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
	25WC	A. BUILDING: _____ B. WING _____	10/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW CREEK RETIREMENT CENTER	49 WILLOW CREEK LANE JACKSON, MS 39272

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M 000	Initial Comments The State Agency (SA) conducted a licensure survey from 9/30/19 through 10/3/19. The SA also conducted a complaint survey for MS #16027, MS #16115, and MS #15907. Upon investigation, the SA could not substantiate any alleged abuse regarding MS #16027 and MS #15907, but did substantiate the facility failed to prevent a resident from falling, related to use of a mechanical lift and cited a licensure deficiency at M640, related to MS #16115. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for the Aged and Infirm. The SA also cited licensure deficiencies at M225, M620 and M640. At the time of the survey, the facility had a census of 85 and held a license for 88 beds.	M 000		
M 225	45.4.1 Nursing Facility Nursing Facility. To be classified as a facility, the institution shall comply with the following staffing requirements: 1. Minimum requirements for nursing staff shall be based on the ratio of two and eight-tenths (2.80) hours of direct nursing care per resident per twenty-four (24) hours. Staffing requirements are based upon resident census. Based upon the physical layout of the nursing facility, the licensing agency may increase the nursing care per resident ratio. 2. Each facility shall have the following licensed personnel as a minimum: a. Seven (7) day coverage on the day shift by a registered nurse.	M 225		11/1/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 10/24/19

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M 225	Continued From page 1 b. A registered nurse designated as the Director of Nursing Services, who shall be employed on a full time (five [5] days per week) basis on the day shift and be responsible for all nursing services in the facility. c. Facilities of one-hundred eighty (180) beds or more shall have an assistant director of nursing services, who shall be a registered nurse. d. A registered nurse or licensed practical nurse shall serve as a charge nurse and be responsible for supervision of the total nursing activities in the facility during the 7:00 a.m. to 3:00 p.m. and 3:00 p.m. to 11:00 p.m. shift. The nurse assigned to the unit for the 11:00 p.m. to 7:00 a.m. shift may serve as both the charge nurse and medication/treatment nurse. A medication/treatment nurse for each nurses' station shall be required on all shifts. This shall be a registered nurse or licensed practical nurse. e. In facilities with sixty (60) beds or less, the director of nursing services may serve as charge nurse. f. In facilities with more than sixty (60) beds, the charge nurse may not be the director of nursing services or the medication/treatment nurse. 3. Non-Licensed Staff. The non-licensed staff shall be added to the total licensed staff, to complete the required staffing requirements. 4. There shall be at least two (2) employees in the facility at all times in the event of an emergency. This Statute is not met as evidenced by: Level II	M 225	1. Immediate actions taken for the	

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M 225	Continued From page 2 Based on record review, facility statement, and staff interview, the facility failed to provide a Registered Nurse (RN) Supervisor, for a facility with a census greater than 60 residents, for eight (8) of 17 days reviewed. Findings include: Review of a document on facility letterhead, undated and signed by the Administrator, revealed the facility does not have a policy for RN staffing. Review of the facility census, during survey, revealed a census of 85 residents. Review of a staffing grid and the working schedule, provided by the Director of Nursing (DON), revealed the DON served as RN Supervisor on 9/16/19, 9/17/19, 9/18/19, 9/19/19, 9/20/19, 9/23/19, 9/24/19, and 9/25/19. A written statement, provided by the DON, on 10/02/19 at 3:22 PM, revealed "I served as Supervisor for all units on the following dates: 9/16/19, 9/17/19, 9/18/19, 9/19/19, 9/20/19, 9/23/19, 9/24/19, and 9/25/19. During an interview on 10/02/19 at 3:22 PM, the DON revealed a lot of times, during the week, she served as the Registered Nurse (RN) Supervisor for both units. She stated on the weekends, she had a RN Supervisor. The DON stated, "To be honest, the lowest the my census has been is 80. I've done treatments, supervising, I've done it all for a while now". The DON stated she had only heard about not being able to be the DON and the Supervisor, once in the past, and had actually	M 225	residents found to have been affected include: A Registered Nurse Supervisor was hired on 9/27/2019. An As Needed (PRN)RN was employed to serve as RN Supervisor on 9/26/2019 & 9/27/2019. 2. Identification of other residents having the potential to be affected was accomplished by: All Residents within the facility have the potential to be affected by this deficient practice. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: An in-service was given to the Director of Nursing Services concerning Adequate RN Coverage in a Nursing Facility according to Federal and State Guidelines on 10/3/2019 by the Facility Administrator. Beginning 10/1/2019 the Nursing Schedule will be audited by the Director of Nursing Services or Staff Development Nurse daily to determine adequate RN Coverage is established. 4. How the corrective actions will be monitored to ensure the practice will not reoccur: The Facility Administrator will audit the Nursing Schedule to determine that RN Coverage is in compliance with Federal and State Regulations for four weeks beginning 10/25/2019. These audits will be presented to the Quality Assurance Performance Improvement Committee for review for recommendations or changes as needed until such time consistent substantial compliance has been achieved as determined by the Quality Assurance Performance Improvement Committee.	

