickly lowered her back into her wheelchair and went for help." She stated that when she stepped out of the room, she was able to get four other staff members to come and help her immediately and she knew she should have had a second person but failed to go get anyone and stated, "I just didn't ask anyone to help me." During an interview on 11/15/22 at 1:10 PM, the Director of Nursing (DON) revealed that she first had knowledge of the incident on 10/21/22 when Registered Nurse #1 came to her and told her that they needed to get an x-ray on Resident #10 and I asked her why and she said because there	M 640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	47TM	A. BUILDING: _____ B. WING _____	11/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREAT OAKS REHABILITATION AND HEALTHCARE C	111 CHASE STREET BYHALIA, MS 38611

(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 640	Continued From page 5 was an incident the other day and her lift sling tore while CNA #1 was lifting her for a transfer and now, she was complaining of pain in her left arm. "I asked who was helping the CNA (CNA#1) and she (RN#1) said that the CNA was in the room by herself utilizing the Hoyer lift. I immediately began to investigate the situation and suspended the CNA." An interview on 11/15/22 at 1:15 PM, with CNA #2 confirmed that she was working the other hall on the day of the incident but was immediately called over to assist and help transfer the resident back to bed. She confirmed that when she went into the room that the resident was sitting in her wheelchair and that the resident had fallen back into her wheelchair when the sling pad started to tear. Record review of Resident #10's Admission Record revealed that she was admitted to the facility on 12/06/2019 with diagnoses of Rheumatoid Arthritis, Age Related Osteoporosis, Cerebral Infarction, and Need for Assistance with Personal Care. Record review of the Minimum Data Set (MDS) revealed that Resident #10 had a Brief Interview of Mental Status (BIMS) score of 08 which indicated that she has moderate cognitive impairment.	M 640		
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;	M 655		12/29/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	47TM	A. BUILDING: _____ B. WING _____	11/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREAT OAKS REHABILITATION AND HEALTHCARE C	111 CHASE STREET BYHALIA, MS 38611

(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 tracheostomy care; tracheal suction; respiratory care; foot care; and prostheses. This Statute is not met as evidenced by: Level II Based on observations, resident and staff interviews and record reviews the facility failed to prevent the likelihood of a combustible event as evidenced by not posting "Oxygen in Use" signage at the entrance of resident's rooms for two (2) of eight (8) residents reviewed with oxygen in use. Unsampled Resident #17 and Resident #108 Findings include: Record review revealed the facility does not have a policy regarding the posting of "Oxygen in Use" signage. The facility administrator provided documentation on the facility letterhead dated 11/15/22 that revealed, "(Facilities proper name) is a non-smoking facility. We do not have a current policy related to smoking signage and oxygen usage". An observation on 11/14/22 at 2:31 PM, revealed Resident #108 sitting in his wheelchair receiving Oxygen (O2) via nasal cannula at 2Liters/minute (L/M) and there was no "O2 in Use" sign on the resident's room door. An observation on 11/15/22 at 9:02 AM, revealed that Resident #108 was on continuous O2 via nasal cannula at 2L/M with no "O2 in Use" sign on the resident's room door. An observation and interview on 11/15/22 at 10:12 AM, revealed Resident #108 lying in bed	M 655	1. Director of Nursing corrected this deficiency on 11/15/22 by putting up "oxygen in use" signage at every door of our residents that use oxygen. Signage was placed on resident room #108 on 11/15/22 that stated "Oxygen in Use" to immediately correct the issue that was noted. 2. Currently 17 residents use oxygen and have the potential to be affected. The system used to ensure the problem does not reoccur is at the daily morning standup meeting of management, we will report out a count of how many current residents are on oxygen and any potential residents coming with oxygen needs. This count will be done before morning standup and recorded daily by the RN Supervisor or designated weekend charge RN. 3.Central Supply has ordered more signage stating "Oxygen in Use" for future residents that require oxygen. Staff was inserviced on 12/2/22. Staff will be inserviced 2 times monthly beginning 12/2/22 for 1 month and then once monthly for 3 additional months. This was approved by the Quality Assurance and Performance Improvement Committee on 12/6/22.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	47TM	A. BUILDING: _____ B. WING _____	11/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREAT OAKS REHABILITATION AND HEALTHCARE C	111 CHASE STREET BYHALIA, MS 38611

(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 receiving O2 via nasal cannula at 2L/M. An interview at this time with the resident revealed he wears the O2 continuously. An observation on 11/15/22 at 2:04 PM, revealed Resident #17 was receiving O2 via nasal cannula at 2L/M with no "O2 in Use" signage on the resident's room door. An observation and interview on 11/15/22 at 3:00 PM, with the Assistant Director of Nurses (ADON) confirmed Resident #108 was receiving O2 continuously and Resident #17 was receiving O2 as needed. She confirmed there was no "O2 in Use" sign on Resident #17 or Resident #108's room doors. An interview on 11/16/22 at 9:10 AM, with the Director of Nurses (DON) and the ADON confirmed that they do not put up "O2 in Use" signs. They both revealed that even petroleum products could cause O2 to combust so therefore the purpose of putting the "O2 in Use" signage up would be to prevent a combustible event from occurring. Record review of Resident #108's Admission Record revealed he was admitted to the facility on 10/31/22 with medical diagnoses that included Acute Respiratory Failure with hypoxia. Record review of Resident #108's Physician's Orders revealed the following: Order dated 10/31/22-O2 at 2 liters per minute via nasal cannula continuously. May titrate to 3-4 LPM to keep O2 saturation (sats) >/=92% (percent),every shift for O2 sat >/=92%. Record review of Resident #108's Minimum Data Set (MDS) with an Assessment Reference Date	M 655	4.RN Supervisor began auditing on 11/15/22 daily. RN Supervisor will report findings to the Quality Assurance and Performance Improvement Committee monthly monthly beginning with our 12/6/22 meeting with no end date. Director of Nursing is responsible for monitoring and compliance. RN Supervisor began auditing daily on 11/15/22 and will continue to do so daily as was approved on 12/2/22.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	47TM	A. BUILDING: _____ B. WING _____	11/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREAT OAKS REHABILITATION AND HEALTHCARE C	111 CHASE STREET BYHALIA, MS 38611

(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 8 (ARD) of 11/2/22 revealed a Brief Interview of Mental Status (BIMS) score of 15 which indicates the resident is cognitively intact. Record review of Resident #17's Admission Record revealed an admission date of 8/12/22 with medical diagnoses that included Acute Pulmonary edema and Chronic Obstructive Pulmonary Disease. Record review of Resident #17's Physician's Orders revealed the following: Order dated 8/30/22-O2 at 2 Liters per minute via nasal cannula continuously. May titrate to 3-4 LPM to keep O2 sats >92% as needed for O2 sat >92%. Record review of Resident #17's MDS with an ARD of 11/14/22 revealed a BIMS score of 14 which indicates the resident is cognitively intact.	M 655		