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
	53SM	A. BUILDING: _____ B. WING _____	10/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STARKVILLE MANOR HEALTH CARE AND REH	1001 HOSPITAL ROAD STARKVILLE, MS 39759

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M 000	Initial Comments The State Agency, (SA) determined during an annual licensure survey, conducted from 10/20/19 to 10/23/19, along with complaints, MS #16161, MS #16246, and MS #16293, the facility was not in compliance with the Mississippi Regulations for Minimum Standards for Institutions for the Aged or Infirm, and cited deficiencies at M610, unrelated to the complaints. The SA substantiated MS #16293, related to the complaint for environment and staffing, and cited M1010. The SA did not substantiate MS #16161, related to Quality of Care or MS #16246, for Quality of Care and misappropriation. The census at the time of the survey was 106 with a bed capacity of 119.	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: Level II Based on resident interview, family interview, staff interview, observation, record review, and policy review, the facility failed to provide Activities of Daily Living (ADL) care as needed, to dependent	M 610	This Plan of Correction does not constitute an admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. This Plan of Correction is prepared solely because it is required by	11/8/19

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M 610	Continued From page 1 residents, as evidenced by dirty, long, jagged, and unkept fingernails and toenails, for four (4) of five (5) dependent residents reviewed for ADL needs, Resident #52, Resident #60, Resident #62, and Resident #196. Findings Include: A review of the facility's policy, Care of Nails, with a revision date of 9/1/17, revealed to trim and clean fingernails. Resident #60 On 10/20/19 at 1:40 PM, an observation of Resident #60's fingernails revealed they extended beyond the length of his fingertips and brown debris was noted under the nails. Some of Resident #60's fingernails were jagged and broken. The Resident stated he did not know when his fingernails had last been cut; he does not like for them to be this long and would like to have them cut. Resident #60 is diabetic and required staff to cut his nails. A review of Resident #60's Physician Orders, dated October 2019, revealed a treatment order for Diabetic nail care, trim monthly on the 19th on the 3-11 shift, and as needed. A review of the October 2019 treatment record, for Resident #60, revealed the 19th of October was not documented for nail care. On 10/22/19 at 10:31 AM, an interview with the Director of Nursing (DON) revealed diabetic nail care should be done every month by the nurse. On 10/22/19 at 10:39 AM, an interview with Licensed Practical Nurse (LPN) #1 revealed she cut Resident #60's nails on 10/20/19, on the 3-11	M 610	the provisions of State law. 1. On 10/24/19, a Root Cause Analysis (RCA) was completed by the Quality Assurance Performance Improvement (QAPI) Committee that identified Residents' #52, #60, #62, and #196 were provided nail care and assessed with no negative outcomes related to nail care by the Director of Nurses (DON) on 10/23/19. 2. Other residents residing in the facility have the potential to be affected by the alleged deficient practice. On 10/24/19, the DON/Assistant Director of Nurses (ADON)/Registered Nurses (RN) Unit Managers conducted a Quality Review to ensure nail care was provided as outlined by the comprehensive care plan. Follow up based on findings. 3. On 10/24/19, the ADON initiated education to licensed nurses and Certified Nursing Assistants (CNAs) on ensuring nail care. On 11/07/19, education was completed. The ADON will educate newly hired licensed nurses and CNAs on ensuring nail care. 4. On 10/24/19, the DON/ADON will conduct a Quality Monitor observing nail care for five (5) residents five (5) times weekly for two (2) weeks, then three (3) residents monthly for six (6) months. Any negative findings will be corrected immediately and for six (6) months Quality Review results will be submitted monthly to the QAPI Committee for the Interdisciplinary Team (IDT) to review. The	

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M 610	Continued From page 2 shift. She stated the resident's nails were long, dirty and jagged, and in need of cutting and cleaning. On 10/22/19 at 10:50 AM, the Assistant Director of Nursing (ADON) stated she had not been able to locate Resident #60's treatment record for September, and was not sure if his nails were cut in September. Resident #52 On 10/20/19 at 1:30 PM, Resident #52 was observed in bed. His daughter, who was at the bedside, stated the resident's fingernails were dirty and long and his toe nails were too long. Resident #52's daughter stated she felt they (staff) should be able to take care of this. She stated she doesn't come very often, but every time she comes she has to clean the resident's nails. She stated the resident often put his hands in his brief, so he needed the nails cleaned. On 10/21/19 at 3:40 PM, an observation and interview with Licensed Practical Nurse (LPN) #3 confirmed Resident #52's fingernails were dirty and needed cleaning. She also confirmed that the fingernails had ragged areas and needed to be filed smooth. LPN #3 also confirmed Resident #52's toenails needed to be trimmed and if nursing could not not get them done, he should be referred to the Podiatrist. On 10/22/19 at 11:00 AM, an interview with the Director of Nursing (DON) revealed the diabetic residents' nail care was done by nurses or the Podiatrist, and the other residents are done by the Certified Nursing Assistants, (CNAs). The DON stated all she could say was the nail care just didn't get done.	M 610	IDT will use RCA to update the Performance Improvement Plan (PIP) as indicated by findings.	

