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 |
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| OCEAN SPRINGS HEALTH & REHABILITATION CENTI | 1199 OCEAN SPRINGS ROAD OCEAN SPRINGS, MS 39564 |

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| M 000 | Initial Comments<br><br>The State Agency (SA) conducted a Complaint Investigation (CI), MS #22125, which was a Facility Reported Incident (FRI), at the facility from 7/24/2023 through 7/26/2023. 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 #22125 related to a resident who was found unresponsive and did not receive Cardiopulmonary Resuscitation (CPR) and notification of a change in resident condition.<br><br>On 7/19/23 at 9:05 PM, Resident #1, who had a Full Code status, was found to be unresponsive and without a pulse or respirations. The nurse incorrectly pulled another resident's chart who had a Do Not Resuscitate (DNR) order. Therefore, the nurse did not initiate CPR or activate emergency services for Resident #1. As a result of the resident misidentification, the Responsible Representative (RR) was not notified of the resident's death until 7/20/23.<br><br>During the investigation, the SA identified an Immediate Jeopardy (IJ) on 7/25/23 and existed at:<br><br>Rule 45.17.2 Resident Rights M500 Level IV<br><br>The facility's failure to review the correct code status and implement the baseline care plan resulted in Resident #1 not receiving CPR and emergency services. The resident subsequently expired at the facility.<br><br>The SA notified the facility's Administrator of the IJ on 7/25/2023 at 4:30 PM. | M 000 | | |

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| M 000 | Continued From page 1<br><br>Based on the facility's implementation of corrective actions on 7/20/23, the SA determined the IJ was removed as of 7/21/23, prior to the SA's first entrance on 7/24/23.<br><br>At the time of the survey, the facility was licensed for 115 beds and had a census of 102. | M 000 | | |
| M 500 | 45.17.2 Residents' Rights<br><br>Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility:<br><br>1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents;<br><br>2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate;<br><br>3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a | M 500 | | 7/26/23 |

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pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action;

4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record;

5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal;

6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law;

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7. is free from mental and physical abuse;
8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint;
9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract;

10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs;

11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care;

12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical

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| M 500 | Continued From page 4<br>record);<br><br>13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record);<br><br>14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record);<br><br>15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and<br><br>16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights.<br><br>This Statute is not met as evidenced by:<br>Level IV Past Non-Compliance<br><br>Based on interviews, record review, and facility policy review, the facility failed to honor a Resident's Right to have Cardiopulmonary Resuscitation (CPR) initiated and emergency services provided to an unresponsive resident for one (1) of four (4) sampled residents. Resident #1. | M 500 | No POC required. Past non-compliance. | |

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| M 500 | Continued From page 5<br><br>Resident #1, who had a Full Code status, was found to be unresponsive and without a pulse or respirations. The nurse incorrectly pulled another resident's chart who had a Do Not Resuscitate (DNR) order. Therefore, the nurse did not initiate CPR or activate emergency services for Resident #1.<br><br>The facility's failure to review the correct code status resulted in Resident #1 not receiving CPR and emergency services. The resident subsequently expired in the facility.<br><br>The situation was determined to be an Immediate Jeopardy (IJ) that began on 7/19/23 when Resident #1 was found by facility staff to be unresponsive and without a pulse or respirations. The facility Administrator was notified of the IJ on 7/25/23 at 4:30 PM.<br><br>Based on the facility's implementation of corrective actions on 7/20/23, the State Agency (SA) determined the IJ to be Past Non-Compliance (PNC) and the IJ was removed as of 7/21/23, prior to the SA's first entrance on 7/24/23.<br><br>Findings Include:<br><br>A record review of the facility's policy "Cardiopulmonary Resuscitation (CPR)" with a revision dare 01/28/2022 revealed "Policy: Cardiopulmonary Resuscitation (CPR) will be provided to all residents who are identified to be in cardiac arrest unless such resident has a valid Do Not Resuscitate (DNR) order. Procedure: ... 2. Two licensed nurses are to verify... Right Identity...Current physician order for code status ... 6. Notify the physician and resident | M 500 | | |

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representative/legal representative 7. Document in the medical record."

