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
	30SR	A. BUILDING: _____ B. WING _____	07/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNPLEX SUB-ACUTE CENTER	6520 SUNSCOPE DRIVE OCEAN SPRINGS, MS 39564

(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 recertification survey from 7/16/19 to 7/19/19. During the survey the SA determined the facility was not in compliance with the Minimum Standards for The Institutions For The Aged And Infirm. The SA cited the state statute M620. The census at the time of the survey entrance was 46, and the facility was licensed for 98 beds.	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. Level II Based on observation, staff interview, record review and facility policy review, the facility failed to provide catheter care in a manner to prevent the possibility of trauma to the urethra and a Urinary Tract Infection for three of three (3 of 3) residents reviewed for catheters and catheter care observation, Resident #36 Findings include: Record review of the facility's policy titled, "Catheter Care, Urinary", dated August 25,2014 revealed the steps in the procedure for male residents included to use a washcloth with warm water and soap to cleanse around the meatus. Cleanse the glans using circular strokes from the	M 620	This Plan of correction does not constitute an admission or agreement by the provider, Sunplex Subacute Center, of the truth of the facts alleged or conclusion set forth in this Statement of Deficiencies. This plan of correction has been respectfully developed solely because it is required by State and Federal Law. • Resident #36 was assessed by the Wound Care Registered Nurse on 7/18/19 for any negative physical findings related to Certified Nursing Assistant (CNA) #1 not providing catheter care in a manner to prevent the possibility of trauma to the urethra and a Urinary Tract Infection with no negative findings noted. Proper catheter care was performed for Resident	8/23/19

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M 620	Continued From page 1 meatus outward. Change the position of the washcloth with each cleansing stroke. With a clean washcloth, rinse with warm water using the above technique. Return foreskin to normal position. Use clean washcloth with warm water and soap to cleanse and rinse the catheter from insertion site to approximately four inches outward. Record review of the facility's training titled, Post Test Catheter Care, revealed Certified Nursing Assistant (CNA) #1 was trained on catheter care on 6/29/18. Record review of Resident #36's Lab Report, dated 6/25/2019, revealed a Urine Culture and Sensitivity (C&S) report was positive for with Vancomycin Resistant Enterococcus (VRE). Record review of the Physicians Orders revealed an order, dated 7/1/19, for Contact Precautions due to VRE in the Urine An observation, on 07/18/19 at 12:21 PM, revealed Certified Nursing Assistant (CNA) #1 provided Resident #36's catheter care. Observations during the catheter care revealed CNA #1 failed to rotate the wipes. CNA #1 failed to change the area of the wipe while cleaning the penis. CNA #1 also failed to secure the tip of the catheter to prevent trauma to the meatus. During an interview, on 07/19/19 at 9:44 AM, (CNA) #1 confirmed she failed to secure the tubing while cleaning the catheter tubing. CNA # 1 said she thought she rotated the wipes, but she was nervous. During an interview, on 07/19/19 at 9:48 AM the Director of Nursing (DON) confirmed CNA #1	M 620	#36 by the Wound Care Resident Nurse on 7/18/19. CNA #1 was in-serviced on 7/18/19 by the Director of Nursing regarding the policy for proper cleaning during catheter care and proper securing of the tip of the catheter while performing catheter care. • The facility recognizes that all residents with catheters, two (2), could have the potential to be affected by the same deficient practice. Two (2) residents with catheters had catheter care observed by The Wound Care Registered Nurse on 7/18/19 to ensure that proper catheter care was provided with no concerns noted. • The Director of Nursing (DON) in-serviced all nursing staff on providing proper catheter care on 8/9/19. New catheter care check offs for all CNAs were initiated on 8/15/19 by the Director of Nursing, Transitional Care Manager Registered Nurse, the Minimum Data Set Licensed Practical Nurse, and the Wound Care Registered Nurse. A catheter care education packet with a post-test was initiated for all CNAs on 8/9/19 by the Director of Nursing. All newly hired CNAs will complete a catheter care check-off, education packet and post-test prior to performing any catheter care in the facility. • The Transitional Care Unit Registered Nurse will observe one resident and document an audit for catheter care twice a week for four (4) weeks, then once a week for eight (8) weeks to ensure proper catheter care is being performed beginning 8/19/19. The Transitional Care Unit Registered Nurse will bring the results of the catheter care observations to the	

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M 620	Continued From page 2 should have rotated the wipes while performing Resident #36's catheter care. The DON also said CNA #1 should have secured the tip of the tubing while performing catheter care. The DON said the resident could develop infections when appropriate catheter care is not provided. A review of the Face Sheet revealed the facility admitted Resident #36, on 05/14/2019, with diagnoses which included Urinary Tract Infection, Acute Cystitis with Hematuria and Pressure Ulcers . A review of Resident #36's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 6/25/2019, revealed Resident #36 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident is cognitively impaired.	M 620	monthly Quality Assurance Performance Improvement Committee for review, revision, and/or resolution.	