

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  255251	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/08/2024
NAME OF PROVIDER OR SUPPLIER  MS Care Center of Dekalb		STREET ADDRESS, CITY, STATE, ZIP CODE  220 Willow Avenue DE Kalb, MS 39328	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>47874</p> <p>Based on observation, resident and staff interview, and facility policy review, the facility failed to provide an appropriately sized wheelchair for one (1) of fifty-three residents residing in the facility during the survey. Resident #37</p> <p>Findings Include:</p> <p>Review of the facility policy titled Resident Rights Policy with a revision date of 9/2022 revealed under, Reasonable Accommodations of Needs/Preferences: The resident has the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.</p> <p>An observation and interview with Resident #37 on 5/6/2024 at 10:57 AM, revealed she was sitting in a wheelchair and slightly slouched forward. There was not enough seating space and the residents' hips, and outer thighs were tight against the edges of the wheelchair. The resident voiced that her wheelchair was too small.</p> <p>An observation and interview with the Director of Nursing (DON) on 5/7/2024 at 10:54 AM, confirmed Resident #37's wheelchair was too small. She revealed the family brought the wheelchair into the facility on admission, but the resident had gained weight and the wheelchair no longer fit the resident's size. She confirmed the resident should have an appropriately sized chair to ensure comfort and prevent skin concerns.</p> <p>Record review of the Facesheet revealed the facility admitted Resident #37 on 10/3/2023 with medical diagnoses that included Morbid obesity, Chronic pain, and Unspecified dementia.</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>46013</p> <p>Based on observation, staff interview, and facility policy review the facility failed to provide residents with a safe environment, as evidenced by various spray bottles and cans of chemical disinfectant, cleaning, and insecticide sprays, found unsecured on two hanging shelves on the B hallway for one (1) of three (3) days of survey.</p> <p>Findings include:</p> <p>Review of the facility policy titled, Storage of Chemicals, undated, revealed, Policy: The facility ensures the quality and safety of our residents through accepted storage practices. Procedure: 1. Chemicals are stored in a storage area, designated only for chemicals that can be locked. 2. Chemicals are safely stored for the protection of others by placing in locked carts while on halls during housekeeping procedures .</p> <p>On 5/06/24 at 10:40 AM, observation during the initial tour revealed on the B-Hall two (2) wooden shelves hanging approximately six (6) feet up on the right side of the wall. Shelf #1 had three chemical spray bottles: Cleaner/ Disinfectant, deodorizer, and fungicide. A label with HALT Danger on the bottles was noted. Shelf #2 revealed a can of chemical crawling insecticide spray and four chemical sprays labeled with HALT Danger.</p> <p>An interview on 5/06/24 at 10:50 AM, Housekeeper #1 confirmed the items were used to sanitize and clean and one was also an insecticide spray. She revealed we used those when we had COVID-19 and they have always stayed up on the wall in the hallway.</p> <p>During an observation and interview on 5/06/24 at 11:00 AM, the Environmental Manager revealed we keep the supplies up there so the staff can spray the equipment off. He confirmed that the chemical supplies were accessible to anyone and that residents could access the shelf with the chemicals on it.</p> <p>Observation and interview on 5/06/24 at 11:05 AM, the Administrator (ADM) confirmed the unsecured chemicals could be an accident hazard and should be kept locked up and away from the residents and visitors.</p> <p>Record review of the accident and incident log for the last year revealed there were no incidents related to chemicals being left unsecure.</p>

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>47874</p> <p>Based on staff interview, record review and facility policy review, the facility failed to monitor a resident receiving anticoagulant medication for signs of bruising and bleeding for one (1) of five (5) residents reviewed for unnecessary medication. Resident #27</p> <p>Findings Include:</p> <p>Record review of the facility policy titled Medication Monitoring with a revision date of 8/13/2023 revealed under, Policy: This facility takes a collaborative, systematic approach to medication management, including the monitoring of medications for efficacy and adverse consequences.</p> <p>Record review of the May 2024 Physician Orders for Resident #27 revealed an order dated 12/16/2020, Eliquis (blood thinner) 2.5 MG (milligrams) by mouth twice a day R/T (related to) circulation.</p> <p>Record review of the Physician Orders and the Medication Administration Record (MAR) revealed there was not a monitoring tool for staff to monitor for signs of bruising and bleeding with the anticoagulant (blood thinner) medication Eliquis.</p> <p>An interview with Licensed Practical Nurse (LPN) #1 on 5/7/2024 at 1:40 PM revealed she considered anticoagulant medication to be a high-risk drug that should be monitored for adverse outcomes. She confirmed the facility did not have a monitoring task implemented on the Medication Administration Record (MAR) for Resident #27 for bruising or signs of bleeding.</p> <p>An interview with the Assistant Director of Nursing (ADON) on 5/7/2024 at 2:02 PM confirmed the facility did not have a system in place to trigger the nurses to monitor for the potential outcomes associated with the use of blood thinners.</p> <p>Record review of the Face Sheet revealed the facility admitted Resident #27 on 12/16/2020 with medical diagnoses that included schizophrenia and unspecified dementia.</p>		