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
	45CM	A. BUILDING: _____ B. WING _____	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON CO NH	1421-A EAST PEACE STREET CANTON, MS 39046

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M 000	Initial Comments The State Agency (SA) conducted an annual recertification survey and a complaint investigation (CI) MS #25141 at the facility from 7/8/24 through 7/10/24. During the survey, the SA determined the facility was not in compliance with the Minimum Standards of Operation for Institutions for the Aged or Infirm, state licensure requirements and deficiencies were cited at M 500, M 610, M 625 and M 1570. The SA determined the facility was in compliance related to CI MS #25141 staff to resident abuse. The facility held a license for 95 beds at the time of survey, and the facility census was 93.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 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; 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; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or	M 500		8/14/24

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M 500	Continued From page 1 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 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;	M 500		

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M 500	Continued From page 2 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; 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	M 500		

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M 500	Continued From page 3 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 record); 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); 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); 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 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. This Statute is not met as evidenced by: Level II	M 500	A. Resident #85 was immediately taken to her room on 07/08/24, redressed	

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M 500	Continued From page 4 Based on observation, staff interview and facility policy review the facility failed to ensure a resident's dignity as evidenced by allowing the resident to sit in a public area with a private body part exposed for one (1) of 21 residents sampled. Resident #85 Findings include: Review of the facility policy titled, "Dignity" with no revision date revealed under, "Policy Interpretation and Implementation ...#11. Staff promote, maintain and protect resident privacy, including bodily privacy ...". An observation on 7/8/24 at 12:10 PM revealed Resident #85 sitting in a reclined wheelchair across from the centralized nurse's station wearing a tank top that had fell from her left shoulder exposing her breast. At this time there were approximately 10 other residents sitting in the area of the nurse's station and day room with staff and visitors walking past the resident. An interview and observation on 7/8/24 at 12:15 PM with Licensed Practical Nurse (LPN) #1 revealed she is Resident #85's nurse and confirmed that the resident needed to be covered. She stated they were having trouble keeping the resident covered today. This observation revealed LPN #1 pulled the residents tank top strap up and began tucking a fleece blanket around the residents' shoulders then stated, "I should've gone and got her something else to wear." An interview and observation on 7/9/24 at 10:30 AM, with Certified Nurse Assistant (CNA) #2 revealed that Resident #85's closet had approximately 4 shirts with sleeves, two long	M 500	appropriately and returned to the public area. B. All residents have the potential to be affected by the deficient practice. C. A comprehensive inservice was assigned to all nursing staff on 07/11/24 on The ABCDs of Dignity Care, which includes assisting residents to dress in their own clothes appropriate to the time of day and maintaining a resident's dignity. The Quality Assurance Coordinator will monitor to ensure all nursing staff have completed the inservice training. D. The Director of Nursing will inspect a minimum of five residents per week beginning 07/19/24 for dignity issues including appropriate clothing for no less than three months. Any findings will be reported to the Quality Assurance and Corporate Compliance Committee for resolution beginning 08/13/24 times three months.	

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M 500	Continued From page 5 sleeve gowns, 4 pairs of pants and a robe. She stated the CNA's dress the resident and the resident should always have clothes that fit her and do not expose her breast for the resident's dignity. An interview on 7/9/24 at 11:00 AM, with LPN #1 confirmed that Resident #85 should have had better clothes on yesterday that did not expose her for the resident's dignity. An interview on 7/9/24 at 1:30 PM, with the Director of Nurses (DON) confirmed that her expectation is that residents should be dressed in a manner that would keep them from exposing private body parts. She stated that Resident #85 having a breast exposed due to an ill-fitting tank top while sitting in the area near the nurses' desk would have been a dignity issue for the resident. Record review of Resident #85's "Face Sheet" revealed the resident was admitted to the facility on 5/31/23 with medical diagnoses that included Senile Degeneration of Brain.	M 500		
M 610	45.21.2 Activities of daily living Activities of daily living. Each resident shall receive assistance as needed with activities of daily living to maintain the highest practicable well being. These shall include, but not be limited to: 1. Bath, dressing and grooming; 2. Transfer and ambulate; 3. Good nutrition, personal and oral hygiene; and 4. Toileting.	M 610		8/14/24

