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
	12AC	A. BUILDING: _____ B. WING _____	04/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF QUITMAN	191 HIGHWAY 511 EAST QUITMAN, MS 39355

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M 000	Initial Comments The State Agency (SA) conducted an annual recertification at the facility from 4/16/23 through 4/19/23. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirement and cited M635, M655, and M815. The facility held a license for 120 beds, with a census of 91.	M 000		
M 635	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, interview and record review the facility failed to provide percutaneous endoscopic gastrostomy (peg) feeding tube care in a manner to prevent complications for one (1) of three (3) residents reviewed with peg feeding tubes. Resident #64 Findings include: A record review of the facility's "Care of a Gastrostomy or Jejunostomy Tube Competency Audit" provided by the Director of Nursing (DON) revealed, " ...Cleansed skin around site with water and soap using gauze ...". Further review	M 635	1. Resident #64 was assessed 4/19/23 by Director of Nursing with no complications noted at percutaneous endoscopic gastrostomy tube (PEG) site. Licensed Practical Nurse (LPN) #2 was in-serviced on 4/20/23 on proper care of PEG site by Assistant Director of Nursing. All residents with PEG's were assessed on 4/20/23 with no complications noted. 2. All residents who have a PEG have the potential to be affected by this deficient practice. 3. To ensure that the deficient practice does not recur, the Director of	5/30/23

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M 635	Continued From page 1 revealed the document did not contain steps for the actual cleansing procedure to include the direction of wipes and the rotation of gauze. A record review of the "Order Summary Report", with "Active Orders As Of: 04/19/2023" revealed Resident #64 had a Physician's Order dated 8/2/22 to "Clean peg tube site with soap and water and leave open to air q (every) shift ..." On 04/18/23 at 2:20 PM, in an observation of Licensed Practical Nurse (LPN) #2 providing peg feeding tube care to Resident #64, she cleaned the peg feeding tube insertion site with a moistened gauze, using a circular motion wiping four (4) times around the site, without folding or rotating the position of the gauze. LPN #2 rinsed the peg feeding tube insertion site with a clean moistened gauze by folding the gauze after each wipe. She then used a clean dry gauze to dry the site, using a circular motion, wiping four (4) times around the insertion site, without folding or rotating the position of the gauze after each circular wipe. On 04/18/23 at 2:40 PM, in an interview with LPN #2, she confirmed that she cleaned around the peg tube insertion several times with the same gauze and that she should have cleaned one side of the peg site, discarded the gauze, and used a clean gauze each time for cleaning and drying the area. She stated her actions could potentially cause Resident #64 to acquire an infection. On 04/19/2 at 09:31 AM, in an interview with the DON, she stated that LPN #2 should have cleaned the peg feeding tube site by using gauze, discarding, and using a clean gauze with each wipe around the site. She stated LPN #2 had contaminated the peg feeding tube site during	M 635	Nursing/Assistant Director of Nursing in-serviced all Licensed Nurses on proper PEG site care 4/20/23-5/5/2023. The Director of Nursing will assess, with return demonstration, each licensed nurse performing PEG site care by 5/12/23. 4. To monitor the performance of our corrective action and to ensure sustainability, the Administrator/Director of Nursing/Assistant Director of Nursing will observe a nurse on each medication cart performing PEG tube site care 3x/week x 4 weeks beginning 4/25/2023, then monthly to ensure proper delivery of PEG tube site care. Any negative findings will be brought to the Quality Assurance Performance Improvement meeting monthly for a minimum of 3 months beginning 5/23/2023 by the Director of Nursing for review and revision as necessary. QA will review the findings and determine if a need to alter our corrective action.	

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M 635	Continued From page 2 cleaning and her actions could put the resident at significant risk for infection. A record review of the "Admission Record" revealed the facility admitted Resident #64 on 02/01/23 and he had diagnoses including Cerebral Infarction, Unspecified Protein-Calorie Malnutrition, and Gastrostomy.	M 635		
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 interview, observation, record review, the facility failed to adhere to accepted standards of practice for the proper storage of a nebulizer mask for two (2) of three (3) observations. Resident # 74 Findings include: During an observation on 04/16/23 at 11:42 AM, Resident #74 was in bed, and his nebulizer mask was noted directly on the floor. There was no visible container designated to store the nebulizer tubing/mask. On 4/16/23 at 2:54 PM, Resident #74 was observed in his bed. His nebulizer mask	M 655	1.Resident #74 was assessed on 4/19/23 by the Director of Nursing with no respiratory complications noted. Licensed Practical Nurse (LPN) #2 was in-serviced on 4/20/23 by the Assistant Director of Nursing regarding nebulizer mask storage when not in use. All residents with nebulizers were assessed 4/20/23 with no complications noted. 2. All residents who have nebulizer treatments have the potential to be affected by this deficient practice. 3. To ensure that the deficient practice does not recur, the Director of Nursing/Assistant Director of Nursing in-serviced all Licensed Nurses on proper	5/30/23