At 09:30 PM on 07/24/2023, during an interview with Licensed Practical Nurse (LPN) #2, she explained she was working the evening of 07/19/2023 when Resident #1 expired. She stated that while she was charting at the nurse's station, LPN #1 came to the station and said that she thought her patient was dead. LPN #1 pulled a chart and pointed out to LPN #2 the DNR page on the chart. LPN #2 stated that she only looked at the DNR page and did not notice it was for Resident #2. LPN #2 explained to LPN #1 that since Resident #1 was a DNR, nothing else had to be done. LPN #1 then asked Registered Nurse (RN) #1 to make the death pronouncement. LPN #1 continued to go through the medical chart and called the doctor, the Director of Nursing (DON), and called the resident's family, but asked LPN #2 to talk to the family on the phone. LPN #2 confirmed that she did not verify the name on the resident's chart or the photo and was not aware that LPN #1 had viewed another resident's chart in error.

At 10:00 PM on 07/24/2023, during an interview with RN #1, she explained on the night of 07/19/2023, she was working on the medication cart and was administering medications when she was approached by LPN #1 who asked her to make a death pronouncement for a resident. She stated LPN #1 informed her the resident had a DNR code status and referred to the resident by the name of Resident #2 and not Resident #1. RN #1 confirmed that she did not verify the code status herself and did not know the resident. RN #1 stated that the resident's body was cold and there were no vital signs, so she confirmed that the resident was deceased, and then went back

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to the hall to complete her medication pass. RN #1 stated that at the end of her shift at approximately 11:00 PM on 7/19/23, LPN #1 reminded her to document in the medical chart the pronouncement of death for the resident and used the name of Resident #2, and not Resident #1. RN #1 explained that she was not aware of the error until the following morning (7/20/2023) when the facility called her and made her aware that the deceased resident was Resident #1 and not Resident #2. She reported that she was at fault in the incident because she did not verify the resident's name or code status.

On 07/25/2023 at 09:30 AM, during an interview with the DON, she explained that on the night of 07/19/2023 after 09:00 PM, she received a call from LPN #1 and was told that Resident #2 had passed away. On 7/20/23 after 8:00 AM, while on her way to the facility, RN #2 called her and told her that she had been informed that the funeral home had called the facility questioning the identity of the body in their possession. The facility immediately began an investigation and discovered the root cause of the incident was that LPN#1 reviewed the wrong chart and the nurses did not verify the identity of the residents when Resident #1 was found to be expired. The DON commented that Resident #1 and Resident #2 did not have similar names, were not in the same room, and had different nurses assigned to them. LPN #1 was assigned to Resident #1 and LPN #2 was assigned to Resident #2. The DON explained that Resident #1 had a full code status and Resident #2 had a DNR status, which resulted in Resident #1 not receiving CPR or emergency treatment. During the facility's investigation on 7/20/23, the DON stated that while interviewing LPN# 1, she would not acknowledge that she had made a mistake, even

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when confronted with the paperwork she had completed in the name of Resident #2 and not Resident #1. LPN #1 said she knew it was Resident #1 who had expired, but she could not understand how she made the mistake and insisted that she had reviewed the correct resident's medical chart. The DON said that she expected the nurses to follow the physician orders, code status, and the facility policies for all residents.

On 07/25/2023 at 10:00 AM, during an interview with the Administrator, she explained the whole incident was upsetting for the facility and the residents' families involved. She explained it was an accident that should never have happened and that the wrong resident's chart had been pulled, the resident was not correctly identified, and there had been no CPR performed on Resident #1 who had a full code status. She explained she expected the nurses to follow physician orders and facility policies.

