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 |
|---|---|---|---|
| | 61BH | A. BUILDING: _____ B. WING _____ | 08/29/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRIAR HILL REST HOME | 1201 GUNTER ROAD FLORENCE, MS 39073 |

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| M 000 | Initial Comments<br><br>The State Agency (SA) conducted a licensure survey from 8/26/19 to 8/29/19. During the survey the SA determined the facility was not in compliance with the Minimum Standards for The Institutions For The Aged And Infirm. The SA cited the state statute M620, M635, and M855..<br><br>The census at the time of entrance was 58, and the facility was certified for 60 beds. | M 000 | | |
| M 620 SS=D | 45.21.4 Urinary incontinence<br><br>Urinary incontinence. Residents with urinary incontinence shall be assessed for need of bladder retraining program. An indwelling catheter will not be used unless the resident ' s clinical condition indicates that catheterization is necessary. These residents shall receive treatment and services to prevent urinary tract infections.<br>Level II<br><br>Based on observation, staff interview, record review an facility policy review the facility failed to provide incontinent care to prevent cross contamination for one (1) of two (2) residents observed for incontinent care Resident #33<br><br>Findings include:<br><br>An observation on 08/26/19 at 9:18 AM revealed a strong urine smell in Resident #33's room.<br><br>A review of the facility policy "Incontinent Care", without a date, revealed it was the policy of the facility to provide routine preventive skin, perineal care to residents after incontinent episode. The policy listed in the steps to remove gloves and | M 620 | 1. An in-service education program was done on September 20, 2019 by the Director of Nursing Immediate action(s) taken for the resident(s) found to have been affected include:<br>Resident #33 was assessed on August 28, 2019 by the Director of Nursing with no sign or symptoms of infection noted and with no negative outcome. Certified Nursing Assistant (CNA #1) failed to follow the policy concerning infection control practices to include proper use of gloves and hand washing while providing incontinent care and perineal care.<br>In-service and competency skill check off for proper use of gloves and hand washing while providing incontinent care and perineal care was performed by Certified Nursing Assistant (CNA#1) and evaluated | 10/1/19 |



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 09/26/19

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| M 620 | Continued From page 1<br>discard, wash hands and apply clean gloves after discarding soiled towels and linen.<br><br>An observation on 08/28/19 at 04:51 PM with Certified Nursing Assistant (CNA) #1 revealed that during perineal care for Resident #33 used peri-wipes wiping front to back once and threw away. CNA #1 turned resident over and wiped over the buttocks and sacrum without changing gloves. CNA #1 then removed her gloves and put on a new pair of gloves without performing hand hygiene. A new brief was put on Resident #33 by CNA #1 and repositioned resident. CNA #1 removed her gloves and performed hand hygiene.<br><br>An interview on 08/28/19 at 4:53 PM with CNA #1 revealed she had just been hired two weeks ago and had completed a competency skills check off during orientation that included perineal care. CNA #1 said the policy of the facility was to wash hands between going from dirty to clean and said she should have washed her hands. CNA #1 said the concern was cross contamination.<br><br>An interview on 8/28/19 at 5:30 PM with Director of Nursing (DON) revealed the policy of the facility was to perform the hand hygiene between dirty and clean to prevent the possible spread of infection.<br><br>A review of Resident # 33's comprehensive care plan revealed the resident had a problem with bowel and bladder incontinence and needed assist with perineal cleansing as needed.<br><br>A review of Resident # 33's Minimum Data Set with an Assessment Reference Date of 7/15/19 revealed resident was always incontinent. | M 620 | by the Staff Development Nurse on August 30, 2019.<br><br>2. Identification of other residents having the potential to be affected was accomplished by:<br>The facility has determined that all residents that require incontinent care and perineal care have the potential to be affected.<br><br>3. Actions taken/systems put into place to reduce the risk of future occurrence include:<br>An in-service education program concerning infection control practices to include proper use of gloves and hand washing while providing incontinent care and perineal care was began on August 30, 2019 by the Staff Development Nurse for the Certified Nursing Assistants (CNA s).<br><br>Competency skills check off s for incontinent care and perineal care by the Director of Nursing or Staff Development Nurse began on August 30, 2019 with the Certified Nursing and Staff Development Nurse for nursing staff concerning infection control practices to include proper use of gloves and hand washing while providing incontinent care and perineal care.<br><br>4. How the corrective action(s) will be monitored to ensure the practice will not recur: | |

