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 |
|---|---|---|---|
| | 24KI | A. BUILDING: _____ B. WING _____ | C 02/18/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| THE PILLARS OF BILOXI | 2279 ATKINSON ROAD BILOXI, MS 39531 |

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| M 000 | Initial Comments<br><br>The State Agency (SA) determined during a complaint investigation (CI MS #17466, CI MS #17561) from 02/17/21 to 02/18/21, the facility was not in compliance with Minimum Standards of Operation for Institutions for the Aged or Infirm state licensure requirements. The facility failed to perform incontinent care before and during wound care for Resident #1, the SA cited 0615 Rule 45.21.3 at a Level II. | M 000 | | |
| M 615 SS=D | 45.21.3 Pressure sores<br><br>Pressure sores. Residents with a pressure sore shall receive necessary treatment and service to promote healing and prevent the development of new pressure sores. Residents without pressure sores will not develop pressure sores unless the residents' clinical condition indicates they were unavoidable.<br><br>This Statute is not met as evidenced by:<br>Based on observation, interview, record review and facility policy review, the facility failed to follow Standard Infection Control Precautions related to performing incontinent care prior and/or during wound care to prevent the possible spread of infection for one (1) of three (3) wound care observations. [Resident #3]<br><br>Findings Include:<br><br>The facility's, "Infection Prevention/Procedure for Major Wounds ", revised June 2013, to provide guidelines for good infection prevention technique in wound care. The resident must not be soil when the dressing change is done. If the resident is soiled, wound care should not be done until her/she is cleaned. | M 615 | Resident # 3 was assessed by the Assistant Director of Nursing (ADON) on 2/18/2020 and noted to have no adverse findings. Registered Nurse (RN) # 1 was educated by the ADON on 2/18/2021 regarding wound care and infection control including providing incontinence care before and during wound care.<br><br>All residents with pressure ulcers have the potential to be affected by the deficient practice. 14 (fourteen) residents identified with pressure sores were assessed by the Wound Care Nurse and Wound Care Nurse Practitioner on 2/25/2021 with no negative outcomes identified.<br><br>All licensed nurses were in-serviced | 3/18/21 |

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| M 615 | Continued From page 1<br>Resident # 3<br>.<br>On 02/18/21 at 10:10 AM, observed Registered Nurse (RN) #1 perform wound care to the coccyx for Resident #3. RN #1 failed to provide incontinent care for Resident #3 prior to wound care being provided. Resident #3 was observed oozing feces, prior to and during wound care.<br><br>Record review of Transfer/Discharge Report revealed the facility admitted Resident #3 on 03/01/2019, with the diagnoses of Osteoporosis and Hypertension.<br><br>In a review of Resident #3's care plan revealed Resident #3 had a self-care deficit with the intervention for staff to perform activities of daily living.<br><br>In a record review of the Quarterly Minimum Data Set (MDS) with the Assessment Reference Date (ADR) of December 4, 2020, revealed Section C-0500, the Brief Interview for Mental Status (BIMS) score was nine (9), which indicated moderate cognitive impairment. Section G, Item G 0110 (I) listed extensive assistance with toilet use.<br><br>On 02/18/21, at 11:58 AM, in an interview with RN #1, stated she did perform wound care when Resident #3 was soiled with feces. RN #1stated Resident #3 was oozing bowel during wound care and confirmed she covered the feces with a towel to not contaminate the wound but did not clean Resident #3 and continued to perform wound care.<br><br>On 2/18/21, at 1:22 PM, in an interview with Registered Nurse (RN) #2/Infection Preventionist (IP), confirmed RN #1 should have stopped the | M 615 | regarding wound care policies and infection control, including providing incontinence care prior to and during wound care beginning 2/19/21 and ending 3/2/2021 by the ADON. The ADON will perform 2 two wound care observations weekly beginning 2/25/21 for 8 (eight) weeks then resume 1 (one) wound care observation monthly ongoing,take immediate action as necessary and document findings.<br><br>The ADON will report findings from weekly wound care observations for 2 (two) months, then monthly wound care observations ongoing to the Quality Assurance and Performance Committee monthly beginning 3/2/2021 for review, revision and/ or resolution of the plan. | |

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| M 615 | Continued From page 2<br>wound care and provided incontinent care for Resident #3 prior to and during wound care.<br><br>On 02/18/21, at 1:53 PM, an interview with the Director of Nurses (DON), revealed the wound care nurse should have followed the facility's infection control policy and cleaned Resident #3 prior to wound care. The DON confirmed if there is feces or a wet brief ,the staff should clean the resident prior to wound care to prevent any type of cross contamination.<br><br>Based on observation, interview, record review and facility policy review, the facility failed to follow Standard Infection Control Precautions related to performing incontinent care prior and/or during wound care to prevent the possible spread of infection for one (1) of three (3) wound care observations. [Resident #3]<br><br>Findings Include:<br><br>The facility's, "Infection Prevention/Procedure for Major Wounds ", revised June 2013, to provide | M 615 | | |

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| M 615 | Continued From page 3 | M 615 | | |

guidelines for good infection prevention technique in wound care. The resident must not be soil when the dressing change is done. If the resident is soiled, wound care should not be done until her/she is cleaned.