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M 610	Continued From page 3 Resident #196 On 10/20/19 at 5:57 PM, an observation revealed Resident #196's fingernails were dirty. Resident #196's toe nails were long with light blue polish on the ends. An observation and interview on 10/21/19 at 3:30 PM, with LPN #3, confirmed Resident #196's fingernails were dirty and needed to be trimmed. She stated the long dirty nails could cause infection and the fingernails should be clean, since she is eating meals now. LPN #3 also confirmed Resident #196 needed to have her toenails trimmed. LPN #3 stated long nails could be a source of infection and it could cause scratches. Resident #62 During an observation and interview on 10/20/19 at 3:00 PM, Resident #62 had his feet uncovered. His toenails were clean, but very long on both feet. The resident stated his toenails had not been trimmed in a while and they were bothersome at this length, getting caught on his bedcovers; that's why he kept his feet uncovered. Resident #62 stated he had told someone on staff he would like his nails trimmed, but he was not sure who he told. Resident #62 is obese and dependent on staff for nail care. Record review revealed a physician's order with a start date of 08/08/18, "Diabetic fingernail trim monthly". There was a standing order for the resident to see the Podiatrist as needed. Review of the resident's chart revealed no indication the resident had been seen by the podiatrist. Review of the Treatment Administration Record (TAR)revealed nail trimming had been provided monthly. There was no order or documentation for toenails to be trimmed.	M 610		

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M 610	Continued From page 4 In an observation and resident interview, on 10/21/19 at 9:22 AM, Resident #62's toenails were still long. Resident # 62 stated he would still like to have his nails clipped. He stated Hospice staff, as well as facility staff, have done this in the past, but no one has trimmed his nails in a while. During an interview on 10/21/19 at 2:51 PM, CNA #3 stated the CNAs cut nails when assisting with hygiene, or when they see the nails are too long, but if the resident is a diabetic, the nurse has to cut them. CNA #3 stated the CNAs verbally tell the nurses, but don't record if the resident's nails needed clipping. She stated if the CNAs clip the nails, it was documented on the kiosk. In an interview on 10/21/19 at 2:53 PM, CNA #4 stated she was assigned to Resident #62, and usually worked with him a couple days a week. The CNA stated Resident #62 was dependent on staff for ADL care and nail care. CNA #4 stated she had bathed the resident and cleaned the nails, but she didn't think they were too long, and had not reported to the nurse of the resident's nails needing to be trimmed. CNA #4 stated the resident is diabetic, and the nurse would have to trim the nails. CNA #4 stated the resident was on hospice and they do care too. During an interview on 10/21/19 at 2:57 PM, the Unit Coordinator/RN #1 stated nurses are to trim the diabetic resident's toenails. RN #1 stated either LPNs or RNs could trim the nails. RN #1 stated when an order for the fingernails to be trimmed is written, the staff know to do a toenail trim also. RN #1 stated if nails are too thick for staff to trim, an appointment with the Podiatrist is scheduled, but at this time the facility staff were able to do care.	M 610		

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M 610	Continued From page 5 An observation and interview on 10/21/19 at 2:59 PM, with LPN #2, revealed she had not been informed Resident #62's nails needed to be trimmed by anyone. LPN stated she had been the resident's Nurse and had not noticed the nails were too long. LPN #2 stated the Podiatrist cuts the diabetic resident's nails if they are too thick for staff to cut. Observation revealed LPN #2 measured Resident #62's toenails and found the great toes bilaterally to measure approximately one (1) inch from the nail bed and the other four (4) toenails measured one half (1/2) inch from the nail bed. LPN #2 stated she would trim the nails.	M 610		
M1010	45.35.1 Housekeeping Facilities and Services Housekeeping Facilities and Services. 1. The physical plant shall be kept in good repair, neat, and attractive. The safety and comfort of the resident shall be the first consideration. 2. Janitor closets shall be provided with a mop-cleaning sink and be large enough in area to store house cleaning supplies and equipment. A separate janitor closet area and equipment should be provided for the food service area. This Statute is not met as evidenced by: CI MS #16293 Level II CI MS #16293 Based on observation, staff interview, resident interview, and facility policy review, the facility failed to ensure a sanitary/safe environment, free of odors, for two (2) of four (4) halls, (A Long and	M1010	1. On 10/20/19, upon initial tour, the Executive Director (ED) was notified by the surveyors of the failure to ensure a sanitary/safe environment free of odors, for two (2) of four (4) halls, (A Long and A Short), and the building entrance during the initial tour of the facility as evidenced by odors of urine/feces, overflowing linen barrel, and debris on a resident's floor. On	11/8/19