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M 225	Continued From page 3 forgot about it. She stated she didn't have anyone else to cover the RN Supervisor position, so she did what she had to do and filled the RN Supervisor position herself. An interview on 10/03/19 at 9:50 AM, with the Administrator, revealed he knew the DON could not serve as Charge Nurse in a facility with more than 60 beds. The Administrator stated he just didn't catch the DON serving as the RN Supervisor. The Administrator stated there were other RN's at the facility some of those days, but they were in and out of the offices doing work. The Administrator stated the DON did serve as RN Supervisor on some days.	M 225		
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 prevent the possible spread of infection during catheter care for one (1) of two (2) resident catheter care observations, which affected Resident #3. Findings include:	M 620	1. Immediate actions taken for the Residents found to be affected include: Resident #3 was assessed on 10/2/2019 by the Director of Nursing Services with no adverse outcomes being identified by this deficient practice. Certified Nursing Assistant #3 was in-serviced by the Staff Development Nurse on 10/2/2019 and CNA #3 observed incontinent care, performed by the Staff Development Nurse on 10/2/2019. 2. Identification of other residents having	11/1/19

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M 620	Continued From page 4 A review of facility's "UTI Prevention with Indwelling Catheter Use" policy, dated January 27, 2015, revealed "A resident with an indwelling catheter is susceptible to Urinary Tract Infections. Catheter care should be provided daily or anytime an incontinent episode occurs". An observation on 10/01/19 at 5:11 PM, revealed Certified Nursing Aide (CNA) #3 entered Resident #3's room to perform catheter care. CNA #3 washed her hands, gloved and touched her uniform as if she was wiping her hands. CNA #3 obtained a cloth and wiped the head of the penis, moving the cloth from place to place around the head of the penis. CNA #3, using the same cloth, and without turning the cloth, wiped up and down the shaft of the penis. CNA #3 removed her gloves, and re-gloved without washing her hands. CNA #3 dried the groin area and the penis with the same area of the towel. During an interview on 10/02/19 at 3:04 PM, CNA #3 revealed that during Resident #3's catheter care, she should have wiped the head of the penis one time, discarded the cloth and retrieved a clean cloth to wipe again. CNA #3 stated she remembered wiping the head of the penis more than once with the same cloth. CNA # 3 stated she should not have wiped the shaft of the penis with the same cloth that she used to wipe the head of the penis; she should have dried each area separately, instead of wiping the whole area with the same towel. CNA #3 stated she should have washed her hands after removing her gloves and before gloving again. During an interview on 10/03/19 at 12:45 PM, Registered Nurse (RN) #2, Infection Control Nurse, confirmed CNA #3, not performing	M 620	the potential to be affected was accomplished by: Incontinent Residents in the Facility as identified by the Electronic Medical Record have the potential to be affected by this deficient practice. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Nursing Services Staff will be in-serviced by 11/01/2019 on the Guidelines of Incontinent Care and following Infection Control Procedures. These In-Services will be conducted by the Director of Nursing Services, Staff Development Nurse or RN Supervisor beginning 10/04/2019. The Staff Development Nurse or Registered Nurse Supervisor will observe CNA Staff providing incontinent Care on five Residents for nine weeks beginning 10/25/2019 through December 2019. 4. How the Corrective Actions will be monitored to ensure the practice will not reoccur: Findings of the weekly Observations will be brought to the Quality Assurance Performance Improvement Committee Monthly and reviewed by the Quality Assurance Performance Improvement Committee for recommendations or changes needed until such time consistent substantial compliance has been achieved as determined by the Quality Assurance Performance Improvement Committee.	