On 07/25/2023 at 11:00 AM, during an interview RN #2, she explained on the morning of 07/20/2023, she made rounds and noticed that Resident #1 was not in his room. She was told by a Certified Nurse Aide (CNA) that Resident #1 had passed away. She went to review Resident #1's records and did not see any documentation, including a record of death. She stated she called LPN #1 for more information and advised her that Resident #1 had a full code status.

At 11:45 AM on 07/25/2023, during an interview with Resident #1's daughter, she explained she was informed by the facility on 7/20/23 that her father had died. She was told that the nurse had pulled the wrong chart which showed the resident was not a full code. She stated "they did nothing

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to try and resuscitate" her father who had a full code status.

On 07/25/2023 at 12:00 PM, during a phone interview with LPN #1, she explained she was walking down the hallway around 9:00 PM and went into Resident #1's room and he was not breathing. She stated she went to the nurse's station and reviewed the medical chart and both herself and LPN #2 verified that the resident was a DNR. She said she called the family and asked LPN #2 to talk to the family because she had another resident who was sick. She said she asked two (2) CNAs to clean up the resident and later saw a woman at the facility who was crying. LPN #1 said that she completed the paperwork and called the coroner. She repeated that she had verified with the other nurse that the resident had a DNR code status, and she did not make a mistake. She expressed that she would never not perform CPR on a resident who had a full code status.

At 12:30 PM on 07/25/2023, during an interview with Resident #3, who was Resident #1's roommate, he stated that he was on the phone with his mother and made the remark that his roommate was quiet tonight. After some time, a nurse came in to check on the resident and went out of the room and then came back with another nurse. The nurse went out again and another nurse came in with a stethoscope and then left. He reported that he called his mom and said he thought Resident #1 had died. He confirmed that he never saw the staff performing CPR on the resident.

Record review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/13/2023 revealed Resident #3 had a

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Brief Interview for Mental Status (BIMS) score of 15, which indicated he was cognitively intact.

Resident #1

A record review of Resident #1's "Admission Record" revealed the facility admitted Resident #1 on 7/17/2023 with diagnoses including Acute Respiratory Failure with Hypoxia, Acute on Chronic systolic (Congestive) Heart Failure, Paroxysmal Atrial Fibrillation, Atherosclerotic heart disease of native coronary artery without angina pectoris.

A record review of the "Order Summary Report", with active orders as of 07/25/2023, revealed Resident #1 had a Physician's Order dated 7/17/23, for "Full Code".

Record review of the "Advance Directives Discussion Document", dated 7/17/23 revealed, " ...Please indicate your wishes regarding the following: Cardiopulmonary Resuscitation: PROVIDE ..." was checked indicating Resident #1's wished to have CPR provided.

Record review of Resident #1's Discharge Minimum Data Set (MDS) dated 07/19/2023 revealed Resident #1 was coded as reason for discharge "Death in facility." Discharge Status was coded as "Deceased."

The facility submitted the following acceptable Corrective Action Plan on 07/26/2023:

Corrective Action Plan

Brief Summary of Events: On July 19, 2023, at 9:05 PM, Licensed Practical Nurse (LPN) #1 noted Resident #1 was without pulse and

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respirations. The facility failed to initiate Cardiopulmonary Resuscitation (CPR) and provide emergency care when Resident #1 was found to be unresponsive and required emergency care. The facility failed to implement a Baseline Care Plan related to the code status of Resident #1. Resident #1 did not receive CPR or emergency care when he was found to be unresponsive and required emergency care. LPN #1 pulled another resident's chart (Resident #2), who had a Do Not Resuscitate (DNR) order, and thought she was reviewing Resident #1's code status and therefore did not perform CPR or provide emergency care. Through root cause analysis, the facility determined LPN #1 failed to accurately identify resident and verify code status. The facility reviewed their CPR and Plan of Care policy and procedures, educated nursing staff on identifying residents, verifying code status, following plan of care and notification of change in resident, and held a quality assurance meeting. The event was reported to Licensure and Certification/Mississippi State Department of Health via email on July 20, 2023, at 10:43 AM, the Mississippi Office of Attorney General on July 20, 2023, at 7:52 PM, State Ombudsmen on July 20, 2023, at 7:30PM, and the Mississippi Board of Nursing on July 20, 2023, at 7:20 PM.

