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
	66SR	A. BUILDING: _____ B. WING _____	08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL STONE COUNTY NURSING & REHABILITA	1436 EAST CENTRAL AVENUE WIGGINS, MS 39577

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M 000	Initial Comments The State Agency (SA) conducted an annual recertification survey form 8/2/2021 to 8/5/2021. The facility was found to not be in compliance with the Minimum Standards of Operation for Institutions for the Aged or Infirm, state licensure requirements and M 500 was cited for Resident Rights.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a	M 500		9/8/21

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pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action;

4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record;

5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal;

6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law;

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M 500	Continued From page 2 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical	M 500		

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M 500	Continued From page 3 record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level III Based on observation, interviews, record reviews and facility policy review the facility failed to medicate the resident prior to providing wound care for one (1) of three (3) wound care observations Resident #31.	M 500	Resident #31 was medicated for pain on 8/4/21 at 11:30 am with Ultram 50mg ordered as a one-time dose by the Nurse Practitioner. Resident #31 interviewed by Licensed Practical Nurse #1 and confirmed pain relief. On 8/4/21 orders were received for Ultram 50mg every 12 hours as needed for pain. Prior to receiving wound care, Resident #31 will be	

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M 500	Continued From page 4 Findings Include: Review of the facility's policy, "Pain Management ", dated 2020, revealed, "Policy: The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences... The facility will utilize a systematic approach for recognition, assessment, treatment and monitoring of pain...1. In order to help a resident attain or maintain his/her highest practicable level of physical, mental, and psychosocial well-being and to prevent or manage pain, the facility will: a. Recognize when the resident is experiencing pain and identify circumstances when the pain can be anticipated. b. Evaluate the resident for pain upon admission, during ongoing scheduled assessments, and when a significant change in condition or status occurs (e.g., after a fall, change in behavior or mental status, new pain, or an exacerbation of pain) c. Manage or prevent pain, consistent with the comprehensive assessment and plan of care, current professional standards of practice, and the resident's goals and preferences...3. Facility staff will be aware of verbal descriptors a resident may use to report or describe their pain. Descriptors include but are not limited to: d. Hurting or aching...Pain Assessment:...2. Based on professional standards of practice, an assessment or evaluation of pain by the appropriate members of the interdisciplinary teams (e.g., nurses, practitioner, pharmacists, and anyone else with direct contact with the resident) may necessitate gathering the following information, as applicable to the resident:...b. Asking the patient to rate the intensity of his/her pain using a numerical scale, a verbal or visual	M 500	assessed for pain as stated in the Plan of Care. The facility recognizes that all residents receiving wound care could potentially be affected by the deficient practice. All residents requiring wound care were reviewed on 8/4/21 by the Assistant Director of Nursing for a current pain management regimen. All residents receiving wound care were assessed for pain on 8/4/21 by RN #3 and medicated if needed. Prior to receiving wound care, Residents will be assessed for pain as stated in the plan of care. A one-on-one in-service was conducted by the Director of Nursing and Assistant Director of Nursing on 8/4/21 with RN #3 regarding assessment of pain prior to administering wound care and proper procedure for addressing pain when residents verbalize pain during wound care. All Registered Nurses, Licensed Practical Nurses, and Certified Nursing Assistants (100%) were in-serviced on 8/5/21 by the director of nursing on pain management, pain assessment to include prior to and during wound care. One-on-one wound care observation was completed with RN#3 on 8/5/21 by the Assistant Director of Nursing. The Director of Nursing, Assistant Director of Nursing or Staff Development Director, will conduct weekly wound care observations on 2 residents beginning 8/9/21 for 8 weeks to ensure compliance with pain management. The results of the wound care observations will be discussed at the Patients at Risk meeting weekly beginning on August 13, 2021 and lasting for 8	

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M 500	Continued From page 5 descriptor that is appropriate and preferred by the resident". Review of Resident #31's Physician Orders, dated August 2021, revealed orders for the following, Acetaminophen 325 milligram (mg) tablet 650 MG by mouth every four (4) hours as needed for pain/ fever, dated 7/14/21; Pressure ulcer of sacral region, stage 2 to sacrum wound, cleanse with normal saline, pat dry, apply promogram to wound bed, cover with dry foam dressing, change every 72 hours; Pressure ulcer of left ankle, unstageable to left malleolus wound cleanse with normal saline pat dry, apply promogran to wound bed. Cover with dry foam dressing. Change every 72 hours, dated 7/30/21; Pressure ulcer of the left hip stage 2 Santyl ointment cleanse left hip wound with normal saline pat dry using 4X4 gauze, apply Santyl to wound bed daily and cover with dry dressing, dated 8/4/21. On 8/4/21 at 11:05 AM, the SA observed wound care on Resident #31 by Registered Nurse #3 (RN). RN #3 was assisted by Certified Nursing Assistant #1(CNA). RN #3 did not assess Resident #31 for pain prior to beginning wound care. Resident #31 started to complain about pain during the wound care to his left hip. RN #3 continued with the wound care even though Resident #31 had complained of pain. Upon completing the wound care to the left hip, RN #3 began wound treatment to Resident #31's sacrum. Resident #31 had facial grimacing and stated repeatedly that his butt was hurting. RN #3 continued with the wound care to the sacrum and did not stop to offer pain medication to the resident. The SA asked RN #3 if Resident #31 had any pain medication and she replied that she knew he did not have any thing (pain medication)	M 500	weeks. The results of the wound care observations will be discussed at the Quality Assurance Committee Meeting and corrective action will be monitored and evaluated by the committee. The Quality Assurance Committee meets at least quarterly and more often as needed, the revisions will be developed and approved by the Quality Assurance Committee to ensure the plan of correction is achieved and sustained. A Quality Assurance meeting was held on August 26, 2021. The next Quality Assurance meeting is scheduled for September 23, 2021. The QA committee includes but not limited to the Medical Director, Nurse Practitioner, Administrator, Director of Nursing, Assistant Director of Nursing, Staff Development, Infection Control RN, and at least 2 members of the facility staff.	

