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
	46MH	A. BUILDING: _____ B. WING _____	07/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYRTLES NURSING CENTER, LLC	1018 ALBERTA AVENUE COLUMBIA, MS 39429

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M 000	Initial Comments The State Agency (SA) conducted a licensure survey from 7/16/19 through 7/19/19. During the survey the SA determined the facility was not in compliance with the Minimum Standards for the Age and Infirm. The SA cited M 500 and M 620. At the time of the survey, the census was 83 and the facility held a license for 98 beds.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical	M 500		8/13/19

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M 500	Continued From page 1 treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time	M 500		

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M 500	Continued From page 2 in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse	M 500		

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M 500	Continued From page 3 practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level II Based on observation, staff interview, record review, and facility policy review, the facility failed to provide privacy during the administration of enteral medication for Resident #64 and for continuous enteral feedings for Resident #72; for two (2) of six (6) residents observed for privacy	M 500	* On 7/18/2019 Director of Nursing was made aware of facility failure to provide privacy during the administration of enteral medication for Resident #64 and privacy for continuous enteral feedings of Resident #72. Director of Nursing assessed Resident #64 and Resident #72 with no adverse findings noted on	

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M 500	Continued From page 4 during medication pass and for residents with enteral feedings. Findings include: A review of the facility policy titled "Administering Medications through Nasogastric or Gastrostomy Tube", revised 3/2018, revealed to provide privacy to the resident. A review of the facility policy titled, "Resident Rights", dated 11/17, revealed the residents residing at this facility would be provided personal privacy, which included any medical treatment. A review of the facility policy titled, "Gastrostomy/Nasogastric Tube", dated 12/18, revealed that during the administration of tube feedings, to provide privacy and explain procedure to resident. Resident #64 An observation on 07/17/19 at 1:54 PM, revealed Licensed Practical Nurse (LPN) #3, while administering enteral medications, left Resident #64's door open and only pulled the middle curtain between the other resident in the room. LPN #3 pulled Resident #64's gown up to under her breast, which was covered, and the sheet was pulled down to the top of the thigh. LPN #3 also went to the door and asked for a cup, but did not close the door. LPN #3 provided the medication per enteral tube, per the Medication Administration Record (MAR) on 7/17/19 at 2:00 PM. An interview on 7/17/19 at 2:15 PM, with LPN #3, revealed it was policy for the door to be closed	M 500	7/18/2019. * All residents receiving enteral medications or enteral feedings have the potential to be affected by this deficient practice. * Director of Nursing conducted one on one in-service with LPN #3 on 7/19/2019 related to proper procedures to ensure privacy during administration of enteral medications. In-service training was initiated on 7/18/2019 for Licenses Practical Nurses, Registered Nurses, Certified Nurse Aides and therapy personnel regarding provision of privacy during enteral medication administration and during enteral feeding. * Director of Nursing and or Charge Nurse will monitor privacy during provision of enteral medications or enteral feedings three (3) times weekly for four (4) weeks and monthly for two (20 months. The Quality Assurance Committee will evaluate during monthly meeting findings from monitoring and make any needed recommendations. Initiation of Quality Assurance and Performance Improvement (QAPI) will be started if warranted.	

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M 500	Continued From page 5 during care and he usually did close the door, but he was nervous. LPN #3 said that he would expect a reasonable person to want the door closed when administering an enteral medication. In an interview on 7/17/19 at 3:00 PM, the Director of Nursing stated it was not the facility policy to leave the door open during any care, and she would expect the door to be closed while administering the enteral medications for the resident's privacy. A review of Resident #64's Minimum Data Set (MDS) with the Assessment Reference Date (ARD) of 6/14/19, revealed severely impaired cognition. Resident #64 was unable to verbalize when asked about the door being open. A review of Resident #64's face sheet revealed diagnoses of unspecified sequelae of unspecified Cerebrovascular Disease and Aphasia. Resident #72 An observation on 07/16/19 at 12:22 PM, revealed the Certified Occupational Therapy Assistant (COTA) brought Resident #72 to the main dining room, with a percutaneous endoscopic gastrostomy (PEG) tube feeding infusing via a feeding pump; the pump/tube/bag was exposed and not covered. An observation on 07/17/19 at 01:32 PM, revealed Resident #72 to be in the Therapy Department with the PEG tube feeding exposed and not covered. In an interview on 07/17/19 at 02:00 PM, LPN #2 stated, concerning Resident #72, "We've never covered the PEG Tube, no one ever told us to do that."	M 500		