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M 610	Continued From page 6 This Statute is not met as evidenced by: Level II Based on observations, staff interview, record review, and facility policy review, the facility failed to provide assistance with activities of daily living (ADLs) for a resident dependent on staff for shaving and changing visibly soiled clothing for two (2) of 21 sampled residents. Resident #20 and Resident #44. Findings Include: Review of the facility policy titled "Activities of Daily Living" undated, revealed, "Policy Statement: Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene..." Resident #20 An observation on 7/8/2024 at 11:44 AM, revealed Resident #20 lying in bed, non-communicative with grayish-black facial hair observed above the upper lip, under the lower lip, and to her chin, measuring approximately 1/4 (one-fourth) inch in length. The resident was wearing a hospital gown and had a tan colored liquid substance spread across the chest area of the gown and two (2) small, cubed pieces of carrot. Review of the lunch menu for 7/8/2024 revealed lunch included a hamburger steak with brown gravy over white rice with sliced cooked carrots. An observation and interview with Registered Nurse (RN) #1 on 7/9/2024 at 10:15 AM, confirmed the presence of Resident #20's facial	M 610	A. 1. Resident #20's soiled gown was changed immediately on 07/08/24 and her facial hair was removed on 07/09/24. 2. Resident #44 was cleaned and her top clothes were changed immediately on 07/08/24. B. All residents have the potential to be affected by the deficient practice. C. Nursing staff were assigned an inservice on the ABCDs of Dignity in Care on 07/23/24, which includes grooming residents and proper use of clothing protectors. D. The Director of Nursing will inspect at least five residents weekly beginning 07/29/24 for dignity including facial hair and proper clothing for no less than three months. Any findings will be reported to the Quality Assurance and Corporate Compliance Committee for resolution beginning 08/13/24 times three months.	

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M 610	Continued From page 7	M 610		

hair and revealed the aides were responsible for shaving the female residents when it was noticeable. RN #1 explained that she glanced into the resident's room daily to ensure her care was completed, and stated she just overlooked the facial hair. She acknowledged that when a resident had soiled clothing, it should be changed immediately.

An interview with the Director of Nursing (DON) on 7/9/2024 at 10:21 AM, revealed the aides were responsible for shaving the female residents on their designated bath day. She explained Resident #20 was able to feed herself but was a messy eater. She revealed her expectations were for staff to check for soiled clothing and immediately changed it when needed.

Record review of the "Face Sheet" revealed the facility admitted Resident #20 on 6/29/2023 with medical diagnoses that included Hemiplegia following Nontraumatic Intracerebral Hemorrhage affecting right dominant side.

Resident #44

An observation on 07/08/24 at 2:06 PM revealed Resident #44 sitting in the day room dressed in personal clothes, with a sliced piece of carrot, approximately six (6) pieces of rice and a nickel size amount of a brown substance on her shirt around her chest area.

Review of the lunch menu for 7/8/24 revealed lunch included a hamburger steak with brown gravy over white rice with sliced cooked carrots.

An interview on 7/9/24 at 11:00 AM with Certified Nurse Assistant (CNA) #1 revealed that Resident #44 has to be fed by the staff and the resident

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M 610	Continued From page 8 should always be cleaned up after feeding because this resident cannot clean herself. She stated lunch is served around 11 AM and they should always make sure there is no food left on the resident's clothes after meal time. An interview on 7/9/24 at 11:22 AM with Licensed Practical Nurse (LPN) #1 confirmed that Resident #44 has to be fed by staff and would have been fed by her CNA yesterday. She stated she expects the CNA that feeds the resident to clean the resident up and make sure there is no food left on their clothes from the meal. An interview on 7/9/24 at 1:20 PM with the DON confirmed that Resident #44 has to be fed by the staff and that she normally wears a bib, but she should be checked before leaving the dining room and cleaned to make sure food is not left on the resident. She revealed it was her expectation that would be done for residents. Record review of Resident #44's "Face Sheet" revealed the resident was admitted to the facility on 5/20/20 with medical diagnoses that included Type 2 Diabetes Mellitus. Record review of Resident #44's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/3/24 revealed in Section GG that the resident was dependent on staff for eating.	M 610		
M 625	45.21.5 Range of motion Range of motion. Residents with limited range of motion shall receive treatment and services to increase range of motion or prevent further decline in range of motion.	M 625		8/14/24

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M 625	Continued From page 9 This Statute is not met as evidenced by: Level II Based on observation, staff interview, record review and facility policy review, the facility failed to provide services to assure a resident maintained the level of range of motion (ROM) for one (1) of three (3) residents positioning and mobility. Resident # 68 Findings include: Review of the policy titled, "Contracture Prevention Protocol," revealed "Policy: ...A resident with a limited ROM (Range of Motion) receives appropriate treatment and services to increase ROM and/or to prevent further decrease in ROM, thus preventing contracture formation..." An observation of Resident #68 on 7/8/24 at 11:00 AM revealed the resident's left hand/wrist to be contracted, a splinting device was observed lying on the counter next to the sink. An observation of Resident #68 on 7/8/24 at 2:45 PM revealed a hand splint laying on the counter next to the sink, resident observed with no splinting devices observed on left hand. Interview with Licensed Practical Nurse (LPN) #2 on 7/9/24 at 10:30 AM, confirmed Resident #68 should have been wearing the resting left-hand splint on 7/8/24 but confirmed she did not check to see if the resident was wearing the splint. She then revealed, after reviewing the Treatment Administration Records (TAR) and the physician's orders for Resident #68, that she did not see the order for the splint. An interview with the Occupational Therapist (OT)	M 625	A. Resident #68's care plan was updated and a splint was in place as of 07/12/24. B. All residents with splints have the potential to be affected by the deficient practice. C. All nursing staff were assigned an inservice on 07/29/24 on Range of Motion. The Quality Assurance Coordinator will monitor to ensure all nursing staff have completed the inservice training. All residents with splints were identified and splints were inspected for proper use. D. The Director of Nursing will inspect all splints for range of motion weekly beginning 07/29/24 for no less than three months. Any findings will be reported to the Quality Assurance and Corporate Compliance Committee for resolution beginning 08/13/24 times three months.	

