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
	55PR	A. BUILDING: _____ B. WING _____	C 08/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL RIVER CO NURSING HOME	305 WEST MOODY STREET POPLARVILLE, MS 39470

(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 an annual recertification survey and Complaint Investigation (CI), MS #22458 and MS #21986, at the facility from 8/21/23 through 8/24/23. The SA investigated MS #21986 related to dietary and there were no citations related to the complaint. MS #22458 was investigated related to an injury of unknown origin and M640 was cited related to the complaint. 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 M655.	M 000		
M 640	45.21.8 Accidents Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies. This Statute is not met as evidenced by: Level II Based on interviews, record review, and facility policy review the facility failed to ensure a resident who was transferred using a mechanical lift was transferred with appropriate supervision for one (1) of three (3) sampled residents transferred with mechanical lifts. Resident #6 Findings include: Review of the facility's policy, "Lifting Machine, Using a Portable", revised September 2017, revealed, " ...The purpose of this procedure is to	M 640	1) Certified Nurses Assistant #1 and Certified Nurses Assistant #2 were both terminated from employment from the facility for not following the plan of care of transferring Resident #6 on 08/22/2023. Resident #6 requires two persons when transferring with a mechanical lift. 2) The facility recognizes that all residents requiring transfers with a mechanical lift had the potential to be affected by this alleged deficient practice. 3) All Nurses and Certified Nurses Aides	10/2/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	55PR	A. BUILDING: _____ B. WING _____	C 08/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL RIVER CO NURSING HOME	305 WEST MOODY STREET POPLARVILLE, MS 39470

(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 640	Continued From page 1 help lift residents using a manual lifting device ...General Guidelines Two (2) nursing assistants are required to perform this procedure ..." An interview on 8/24/23 at 09:00 AM, with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON), revealed Certified Nurse Aide (CNA) #1 and CNA #2 had been terminated from the facility for not following the facility policy which required two persons when transferring a resident with a mechanical lift. The DON stated that during an incident investigation, the CNAs were interviewed again and it was discovered that CNA #1 had transferred Resident #6 to the shower stretcher without using the required number of staff and CNA #2 had transferred Resident #6 from the shower stretcher to her bed without the appropriate number of staff. During an interview on 8/24/23 at 11:00 AM, with CNA #1, she confirmed she transferred Resident #6 to the shower stretcher with a mechanical lift and did get another staff member to assist her. CNA #1 said she showered the resident and took her to her room. During an interview on 8/24/23 at 11:15 AM, with CNA #2, she confirmed she transferred Resident #6 from the shower stretcher to the bed without another staff member assisting. She stated that Resident #6 was on the shower stretcher in her room and she cut the resident's hair and transferred her back to her bed. CNA #2 explained that she was aware that the facility required two (2) staff when using a mechanical lift. Record review of the "Face Sheet" revealed the facility admitted Resident # 6 on 9/05/07 and she	M 640	were provided education, by the Assistant Director of Nurses, beginning on 08/17/2023 and ongoing to the completion date of 08/21/2023, in regards to transferring with a mechanical lift policy, and the requirement of two persons during the transferring with a mechanical lift. Maintenance Director will be required to perform monthly functioning and mechanical checks on each lift that the facility owns beginning 08/23/2023. These checks will be documented and turned into the Quality Assurance Coordinator on 09/15/2023 and ongoing at least monthly for 90 days. 4) The results of the monitoring will be brought to the Quality Assurance Performance Improvement (QAPI) Committee by the Quality Assurance Coordinator monthly for at least 3 months. If any revisions in the plan of corrections are needed, the revisions will be developed and approved by the Quality Assurance Improvement Committee to ensure the plan of correction is achieved and sustained. Charge Nurses will monitor two transfers daily for the first 30 days. Ongoing, the Charge Nurse will monitor two mechanical lift transfers weekly for the next 60 days. These monitoring checks will begin on 09/11/2023. These monitoring sheets will be given to the Director of Nurses upon completion for compliance, and the Director of Nurses will give to the Quality Assurance Coordinator on 09/29/2023 and on going at least monthly for 90 days.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	55PR	A. BUILDING: _____ B. WING _____	C 08/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL RIVER CO NURSING HOME	305 WEST MOODY STREET POPLARVILLE, MS 39470

(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 640	Continued From page 2 had diagnoses including Paraplegia, Multiple Sclerosis, and Osteoporosis. Record review of the Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/23/23 revealed Resident #6 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated Resident # 6 was cognitively intact. Further review revealed Resident #6 was dependent upon facility staff for transferring and required two persons to assist with the transfers.	M 640		