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
	61MA	A. BUILDING: _____ B. WING _____	03/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JNH-MADISON INN	3550 HIGHWAY 468 WEST PO BOX 207 BLGS 28 &34 WHITFIELD, MS 39193

(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) determined, during an annual recertification survey conducted from 3/5/19 through 3/8/19, the facility was not in compliance with the Mississippi Regulations for Minimum Standards for Institutions for Aged or Infirmed. The SA cited deficiencies at M610. The facility was licensed for 85 beds, and had a census of 70 at the time of the survey.	M 000		
M 610	45.21.2 Activities of daily living Activities of daily living. Each resident shall receive assistance as needed with activities of daily living to maintain the highest practicable well being. These shall include, but not be limited to: 1. Bath, dressing and grooming; 2. Transfer and ambulate; 3. Good nutrition, personal and oral hygiene; and 4. Toileting. This Statute is not met as evidenced by: Based on observation, staff interview, and facility policy review, the facility failed to provide Activity of Daily Living (ADL) care to maintain good personal hygiene for two (2) of three (3) residents reviewed for ADL care, Resident #9 and Resident #26. Findings include: Review of the Facility Policy titled, "Resident Personal Hygiene", dated January 2017, revealed: This policy provides guidelines for assisting residents with daily hygiene and	M 610	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? On March 5, 2019, following notification of the resulting observation of Resident #9, Resident #9 was assessed by the Director of Nursing. Resident was noted to have residue on both sides of her mouth. Oral care was provided for Resident #9 on March 5, 2019, by the Treatment Nurse to ensure no residue is on the lips, side of	4/28/19

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M 610	Continued From page 1 grooming. This policy applies to all facility residents and employees. Daily personal grooming needs will be met in order to maintain the dignity and health of all residents. Residents will be encouraged to receive oral care at least daily and PRN, with staff assistance as needed. Resident #26 On 03/05/19, at 11:30 AM, an observation of Resident #26 revealed dry, tan, crusty matter on the resident's lips and tongue. The Residents mouth was open. During an observation on 03/06/19 at 04:30 PM, Resident #26 had tan, crusty matter observed on the tongue and lips. The Resident appeared to be mouth breathing, with the tongue pushing toward the lips. Tan crust was noted on the left side of the resident's chin. On 03/06/19 at 05:02 PM, observation of Resident #26 and interview with LPN #1, confirmed that the resident had tan, crusty secretions on his lips, tongue and chin. LPN #1 stated, "Looks like he could could use some mouth care. The crusts on his chin could be secretions from his mouth." On 03/06/19 at 04:52 PM, interview with Licensed Practical Nurse #1 (LPN), revealed nurses perform oral care for Resident #26. LPN #1 stated that it should be documented on the Treatment Chart (TC) and upon his review of the the Treatment Chart, he stated, "I don't see it on here. I think his mouth care is once a day and as needed (prn). I thought it would be on the TC." On 03/06/19 at 05:16 PM, during an interview and observation of Resident #26, the Director of Nursing (DON) confirmed the tan crusts on the	M 610	mouth, or chin. Resident #9's face was clean and had no negative outcome. Oral care was provided for Resident #26 by the Treatment Nurse on March 7, 2019. The Director of Nursing counseled Registered Nurse #2 (Minimum Data Set Nurse) on updating and revising care plans on March 8, 2019. Resident # 26 was assessed by Director of Nursing on March 7, 2019 and was found with no negative outcome related to the deficient practice. Following the notification of Activities Of Daily Living (ADL) not being provided to Resident #9 and Resident #26, the Care Plan, Activities Of Daily Living (ADL) Sheets, Treatment Administration Record (TAR) of Resident #9 were updated to include oral care before and after meals and as need. Following the notification of Activities Of Daily Living (ADL) not being provided to Resident #9 and Resident #26, the Care Plan, Activities Of Daily Living (ADL) Sheets, Treatment Administration Record (TAR) and Physician Orders of Resident #26 were reviewed and updated to include mouth care including the use of Glycerin swabs every four (4) hours until bedtime by the Minimum Data Set nurse. How will you identify other residents having the potential to be affected by the same deficient practice, and what corrective action will be taken? On March 7, 2019, the Director of Nursing,	

