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
	69SC	A. BUILDING: _____ B. WING _____	01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENATOBIA HEALTHCARE & REHAB	402 GETWELL DR SENATOBIA, MS 38668

(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 CI MS #16433 The State Agency (SA) conducted an annual recertification survey with a complaint survey, CI MS #16433, from 1/20/2020 to 1/23/2020. During the survey, the SA determined the facility was not in compliance with the requirements of participation for the Minimum Standards for the Aged tor Infirm. The SA substantiated CI MS # 16433 for behaviors and cited M735. The facility had a license for 106 beds and the census was 93.	M 000		
M 735	45.25.1 Medical Records Management Medical Records Management. 1. A medical record shall be maintained in accordance with accepted professional standards and practices on all residents admitted to the facility. The medical records shall be completely and accurately documented, readily accessible, and systematically organized to facilitate retrieving and compiling information. 2. A sufficient number of personnel, competent to carry out the functions of the medical record service, shall be employed. 3. The facility shall safeguard medical record information against loss, destruction, or unauthorized use. 4. All medical records shall maintain the following information: identification data and consent form; assessments of the resident's needs by all disciplines involved in the care of the resident; medical history and admission physical exam;	M 735		2/21/20

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M 735	Continued From page 1 annual physical exams; physician or nurse practitioner/physician assistant orders; observation, report of treatment, clinical findings and progress notes; and discharge summary, including the final diagnosis. 5. All entries in the medical record shall be signed and dated by the person making the entry. Authentication may include signatures, written initials, or computer entry. A list of computer codes and written signatures must be readily available and maintained under adequate safeguards. 6. All clinical information pertaining to the residents stay shall be centralized in the resident's medical records. 7. Medical records of discharged residents shall be completed within sixty (60) days following discharge. 8. Medical records are to be retained for five (5) years from the date of discharge or, in the case of a minor, until the resident reaches the age of twenty-one (21), plus an additional three (3) years. 9. A resident index, including the resident's full name and birth date, shall be maintained. This Statute is not met as evidenced by: Based on observation, staff interview, record review and facility policy review, the facility failed to update the comprehensive care plan for resident behaviors for one (1) of 21 resident care plans reviewed. Resident # 89. Findings include:	M 735	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceeding and submit these responses pursuant to our regulatory obligations.	

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M 735	Continued From page 2 Review of the facility's "Total Care Plan policy," not dated, revealed, "It is the policy of this facility that the total care plan will be done as follows: Updated, ongoing as changes occur in the resident's condition or plan of care." Record review revealed a Progress Note dated 11/10/19 at 5:50 PM, indicated Resident #89 was restless and agitated and when staff redirected her, she was hitting at staff and other residents. On 11/16/19 at 8:59 AM, Resident #89 was agitated and rolling up behind other residents in their wheelchairs with her fist balled up and shaking it at residents and staff. Resident #89 was hitting at staff and other residents in the dayroom. On 11/16/19 at 5:07 PM, Resident #89 was placed on 1:1 with Certified Nursing Assistant (CNA). Resident #89 hit a CNA on 11/23/19 at 2:02 PM. ON 11/23/19 at 2:39 PM, Resident #89 was yelling out in the hallway and attempting to kick at visitors as they come by her doorway. On 12/02/19 at 4:30 PM, Resident #89 began yelling and attempting to hit and kick residents and staff. On 12/2/19 at 5:30 PM, Resident #89 was administered Intramuscularly (IM) Ativan 0.25 Milligrams (MG). Review of the care plan initiated on 04/22/18 and with a revision date of 01/13/20, revealed, delusional and verbal aggressive behavioral problems. Further review of Resident #89's care plan revealed, the documented behaviors, in the Progress Notes, that occurred on 11/10/19, 11/16/19, 11/23/19, and 12/02/19, were not identified. The care plan was not revised to reflect incidents of behaviors and 1:1 monitoring for those dates. On 01/21/20 at 10:50 AM, an observation	M 735	1. On January 21, 2020, a comprehensive care plan was revised for resident #89 to include an individualized intervention for behaviors. 2. Residents with behaviors have the potential to be affected by the failure to update comprehensive care plans with interventions for behaviors. 3. On January 21, 2020, in-servicing of licensed nurses was initiated by the Assistant Director of Nursing (ADON) and Staff Development Coordinator (SDC) to include: Comprehensive Care Plan Policy, updating comprehensive care plans for behaviors, Abuse Policy, Resident Rights, Mississippi Vulnerable Persons Act and reporting of physical and/or verbal aggression to the Director of Nursing (DON) and/or ADON. 4. The DON or Minimum Data Set (MDS) nurses began monitoring comprehensive care plans of residents with behaviors on January 27, 2020, to ensure comprehensive care plans are updated for behaviors weekly x four weeks and monthly x two months. The monitoring results will be submitted by the DON to the Quality Assurance Performance Improvement Committee beginning on February 20, 2020, for review and recommendations monthly x three months.	

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M 735	Continued From page 3 revealed, Resident #89 sitting in her Broda Chair, appeared pleasant, smiled at times when spoken too, and the resident sat in the day room with other residents, not exhibiting any behaviors at that time. An interview with the Director Of Nursing (DON) confirmed, the facility did not revise the care plan to address the incidents of increased behaviors for Resident #89 and stated, "We are revising it now to reflect the documented behaviors." An interview on 01/21/20, at 3:10 PM, with Licensed Practical Nurse (LPN) #1 confirmed that the care plan was not updated to reflect behaviors for Resident #89 for the dates of 11/10/19, 11/23/19, and 12/02/19.	M 735		