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
	58GR	A. BUILDING: _____ B. WING _____	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PONTOTOC HEALTH & REHAB CENTER	278 WEST EIGHTH STREET PONTOTOC, MS 38863

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M 000	Initial Comments The State Agency (SA) conducted an annual re-certification survey at the facility from 06/05/23 to 06/08/23. During the survey, the SA determined that the facility was not in compliance with the Minimum Standards of Operation for Institutions of Aged or Infirm, state licensure requirements and deficiencies were cited at M1570. The facility held a license for 60 beds at the time of the survey, and the census was 49.	M 000		
M1570 SS=D	48.58.1 Infection Control The following infection control standards shall be met: 1. The facility must maintain and document an effective infection control program that protects patients, families, visitors, and facility personnel by preventing and controlling infections and communicable diseases. 2. The facility must have an active surveillance program that includes specific measures for prevention, early detection, control, education, and investigation of infections and communicable diseases in the facility. There must be a mechanism to evaluate the effectiveness of the program(s) and take corrective action when necessary. The program must include implementation of nationally recognized systems of infection control guidelines to avoid sources and transmission of infections and communicable diseases. 3. The facility must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of	M1570		7/10/23

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M1570	Continued From page 1 standard precautions. This Statute is not met as evidenced by: Level II Based on observations, staff interviews, record review and facility policy review the facility failed to prevent the possible spread of infection during medication pass for two (2) of 35 medication administrations observed (Resident #18 and Resident #21) and by not storing a nebulizer mask properly when not in use for one (1) of five (5) residents reviewed for respiratory care (Resident #16). Findings Include: Review of the facility policy titled, "Infection Prevention and Control" with a revision date of 5/12/23 revealed, "Policy ...This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines." Review of the typed statement on facility letterhead revealed the facility did not have a policy on utilizing a barrier when administering medications and was signed by the Administrator dated 6/7/23. Review of the typed statement on facility letterhead revealed the facility did not have a policy on nebulizer storage when not in use that was signed by the Administrator and dated 6/7/23.	M1570	1. LPN(Licensed Practical Nurse)#1 and LPN(Licensed Practical Nurse)#2 were inserviced on 6/7/2023 by the Director of Nursing to always use a barrier for items taken into residents room that will be placed back into the medication cart to prevent the possible spread of infection. LPN#2 was inserviced on 6/7/2023 by Director of Nursing on proper storage of nebulizer mask when not in use. 2. The facility has determined that all residents using medications that require a barrier have the potential to be affected by this practice. The facility also determined that all residents requiring the use of nebulizer treatments have the potential to be affected by this practice. 3. All licensed nursing staff were inserviced by Staff Development Nurse on the use of barriers when taking items from the medication cart into a resident's environment that has the potential for spread of infection. The inservice began on 6/7/2023 was completed on 6/9/2023. All licensed nursing staff were inserviced by Staff Development Nurse on the proper storage of nebulizer masks when not in use. The inservice began on 6/7/2023 was completed on 6/9/2023. 4. The Quality Assurance Nurse will complete Medication Administration Competencies beginning week of 6/12/2023 to ensure nurses are compliant with use of barriers when required during	

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M1570	Continued From page 2 Resident #18 An observation on 6/7/23 at 9:18 AM with Resident #18 revealed Licensed Practical Nurse (LPN) #2 entered the resident's room to administer medications and eye drops to the resident and placed a bottle of eye drops on the resident's bedside table with no barrier and did not wipe down the table prior to placing the eye drops on the table. LPN #2 then administered the resident's other medications, followed by the eye drops. After administering the eye drops, LPN #2 returned the eye drop bottle to her medication cart and placed them back in the drawer of the medication cart. An interview on 6/7/23 at 9:30 AM, with LPN #2 confirmed that she should have put a barrier down to set the eye drops on instead of setting them directly on the resident's bedside table, because there was no way to know what could have been on that table. She stated that the barrier would have prevented the possible spread of infection. Record review of Resident #18's June 2023 Physician Orders revealed an order dated 12/27/18 for Artificial Tears one drop each eye twice per day for Dry Eyes. Record review of Resident #18's Face Sheet revealed the resident was admitted to the facility on 11/22/17 with medical diagnoses that included Dry Eye Syndrome. Record review of Resident #18's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/16/23 revealed in Section C a Brief Interview for Mental Status (BIMS) of 15, which indicated the resident was cognitively intact.	M1570	medication administration. These competencies will be conducted 2 (two) times per week for 4 (four) weeks, then 1 (one) time per week for 4 (four) weeks and continue annually thereafter. The Quality Assurance Nurse will complete audits 2 (two) times weekly for 4 (four) weeks, then 1 (one) time weekly for 4 (four) weeks and then monthly thereafter to ensure nebulizer mask are stored properly when not in use. The Quality Assurance Nurse will report any issues identified to the Director of Nursing, who will bring all findings to the Quality Assurance Committee on July 5, 2023 for review and recommendations. The Director of Nursing will continue to bring the findings from the audits to the Quality Assurance Committee monthly for 4(four) months.	

