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
	24LA	A. BUILDING: _____ B. WING _____	C 07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW NURSING CENTER	16411 ROBINSON ROAD GULFPORT, MS 39503

(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 000	Initial Comments The State Agency (SA) conducted a Complaint Investigation (CI), MS#25586 at the facility on 07/02/24. CI MS #25586 was investigated related infection control regarding hand hygiene. During the survey, the SA determined the facility was not in compliance with the the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements and cited M1570.	M 000		
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. 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:	M1570		8/13/24

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M1570	Continued From page 1 Level II Based on observation, interviews, record review, and facility policy review, the facility failed to ensure infection control measures were consistently implemented to prevent the development and/or transmission of infection, for one (1) of four (4) observations of staff entering and exiting residents' rooms. Findings include: Record review of the facility's policy titled, "Hand Hygiene: Clean Hands Save Lives," with date implemented 1/21/21 revealed, " ... It is the policy of this facility that hand hygiene will be handled as follows: ... Hand hygiene is a way of cleaning one's hands that substantially reduces potential pathogens (harmful microorganisms) on the hands ... Facts to Consider: ...Germs can spread from ...surfaces when you ...touch a contaminated surface or objects ...Washing hands can keep you healthy and prevent the spread of ...infections from one person to the next ..." Record review of the facility's policy titled, "Perineal Care Policy," revised 2/21 revealed, " ... " ...Policy: Peri care is to be performed following this procedure to ensure ... cross contamination if avoided .... remove gloves ...wash hands with soap and water." On 7/2/24 at 12:15 PM, during an observation and interview Certified Nurse Aide (CNA) #1, was observed coming out of a resident's room on the 400 Hall, with a brief rolled up in her gloved hands. CNA#1 was observed walking down the hall to the soiled utility room and opened the door with her gloved hand and entered the room. CNA	M1570	1. On 7/2/24, Certified Nursing Assistant (CNA) #1 Was observed coming out of a resident's room on the 400 hall with a brief rolled up in her gloved hands. CNA #1 was observed walking down the hall to the soiled utility room and opened the door with her gloved hand and entered the room. CNA #1 was not observed using hand sanitizer or washing her hands. On 7/2/24 CNA #1 was immediately educated by Quality Assurance (QA) nurse #2 on hand hygiene, proper peri care and on how to handle soiled linen and trash. 2. All residents are at risk for this deficient practice. 3. On 7/5/24 an in-service on Hand Hygiene Policy, Infection Prevention Control and Program Policy, Handling Soiled Linen and Trash Policy and Perineal Care Policy was given to all staff by (QA) nurse #1 and is ongoing. In addition staff was educated where to locate assessable trash bags. Trash bags will be centrally located in the linen closets and to be accessed prior to entering resident's rooms. All staff will be competent on prevention of cross contamination. 4. Quality Assurance (QA) nurses will complete three return demonstrations on hand hygiene weekly beginning 7/15/24 X four weeks, then monthly X three months. Results will be brought to the monthly QA meeting beginning on 8/13/24 X three months. QA nurses will monitor staff on handling soiled linen and trash three X	

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M1570	Continued From page 2 #1 was not observed using hand sanitizer or washing her hands. During an interview with CNA #1, she confirmed that she had a brief in her gloved hands. She explained she did not have a trash bag to put the brief into, so she just took it to the soiled room. She reported the brief should have been placed in a trash bag and then taken to the soiled room and she knows not to wear gloves in the hallway. On 7/2/24 at 12:50 PM, during an interview with the Infection Preventionist (IP) Nurse/Registered Nurse #1, she confirmed a staff member should never come out of a resident's room with a soiled brief in their hands and gloves on. The IP Nurse stated all staff have had education regarding the importance of not wearing gloves in the hallways. The IP Nurse added that CNA #1 should have placed the brief in a bag and disposed of it properly. At 1:00 PM on 7/2/24, during an interview with the Director of Nursing (DON), she confirmed CNA #1 had reported to her that she was wearing gloves and had a brief rolled up in her hands while she transported the soiled brief to the soiled utility room. The DON stated she expects all staff to follow infection control guidelines at all times.	M1570	weekly beginning 7/15/24 X four weeks then monthly X three months. Results will be brought to the monthly QA meeting beginning on 8/13/24 X three months.	