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
	34HH	A. BUILDING: _____ B. WING _____	C 07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE CENTER OF LAUREL	935 WEST DR LAUREL, MS 39440

(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 Complaint Investigations (CI) at the facility for three (3) complaints, CI MS #21838, CI MS #22109, and CI MS #22131 from 7/24/23 through 7/26/23. 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. The SA investigated CI MS #21838 for resident not groomed, therapeutic diets, and care not received and CI MS #22131 for services not performed per plan of care, cold food, and staff improperly qualified. The SA did not cite any deficiencies for those complaints. The SA investigated CI MS #22109 for quality of care and cited M635.	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 interviews, record review, and facility policy review, the facility failed to notify the physician of feeding tube complications for one (1) of two (2) residents reviewed with feeding tubes. Resident #1. Findings Include: Record review of the facility's "Gastrostomy/Jejunostomy/Nasogastric Tube"	M 635	1) Root Cause Analysis was conducted by the Interdisciplinary Team (IDT) on 08/02/2023 and based on findings the Licensed Practical Nurse (LPN) #1 did not notify the physician of feeding tube complications for Resident #1. LPN #1 was educated on 07/25/2023 to ensure the physician is notified if a resident has feeding tube complications on Gastrostomy/Jejunostomy/Nasogastric Tube Policy by the Director of Nurses	8/29/23

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M 635	Continued From page 1 policy, revised 01/22, revealed, " ...Administration of Tube Feedings ...6. For Gastrostomy and Nasogastric tubes ...C. If more than 100 (cc) cubic centimeter of residual is aspirated, return the residual to the stomach, discontinue the tube feeding, and notify the physician ..." Record review of the "Face Sheet" revealed the facility admitted Resident #1 on 6/5/23 with a diagnosis of Cerebral infarction, unspecified, and Gastrostomy status. Record review of "Physician Orders" for the month of July 2023 revealed Resident #1 had a Physician's Order with an order date of 6/5/23 to "Check residual; notify MD (Medical Doctor) if greater than 100 ml (milliliters)." A record review of the "Departmental Notes" revealed on 7/2/23 at 6:45 AM and 7:45 AM, License Practical Nurse (LPN) #1 and Registered Nurse (RN) #1 have no documentation of notifying the MD of Resident #1 feeding tube residual of greater than 100 ml. On 7/24/23 at 2:37 PM, an interview with RN #1 confirmed she is the day shift supervisor, and she did not notify the physician on 7/2/23 when she reported on duty that Resident #1 gastrostomy tube residual was greater than 100 ml. RN #1 revealed that the resident was not in any distress and was not gurgling, vomiting, or having shortness of breath when she arrived on duty at 7:00 AM. On 7/24/23 at 3:37 PM, an interview with LPN #1 confirmed she did not follow the physician's orders to notify the MD of the residual of greater than 100 ml on 7/2/23. She relayed she should have followed the physician's orders to notify him	M 635	(DON). Resident #1 discharged from the facility on 07/02/2023. 2) Residents who receive tube feeding have the potential to be affected by this deficient practice. 3) On 07/26/2023, an audit was conducted by the DON to ensure the physician is notified if a resident has a tube feeding complication. Beginning on 07/26/2023, licensed nurses were educated by the DON and/or Staffing Nurse on ensuring the physician is notified if a resident has a tube feeding complication regarding Gastrostomy/Jejunostomy/Nasogastric Tube Policy and will be completed by 08/04/2023. New hires will be educated upon hire on ensuring the physician is notified if a resident has a tube feeding complication regarding Gastrostomy/Jejunostomy/Nasogastric Tube Policy. 4) Beginning on 07/27/2023, the DON and/or Nurse Supervisor will review nurses' notes to ensure the physician is notified if a resident has a tube feeding complication on 5 residents 5 times a week for 4 weeks and then 5 residents per month for 3 months. Areas of concern will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee for review. The QAPI Committee will convene on 08/28/2023 to discuss further recommendations as	

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M 635	Continued From page 2 of the resident residual. On 7/25/23 at 10:35 AM, an interview with the Director of Nursing (DON) stated it is my expectation that the nurses follow the physician's orders. LPN #1 should have notified the physician of Resident #1 residual or any acute problems. On 7/25/23 at 11:00 AM, an interview with the MD confirmed on 7/2/23, the nurses did not notify him of Resident #1 residual of greater than 100 and that the tube feeding was placed on hold. During the interview, the MD stated that he would not have done anything differently since the resident was not in any acute distress.	M 635	needed and then review for 3 months. Additional training and/or disciplinary action will be considered as warranted.	