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M 655	Continued From page 3 continued to be on the floor, with no visible container to store the mask to prevent contamination. On 4/16/23 at 3:04 PM, during an interview with Licensed Practical Nurse (LPN) #2, she explained Resident #74 had scheduled nebulizer treatments, but was unsure how often. She stated that the nebulizer mask should be kept in a bag when it is not in use because of infection control. LPN #2 entered Resident #74's room and confirmed the nebulizer mask was lying on the floor. She also confirmed there was no container or designated area to store the mask to prevent contamination. She explained the nebulizer mask was contaminated and that it was not standard practice for the mask to be on the floor. LPN #2 stated that she would get a plastic bag to store the mask and a new mask for the resident's use. On 04/19/23 at 11:00 AM, during an interview with the Director of Nursing (DON), she explained all oxygen tubing and nebulizer equipment should be stored in a plastic bag while not in use. She stated any equipment noted on the floor should be thrown away and replaced and it is not the facility's normal practice or the standard for those items to be on the floor. She expected the staff to observe for any equipment not properly stored and correct the problem. A record review of the "Admission Record" revealed the facility admitted Resident #74 on 03/01/2023 with diagnoses including Pneumonia and Chronic Obstructive Pulmonary Disease (COPD). A record review of the "Order Summary Report" with "Active Orders As Of: 04/19/2023" revealed	M 655	nebulizer storage on 4/20/23-5/5/2023. 4. To monitor the performance of our corrective action and to ensure sustainability, the Administrator/Director of Nursing/Assistant Director of Nursing will observe nebulizer mask storage 3x/week x 4 weeks beginning 4/25/2023, then monthly to ensure proper nebulizer mask storage. Any negative findings will be brought to the Quality Assurance Performance Improvement meeting monthly for a minimum of 3 months beginning 5/23/2023 by the Director of Nursing for review and revision as necessary. QA will review the findings and determine if a need to alter our corrective action.	

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M 655	Continued From page 4 Resident #74 had Physician's Orders, dated 3/1/23 for, "for Budesonide Inhalation Suspension 0.5 MG(milligram)/2 ML(milliliter) ...1 vial inhale orally two times a day for COPD" and "Albuterol Sulfate Inhalation Nebulization Solution (2.5 MG/3 ML) 0.083% (Albuterol Sulfate)1 vial inhale orally every 6 hours as needed for SOB (shortness of breath)."	M 655		
M 815	45.29.1 Safe Food Handling Procedures Safe Food Handling Procedures. Food shall be prepared, held, and served according to current Mississippi State Department of Health Food Code Regulations. This Statute is not met as evidenced by: Level II Based on observation, interviews, record review and facility policy review the facility failed to remove expired, undated, and spoiled food items from storage areas for one (1) of four (4) kitchen observations. This had the potential to affect all residents in the facility receiving food from the dietary department. Findings include: Review of facility's policy, "Food and Supply Storage Procedures, undated, revealed, " ...Remove from storage any items for which the expiration date has expired ..." Review of the facility's policy, "Food Storage: Dry Goods," revised 9/2017, revealed, "All dry goods will be appropriately stored will be appropriately stored in accordance with the FDA Food Code ...	M 815	1. Expired and improperly stored food items in the kitchen were discarded on 4/16/2023 by the Dietary Manager. All residents consuming oral diets were assessed on 4/19/23 by the Director of Nursing and Assistant Director of Nursing with no complications noted from unsafe food handling. 2. All residents who consume an oral diet have the potential to be affected by this deficient practice. 3. To ensure that the deficient practice does not recur, the Dietary Manager in-serviced all dietary staff regarding proper food storage and assigned specific staff roles to audit storage of food items daily on 4/19/2023.The Administrator also in-serviced all dietary staff from 4/20/23-5/3/2023 regarding proper food	5/30/23

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M 815	Continued From page 5 5. All packaged and canned food items will be kept clean, dry, and properly sealed. 6. Storage areas will be neat, arranged for easy identification, and date marked as appropriate." Review of facility's policy, "Receiving," revised 9/2017, revealed, " ... 5. All food items will be appropriately labeled and dated wither through manufacturer packaging or staff rotation ..." On 4/16/23 at 11:00 AM, during an initial tour of the kitchen with the facility's Cook, an observation of the dry storage area revealed, a 32-ounce bottle of liquid smoke that was opened, undated, without a top and loosely covered with plastic wrap, a one (1) gallon container of salad dressing with an expiration date of 11/8/21, a one (1) gallon container of barbeque sauce with an expiration date of 8/15/22, a 16-ounce bag of unsealed marshmallows, dated of 12/22, and a one (1) gallon container of sliced jalapeno peppers that was opened and had visible biological growth. On 4/16/23 at 11:47 AM, in an interview with the Cook, he stated all the staff are responsible for removing expired food. She stated the Dietary Aide is responsible for stocking the groceries when delivered and checking expiration dates prior to putting them on the shelves. On 4/18/23 at 12:29 PM, in an interview with the Dietary Aide, he confirmed he is responsible for checking expiration dates as he receives the food from the delivery truck but stated that all staff should check for expired foods. On 4/18/23 at 12:35 PM, in an interview with the Dietary Manager (DM), he revealed all staff are responsible for checking for expired foods and	M 815	storage. 4. To monitor the performance of our corrective action and to ensure sustainability, the Dietary Manager will observe food procurement, storage, preparation, and serving 3x/week x 4 weeks beginning 4/25/2023, then monthly to ensure proper food sanitation. Any negative findings will be brought to the Quality Assurance Performance Improvement meeting monthly for a minimum of 3 months beginning 5/23/2023 by the Director of Nursing for review and revision as necessary. QA will review the findings and determine if a need to alter our corrective action.	

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M 815	Continued From page 6 removing them from the shelves, as expired foods could cause foodborne illnesses. The DM also noted that when foods are opened, they should be dated and discarded according to their facility policy, which referenced the Food and Drug Administration (FDA) Food Code. On 4/19/23 11:18 AM, in an interview with the Administrator, she stated dietary staff should put "opened dates" on food items as they are opened and make sure they are properly sealed when they are placed on the shelves. The Administrator revealed the Cook and Assistant Cook should read the labels as they pull foods from the shelves and check expiration dates, as expired foods, if contaminated, could lead to foodborne illnesses. The said she expected all dietary staff to make rounds, clean the department, and remove expired foods from the shelves.	M 815		