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scheduled to take today. RN #3 continued with the dressing change to the sacrum after being asked by SA. RN #3 measured the wound with a ruler and used a cotton tipped applicator to check the depth of the wound. The wound measured 3.50 cm length x 2.50 cm width with depth of 0.2 cm. Resident #31 continued to repeat "my butt hurts really bad". After RN #3 had completed the wound care, Licensed Practical Nurse (LPN) #1 entered the room with Ultram 50 milligram (mg) crushed in chocolate pudding for Resident #31. LPN #1 asked Resident #31 what his pain level was on a scale of one (1) to ten (10) and he replied it was a ten (10). Resident #31 took the Ultram in the pudding. RN #3 and CNA #1 asked Resident #31 if they could change his brief after he received his pain medication, but he repeatedly declined and stated his butt was hurting.

A review of the August 2021 Medication Administration Record (MAR) revealed Resident #31 did not receive any pain medication prior to wound care by RN #3 on 8/4/21.

On 8/4/21 at 5:03 PM, in an interview with RN #3, the Wound Care Nurse, she admitted she should have asked Resident # 31 about his pain his level before she started wound care. She stated she does not know why she did not ask the resident. She stated, "I don't if it was because I was nervous", and that she continued with wound care because she did not want to leave the wound open. She stated it is more important that the resident not be in pain during wound care than being concerned about the wound being uncovered. She stated she should have stopped the wound care and got the resident some pain medication immediately. She confirmed that pain can have a negative effect on the resident and

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she knew he did not have any scheduled or routine pain medications ordered by the physician.

On 8/4/21 at 5:14 PM, in an interview with License Practical Nurse #1 (LPN), Admissions Coordinator, stated she contacted the Nurse Practitioner (NP) because she felt as if the resident needed something for pain and that is why she gave him the Ultram 50 mg. The Ultram 50 was a one time order. She stated she went back to check on the resident after giving him medication and he was fine. She stated RN#3 should have given him pain medication as soon as Resident #31 complained of pain. She stated she felt like the Tylenol that was ordered would not help with the pain and she believed something was hurting him since he said his pain level was a 10. She stated it is unusual for Resident #31 to yell out during wound care. She confirmed RN #3 should have stopped the care and gave the resident pain medication when he first complained of pain. She stated that during wound care when a resident is in pain, it can cause the resident to have mental changes. She stated the resident's wound cannot heal properly if he is in pain during care and may cause a resident to refuse wound care the next time. She stated when a resident refuses wound care that it can lead to an infection.

On 8/4/21 at 5:43 PM, in an interview with RN#1, Director of Nursing (DON), stated she spoke with RN #3 regarding giving pain medication prior to wound treatments. She stated RN #3 told her she felt bad because she did not stop the wound care when Resident #31 was in pain. She stated RN #3 should have assessed the resident for pain before starting wound care. She stated when a nurse is doing wound care and the resident is in

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pain, the nurse should stop the wound care, and give pain medication, and then proceed after the resident has received medication. She stated the wound care nurse should have asked the resident's LPN to administer his pain medication and then let her know so that she may provide wound care. She stated by not administering pain medication before wound care., Resident #31 will probably refuse wound care.

On 8/4/21 at 5:54 PM, in an interview with RN #2, the Assistant Director of Nursing (ADON), she stated if she was doing wound care on a resident and they complained of pain, she would stop and get an order for pain medication, and after she gave the pain medication, she would wait until the medication became effective before continuing wound care. She stated RN #3, should have stopped the wound care and called the NP. RN #2 stated she completed a wound care check off (competency) with RN #3 and confirmed that was trained to assess residents for pain prior to beginning wound care. RN #2 confirmed RN #3 should have assessed the resident for pain before beginning wound care. She stated doing wound care on a resident in pain can cause the resident to have emotional pain.

Review of Resident #31's Face Sheet revealed an initial admission date of 2/2/21 and a readmission date of 7/14/21. Medical diagnoses include Pressure Ulcer of the left ankle, unstageable, Pressure Ulcer of the sacral region, stage 2, Muscle Spasms, Pressure induced deep tissue damage of the left hip and Anxiety Disorder.

Review of Resident #31's "Comprehensive Care Plan", dated 2/5/21, with a goal target date of 11/4/21, revealed he has an alteration in comfort

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related to mild pain, arthritis, a history of muscle spasms, and a history of wounds. The care plan goal is that the resident will express relief of pain after receiving pain reliving measures. The care plan interventions include pain assessment as needed, allow adequate time for pain medications to take effect prior to resuming care and/or treatment. Pain medications include: Tylenol and Baclofen and to document the effectiveness of pain medication as needed.

Record review of Physician orders, dated 8/4/21, revealed Ultram 50mg PO (by mouth) q (every) 12 hours PRN (as needed) was ordered at 11:30 AM.

A review of the facility's Emergency Drug Kit sign out slip reveals Ultram 50 mg was signed out on 8/4/21.

Record review of the MAR revealed Ultram 50 mg was given at 11:30 AM.

A Review of the significant change Minimum Data Set (MDS) with an Assessment Record Date (ARD)date of 7/20/21, revealed a Brief Interview of Mental Status (BIMS) score of seven (7). A BIMS of 7 indicates Moderately Cognitive Impaired.