Resident # 3

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On 02/18/21 at 10:10 AM, observed Registered Nurse (RN) #1 perform wound care to the coccyx for Resident #3. RN #1 failed to provide incontinent care for Resident #3 prior to wound care being provided. Resident #3 was observed oozing feces, prior to and during wound care.

Record review of Transfer/Discharge Report revealed the facility admitted Resident #3 on 03/01/2019, with the diagnoses of Osteoporosis and Hypertension.

In a review of Resident #3's care plan revealed Resident #3 had a self-care deficit with the intervention for staff to perform activities of daily living.

In a record review of the Quarterly Minimum Data Set (MDS) with the Assessment Reference Date (ADR) of December 4, 2020, revealed Section C-0500, the Brief Interview for Mental Status (BIMS) score was nine (9), which indicated moderate cognitive impairment. Section G, Item G 0110 (I) listed extensive assistance with toilet use.

On 02/18/21, at 11:58 AM, in an interview with RN #1, stated she did perform wound care when Resident #3 was soiled with feces. RN #1stated Resident #3 was oozing bowel during wound care and confirmed she covered the feces with a towel to not contaminate the wound but did not clean

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| M 615 | Continued From page 4<br>Resident #3 and continued to perform wound care.<br><br>On 2/18/21, at 1:22 PM, in an interview with Registered Nurse (RN) #2/Infection Preventionist (IP), confirmed RN #1 should have stopped the wound care and provided incontinent care for Resident #3 prior to and during wound care.<br><br>On 02/18/21, at 1:53 PM, an interview with the Director of Nurses (DON), revealed the wound care nurse should have followed the facility's infection control policy and cleaned Resident #3 prior to wound care. The DON confirmed if there is feces or a wet brief ,the staff should clean the resident prior to wound care to prevent any type of cross contamination.<br><br>Level II<br><br>Based on observation, interview, record review, and facility policy review, the facility failed to follow Standard Infection Control Precautions related to performing incontinent care prior and/or during wound care to prevent the possible spread of infection for one (1) of three (3) wound care | M 615 | | |

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| M 615 | Continued From page 5<br>observations. [Resident #3]<br><br>Findings Include:<br><br>The facility's, "Infection Prevention/Procedure for Major Wounds ", revised June 2013, to provide guidelines for good infection prevention technique in wound care. The resident must not be soil when the dressing change is done. If the resident is soiled, wound care should not be done until her/she is cleaned.<br><br>Resident # 3<br><br>On 02/18/21 at 10:10 AM, observed Registered Nurse (RN) #1 perform wound care to the coccyx for Resident #3. RN #1 failed to provide incontinent care for Resident #3 prior to wound care being provided. Resident #3 was observed oozing feces, prior to and during wound care.<br><br>Record review of Transfer/Discharge Report revealed the facility admitted Resident #3 on 03/01/2019, with the diagnoses of Osteoporosis and Hypertension.<br><br>In a review of Resident #3's care plan revealed Resident #3 had a self-care deficit with the intervention for staff to perform activities of daily living.<br><br>In a record review of the Quarterly Minimum Data Set (MDS) with the Assessment Reference Date (ADR) of December 4, 2020, revealed Section C-0500, the Brief Interview for Mental Status (BIMS) score was nine (9), which indicated moderate cognitive impairment. Section G, Item G 0110 (I) listed extensive assistance with toilet use. | M 615 | | |

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| M 615 | Continued From page 6<br><br>On 02/18/21, at 11:58 AM, in an interview with RN #1, stated she did perform wound care when Resident #3 was soiled with feces. RN #1stated Resident #3 was oozing bowel during wound care and confirmed she covered the feces with a towel to not contaminate the wound but did not clean Resident #3 and continued to perform wound care.<br><br>On 2/18/21, at 1:22 PM, in an interview with Registered Nurse (RN) #2/Infection Preventionist (IP), confirmed RN #1 should have stopped the wound care and provided incontinent care for Resident #3 prior to and during wound care.<br><br>On 02/18/21, at 1:53 PM, an interview with the Director of Nurses (DON), revealed the wound care nurse should have followed the facility's infection control policy and cleaned Resident #3 prior to wound care. The DON confirmed if there is feces or a wet brief ,the staff should clean the resident prior to wound care to prevent any type of cross contamination. | M 615 | | |