On July 19, 2023, at 9:05 PM, LPN #1 requested LPN #2 to confirm Resident #1 was without pulse and respirations. LPN #2 confirmed Resident #1 was without pulse and respirations. LPN #1 requested Registered Nurse (RN) #1 to pronounce Resident #1. At 9:10 PM, on July 19, 2023, LPN #1 notified Director of Nursing (DON), Medical Director, and Responsible Party of Resident #2, of Resident expiration. At 10:05 PM, on July 19, 2023, LPN #1 notified local funeral home and coroner of Resident expiration.

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| | 300S | A. BUILDING: _____ B. WING _____ | C 07/26/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| OCEAN SPRINGS HEALTH & REHABILITATION CENTI | 1199 OCEAN SPRINGS ROAD OCEAN SPRINGS, MS 39564 |

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| M 500 | Continued From page 12<br><br>On July 20, 2023, at 8:00 AM local funeral home called facility and spoke with RN #2 requesting information on the Resident in their possession. On July 20, 2023, at 8:10 AM, RN #2 contacted Resident #2 Responsible Party. At 8:20 AM on July 20, 2023, RN #2 informed Executive Director (ED) and DON of issue and investigation began. On July 20, 2023, at 11:30 AM, LPN #2 suspended pending investigation, by RN #3. On July 20, 2023, at 12:00 PM, RN #1 suspended pending investigation, by RN #3. At 1:30 PM on July 20, 2023, LPN #1 suspended pending investigation, by RN #3.<br><br>On July 20, 2023, at 9:30 AM, RN #2 initiated education to nursing staff on accurately identifying resident, verifying code status, following plan of care, abuse, neglect, resident rights and notification of change in resident, to include 50 certified nursing assistants, 26 licensed practical nurses, and 12 registered nurses. No current licensed nurses or newly hired licensed nurses will work without the aforementioned education. On July 20, 2023, at 9:45 AM, ED reviewed all resident photos inside Point Click Care (PCC). No adverse findings. At 10:00 AM on July 20, 2023, LPN #3 audited all resident charts for accurate code status in Point Click Care (PCC), advance directive on chart, and chart tags. Findings of audit were one (1) chart did not have advanced directive election sheet on chart, but it was in PCC, and one (1) chart needed updated advanced directive from hospital return. Advanced Directive election sheet added to chart and advanced directive updated on July 20, 2023, by LPN #3 and RN #3. At 10:00 AM on July 20, 2023, Certified Nursing Assistant (CNA) #1 and CNA #2 checked all door labels for accurate resident names. Findings | M 500 | | |

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| M 500 | Continued From page 13 | M 500 | | |

include one (1) room noted without a name label. Name label was placed on name plate by CNA #1 and CNA #2 on July 20, 2023. On July 20, 2023, at 12:30 PM, RN #2 and LPN #4 initiated mock code drill for all nursing staff. Mock code drill will be completed on all shifts. On July 20, 2023, at 3:00 PM, ED initiated education to all non-nursing to notify a nurse if resident is observed unresponsive, abuse, neglect, and resident rights, to include 11 dietaries, 7 housekeeping, 4 laundry, 2 maintenance, 3 activity, and 8 administrative. No current non-nursing staff members or newly hired non-nursing staff members will work without the aforementioned education. On July 20, 2023, at 8:00 PM, RN #2 and RN #3 audited care plans for accuracy of code status. No adverse findings.