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M 500	Continued From page 6 In an interview on 07/17/19 at 02:05 PM, Certified Nursing Assistant (CNA) #1 stated, "We've never covered the PEG tubes." In an interview on 07/18/19 at 12:02 PM, the Director of Nursing (DON) stated, "They have never covered the PEG tube feeding bags up." The DON also stated, "I do not have a policy for PEG tubes being covered." In an interview on 07/18/19 at 2:17 PM, Resident #72 stated, "I don't understand about the PEG Tube."	M 500		
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 cross contamination and trauma to the bladder for one (1) of two (2) catheter care observations for Resident #3. Findings include: A review of facility policy titled: Perineal Care-Resident with Catheter", revised 10/18, revealed: The purpose of the policy is to prevent	M 620	* Director of Nursing and Infection Control Nurse RN #1 were notified of the deficient practice on 7/17/2019 of Certified Nurse Aide (CNA) #3 not washing her hands appropriately through out the catheter care process, tossing cloth in her hand after wiping an area and then wiping another area, holding catheter tubing at the base of the drainage bag and wiping the catheter tubing upward toward the head of the penis during care of Resident #3. Director of Nursing assessed Resident #3 on 7/17/2019 with no adverse findings noted.	8/13/19

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M 620	Continued From page 7 irritation or infection. When preparing for care, perform hand hygiene and apply gloves. While performing perineal care, secure the catheter tubing to one leg without causing traction of the urethra. Once perineal care has been provided, unfasten the tubing from the leg. Using one hand hold the catheter close to the urethral opening to prevent tension as you wash the tubing. Do not let the tubing cause traction on the urethra opening at any time. Use a clean washcloth or wash wipe, start as the meatus and wash the tubing in a circular motion away from the body about 4-5 inches. Rinse in the same method. Observe the tubing for any cracks, breaks or occlusions. Observe the urine in the tubing for any sediment, blood or discoloration. Re-secure the tubing to the resident's leg once it has been cleaned. Ensure tubing is not kinked or coiled and is not positioned above the level of the bladder. Remove gloves. Perform hand hygiene. An observation on 07/17/19 at 1:50 PM, revealed Certified Nurse Aide (CNA) CNA #3 performed catheter care on Resident #3 and CNA #2 assisted. CNA #3 gloved and assisted CNA #2 to pull Resident #3 up in bed. CNA #3 used the same gloves to unbutton Resident #3's pants and to pull his pants down. Resident #3 was lying flat on his bed with both legs up on bed. Resident #3's head of bed (HOB) was flat. The Indwelling urinary Catheter was located at Resident #3's right ankle with the strap loosened but intact on his leg. CNA #3 then un-taped Resident #3's brief and when she went to pull the brief from between his legs Resident #3 yelled out, "it hurts". The Indwelling catheter bag tubing was noted to be pulled very tight. CNA #3 then removed the brief from between Resident #3's legs and left the brief lying under Resident #3 buttocks. CNA #3 did not change her gloves or wash her hands	M 620	* All residents with indwelling urinary catheters have the potential to be affected by this deficient practice. * On 7/20/2019, RN #1 conducted one on one in-service training with CNA#3 related to proper care of indwelling catheter, including proper hand washing technique. In-servicing for Certified Nurse Aides initiated regarding Perineal Care of residents with catheters with completion date of 8/7/2019. * The Director of Nursing and or Infection Control Nurse and or Charge Nurse will observe Perineal Care of four (4) residents with indwelling urinary catheters per week for four (4) weeks and then monthly for two (2) months. the Quality Assurance Committee will evaluate the Director of Nursing and or Infection Control Nurse and Charge Nurse assessments monthly for three (3) months to make any needed recommendations to ensure ongoing compliance. Quality Assurance and Improvement Performance (QAPI) will be initiated if warranted.	

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M 620	Continued From page 8 after pulling Resident # 3 up in bed, pulling Resident #3's pants down or after pulling brief from between Resident #3's legs. The Indwelling Catheter tubing was pulled tight from Resident #3's penis to the bag located at ankle. CNA #3, with assistance from CNA #2, reached and pulled the catheter drainage bag up on Resident #3's leg and reattached the strap to hold the bag above Resident #3's knee. The catheter bag/tubing was never detached from the leg during perineal care. Resident #3's right leg was bent in a position that the bag was pointing down towards the tubing, allowing the urine to possibly flow back into the tubing/bag. Approximately 250 cubic centimeters (cc) of urine was noted in the catheter drainage bag at this time. CNA #3 took an unfolded wash cloth and applied soap and water, wiped Resident #3's right groin with one (1) sweep downward, then tossed the cloth around in her hand and wiped the left groin area downward, and then tossed and flipped cloth again to wipe the left groin a final time. The wash cloth was then discarded in a bag. There was no way to determine the area used on cloth was not a repeat area. CNA #3 then took another wash cloth with soap and water and wiped the right groin area downward then tossed cloth around in hand, wiped the left groin area downward, and then tossed the cloth in her hand again and wiped the left groin a final time. CNA #3 dried the area with a towel. CNA #3 took another washcloth with soap and water, pulled back the foreskin on the head of the penis, and wiped it with the soapy cloth. CNA #3 then tossed the cloth in her hand and took her fingers and held the catheter tubing at the point it joins the catheter bag and wiped the tubing upwards toward Resident #3's penis. CNA #3 was then told by CNA #2 to hold the tubing at the base of the penis. CNA #3 then tossed the cloth in one hand and moved her other hand to	M 620		

