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
	44AA	A. BUILDING: _____ B. WING _____	C 02/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA HEALTH AND REHABILITATION	310 EMERALD DRIVE COLUMBUS, MS 39702

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M 000	Initial Comments The State Agency (SA) conducted a complaint survey for CI MS #16986, CI MS #17223, CI MS #17227, and CI MS #17314 at the facility from 02/24/21 through 02/26/21. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid. The SA substantiated CI MS #17314 and CI MS #17227 for quality of care regarding pressure ulcers and cited F686 at the "G" level. CI MS #16986 was not substantiated for Neglect, and CI MS #17223 was not substantiated for pressure sores, infection control, and environment. The census at the time of suvey was 81.	M 000		
M 615	45.21.3 Pressure sores 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. This Statute is not met as evidenced by: Level II Based on staff interview, record review, observation and facility policy review, the facility failed to prevent the development of pressure ulcers and the worsening of existing pressure ulcers for one (1) of five (5) residents reviewed, (Resident #1). Findings include: Review of the facility's policy titled, "Skin Management Standards - Routine Preventative	M 615	Preparation and/or execution of this plan do not constitute admission or agreement by the provider the deficiency exist. This response is also not to be considered as an admission of fault by the facility, its employee, agents or the other individuals who may be discussed in this response and plan of correction. This plan of corrections is submitted as the facility□s credible allegation of compliance. 1. Immediate action taken for the resident found to have been affected includes:	4/9/21

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M 615	Continued From page 1 Care", last updated 11/2017, revealed, "According to AHCPR (Agency for Healthcare Policy and Research) Prevention and Treatment of Pressure Ulcers: 1. All individuals at risk should have a systematic skin inspection at least once a week, paying particular attention to the bony prominences. Vanguard requires...a minimum skin check of at least weekly by a licensed nurse. Findings will be documented in the medical record." Resident #1 Review of Resident #1's "Long Term Care Evaluation V4's" which include the weekly skin assessments revealed the following: 07/06/2020 - skin assessment completed. 07/25/2020 - skin assessment completed - nineteen (19) days between assessments. 08/22/2020 - skin assessment completed - twenty-eight (28) days between assessments. 09/05/2020 - skin assessment completed - fourteen (14) days between assessments. 09/13/2020 - skin assessment completed. 09/21/2020 - skin assessment completed. 10/11/2020 - skin assessment completed - twenty (20) days between assessments. 10/19/2020 - skin assessment completed. 10/25/2020 - skin assessment completed. 11/08/2020 - skin assessment completed - 14 days between assessments. 11/22/2020 - skin assessment completed - 14 days between assessments. 12/06/2020 - skin assessment completed - 14 days between assessments. 12/20/2020 - skin assessment completed - 14 days between assessments. 12/26/2020 - skin assessment completed. 01/03/2021 - skin assessment completed. 01/09/2021 - skin assessment completed.	M 615	-On 2/26/2021 a systematic skin inspection was completed by the Director of Nursing and the Administrator on Resident #1 and no new pressure ulcers were identified. 2. Identification of other resident having the potential to be affected was accomplished by: -All facility residents have the potential to be affected by the stated deficient practice of having a systemic skin inspection at least once a week by a licensed nurse. On 3/1/2021-3/2/2021 a systematic skin inspection was completed by the Director of Nursing and the Administrator on all facility residents and no new pressure ulcers were identified. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: -On 3/1/2021, the Director of Nursing, Nurse Educator and Administrator reviewed the facility policy for Skin Management Standard Routine Preventative Care. No changes to the policy are indicated at this time. -On 2/27/2021, the Director of Nursing updated the weekly skin inspection schedule for all facility residents and placed a copy on each medication cart. -On 2/27/2021-3/1/2021, the Director of Nursing added the weekly skin inspection schedule to each facility resident's Medication Administration Record to prompt the Licensed Nurse that the skin inspection was due on that date. -On 3/1/2021, an in-service was initiated by the Director of Nursing and the Nurse Educator for Registered Nurses and Licensed Practical Nurses on the facility	