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| M 620 | Continued From page 2 | M 620 | The Director of Nursing Services or Registered Nurse or Staff Development Nurse will complete a random competency skills check off of proper use of gloves and hand washing while providing incontinent care and perineal care weekly with three (3) Certified Nursing Assistant (CNA s) for four (4) consecutive weeks beginning the week of September 2, 2019, two (2) weeks beginning October 1, 2019 and once (1) beginning November 1, 2019. These Certified Nursing Assistant check off s will be completed to ensure that appropriate infection control practices are being followed.<br>Staff Development Nurse will complete a competency skills check off with Certified Nursing Assistant (CNA) during orientation that will include proper use of gloves and hand washing while providing incontinent care and perineal care.<br>Findings of this validation check offs performed by the direct care staff will be discussed monthly with the Administrator. The Quality Assurance monthly meeting will make recommendations and changes as needed until such time consistent substantial compliance has been met. | |
| M 635 | 45.21.7 Gastric feeding<br><br>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 | M 635 | | 10/1/19 |

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| M 635 | Continued From page 3<br>eating skills.<br><br>This Statute is not met as evidenced by:<br>Level II<br><br>Based on observation, staff interview, record review and facility policy review, the facility failed to provide Resident #38's Percutaneous Endoscopic Gastrostomy (PEG) tube site care in a manner to prevent the possibility for cross contamination and/or infection. This concern was identified for one (1) resident observed for PEG tube site care out of a total of four (4) wound care observations.<br><br>Findings Include:<br><br>Review of a typed statement on the facility's letterhead, dated August 25, 2019, and signed by the Director of Nurses (DON), revealed the facility did not have a policy for stoma site care.<br><br>A review of facility's policy titled, "Dressing Change" not dated, revealed, "A dressing change will be done to promote wound healing, prevent infection and to provide an opportunity for wound healing".<br><br>An observation, on 08/28/19 at 2:25 PM, revealed Registered Nurse (RN) #1 entered Resident #38's room to provide Enteral Feeding Care and stoma (site) care. RN #1 put gloves on as she was standing in the hall at the wound care cart. RN #1 wiped the tray with Sani-cloth bleach wipes. RN #1 removed her gloves and entered Resident #38's room. Licensed Practical Nurse (LPN) #1 entered the room to assist RN #1 in positioning the resident. RN #1 placed a red bag inside the garbage can by the Resident #38's bed. RN #1 placed a paper towel on the over bed | M 635 | 1. Immediate action(s) taken for the resident(s) found to have been affected include:<br><br>Resident #38 was assessed on August 29, 2019 by the Director of Nursing with no signs or symptoms of infection noted and with no negative outcome. Registered Nurse (RN#1) failed to follow the policy concerning infection control practices to include hand washing and stoma site care. In-service and competency skill check off for hand washing, and stoma site care was performed by Director of Nursing on August 30, 2019 for Registered Nurse (RN#1).<br><br>2. Identification of other residents having the potential to be affected was accomplished by:<br>The facility has determined that residents that need stoma site care have the potential to be affected.<br><br>3. Actions taken/systems put into place to reduce the risk of future occurrence include:<br><br>An in-service education program concerning infection control relating to hand washing and stoma site care was began on August 30, 2019 by the Director of Nursing with Registered Nurses and License Practical Nurses.<br><br>Competency skills check off s for hand | |

