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
	MS38BM	A. BUILDING: _____ B. WING _____	06/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CARE CENTER OF MARION	6434 A DALE DR MARION, MS 39342

(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 615	45.21.3 Pressure sores Pressure sores. Residents with a pressure sore shall receive necessary treatment and service to promote healing and prevent the development of new pressure sores. Residents without pressure sores will not develop pressure sores unless the residents' clinical condition indicates they were unavoidable. This Statute is not met as evidenced by: Level III Based on observation, staff interview, record review, and facility policy review, the facility failed to prevent a resident from developing a heel pressure ulcer, as evidenced by failure to perform weekly assessments, and failure to ensure interventions were provided to prevent the pressure ulcer, for Resident #87, a resident who was at risk of a pressure ulcer, related to immobility and recent surgery. This affected one (1) of three (3) residents observed with pressure sores. Findings include: A review of a facility policy titled, "Prevention of Pressure Ulcers", revised October 2010, revealed to assess the resident's skin, according to facility protocol. Interview with the Director of Nursing (DON) on 6/20/19 at 10:20 AM, revealed the policy was to perform skin assessments weekly. An observation on 6/17/19 at 4:57 PM, revealed Resident #87 was up in wheelchair with a padded boot on the right foot. Review of an assessment, upon return from the hospital on 2/26/19, on the form "Nursing	M 615	1. Resident #87 skin audit was completed by assigned licensed practical nurse on 6/20/19. Wound to right heal improving and no new skin issues noted. 6/27/19 skin audit revealed no changes from previous week. No required changes to care plan for 6/20/19 and 6/27/19 skin audits. Resident Care Coordinators will audits weekly thereafter. 2. All resident with pressure ulcers and /or at risk for skin breakdown have the potential to be affected by the identified deficient practice. There are currently 10 residents with pressure ulcers. Resident Care Coordinator has been monitoring body audits since 6/20/19 and no other residents with pressure areas have had any missed body audits. 3. Director of Nursing began in-servicing nurses on 8/7/19 and will complete in-servicing all nurses by 8/15/19 on up-dating care plans for proper use of protective devices and weekly skin audits. Review of body audits began on 6/20/19 by Resident Care Coordinator. All residents with pressure ulcers will be monitored weekly by Resident Care Coordinators and/or Treatment nurse. 4. Resident Care Coordinators will report audit findings monthly to the Quality	8/15/19

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M 615	Continued From page 1 Admission History and Physical Assessment", revealed skin conditions would only be documented if there was a problem. There was no documentation of skin issues to Resident #87's right heel. The assessment revealed documentation of "dry" skin/island dressing intact to right hip and bruise to left foot, right hand and wrist, bilateral arms. The lower extremities were documented "not applicable".There were no weekly skin assessments documented from 2/26/19 until 3/19/19, and again no issues were identified on the assessment. A review of the Resident #87's Braden scale dated 2/26/19, completed by RN #2, revealed a score of "16", which indicated a "moderate risk" for skin breakdowns. A review of Resident #87's Care Area Assessments (CAA's) section on the Minimum Data Set (MDS), dated 3/5/19, indicated the care area Pressure Ulcer was triggered, and the decision to care plan was marked to proceed, related to Resident #87's declined mobility and continent status . A review of Resident #87's "Even Tracking Report" dated 3/6/19 revealed a care plan problem "at risk for skin breakdown related to increased need for mobility positioning and right hip fracture." There were no interventions for skin assessments and/or interventions for prevention of heel breakdown. Review of Nurse's Notes, dated 3/21/19, revealed Resident #87 became agitated and aggressive when staff attempted to perform daily care. Review of Nurse's Notes, dated 3/24/19 at 5:07 PM, revealed Licensed Practical Nurse (LPN) #5	M 615	Assurance (QA) committee for review and further action as needed.	

