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
	17DH	A. BUILDING: _____ B. WING _____	02/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESOTO HEALTHCARE CENTER	7805 SOUTHCREST PARKWAY SOUTHAVEN, MS 38671

(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 licensure and complaint, CI MS #16660, survey from 2/25/2020 to 2/27/2020. The complaint was related to inappropriate discharge. During the survey, the SA did not substantiate the complaint and no deficiencies were cited related to the complaint. The SA did determine the facility was not in compliance with the Minimum Standards for The Institutions For The Aged And Infirm. The SA cited the state statute M655. The census at the time of entrance was 111, and the facility was certified for 120 beds.	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, staff interview, resident interview, record review and facility policy review, the facility failed to ensure the resident's oxygen cannula and tubing was stored in a manner to prevent the possibility for infection or cross contamination for two (2) of three (3) residents reviewed for oxygen therapy, Resident #22 and #36. Findings include:	M 655	(1) Resident # 22□s oxygen tubing was replaced on 2/25/2020. Oxygen tubing was stored in a bag and dated for 02/25/2020 by Licensed Practical Nurse #2. Resident #36□s oxygen tubing was replaced on 2/25/2020. Oxygen tubing was stored in a bag and dated for 02/25/2020 by Quality Assurance Nurse #1. The Respiratory Therapist received a one on one counseling to include that oxygen and cannulas are to be stored in	3/27/20

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

Electronically Signed | 03/31/20

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M 655	Continued From page 1 Review of the facility's "Oxygen Policy", dated March 1, 2004, revealed, "It is the policy of this facility that oxygen will be utilized included: With specific physician's order. Date the tubing and the humidifier. Document the tubing change on the MAR (Medication Administration Record) (Tubing is to be changed weekly). Care plan the oxygen usage. Store the Oxygen cannulas in a ziplock bag when not in use. Resident #22 On 2/25/2020 at 11:00 AM, during the initial tour of the facility, an observation revealed Resident #22's oxygen (O2) tubing was draped across the oxygen concentrator in the resident's room. There was no date on the tubing or humidifier bottle. Licensed Practical Nurse (LPN) #2 was called into the room and confirmed there was no date on the tubing and that it was not stored properly. LPN#2 reported the tubing should be labeled with the date it was placed and in a bag so nothing is dropping on the floor. It's normally changed every Saturday. LPN #2 stated, "We don't want to cross contaminate anything, get germs or anything like that". Review of a Physician's Telephone Order, dated 2/23/2020, revealed an order for continuous Oxygen (O2) at two (2) liters (L) biprong nasal cannula (BNC) per concentrator or tank. Review of a Physician's Telephone Order, dated 2/25/2020, revealed an order to change continuous O2 to as needed (PRN) for O2 saturation (Sat) less than (<) 93%. Review of the Face Sheet revealed Resident #22 was admitted by the facility, on 12/12/2019, with the included diagnoses Acute Bronchitis, Heart	M 655	bags and never back dated. On 2/26/2020 Resident #36□s physician□s orders were updated to include an order to change oxygen tubing weekly on Sunday. On 2/27/2020 at 10am Resident #22 and Resident #36 were assessed by the Assistant Director of Nursing and found not to have any signs or symptoms of infection at that time. (2) The facility has determined that all residents who use oxygen have the potential to be negatively affected by the failure to store oxygen cannula and tubing in a manner to prevent the possibility for infection or cross contamination. (3) On 3/3/2020 an in-service was initiated by the Staff Education Nurse for Registered Nurses, Licensed Practical Nurses, Respiratory Therapist to include that oxygen was to be stored in a bag when not in use, the oxygen is to be changed out weekly and the tubing/bag is to be dated on the day that it is changed out. On 3/25/2020 the night shift Respiratory Therapist changed out all oxygen tubing and bags and dated them for the day they were changed out. (4) The Assistant Director of Nursing and the Order Entry Nurse initiated a daily audit, Monday through Friday, to ensure that oxygen orders included an order to change tubing weekly on Sundays.	

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M 655	Continued From page 2 Failure, Mild Cognitive Impairment and Unspecified Escherichia Coli as the Cause of Diseases Classified Elsewhere. Resident #36 On 02/25/20 at 8:35 AM, an observation, during the initial tour, revealed Resident #36's O2 nasal cannula was draped over the O2 concentrator and there was no bag to store it in. Resident #36 was sitting at her bedside, and an interview with her at this time revealed she stated, "I ain't seen a bag over there for a good minute." An observation, on 2/25/2020 at 11:30 AM, revealed Resident #36's nasal cannula was now in a ziplock bag, dated 2/22/2020. Review of Resident #22's February 2020 Physician's Orders revealed an order, dated 9/30/2019, for O2 PRN at 2 LPM (Liters per minute) per tank or concentrator r/t (related to) SOB and COPD (Shortness of Breath and Chronic Obstructive Pulmonary Disease. On 2/25/2020 at 11:40 AM, an interview with the Respiratory Therapist (RT) regarding Resident #36's O2 cannula and tubing observed in a ziplock bag now, revealed she stated, "I saw that her oxygen cannula was draped over her concentrator in her room, and they are supposed to all be bagged. So, I went to central supply and got a bag and attached it to the concentrator for her." The RT stated, "I guess I just dated it for when I knew it should have been changed. They change them on the night shift on Sunday nights." An interview, on 2/26/2020 at 3:30 PM, revealed the Director of Nursing (DON), stated she "had looked all through her chart, and there is no order	M 655	Quality Assurance Nurse #1 began a daily audit on 3/2/2020, Monday through Friday, to extend for one week on to ensure that oxygen is changed, labeled and stored correctly. Then Quality Assurance nurse will continue audit weekly. The Medical Records Nurse will audit oxygen orders monthly to ensure that oxygen orders included an order to change tubing weekly on Sundays. All discrepancies will be brought to the Director of Nursing for further review and corrective action. The Quality Assurance Nurses will bring all discrepancies to Quality Assurance committee monthly for further review and any corrective actions needed. The Quality Assurance Committee met on 3/16/2020 and discussed the deficiency and possible corrective actions. Further problems and concerns identified by continued monitoring will be presented to the Quality Assurance Committee as the need arises.	

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M 655	Continued From page 3 for them to sign when they change out the oxygen tubing, and it is not on the care plan. So I guess they just know to do it". Review of Resident #36's February 2020 Medication Administration Record (MAR) revealed there was no orders or documentation for changing/dating the O2 cannula and tubing. Review of the Face Sheet revealed Resident #36 was admitted by the facility, on 3/29/2020, with the included diagnoses COPD, Secondary Malignant Neoplasm of Unspecified Lung, Heart Failure, Cough, and Wheezing.	M 655		