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
	25WC	A. BUILDING: _____ B. WING _____	C 03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW CREEK RETIREMENT CENTER	49 WILLOW CREEK LANE BYRAM, MS 39272

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M 000	Initial Comments The State Agency (SA) conducted four Complaint Investigations (CI MS #24189, CI MS #23825, CI MS #23818 and CI MS #23449), at the facility from 3/11/24 through 3/13/24. MS #24189 was investigated for Resident Neglect related to Pressure Sores. CI MS #23825 was investigated for Quality of Care regarding resident left wet for extended periods and no pressure sore precautions. CI MS #23818 was investigated for Accidents related to Falls. CI MS #23449 was investigated for Resident Neglect regarding Pressure Sores and for Quality of Care/Treatment regarding resident left wet for extended periods and inappropriate feeding assistance. 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 deficient practice at M615 related to CI MS #24189 and CI MS #23449. During the survey, M620 was also cited, unrelated to the complaint investigation.	M 000		
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 II Based on observation, interviews, record review, and facility policy review, the facility staff failed to provide treatment and services in a manner to promote the healing and prevent complications of	M 615	1. Immediate action(s) taken for the resident(s) found to have been affected include: The Director of Nursing Services (DNS) assessed resident #2 for any adverse outcomes related to the alleged deficient	4/15/24

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M 615	Continued From page 1 a pressure ulcer for one (1) of three (3) sampled residents with pressure ulcers. (Resident #2) Findings include: Review of the facility's policy, titled "Dressing Change" undated, revealed, "Policy: A dressing change will be done to promote wound healing, prevent infection and to provide an opportunity for wound assessment ..." Review of the facility's policy, titled "Hand Hygiene, reviewed 6/12/22, revealed "Policy: All staff will perform hand hygiene procedures to prevent the spread of infection...Policy Explanation and Compliance Guidelines: 6. Additional considerations: a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves." On 3/13/24 at 11:55 AM, an observation revealed the facility Treatment Nurse provided wound treatment for a Stage 2 pressure ulcer, with non-intact skin on the left upper back of Resident #2. After the Treatment Nurse removed the dressing from the wound, she removed her gloves and donned (put on) clean gloves without performing hand hygiene. During the procedure, the Treatment Nurse dropped the sterile calcium alginate dressing on the mattress, picked the dressing up and applied the dressing to the wound. The Calcium Alginate dressing was larger than the wound. The adhesive and edge of the Calcium Alginate bordered dressing used to cover the wound protruded past the wound margins. Record review of the "Instructions For Use" on the Calcium Alginate dressing package revealed	M 615	practice. The Treatment Nurse was in-serviced on proper handwashing and dressing changes on 3/13/2024. Following the in-service a competency assessment of proper handwashing and dressing changes was completed on 3/13/2024 by the DNS. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents with wounds have the potential to be affected. A review of physician orders in the electronic medical record was completed on 3-14-24 to identify potentially affected residents. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: All licensed nurses providing wound care were in-serviced on the facility□s policy on dressing changes and proper handwashing with donning/doffing gloves. In-services began on 3/13/2024 with the nurses working. All other nurses were in-serviced prior to next patient care assignment. On 3-22-24, the Quality Assurance/Performance Improvement (QAPI) Committee reviewed the dressing changes and proper handwashing with donning/doffing gloves policies. There were no recommended changes to the policy. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Director of Nursing Services (DNS) or Assistant Director of Nursing Services	

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M 615	Continued From page 2 " ...Make sure the dressing DOES NOT overlap the wound margins..." On 3/13/24 at 12:30 PM, during an interview with the Treatment Nurse, confirmed she had not performed hand hygiene after removal of the dressing from the resident's wound and removing her gloves, prior to donning fresh gloves and applying the calcium alginate dressing. The Treatment Nurse stated that she did not perform hand hygiene because the hand sanitizer was in a wall mounted dispenser, located next to the door, and she did not want to leave her clean field to use the hand sanitizer or the bathroom sink. The Treatment Nurse did not respond regarding the application of the Calcium Alginate dressing to the resident's wound, after being dropped on the mattress, nor did she respond to the Calcium Alginate dressing overlapping the wound margins. On 3/13/24 at 4:55 PM, in an interview the Director of Nurses (DON) confirmed that the facility policy on hand hygiene stated that hand hygiene was to be performed upon removal of used gloves and prior to the donning of clean gloves. A record review of the "Face Sheet" for Resident #2 revealed the facility admitted the resident on 9/15/23. The resident had diagnoses that included Pressure Ulcer of Unspecified Part of Back, Stage 2, Venous Insufficiency, and Type 2 Diabetes Mellitus. A record review of the March 2024 "Physician Orders," for Resident #2 revealed an order dated 3/05/24 "Clean Left upper back Stage 2 pressure ulcer with normal saline, apply Aquacel AG (Calcium Alginate) and cover with outer dressing.	M 615	(ADNS) will make rounds with wound care nurse weekly for four consecutive weeks beginning on 3/14/24 and ending on 4-12-24. No less than three residents weekly will be monitored for proper handwashing techniques and utilization of wound dressing per manufacturer□s instructions. Results of the weekly monitoring will be reviewed daily in Clinical Meeting. The in-service and weekly wound care monitoring will be reviewed in the QAPI meeting held on 4/15/24 to determine substantial compliance. Monthly wound care monitoring will continue for two additional months to ensure treatment nurses are providing wound care in accordance with facility policies. The results of monthly wound care monitoring will be reviewed by the QAPI Committee monthly for two months.	