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M1570	Continued From page 3 Resident #21 An observation on 6/7/23 at 8:57 AM, with Resident # 21 revealed that LPN #1 entered the resident's room, set the resident's ordered eye drop bottle on the overbed table with no barrier, administered the residents by mouth (PO) medications and then picked the eye drop bottle up off of the overbed table and administered the eye drops. LPN #1 then left the residents room and returned the eye drop bottle to the medication cart drawer. An interview on 6/7/23 at 9:15 AM, with LPN #1 confirmed she set Resident #21's eye drops on the overbed table with no barrier before administering and then returned them to the medication cart. She revealed that she should have used a barrier under the eye drops before setting them on the overbed table to prevent the possible spread of infection and she stated that she knew better. An interview on 6/7/23 at 9:50 AM, with the Infection Preventionist (IP) confirmed that the nurses should have placed a barrier down to place the eye drop bottle on instead of setting them directly on the resident's furniture. She stated that they are absolutely supposed to use a barrier and that the nurses are trained in using a barrier for infection control purposes when they are hired and during annual in-services. An interview on 6/7/23 at 2:10 PM, with the Director of Nurses (DON) confirmed that the nurses should not set an eye drop bottle down in the resident's room without using a barrier to prevent the spread of infection.	M1570		

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M1570	Continued From page 4 Record review of Resident #21's Physician Orders List revealed an order dated 3/31/21 for Olopatadine HCL 0.1% eye drops, administer one drop in both eyes daily for Allergies. Record review of Resident #21's Face Sheet revealed the resident was admitted to the facility on 3/31/21 with medical diagnoses that included Unspecified Dementia, Unspecified Severity with behavioral disturbances and Allergic Rhinitis Unspecified. Record review of Resident # 21's MDS with an ARD of 5/30/23 revealed in Section C a BIMS of 11 which indicated the resident was moderately cognitively impaired. Record review of the facility in-services regarding infection control revealed the facility had an in-service on 7/22/22 and 2/16/23 that was attended by all nursing staff including LPN #1 and LPN #2. Resident #16 An observation and interview on 06/05/23 at 11:05 AM, with Resident #16 revealed his nebulizer machine and mask were located on the bedside table with no storage bag placed over the nebulization mask. The resident revealed he used the nebulizer several times a day. An observation on 06/06/23 at 9:05 AM, revealed Resident #16's nebulizer mask lying on the bedside table with no storage bag over the mask. An observation on 06/07/23 at 9:30 AM, revealed Resident #16's nebulizer mask clipped onto the nebulizer machine located on the bedside table	M1570		

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M1570	Continued From page 5 with no storage bag placed over the mask. An interview on 06/07/23 at 9:40 AM, with Licensed Practical Nurse (LPN) #2 confirmed that Resident #16's nebulizer mask was not placed in a storage bag. She revealed that not placing the mask in a storage bag could cause the mask to become contaminated with germs and could lead to respiratory issues. An interview on 06/07/23 at 9:55 AM, with the Infection Preventionist (IP) revealed that staff are supposed to keep the nebulizer mask bagged if not in use. She revealed that leaving Resident #16's mask out of the storage bag could cause bacteria to enter the mask and could cause respiratory infection. An interview with the Director of Nursing (DON) on 06/07/23 at 10:10 AM, acknowledged that Resident #16's nebulizer mask should not be left out in the environment and doing so could lead to respiratory infection. She stated that the facility has "IP's" (in pouches) that the mask should be stored in between usage. Record review of the medical record revealed Resident #16 was re-admitted to the facility on 8/26/16 with diagnoses that included Personal history of COVID-19, Centrilobular Emphysema, Anxiety Disorder, and Shortness of Breath. Record Review of Resident #16's Physician Orders List revealed an order dated 01/12/23, "DUO-NEB 0.5-2.5MG(milligrams)/3ML(milliliter) neb (nebulizer) give 3ML inhalation via nebulizer QID (four times a day); Emphysema...." Record review of the MDS with an ARD of 04/04/23 revealed under section C a Brief	M1570		

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M1570	Continued From page 6 Interview for Mental Status (BIMS) score of 13, which indicates Resident #16 is cognitively intact.	M1570		