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M 625	Continued From page 10 on 7/9/24 at 10:35 AM, revealed she has not had Resident #68 on case load for a while but confirmed that Resident #68 should be wearing her left-hand splint to prevent worsening of contractures, and she confirmed she had not discontinued the device. Record review of OT notes for Resident #68 revealed she began OT services on 1/2/2022 for functional decline with left-hand contracture, muscle wasting and atrophy after a hospital stay. OT services were discontinued on 2/10/22 related to goals met. Record review of a written Physician's Order for Resident #68 provided by the facility dated 2/10/22 revealed, resident to wear (L) left resting hand splint four (4) hours per day with staff monitoring skin for irritation to decrease risk of worsening joint deformity with no discontinue date. Record review of the July 2024 Physician's Orders for Resident #68 revealed no order for a left resting hand splint. Interview with Restorative Nurse on 7/9/24 at 10:40 AM, she revealed after review of Resident #68's physician's orders, she confirmed she was unable to find the splinting device for the left hand listed at all, and the purpose of the left-hand splint was to prevent worsening of the contracture. An interview with the Director of Nursing (DON) on 7/10/24 at 8:30 AM, revealed after further investigation it was found that the order for the left-hand splint was entered into the computer system to alert staff on 2/10/22 when Resident #68 was discharged from OT, but for some reason dropped off in May 2022 and was never	M 625		

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M 625	Continued From page 11 re-entered in the computer system. Record review of the "Face Sheet" revealed Resident #68 was admitted by the facility on 11/11/20 with diagnoses including Cerebral Palsy and Hemiplegia. Record review of Resident #68's Section C of the Minimum Data Set (MDS) revealed that on 6/14/24 the Brief Interview for Mental Status (BIMS) score was 0, indicating the resident was severely cognitively impaired. Section GG0115: Functional Limitation in Range of Motion was coded 1. Impairment on one side to upper extremity.	M 625		
M1570	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.	M1570		8/14/24

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M1570	Continued From page 12 3. The facility must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of 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 possibility of infection as evidenced by failing to cleanse and properly store a Percutaneous Endoscopic Gastrostomy (PEG) tube syringe for (1) one of (5) five resident care observations. Resident # 68 Findings include: Review of the facility policy titled, "Standard Precaution," revealed, "...Policy Interpretation: Any equipment or items that may be suspected of contamination with body fluids must be handled in a manner to prevent possible transmission of infectious agents..." Review of the facility policy titled, "Feeding Syringe Policy," revealed, "Our policy for the cleanliness of syringes is they are dated and stored on a pole bag. Syringes are stored separated after use." An observation of Resident #68's room on 7/8/24 at 11:00 AM, revealed a PEG tube syringe separated and laying on the bedside table, with no clean barrier or storage bag observed on the table. Interview with Licensed Practical Nurse (LPN) #2	M1570	A. Resident #68's Percutaneous Endoscopic Gastrostomy (PEG) tube syringe was replaced on 07/08/24 and the new one was dated and placed in appropriate bag for the next use. B. All residents who receive PEG tube feeding have the potential to be affected by the deficient practice. C. Nurses were inserviced on our updated infection control policy related to Resident Equipment Cleaning and Disinfection which inclludes PEG tube syringe storage on 07/26/24. D. The Director of Nursing will pick five residents who use feeding syringes and inspect them for proper storage weekly for not less than three months beginning 07/29/24. Any findings will be reported to the Quality Assurance and Corporate Compliance Committee for resolution beginning 08/13/24 times three months.	

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	45CM	A. BUILDING: _____ B. WING _____	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON CO NH	1421-A EAST PEACE STREET CANTON, MS 39046

(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
M1570	Continued From page 13 on 7/9/24 at 10:30 AM revealed she was assigned to Resident #68 and confirmed she left the PEG tube syringe laying on the bedside table. She revealed she should have cleansed the syringe, dried it and placed it in a clean storage bag. She then stated that by not cleaning and storing the PEG tube syringe correctly, it placed Resident #68 at increased risk for transmission of bacteria and infection into the gastric site. Interview with the Infection Control Nurse on 7/09/24 at 10:40 AM, revealed that the PEG tube syringe should have been cleaned and dried and stored in a clean storage bag. She stated by not cleaning and storing the PEG tube syringe appropriately, Resident #68 was placed at increased risk for transmission of infection or bacteria and germs to the PEG site. A record review of the July 2024 Physician's Orders for Resident #68 revealed she received all medications, nutrition, and fluid requirements via the PEG tube. Record review of the "Face Sheet" revealed Resident #68 was admitted by the facility on 11/11/20 with diagnoses including Cerebral Palsy and Encounter for Attention to Gastrostomy.	M1570		