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
	32JE	A. BUILDING: _____ B. WING _____	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEFFERSON COUNTY NURSING HOME	910 MAIN STREET FAYETTE, MS 39069

(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 an annual recertification survey at the facility from 5/12/2025 through 5/15/2025. 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 requirements and cited M 620.	M 000		
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 reviews, and facility policy reviews, the facility failed to ensure incontinent residents received appropriate care and services to prevent the possibility of a urinary tract infection for one (1) of two (2) residents observed for incontinent care (Resident #8). Specifically, the facility failed to provide timely incontinence care and maintain cleanliness, which placed the resident at risk for skin breakdown and urinary tract infection. Findings Include: A record review of the facility's "Perineal Care" policy with a revision date of 1/2025 revealed: "It is the practice of this facility to provide perineal	M 620	M620: The facility failed to ensure that appropriate and timely incontinence care was provided for Resident #8. Certified Nurse Aide staff did not provide incontinence care in accordance with facility policy or professional standards, resulting in prolonged exposure to urine, soiled clothing and equipment, and increased risk of urinary tract infection and skin breakdown. 1. Corrective Action for Resident #8 * Resident #8 was immediately provided with complete incontinence care and hygiene, including clothing change and wheelchair cleaning May 13, 2025 by Certified Nurses Aide number one and	6/30/25

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M 620	Continued From page 1 care to all incontinent residents during routine bath and as needed in order to promote cleanliness and comfort, prevent infection to the extent possible and to prevent and assess for skin breakdown..." On 05/13/25 at 3:15 PM, an observation of peri-care being performed by Certified Nursing Assistant (CNA) #1, assisted by CNA #2, revealed CNA #1 removed Resident #8's brief, which was heavily soiled with amber-colored urine and emitted a strong urine odor. The resident's wheelchair and pants were also soaked in urine. On 05/13/25 at 3:32 PM, in an interview, CNA #1 confirmed the brief was heavily soiled with amber-colored urine. She confirmed the resident 's chair and pants were also heavily soiled. She stated she was assisting CNA #2 and did not know when the resident was last checked or changed. On 05/13/25 at 3:36 PM, CNA #2 confirmed in an interview that the chair, pants, and brief were heavily soiled with urine. She stated she changed Resident #8 around 10:30 AM, right before lunch. CNA #2 acknowledged she was supposed to check the resident every two hours but had not done so because she was busy. She confirmed that the resident had not received peri-care for over four and a half hours. CNA #2 stated she is expected to provide peri-care every two hours. She acknowledged the resident could develop a urinary tract infection and skin infection from the delay in care. On 05/14/25 at 11:50 AM, the Director of Nursing (DON) stated in an interview that Resident #8 should be checked and changed every two hours	M 620	two. A full skin assessment was completed to access for irritation or breakdown. on May 13, 2025 by the Treatment Nurse. The incident was reported to the Charge Nurse and Director of Nursing DON on May 13, 2025, and immediate documentation was completed. Certified Nursing Aide CNA # 1 and Certified Nursing Aide CNA #2 were immediately, counseled, and provided one-on-one education on proper perineal and incontinence care procedures by the Staff Development Nurse and educated by an outside RN on May 30, 2025. * Resident #8's care plan was reviewed and updated May 19, 2025 to reinforce incontinence care frequency and check reminders by the Minimum Data Set Nurse MDS. 2. Identification of Other Residents Who May Have Been Affected * The facility completed and audit of all incontinence residents on May 19, -23, 2025 to ensure timely and proper incontinence care was being provided, access for any signs of skin breakdown or infection risk. Any resident found to have issues with hygiene, documentation, or delayed care received: Immediate hygiene intervention, A nursing assessment, and Updated interventions in their care plans. 3. Systemic Changes to Prevent Recurrence All Certified Nursing Aide CNAs were	

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M 620	Continued From page 2 if soiled. She further stated that if a resident is a heavier wetter, they should be checked every hour. She confirmed that her expectation of CNAs is to check and change residents every two hours to ensure they remain dry and clean. The DON acknowledged that residents left soiled for extended periods are at risk for skin breakdown and skin infections. A record review of Resident #8's Admission Record revealed an original admission date of 08/22/06, with diagnoses including acute kidney failure and mild intellectual disabilities. A record review of the Minimum Data Set (MDS) for Resident #8, conducted 3/20/25, revealed a Brief Interview for Mental Status (BIMS) score of 3, indicating the resident was severely cognitively impaired and reliant on staff for care.	M 620	in-serviced on the facility's Perineal and Incontinence Care on May 30, 2025 Policy including: Frequency of checks and care (per schedule and as needed), Proper technique for cleansing, drying, and redressing, Documentation and verbal reporting of soiled clothing or risk factors to nursing staff. The facility implemented scheduled incontinence rounds every one to two hours per the resident care plan during waking hours, with documentation logs monitoring by Charge Nurses on May 19, 2025, Spot check of incontinence care will be completed by Charge Nurses or Staff Development Nurse each shift starting May 19, 2025. Environmental services were instructed to check wheelchairs for cleanliness during room rounds and report any soiling to the charge nurse. starting May 19, 2025. Care plans of all incontinent residents were reviewed to ensure they reflect individualized toileting and hygiene needs Starting May 19, 2025 4. Monitoring and Quality Assurance The Staff Development Nurse or Day Shift Supervisor will perform audits on five incontinent residents per week for 12 weeks, then monthly for three months checking starting May 19, 2025: * Timeliness and quality of incontinence care, * Cleanliness of resident clothing and mobility devices, * Documentation in Certified Nurse Aide flow sheets or POC logs. * Audit results will be reported monthly to	

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M 620	Continued From page 3	M 620	the Quality Assurance Performance Improvement Committee for 6 months starting June 26, 2025 for evaluation and changes	