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M1010	Continued From page 6 A Short), and the building entrance, during the initial tour of the facility. This was evidenced by odors of urine/feces, overflowing linen barrels, and debris on a resident's floor. Findings Include: A review of the facility's policy, "Hospitality Services", dated 11/30/14, revealed: Policy, Standards for routine cleaning of all interior spaces will be followed, including, but not limited to patient rooms, patient and public baths, tub and shower rooms, closets, utility rooms, offices, diet kitchens, storage spaces, TV and sitting rooms. Procedure: The Hospitality Services Supervisor will: Ensure the cleanliness of all interior areas indicated above. Upon entrance to the front door of the building, on 10/20/19 at 1:00 PM, there was a strong odor of urine. Strong odors of urine were also noted at the end of A hall short. On 10/20/19 at 1:10 PM, an observation of a linen barrel was overflowing with dirty, soiled linens at the end of the hallway, by room A1. Dirty gloves and garbage bags were also observed sitting in the floor of the room and bathroom of room A2A, along with a broken razor and urinal lying on the floor. On 10/20/19 at 1:30 PM, during the initial tour, an observation of A Long Hall revealed urine and bowel movement odors down the hallway, more pronounced at the end of the hall. On 10/20/19 at 2:00 PM, an interview with a resident, who wished to remain anonymous, stated, "Normally this place smells like shit, but when y'all walked in they started spraying air freshener and it smells a little better now." A visitor, who wished to remain anonymous, stated	M1010	10/20/19, upon notification of not ensuring a sanitary/safe environment, the ED had the housekeeping staff clean two (2) of four (4) halls, (A Long and A Short), and the building entrance of the facility to reduce the odors. On 10/24/19, a Root Cause Analysis (RCA) was completed by the Quality Assurance Performance Improvement (QAPI) Committee on ensuring a sanitary/safe environment. 2. Other residents residing in the facility have the potential to be affected by this alleged deficient practice. On 10/20/19, the ED and the Director of Nurses (DON) conducted a facility wide observation Quality Review to ensure a sanitary/safe environment and that the facility was cleaned as previously stated. Follow up based on findings. 3. On 10/20/19, the Assistant Director of Nurses (ADON) initiated education with housekeeping staff, licensed nurses, and Certified Nursing Assistants (CNAs) regarding ensuring a sanitary/safe environment. On 11/07/19, education was completed. Newly hired staff will be educated by the ADON on ensuring a sanitary/safe environment. 4. On 10/24/19, the ED/DON will conduct a Quality Monitor to ensure a sanitary/safe environment for five (5) times weekly for two (2) weeks, then for six (6) months. Any negative findings will be corrected immediately and for six (6) months Quality Review results will be submitted monthly to the QAPI Committee for the Interdisciplinary Team (IDT) to review. The	

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M1010	Continued From page 7 he visits often and the anonymous resident was telling the truth about the odors. On 10/20/19 at 2:30 PM, an interview with Certified Nursing Assistant (CNA) #1 revealed she really could not smell any odors. The CNA stated she had worked in the area so long that she just does not notice it anymore. On 10/20/19 at 2:40 PM, an interview with the Administrator revealed A Long Hall is the worse hall in the building as far as odors. The Administrator confirmed A Hall smelled of urine and feces. The Administrator stated there were three (3) Housekeeping staff in the building and this was the normal amount for day shift. On 10/20/19 at 3:00 PM, an interview with Resident #60 revealed he had noticed odors in the building. Resident #60 stated, "Sometimes it's worse than others". He stated he couldn't identify what the odor was, but it wasn't pleasant. He stated staff will sometimes spray some stuff that helps with the odors. On 10/21/19 at 10:42 AM, an interview with the Housekeeping Supervisor (HS) revealed she didn't know what happened with the crew that was working yesterday. The HS stated normally she will have some full time staff on the weekend, but does supplement with PRN (as needed) staff on the weekends. She stated when she came in yesterday, she smelled the urine odors which were worse on the Long Hall of A unit. The Supervisor stated she, along with her staff on duty, started working to remove the odors from the building. An Interview on 10/23/19 at 10:45 AM, with Certified Nursing Assistant #2 (CNA), revealed	M1010	IDT will use RCA to update the Performance Improvement Plan (PIP) as indicated by findings.	

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M1010	Continued From page 8 she rotated to help on different halls. She confirmed that she was working on A Hall short on 10/20/19, and she did notice urine odors on the hall. She stated there is a resident on A hall who tried to empty his own catheter bag, and he had poured urine in the floor. She confirmed the linen barrel was overflowing with dirty linens at the end of A Hall Short. CNA #2 stated the shower aids usually take the barrels out to the laundry department, but they were just busy.	M1010		