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M 615	Continued From page 2 was called to Resident #87's room and noted a pressure ulcer to the resident's right heel with some blackness noted around the area and the Charge Nurse then assessed Resident #87. A review of Resident #87's "Incident Case Report", dated 3/24/19 at 4:47 PM, revealed a noted pressure ulcer to the right heel with some blackness noted. The documentation on the incident report revealed the Nurse Practitioner was notified, footwear was on; the resident used a wheelchair and required assistance. A review of the Resident #87's care plan with a problem, dated 3/25/19, revealed an unstageable pressure injury to right heel-progression of wound to stage 3 pressure injury 4/30/19. The care plan had interventions with wound care, and off loading boot to right lower extremities every shift to keep heel floated at all times. A review of Resident #87's "Initial Wound Assessment", dated 3/24/29, revealed the wound was new and located on the right heel. The wound assessment also listed the etiology was "other, unstageable" with "slough/eschar" that measured 3 centimeters (cm) length by 4.6 cm width. A review of the Resident #87's "Weekly Wound Assessment" dated 3/25/19, revealed a "new" pressure ulcer with unstageable with slough/eschar that measured 2.8 cm length by 5.3 cm width by 0 cm depth, identified on 3/24/19, and signed by RN #3. Review of the Treatment Administration Record (TAR) for June 2019, revealed Off Loading Boot to right lower extremity every shift to keep heel floated at all times, initiated 3/25/19.	M 615		

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M 615	Continued From page 3 An interview on 06/19/19 at 1:36 PM, with RN #3, revealed Resident #87 did remove her boot, and she had to put the boot back on very often during the day. A review of Resident #87's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/26/19, revealed Section M0210 was documented "1" and Section M0300, F, was documented "1" indicating one (1) unstageable wound with slough and/or eschar. A review of Resident #87's physician's orders revealed an order, with a date of 4/30/19, clean right heel with wound cleanser, pat dry, apply Santyl ointment, cover with gauze and apply Allevyn heel to heel, and secure with Kerlix daily related to progression of wound to Stage 3 pressure injury. Review of a "Procedure Note", dated 5/9/19, by the Wound Doctor, revealed the pre-operation diagnosis was right heel ulcer and the procedure performed was selective debridement of right heel ulcer including non-viable slough and exudate with 2.4 x 1.5 cm debrided. A review of a facility statement dated 6/19/19, signed by the DON, revealed the facility believed that Resident #87's right heel wound was clinically unavoidable related to impaired mobility due to fracture, lab levels, weight loss, and refusal of care, however there were no documented interventions for the refusal of care by Resident #87. An interview on 06/19/19 at 10:21 AM, with Registered Nurse (RN) #3/Treatment Nurse, confirmed Resident #87 had a pressure ulcer on	M 615		

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M 615	Continued From page 4 her right heel and said the ulcer was facility acquired in March 2019. She said it was found on a weekly skin check over a weekend. RN #3 said Resident #87's ulcer started as a blister and quickly developed into a Stage 3. She stated the resident was able to move extremities freely but not able to walk. RN #3 said Resident #87 used her feet to "scoot" herself in the wheelchair. RN #3 also said the resident had not been going to the wound clinic, but the Wound Doctor had seen and debrided the wound. An interview on 06/19/19 at 11:16 AM, with RN #2, confirmed Resident #87's weekly skin audit was completed on 3/19/19, and the documentation revealed no skin problems. RN #2 stated the documentation indicated it was eschar on the wound care assessment completed on 3/25/19, by RN #3. She also confirmed the last prior skin assessment was completed on 2/26/19, on the form "Nursing Admission History and Physical Assessment" upon hospital return, which documented skin conditions would only be documented if there was a problem. RN #2 confirmed there was no documentation related to the right heel on the assessment. RN #2 confirmed there were no documented weekly assessments from 2/26/19 until 3/19/19. During an interview on 06/19/19 at 1:26 PM, Certified Nursing Assistant (CNA) #2 said she did not remember seeing a skin problem with Resident #87 before they found the ulcer on her heel. She said the resident wore tennis shoes and sandals before she went out to the hospital. She said when Resident #87 would walk, it was on the side of her foot. CNA #2 said the resident's sandals did not cover her heel. CNA #2 also said Resident #87 moved her own legs and positioned them independently.	M 615		