On July 20, 2023, at 12:10 PM, RN #2 initiated education to LPN #1, LPN #2, and RN #1 on accurately identifying residents, verifying code status, following plan of care, abuse, neglect, resident rights and notification on change in resident. At 5:30 PM on July 20, 2023, the Quality Assurance Performance Improvement (QAPI) Committee met to review findings of investigation and conducted a Root Cause Analysis (RCA) and review of Cardiopulmonary Resuscitation (CPR), Plan of Care, and Notification of Change in Resident policy and procedures for changes. Attendees were the Executive Director (ED), Director of Nursing (DON), Director of Rehabilitation (DOR), Unit Manager/RN, Unit Manager/LPN, Infection Control Preventionist, Minimum Data Set (MDS), Assistant Business Office Manager (ABOM), Central Supply Certified Nurse Assistant (CNA), Medical Records, Staffing Development LPN, and Human Resources Director (HRD). The Medical Director (MD) attended by phone. RCA

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| M 500 | Continued From page 14<br>determined additional needs for education to all nurses on accurately identifying residents, verifying code status, following plan of care and notification of change in resident. No changes made to policies.<br><br>Ongoing monitoring will begin on July 26, 2023, as follows: Code status of all new admissions will be audited within 24 hours of admission by Director of Nursing. All resident Code statuses will be audited weekly times four weeks, then monthly times three months. Mock Code drills will be performed quarterly rotating shifts. Findings will be discussed in Quality Assurance Performance Improvement (QAPI) meeting quarterly.<br><br>Based on the steps the facility initiated and completed for this event, the facility alleges that corrective actions were completed as of July 20, 2023, and represents past noncompliance since all measures were completed prior to complaint survey entrance.<br><br>The State Agency (SA) validated the facility's Corrective Action Plan on 07/26/2023.<br><br>On 07/26/2023, the SA validated through record reviews and resident and staff interviews the root cause of the Facility Reported Incident on 07/19/2023 was LPN #1 pulled the wrong resident's chart and the chart or resident was not verified by two (2) nurses.<br><br>On 07/26/2023, the SA validated through record review and resident and staff interviews Resident #1 was found without pulse and respirations. Resident #2's daughter was notified, and the local funeral home and coroner was notified of resident's expiration. | M 500 | | |

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| M 500 | Continued From page 15<br><br>On 07/26/2023, the SA validated through record review and staff interviews the facility began investigating on 07/20/2023 and LPN #1, LPN #2, and RN #1 were suspended during the investigation.<br><br>On 07/26/2023, the SA validated through record reviews of in-service training sign in sheets and staff interviews the in-service was completed on 07/20/2023 to include mock code drill, CPR policy, accurately identifying resident, verifying code status, following plan of care, abuse, neglect, resident rights, and notification of change in resident. All resident photos were reviewed in Point Click Care (PCC), all resident's charts for accurate code status in Point Click Care (PCC), advance directive on chart, and chart tags. All residents' door labels checked for accurate resident names. Sign in sheet for in-service to all non-nursing to notify a nurse if resident is observed unresponsive, abuse, neglect, and resident rights. An audit on all residents' care plans for accuracy of code status was completed on 07/20/2023.<br><br>On 07/26/2023 through record review of sign in sheet for in-service for LPN #1, LPN #2, and RN #1 was completed on accurately identifying residents, verifying code status, following plan of care, abuse, neglect, resident rights and notification on change in resident. A record review of the Quality Assurance Performance Improvement (QAPI) Committee met at 5:30 p.m. on July 20,2023, to review findings of investigation and conducted a Root Cause Analysis (RCA) and review of Cardiopulmonary Resuscitation (CPR), Plan of Care, and Notification of Change in Resident policy and procedures for changes. Attendees were the | M 500 | | |

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| M 500 | Continued From page 16<br><br>Executive Director (ED), Director of Nursing (DON), Director of Rehabilitation (DOR), Unit Manager/RN, Unit Manager/LPN, Infection Control Preventionist, Minimum Data Set (MDS), Assistant Business Office Manager (ABOM), Central Supply Certified Nurse Assistant (CNA), Medical Records, Staffing Development LPN, and Human Resources Director (HRD). The Medical Director (MD) attended by phone. RCA determined additional needs for education to all nurses on accurately identifying residents, verifying code status, following plan of care and notification of change in resident. No changes made to policies. | M 500 | | |