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M 610	Continued From page 2 lips, tongue and left side of chin, she stated, "That certainly should not look like that, that needs to be taken care of right now. He's a mouth breather and would need more frequent mouth care." The DON revealed that the nurses perform the mouth care for all residents with Percutaneous Endoscopic Gastrostomy (PEG) tubes and that it would be documented on the Treatment Chart (TC). On 03/07/19 at 08:51 AM, interview with Registered Nurse #2, Minimum Data Set (MDS) Nurse, revealed that Resident #26 had a new order for mouth care upon re-entry from the hospital on 2/26/19. She stated that mouth care should be done every four (4) hours . Record review of the March 2019 Treatment Chart, the March 2019 Medication Chart, and the March 2019 Activity of Daily Living (ADL) records, revealed that oral care was not found to be listed on these records. Record review of the Identification and Summary Sheet for Resident #26 revealed that the facility admitted resident on 6/20/11, with diagnoses of Huntington's Chorea, Dementia, Psychosis, Dysphagia and Percutaneous Endoscopic Gastric Tube. Review of the Quarterly MDS, dated 1/4/19, revealed that the resident was totally dependent on staff for Personal Hygiene and staff assessed Resident #26's cognitive skills for daily decision making as severely impaired. Resident #9 An observation on 03/05/19 at 11:45 AM, of Resident #9 in her room, revealed the resident lying in bed with dry crusty residue on her upper lip, both sides of her mouth, under her lower lip, and a line of residue from the the left corner of	M 610	Head Nurses and Minimum Data Set Nurse reviewed the census to determine other residents who were affected by the deficient practice. The facility has determined that 72 residents had the potential to be affected. Resident #9 and Resident #26 were the only residents affected. Beginning March 11, 2019 the Director of Nursing and Head Nurse re-educated the Certified Nursing Assistants and the licensed nursing staff on Policy (J550-08) Residents Personal Hygiene with emphasis on proper care of oral hygiene and Activities Of Daily Living (ADL) Care Plan. All newly hired Certified Nursing Assistants will be checked off by the Director of Nursing or Head Nurse on oral hygiene to ensure competency during orientation then quarterly thereafter. Scheduled Certified Nursing Assistants were checked off on oral care by the Director of Nursing and Head Nurse beginning March 11, 2019. What measures will be put into place, or what systemic changes will you put into place or make to ensure that the deficient practice does not recur? Beginning March 11, 2019, the Head Nurse or Director of Nursing will assess oral care for all residents who are unable to provide oral care for themselves after lunch meals twice a week for a month then weekly for a month. Licensed nurses on each shift will monitor the	

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M 610	Continued From page 3 her mouth down to her chin. An observation of Resident #9, and interview with Certified Nursing Assistant (CNA) #1, on 03/05/19 at 03:03 PM, revealed the resident lying in bed with dry crusty residue on her upper lip, both sides of her mouth, under her lower lip, and a line of residue from the left corner of her mouth down to her chin. CNA #1 revealed she was assigned to care for the resident and had bathed the resident in bed this morning. CNA #1 stated she had washed the resident's mouth and provided oral care this morning, but had not done so since. CNA #1 stated it appeared that no one had cleaned the resident's face since this morning, but she would do it now. CNA #1 stated she was supposed to check on the resident every two (2) hours and if she saw a need to clean the resident's face, she was to do it then. CNA #1 stated she had provided care to the resident since this morning, but had not cleaned her mouth or face and should have. A review of Resident #9's Activities of Daily Living (ADL) log revealed Personal Hygiene was listed under AM (morning) care and PM (evening) care. A review of Resident #9's Treatment Chart for March 2019, revealed treatments of "Clean mouth with lemon glycerin swab Q (every) shift and Oral Care Q shift." Each of these treatments had no initials for the A shift (7 AM-3 PM) on March 1st, 3rd, or 4th. There were no other treatments regarding cleaning the resident's face, mouth or oral care listed on the Treatment Chart. The chart listed CNAs as responsible for completing the interventions. An interview on 03/07/19 at 10:05 AM, with Registered Nurse (RN) #1, who was the Charge Nurse, revealed it was expected that CNAs should observe dependent residents at least every two (2) hours and provide hygiene care if needed.	M 610	documentation twice a week for two months then weekly for a month to ensure the Activities Of Daily Living (ADL) care plans are followed for all residents who are unable to provide oral care for themselves. Any deficiencies found will be corrected at that time and reported to the Director of Nursing for follow-up. The Head Nurse will conduct an audit beginning April 5, 2019 on at least five (5) residents per week for two (2) months to ensure the residents interventions match the Treatment Administration Record (TAR), the Activities of Daily Living Sheet (ADL), and the Care Plans. Any errors noted will be corrected at that time. The results will be documented on the Weekly Care Plan Calendar Checklist and provided to the Nursing Home Administrator and Director of Nursing for any necessary follow-up action. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? The Director of Nursing will review the Weekly Care Plan Calendar Checklist each week. The Nursing Home Administrator and Director of Nursing will report monthly to the Quality Assurance and Performance Improvement (QAPI) Committee on the outcomes of the Audits. The effectiveness of the above system will be reviewed at that time and changes made as necessary to this plan to ensure compliance.	

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M 610	Continued From page 4 An interview with RN #2, MDS/Care Plan nurse on 03/07/19 at 02:20 PM, confirmed the care plan for Resident #9 had an intervention to wash hands and face before and after meals and PRN. The MDS nurse stated that if the resident's mouth had residue on it, nursing staff should have cleaned it as needed. She stated that if the Treatment Chart/Treatment Administration Record (TAR) was not initialed for oral care and/or lemon glycerine swab, then there is no way to know if the care was done. The RN confirmed the TAR nor ADL sheet included the intervention of washing hands and face before and after meals and PRN, and believes the TAR should match the interventions on the care plan. A review Resident #9's quarterly MDS with an Assessment Reference Date (ARD) of 12/14/19, revealed Resident #9 was assessed by staff to be severely impaired and was totally dependent on staff for personal hygiene.	M 610		