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M 615	Continued From page 3 Change daily and PRN (as needed)."	M 615		
M 620	45.21.4 Urinary incontinence 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. This Statute is not met as evidenced by: Level II Based on observation, interviews, record review, and facility policy review, the facility failed to provide care and services for a resident with an indwelling urinary catheter in a manner to prevent the potential for a urinary tract infection (UTI) for one (1) of two (2) sampled residents with indwelling urinary catheters. (Resident #6) Finding include: Record review of the facility policy titled, "UTI Prevention with Indwelling Catheter Use," dated 1/27/2015, revealed, "Policy: A resident with an indwelling catheter is susceptible to urinary tract infections... Policy Explanation ... 3. Urinary drainage tubing should be positioned so as not to touch the floor..." On 3/12/24 at 12:40 PM, an observation revealed Certified Nursing Assistant (CNA) #1 answered the call light for Resident #6, who was seated on the toilet in her room. The resident's catheter	M 620	1. Immediate action(s) taken for the resident(s) found to have been affected include: The certified nursing assistant (CNA) identified was immediately in-serviced on the facility□s policy on Urinary Tract Infection (UTI) prevention with indwelling catheter use. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that any resident with an indwelling catheter is at risk. A review of physician orders in the electronic medical record was completed on 3-14-24 to identify all residents potentially affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: On 3-12-24 CNA #1 was in-serviced on the facility□s UTI prevention with indwelling catheter use policy. All CNA□s and nurses working on 3-12-24 were	4/15/24

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M 620	Continued From page 4 drainage bag and approximately three (3) inches of drainage tubing were lying on the floor next to the toilet. On 3/12/24 at 12:45 PM, in an interview with CNA #1, she confirmed the catheter drainage bag and tubing should not have been on the floor due to the risk of urinary tract infection. On 3/13/24 at 4:20 PM, an interview with Medical Doctor (MD) #1, he confirmed that catheter drainage bag and tubing should be kept off of the floor due to the risk of urinary tract infection. On 3/13/24 at 4:55 PM, during an interview the Director of Nurses (DON) confirmed that catheter drainage bags and drainage tubing should not be on the floor and that bags and tubing laid on the floor could increase the risk of a urinary tract infection. Record review of the "Face Sheet" for Resident #6 revealed the facility admitted the resident to the facility on 11/21/23, with diagnoses that included Unspecified Hydronephrosis and Cognitive Communication Deficit. Record review of the March 2024 "Physician Orders" revealed, an order dated 11/21/23 "Insert 16F (French, size of catheter) 10cc (centimeter) bulb indwelling foley catheter r/t (related to) hydronephrosis."	M 620	in-serviced on the importance of not allowing the urinary drainage tubing to touch the floor due to increased risk of urinary trac infection. All other direct care staff were in-serviced prior to next patient care assignment. In-service training included observation of each CNA performing the procedure. A Validation Checklist was completed for every CNA to determine if the individual was performing the procedure correctly. On 3-22-24 the Quality Assurance/Performance Improvement (QAPI) Committee reviewed the UTI prevention and indwelling catheter use policy with no recommended changes to the policy. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Director of Nursing Services (DNS) or Assistant Director of Nursing Services (ADNS), will complete weekly validation checklists of CNAs performing perineal care weekly for four consecutive weeks beginning on 3/15/2024 and ending on 4/12/24. Results of those weekly validation checklists will be reviewed in daily Clinical Meeting. The in-service and weekly validation checklists will be reviewed in the QAPI meeting held on 4/15/24 to determine substantial compliance. Monthly validation checks will continue for three months to ensure CNAs are performing perineal care in accordance with our facility□s policy. The Validation checklists will be reviewed by the QAPI Committee monthly for two months.	