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| M 635 | Continued From page 4<br><br>table and placed the tray containing the supplies on the paper towel. RN #1 washed her hands and dried her hands with a paper towel and then used the same paper towel to turn the faucet off. RN #1 pulled the divider curtains between Resident #38's bed and her roommate's bed. RN #1 gloved and stated, "I should have washed my hands again after touching the curtains and gloving". RN #1 kept the gloves on and continued to provide care. RN #1 removed the soiled dressing from around the PEG tube stoma and placed it in the red biohazard bag. RN #1 removed her gloves, washed her hands and dried them with a paper towel and then used the same paper towel to turn the faucet off. RN #1 gloved, opened a pack of gauze, and took the gauze from the packet holding the gauze in her gloved hand. RN #1 poured normal saline onto the gauze she was holding in her hand. RN #1 took the gauze and wiped around the stoma, holding the tubing in the left hand, in a dabbing motion from one side of the stoma to the other side. RN #1 turned the gauze over and continued to wipe the stoma again. RN #1 took the gauze and rubbed an area on each side of the stoma trying to get dried exudate removed from the skin using the same gauze. RN #1 discarded the gauze in the red biohazard bag. RN #1 opened another pack of gauze, holding it in her gloved hand, and poured normal saline onto the gauze. RN #1 wiped the tubing in a circular motion, using the same spot on the gauze, around the tubing from the point of entry into the stoma continuing all the way up the tubing. RN #1 removed her gloves, washed her hands, dried her hands with a paper towel and used the same paper towel to turn the faucet off. RN #1 gloved, opened a sponge gauze and applied the gauze around the tubing and stoma site. RN #1 put a piece of tape onto the sponge to secure the dressing to the skin. RN #1 did not | M 635 | washing and stoma site care by the Director of Nursing and Staff Development began on August 30, 2019 with Registered Nurses and License Practical Nurses.<br><br>An in-service education program was done on September 20, 2019 by the Director of Nursing concerning infection control to include hand washing and stoma site care for nursing staff.<br><br>4. How the corrective action(s) will be monitored to ensure the practice will not recur:<br><br>The Director of Nursing Services or Registered Nurse or Staff Development Nurse will complete a random competency skills check off of hand washing and stoma site care weekly with one (1) Registered Nurse or License Practical Nurse for four (4) consecutive weeks beginning the week of September 2, 2019, two (2) weeks beginning October 1, 2019 and once (1) beginning November 1, 2019. These Registered Nurses and Licensed Practical Nurses check off s will be completed to ensure that appropriate infection control practices are followed.<br><br>Director of Nursing and Staff Development Nurse will complete a competency skills check off with Registered Nurses and Licensed Practical Nurses during orientation that will include hand washing and stoma site care.<br>Findings of this validation check offs performed by the direct care staff will be discussed monthly with the Administrator. The Quality Assurance monthly meeting | |

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| M 635 | Continued From page 5<br><br>date or initial the dressing. RN #1 picked up Resident #38's covers and placed them back over her. RN #1, using the same gloves, attempted to roll Resident #38 over in the bed with the assistance of LPN #1. RN #1 loosened the tape on Resident #38's brief to begin wound care to her coccyx. RN #1 realized she needed to go to the other side of the bed to assist Resident #38 over on to her left side so she could see the coccyx better from the right side. RN #1 moved the bed and went to the other side of the bed handling the brakes on the bed with her gloved hands and then handling the linens on the bed. RN #1 started back around the bed and she picked up trash on the floor at the foot of the bed. RN #1 threw the trash away and continued care with the same gloves on. RN #1 returned to the right side of Resident #38 pulling up on Resident #38's hip to view the coccyx. RN #1 kneeled down to view the coccyx taking her gloved hands and touching the hips and buttocks. RN #1 stated "the wound is closed so I want to use a different treatment on the wound. I need to go call the Nurse Practitioner and get a new order for a different treatment". RN #1 removed her gloves, washed her hands, dried her hands with a paper towel and turned the faucet off with the same gloves. RN #1 gathered trash and placed it in the red biohazard bag and exited the room placing the red biohazard bag into another red biohazard bag on her wound care cart. RN #1 pushed the wound care cart down the hall toward the nursing station stating, "I'm going to call the Nurse Practitioner now". RN #1 did not wash her hands after handling the trash and red biohazard bag.<br><br>An interview, on 8/29/19 at 8:30 AM, with RN #1 revealed, "I didn't realize I touched the faucet with the same paper towel until you told me. I did realize I touched the curtain and should have | M 635 | will make recommendations and changes as needed until such time consistent substantial compliance has been met. | |

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| M 635 | Continued From page 6<br><br>rewashed my hands. I do remember picking the trash up and continuing care with my gloves, but I didn't think about it until now. I remember rubbing the area around the stoma several times with the same gauze and I remember turning it over. I did turn the gauze around and around on the tubing. I was just so nervous. I stayed up last night remembering things I should have done better. I guess all of this would be an infection control issue".<br><br>An interview, on 8/29/19 at 11:13 AM, revealed the Director of Nursing (DON) stated, "RN #1 not performing Percutaneous Endoscopic Gastrostomy (PEG) stoma care properly was improper technique according to our policy. RN #1 should have used one gauze for each wipe made around the stoma and with the tubing. It could have caused the spread of infection with her using one gauze for multiple wipes".<br><br>Review of the facility's Education Training In-service, dated 4/19/19, revealed RN #1 attended an in-service on infection control, handwashing, universal precautions, and contaminated clothing policy.<br><br>Review of the facility's Education Training In-service, dated 8/23/19, revealed RN #1 attended an in-service on Handwashing practices and infection control.<br><br>An interview, on 8/29/19 at 1:13 PM, revealed the DON reported she cannot find a check-off competency for RN #1 regarding PEG tube care including stoma care. | M 635 | | |
| M 855 SS=D | 45.30.7 Food Preparation | M 855 | | 10/1/19 |