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M 620	Continued From page 9 hold the catheter at the base entering the penis and wiped down the tubing towards the catheter drainage bag. CNA #3 then rinsed and dried the tubing. CNA #3 then removed the old brief from under Resident #3's buttocks, applied a new brief and pulled Resident #3's pants back up. CNA #3 still had the same gloves on as used during the entire process. An interview on 07/17/19 at 2:12 PM, with Licensed Practical Nurse (LPN) #4, revealed that Resident #3 does have a catheter with a leg drainage bag and it is supposed to be anchored to his thigh so it won't move. LPN #4 stated, "We are supposed to keep the bag below the bladder for drainage". LPN #4 stated that the head of the bed should be elevated when Resident #3 is lying in bed. LPN #4 stated that she could see how with Resident #3 lying flat in bed with the catheter drainage bag strapped to his leg and the drainage bag not being below the bladder, could possibly allow the urine to backflow into the tubing and possibly back into the bladder. LPN #4 stated "It could very well cause an issue. If the bag is not secured where it will not move, it could cause a problem to the urethra". LPN #4 stated that she didn't think the bag could possibly be below the bladder with Resident #3 lying flat in bed. LPN #4 stated that Resident #3 should always have the head of the bed elevated so that the bag would be below the bladder. LPN #4 confirmed that Resident #3 had numerous appointments with a Urologist. LPN #4 reviewed Resident #3's chart and revealed that Resident #3 had appointments with the Urologist on 4/3/19, 5/14/19, 5/6/19, 6/13/19 and 7/2/19 (appointment rescheduled for 7-10-19 per daughter). Resident had a diagnosis of Urinary Retention. An interview on 07/17/19 at 02:27 PM, with CNA	M 620		

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M 620	Continued From page 10 #3, revealed that she had changed Resident #3's linens before doing catheter care and she had left Resident #3 lying flat on the bed. CNA #3 stated that she did not know how long the catheter strap had been loosened or how long the catheter bag had been located at Resident #3's ankle, since she had not assisted him to the restroom today. CNA #3 stated that she remembered holding the catheter at the top of the bag and wiping upward on the catheter tubing towards the head of the penis during catheter care and then she caught herself and moved her hand to hold the tubing at the penis and then she wiped down. CNA #3 stated she did toss the cloth in her hand during catheter care and wiped with the same cloth three (3) times when washing and rinsing Resident #3's catheter tubing and washing his groin area. She stated the cloth was not folded but, "I could tell where I was on the cloth, I can assure you". CNA #3 could not demonstrate with a clean cloth how she could determine what area on the cloth was used. CNA #3 stated that she "just knew what area had been used ". CNA #3 verified the wash cloth was not folded but rather moved around in her hand to different areas. CNA #3 stated she did not wash hands or change gloves after removing the dirty brief from between Resident #3's legs and before doing catheter care. An interview on 07/17/19 at 02:27 PM, with CNA #2, confirmed CNA #3 did wipe upward on the catheter tubing towards the penis while doing catheter care. CNA #2 stated that CNA #3 was nervous and she was trying to talk her through it. She stated that CNA #3 grabbed the tubing at the bag and not at the head of penis and wiped upward on the tubing. CNA #2 stated that CNA #3 did toss the cloth in her hand and she could see where it might be hard to tell where she was on the cloth and to know if she was using a clean	M 620		

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M 620	Continued From page 11 area on the cloth. An interview on 07/18/19 at 08:30 AM, with RN #1/Infection Control Nurse, revealed that It was an infection control issue with CNA #3 not washing her hands appropriately through-out the catheter care process. It was an infection control issue with CNA #3 tossing the cloth in her hand after wiping an area and then wiping another area. It could have been cross contamination. RN #1 confirmed CNA #3 holding the catheter tubing at the base of the drainage bag and wiping the catheter tubing upward towards the head of the penis could have caused trauma to the Urethra with the tubing pulled so tight. It could cause a urinary tract infection with him lying flat in bed and the bag being at the ankle. An interview on 07/18/19 at 8:30 AM, with the Director of Nursing (DON), revealed, "I agree with the statements made by Registered Nurse (RN) #1. We do work hard at training our CNA's on infection control and catheter care". Record Review revealed Resident #3 had the following diagnoses: Urinary tract infection, Retention of Urine, Benign prostatic hyperplasia with lower urinary tract, Unspecified complication of genitourinary prosthetic device/graft, Chronic kidney disease, and Unspecified urethral stricture. Record Review of Physician Orders dated July 2019, revealed Resident #3 ordered Pyridium 100 milligram (mg) tablet three (3) times a days needed for bladder pain, since 7/7/17. Record Review of Physician Orders dated 5/15/19, revealed Resident #3 received an order for the Antibiotic Ciprofloxacin for Urinary	M 620		

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MYRTLES NURSING CENTER, LLC	1018 ALBERTA AVENUE COLUMBIA, MS 39429

(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 620	Continued From page 12 Retention.	M 620		