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M 615	Continued From page 5 An observation of Resident #87's wound care on 06/19/19 at 1:32 PM, provided by Registered Nurse (RN) #3, revealed the resident had a right heel ulcer, which measured 1.2 cm length by 1.3 cm width by 1.4 cm depth. The wound was located above the back of the heel about 0.5 inch from the bottom of the foot. The wound was round with distinct edges, pink and no discharge. An interview on 06/20/19 at 9:50 AM, with CNA #3, Bath Aide, revealed Resident #87 had always had a covering on her heel since she started bathing her. CNA #3 stated Resident #87 would complain of pain, but it was related to the right hip fracture. CNA #3 said the policy was to do a complete body check during the bath and to notify her nurse if any problems were noted. On 06/20/19 at 10:21 AM, an interview and observation with the DON and RN #3/Treatment Nurse, revealed one (1) pair of Resident #87's tennis shoes was a pink, size 7.5 with a stiff back that was indented halfway down the heel and had shoe laces. The DON placed the tennis shoe on Resident #87 and confirmed it would hit the area of the breakdown if she was wearing the shoes prior to the breakdown. RN #3, said the prevention measures should included a weekly body audit that was done by the LPN's, and Resident #87 would be at risk for breakdown from the recent hip fracture. RN #3 said once the wound was found, the boot was applied, weekly checks were performed by the RN Wound Care Nurse, and an air mattress was applied to the bed. RN #3 said the resident did not wear any shoes on the right foot since the wound was found. RN #3 confirmed it was eschar with a blister when she evaluated Resident #87's heel wound on Monday 3/25/19, which was originally	M 615		

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M 615	Continued From page 6	M 615		

found on 3/24/19. The DON said she would expect Resident #87 to be at risk for pressure ulcers after the surgery, related to her limited range of motion (ROM), and the care plan should address the CAA's and Braden score to determine if the resident's at risk. The DON said the facility policy was to complete weekly skin checks by the LPN's, but the nurses had only completed a weekly skin check on 3/19/19, since Resident #87's 2/26/19 hospital return. The DON then stated an investigation was completed by her on 6/19/19, with the review of the Resident #87's medical record. The DON did not have a reason as to why the investigation was done at this time, and did not provide a policy for the investigation.

An interview on 06/20/19 at 11:03 AM, with Resident #87's Medical Doctor (MD) revealed the facility had policies for preventive measures for wounds, but would have to review Resident #87's chart and call back. MD never returned the call.

An interview on 06/20/19 at 11:09 AM, with Licensed Practical Nurse (LPN) #4/MDS Nurse, revealed residents were evaluated for risk of skin breakdowns by the Braden scale, and the Care Area Assessments (CAA's) would trigger the care plan to be completed, with interventions to prevent breakdown.

On 06/20/19 at 11:31 AM, an interview with LPN #5 confirmed she was working the day the pressure ulcer was found on Resident #87's right heel. LPN #5 said she had been here about five (5) months and was one (1) of the nurses that took care of Resident #87. LPN #5 said CNA #4 called her to the resident's room, during the 3-11 shift, because Resident #87's "sock was soiled". LPN #5 said the drainage was brown tinted. She

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M 615	Continued From page 7 said Resident #87 would previously walk on the outside of her heels because her sandals were too small and had to get new shoes prior to the wound being found. LPN #5 said Resident #87 never complained of pain with right ankle/foot. LPN #5 said she notified the Charge Nurse and completed the incident report. An interview on 06/20/19 at 2:30 PM, with CNA #4, revealed she had been working in the facility since February of 2019. CNA #4 stated she was working the day the ulcer was found on Resident #87's right heel. CNA #4 said the resident had on the gray tennis shoes when she put her to bed that afternoon on 3/24/19. CNA #4 stated she took off Resident #87's shoes and the inside of the right shoe was wet and the sock was wet around the heel with a brown discharge stain. CNA #4 said she then notified LPN #5. CNA #4 said the facility policy was to check the skin every time you assist a resident and report to the supervisor any abnormal findings. An interview on 06/20/19 at 1:09 PM, with the DON, revealed the "16" on the Braden scale indicated the resident was at risk for skin breakdowns. The DON also said with the CAA's and the Braden scale, Resident #87 should have a care plan related to the risk of skin breakdown, with interventions in place. On 06/20/19 at 1:16 PM, an attempt was made to interview the Wound Doctor, but he was out of town and not available at his office.	M 615		