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M 615	Continued From page 2 01/17/2021 - skin assessment completed. 01/26/2021 - skin assessment completed. 01/31/2021 - skin assessment completed 02/14/2021 - skin assessment completed - 15 days between assessments. Review of Resident #1's "Weekly Wound Evaluations" revealed the following: 07/16/2020 - a stage II pressure ulcer was noted to the right buttock 07/23/2020 - a stage III pressure ulcer was noted to the right elbow Both wounds were found in the 19 days of missed weekly skin assessments between 07/06/2020 and 07/25/2020. 08/16/2020 - a Deep Tissue Injury (DTI) was noted to the right heel 08/16/2020 - an Unstageable pressure ulcer was noted to the left heel Both wounds were found in the 28 days of missed weekly skin assessments between 07/25/2020 and 08/22/2020. Review of Resident #1's medical record revealed a nurses note dated 8/30/2020, that stated, the wound on Resident #1's left heel now has an odor and is being cultured. This occurred in the 14 days of missed weekly skin assessments between 08/22/2020 and 09/05/2020. On 09/08/2020, Resident #1 received an order for Cipro 500 milligrams (mg) two times a day for 14 days for a wound infection to the left heel. Further review of the "Weekly Wound Evaluations" revealed on 09/28/2020 a new Suspected Deep Tissue Injury (SDTI) was noted to his right lateral heel. This wound was found during the 20 days of missed skin assessments	M 615	policy for Skin Management Standard Routine Preventative Care to include special focus on all individuals at risk should have a systematic skin inspection at least once a week by a licensed nurse, paying particular attention to the bony prominences. This in-service includes that the weekly skin inspection schedule was updated and placed on each medication cart and the new procedure of signing the completion of weekly skin inspection on the resident's Medication Administrator Record. 4. How the corrective actions will be monitored to ensure the practice will not recur: -The Director of Nursing or Unit Manager will conduct quality assurance audits to validate proper and consistent procedure of ensuring that the skin inspections are completed weekly on each resident as per facility policy. These audits will be done on five (5) residents and occur at least weekly for eight (8) weeks, then bi-weekly for four (4) months, then monthly or until the stated deficient practice has been resolved and/or until 100% compliance is achieved. Audits began on 3/8/2021. Negative findings will be addressed immediately. -The Director of Nursing or Unit Manager will conduct quality assurance audits to validate proper and consistent procedure of ensuring that the Licensed Nurse is signing off the resident□'s Medication Administration Record with the completion of the weekly skin inspection. These audits will be completed on five (5) residents and occur at least five (5) times	

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M 615	Continued From page 3 between 09/21/2020 and 10/11/2020. On 02/26/2021, at 3:40 PM, wound care was observed for Resident #1's multiple wounds to his bilateral feet and sacrum. All wounds appear clean and are healing. There are no signs and symptoms currently of infection. There was no break in infection control techniques by RN #1, and the resident did not appear to experience any discomfort during the treatment session. Review of Resident #1's Minimum Data Set (MDS) assessments revealed he had not been discharged from the facility since February of 2020, which would have equated for missed weekly assessments. During an interview with the Director of Nursing (DON) on 02/26/2021, at 2:45 PM, she stated the nurses were supposed to do a skin assessment weekly as part of the assessments within the "Long Term Care Evaluations". She reviewed the Skin Assessment Log with the State Agency (SA) and verified there were several weeks between assessments, and there were no other places within the chart the documentation should occur. She indicated there seemed to be a pattern to the missed assessment, and that his wounds were all found within the weeks the assessments were not completed. During an interview with the MDS/Care Plan nurse, she stated there was no other place within the electronic medical record for the nurses to document weekly skin assessments other than within the "Long Term Care Evaluation V4" assessment, unless they were a skilled resident, and Resident #1 was not skilled. The facility's failure to do weekly skin	M 615	a week for one (1) week, then three (3) times a week for two (2) weeks, then one (1) time a week for four (4) weeks or until the stated deficient practice has been resolved and/or until 100% compliance is achieved. Negative findings will be addressed immediately. -The Director of Nursing and Administrator will review the data obtained from the quality assurance audits, analyzing for patterns/trends and reporting monthly in Quality Assurance/Performance Improvement meetings. The Quality Assurance/Performance Improvement Committee will make recommendations as needed. Stated deficient practice of having a systemic skin inspection at least once a week by a licensed nurse and audit findings to date were reviewed on 3/24/2021 during the facility□'s QA meeting. Audit findings will be reviewed in the facility's QA meeting monthly for four (4) months.	