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| M 855 | Continued From page 7<br>Food Preparation. Foods shall be prepared by methods that conserve optimum nutritive value, flavor, and appearance. Also, the food shall be acceptable to the individuals served. A file of tested recipes shall be maintained to assure uniform quantity and quality of products.<br><br>This Statute is not met as evidenced by:<br>Level II<br><br>Based on observation, record review, staff interview, resident interview and facility policy review, the facility failed to honor Resident #44's food preferences, for one (1) of 19 resident dining observations.<br><br>Findings include:<br><br>A review of the facility's policy titled, "Alternate Foods for Food Preferences", with a revised date of 8/17, revealed the facility would serve food or beverages to meet individual resident food allergies, intolerance's, preferences or requests.<br><br>An interview and observation, on 8/26/19 at 11:51 AM, revealed Resident #44 stated she told the staff last week she didn't like broccoli and then pointed to it on her plate. Resident #44 said she didn't usually like spaghetti, but they didn't offer an alternative.<br><br>A review of Resident #44's tray card revealed the card did not list any likes or dislikes.<br><br>A review of Resident #44's current Comprehensive Care Plan revealed an intervention to offer food alternatives when appropriate for any meal and to maintain a list of food likes and dislikes. | M 855 | Immediate action(s) taken for the resident(s) found to have been affected include:<br>Dietary Manager discussed food preference with Resident #44 on August 28, 2019 and made corrections to Dietary tray card concerning broccoli and all other food likes and dislikes.<br><br>2. Identification of other residents having the potential to be affected was accomplished by:<br>The facility has determined that all residents that have food preferences have the potential to be affected by the deficient practice.<br><br>3. Actions taken/systems put into place to reduce the risk of future occurrence include:<br>Dietary staff were in-serviced August 30, 2019 on Resident Rights/Quality of Life and Food Preferences by the Dietary Manager. The Dietary Manager interviewed Residents concerning their food preferences beginning August 30, 2019 to ensure their food preferences are honored. A Validation Checklist was completed by the Dietary Manager on September 3, 2019 to determine if food preferences for six random residents were notated on meal tickets and during meal | |

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| M 855 | Continued From page 8<br><br>A review of the August 2019 Physician's Orders revealed an order for a Low Concentrated Sweets (LCS) diet.<br><br>An interview, on 8/28/19 at 2:16 PM, with the Dietary Manager (DM) revealed she completed the initial assessment on Resident #44. The DM said the preferences and dislikes would be entered by her into the computer. The DM said when she is notified after she has completed the assessments, she would enter those in the computer as soon as she knew about it. The DM also said the tray cards would have the dislikes listed with a (D) beside the food item. The DM confirmed Resident #44 did not have any listed on her tray cards. The DM said the server and the dietary aide would see the tray card during the tray line. The DM said she was not aware Resident # 44 did not like broccoli. The DM also confirmed the care plan said to follow the resident's preferences and agreed the resident has the right to her preferences.<br><br>A review of Resident #44's Minimum Data Set, with an Assessment Reference Date of 8/14/19, revealed her Brief Interview for Mental Status (BIMS) was 15, which indicated the resident was cognitively intact. | M 855 | service.<br>An in-service education program was done on September 20, 2019 by the Director of Nursing concerning Resident food likes and dislikes with the nursing staff.<br><br>4. How the corrective action(s) will be monitored to ensure the practice will not recur:<br>The Administrator or Dietary Manager will complete a Validation Checklist 2 x's a week for 2 weeks then weekly for 2 weeks then monthly for 2 months to determine if food preferences were notated on meal tickets and during meal service.<br>Findings will be reviewed with Administrator monthly to ensure menus meet resident food preferences. The Quality Assurance monthly meeting will make recommendations and changes as needed until such time consistent substantial compliance has been achieved as determined by the committee. | |