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M 615	Continued From page 4 assessments for Resident #1 resulted in a Stage II pressure ulcer to his right buttock, a stage III pressure ulcer to his right elbow, Deep Tissue Injury (DTI) pressure ulcer to his right heel, and an unstageable pressure ulcer to his left heel that became infected and required antibiotics for 14 days. Review of the Admission Record for Resident #1 revealed the resident was admitted to the facility on 07/16/2013 with diagnoses of Anxiety, Dementia with Behaviors, Depression, Anorexia, Gastroesophageal Reflux Disease (GERD), Insomnia, Alzheimer's Disease, and Osteoarthritis. Review Resident #1's last annual MDS dated 02/04/2021 revealed a Brief Interview of Mental Status (BIMS) score of five (5). Resident #1 required total assistance of two staff members for his Activities of Daily Living (ADL's). Resident #1 is always incontinent of bowel and bladder.	M 615		
M 735	45.25.1 Medical Records Management Medical Records Management. 1. A medical record shall be maintained in accordance with accepted professional standards and practices on all residents admitted to the facility. The medical records shall be completely and accurately documented, readily accessible, and systematically organized to facilitate retrieving and compiling information. 2. A sufficient number of personnel, competent to carry out the functions of the medical record service, shall be employed.	M 735		4/9/21

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M 735	Continued From page 5 3. The facility shall safeguard medical record information against loss, destruction, or unauthorized use. 4. All medical records shall maintain the following information: identification data and consent form; assessments of the resident's needs by all disciplines involved in the care of the resident; medical history and admission physical exam; annual physical exams; physician or nurse practitioner/physician assistant orders; observation, report of treatment, clinical findings and progress notes; and discharge summary, including the final diagnosis. 5. All entries in the medical record shall be signed and dated by the person making the entry. Authentication may include signatures, written initials, or computer entry. A list of computer codes and written signatures must be readily available and maintained under adequate safeguards. 6. All clinical information pertaining to the residents stay shall be centralized in the resident's medical records. 7. Medical records of discharged residents shall be completed within sixty (60) days following discharge. 8. Medical records are to be retained for five (5) years from the date of discharge or, in the case of a minor, until the resident reaches the age of twenty-one (21), plus an additional three (3) years. 9. A resident index, including the resident's full name and birth date, shall be maintained.	M 735		

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M 735	Continued From page 6 This Statute is not met as evidenced by: Based on staff interview, record review, observation and facility policy review, the facility failed to implement care plan interventions to prevent the development of pressure ulcers and the worsening of existing pressure ulcers for one (1) of five (5) residents reviewed, (Resident #1). Findings include: Review of the facility's policy titled, "Comprehensive Care Plan" revealed, "It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with residents' rights, that includes measurable objective and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the residents' comprehensive assessment....6. The comprehensive care plan will describe, at a minimum, the following: a. the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being...." Review of Resident #1's wound care plan revealed, "Resident #1 had pressure ulcers present with potential for further breakdown...New Desired Outcome: Pressure ulcers will show signs or healing and remain free from infection by/through review date...New Interventions: Monitor/document/report to MD PRN changes in skin status...". Review of Resident #1's "Long Term Care Evaluation V4's" which include the weekly skin assessments revealed the following: 07/25/2020 - skin assessment completed.	M 735	Preparation and/or execution of this plan do not constitute admission or agreement by the provider the deficiency exist. This response is also not to be considered as an admission of fault by the facility, its employee, agents or the other individuals who may be discussed in this response and plan of correction. This plan of corrections is submitted as the facility□s credible allegation of compliance. 1.Immediate action taken for the resident found to have been affected includes: - On 2/26/2021 a care plan record review was completed by the Minimum Data Set Licensed Practical Nurse on Resident #1 for care plan interventions to prevent the development of pressure ulcers and the worsening of existing pressure ulcers. 2. Identification of other resident having the potential to be affected was accomplished by: -All facility residents at high risk for pressure ulcers have the potential to be affected by the stated deficient practice. -On 3/8/2021 a care plan record review was completed by the Minimum Data Set Licensed Practical Nurse on all facility residents at high risk for pressure ulcers. Care plans were reviewed to ensure that care plan interventions to prevent the development of pressure ulcers and worsening of existing pressure ulcers have been implemented. No issues were noted. 3. Actions taken/systems put into place to reduce the risk of future occurrence include:	

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M 735	Continued From page 7 08/22/2020 - skin assessment completed - twenty-eight (28) days between assessments. 09/05/2020 - skin assessment completed - fourteen (14) days between assessments. On 08/16/2020 an Unstageable pressure ulcer was noted to the left heel. This wound was found by the nurse between 07/25/2020 and 8/22/2020, during the 28 days of missed weekly skin assessments. Review of Resident #1's medical record revealed a nurse note dated 08/30/2020, stating the wound on Resident #1's left heel now had an odor, and was being cultured. This occurred in the 14 days of missed weekly skin assessments between 08/22/2020 and 09/05/2020. On 09/08/2020, Resident #1 received an order for Cipro 500 milligrams (mg) two times a day for 14 days for a wound infection to the left heel. On 02/26/2021, at 3:40 PM, wound care was observed for Resident #1's multiple wounds to his bilateral feet and sacrum. All wounds appear clean and are healing. There are no signs and symptoms currently of infection. There was no break in infection control techniques by RN #1, and the resident did not appear to experience any discomfort during the treatment session. During an interview with the Director of Nursing (DON) on 02/26/2021 at 2:45 PM, she stated the nurses were supposed to be doing a skin assessment weekly as part of the assessments within the "Long Term Care Evaluations". She verified they had not followed the wound care plan to monitor Resident #1's skin in order to prevent pressure ulcers or them worsening.	M 735	-On 3/1/2021, the Director of Nursing, Nurse Educator and Administrator reviewed the facility policy for Comprehensive Care Plans. No changes to the policy are indicated at this time. -On 3/11/2021, an in-service was initiated by the Director of Nursing and the Nurse Educator for Registered Nurses and Licensed Practical Nurses on the facility policy for Comprehensive Care Plans with special focus on following residents care plan interventions to prevent the development of pressure ulcers and the worsening of existing pressure ulcers 4. How the corrective actions will be monitored to ensure the practice will not recur: -The Director of Nursing or Unit Manager will conduct quality assurance audits on comprehensive care plans to ensure that care plan interventions to prevent the development of pressure ulcers and worsening of existing pressure ulcers have been implemented and followed on each high risk resident as per facility policy. These audits will be completed on five (5) residents and occur at least at least weekly for eight (8) weeks, then bi-weekly for four (4) months, then monthly or/until the stated deficient practice has been resolved and/or until 100% compliance is achieved. These audits were started on 3/12/2021. Negative findings will be addressed immediately. -The Director of Nursing and Administrator will review the data obtained from the quality assurance audits, analyzing for patterns/trends and reporting monthly in Quality Assurance/Performance	

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M 735	Continued From page 8 During an interview with the MDS/Care Plan nurse, on 02/26/21 at 2:57 PM, she stated there was no other place within the electronic medical record for the nurses to document weekly skin assessments other than within the "Long Term Care Evaluation V4" assessment, unless they were a skilled resident, and Resident #1 was not skilled. She also stated the facility had not caught his wounds until they were higher stages and verified Resident #1 had required antibiotic therapy for his left heel wound. She agreed the facility had not been following Resident #1's care plan for monitoring his skin as they should have been. The facility's failure to follow the care plan to monitor Resident #1's skin resulted in an Unstageable pressure ulcer being identified to his left heel that became infected and required antibiotics for 14 days. Record review of the Admission Record for Resident #1 revealed he was admitted to the facility on 07/16/2013 with diagnoses of Anxiety, Dementia with Behaviors, Depression, Anorexia, Gastroesophageal Reflux Disease (GERD), Insomnia, Alzheimer's Disease, and Osteoarthritis. Record review of Resident #1's last annual MDS dated 02/04/2021, revealed a Brief Interview of Mental Status (BIMS) score of five (5). Resident #1 required total assistance of two staff members for his activities of daily living (ADL's), and is always incontinent of bowel and bladder.	M 735	Improvement meetings. The Quality Assurance/Performance Improvement Committee will make recommendations as needed. Stated deficient practice of following the interventions of the resident's comprehensive care plan audit findings to date were reviewed on 3/24/2021 during the facility's QA meeting. Audit findings will be reviewed in the facility's QA meeting monthly for four (4) months.	