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M 620	Continued From page 5 catheter care correctly, could be considered an Infection control issue, sending germs straight to the bladder. She stated that not washing hands and gloving properly is also an infection control issue. During an interview on 10/03/19 at 12:55 PM, the Director of Nursing (DON) stated the lack of training was an issue as well as technique with Infection Control. The DON stated that CNA #3 wiping the head of the penis and the shaft of the penis, with the same cloth, could have caused germs to enter the head of the penis, resulting in an infection. She stated it was a big UTI risk. She stated, "By not doing hand hygiene/gloving properly, you can spread germs and infection. The DON stated the whole process was an infection control issue.	M 620		
M 640 SS=D	45.21.8 Accidents Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies. This Statute is not met as evidenced by: Level II Complaint #MS #16115 Based on staff interview, record review, and facility policy review, the facility failed to provide adequate supervision and assistance, related to the use of mechanical lifts, to prevent falls with minor injury for one (1) of four (4) residents	M 640	1. Immediate Actions taken for the residents found to have been affected include: The Certified Nursing Assistant involved in this deficient practice was terminated on 7/20/2019. The Licensed Practical Nurse Charge Nurse on duty performed an In-service on Proper Body Mechanics, Proper Use of a Mechanical Lift and the Dot Identifier System for using	11/1/19

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M 640	Continued From page 6 reviewed for accidents, Resident #9. Findings include: Review of the facility's "Modified Lifting Policy", revised 5/29/15, revealed the staff would follow the documented lifting protocol deemed appropriate for each resident. The policy also revealed the information related to the lift would be documented in the smart charting and a sticker system, which was located on each lift. Review of a "Resident Incident Report", dated 7/20/19, and the facility investigative report, dated 7/26/19, revealed Resident #9 was found lying on her right side on the floor in her room. The incident report documented that Certified Nurse Aide (CNA) #2 used the wrong lift to transfer the resident; she used the sit-to-stand lift and the resident had been assessed for the total lift. The CNA reported Resident #9 didn't stand up, while using the lift, so she lowered her to the floor. Resident #9 was transferred to the hospital, where X-rays revealed a dislocation of the right shoulder. Treatment included a shoulder immobilizer. Review of Resident #9's Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 3/26/19, revealed the resident needed extensive assist of two (2) persons to transfer. The care plan, initiated 3/19/19, revealed Resident #9 required the use of the total lift with two (2) person assistance. Review of the "Departmental Notes", dated 7/20/19 at 7:17 AM, documented by LPN #4, revealed a CNA reported she was transferring Resident #9 with the sit-to-stand lift and the	M 640	the correct lift on 7/20/2019 the morning of the incident. The Staff Development Nurse performed an In-Service on Facility Policy on 7/20/2019 requiring two people assisting when using any lift while transferring a Resident. This In-service also includes the use of the Dot Identifier System for identifying the correct mechanical lift and using the Kiosk System, placed throughout the facility, to find the lift requirements for residents. This In-Service was performed on 7/20/2019. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected by this deficient practice. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Nursing Services will be In-Serviced by the Director of Nursing Services, Staff Development Nurse or Registered Nurse Supervisor on the policy for Accidents and Supervision beginning 10/21/2019 to be completed by 11/01/2019. All Resident Falls/Accidents will be reviewed daily by the Interdisciplinary Team during the Morning Stand Up Meeting to ensure appropriate implementation of safety interventions including updating the Plan of Care. 4. How the Corrective Actions will be monitored to ensure the practice will not reoccur: The Interdisciplinary Team and the Director of Nursing Services, Facility	

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M 640	Continued From page 7 resident was unable to stand up, so she assisted her to the floor, lying on her right side. Resident #9 complained of pain in her right shoulder, the physician was notified and a new order received for a stat X-ray to the right arm. Tylenol 650 milligram (mg) administered for pain. Interview on 10/01/19 at 09:46 AM, with the Administrator revealed the facility policy was to use two (2) people for all lifts, and to transfer residents according to the resident assessment. The Administrator stated CNA #2 was terminated after the investigation on 7/21/19, for failure to follow the facility policy. An attempt to call CNA #2 at 10/01/19 at 02:59 PM, was unsuccessful, with a message left to return the call. Review of CNA #2's personnel file revealed she was terminated on 7/21/19, for wrong or improper lift with a resident causing an injury. During an interview on 10/01/19 at 3:46 PM, LPN #4 said she first became aware of the incident after CNA #2 called for help and Resident #9 was already on the floor. LPN #4 said the stand-up-lift was still in the resident's room. LPN #4 stated Resident #9 complained of pain in her shoulder, so she notified the Physician, received orders for an X-ray, and gave the resident Tylenol. Review of the Departmental Notes dated 7/20/19 at 11:25 AM revealed Resident #9 was transferred to the hospital for evaluation. Review of the "Radiology Report", dated 7/20/19, revealed the humerus of Resident #9's right shoulder was anteriorly and inferiorly dislocated, with respect to the glenoid. There was no fracture. Conclusion: Anterior shoulder	M 640	Administrator or RN Supervisor will review each incident report upon occurrence beginning 10/04/2019 to ensure appropriate interventions are implemented and an updated Plan of Care is complete. The Director of Nursing Services or RN Supervisor will complete weekly chart audits for two months through December 2019 and will review all fall incident reports to ensure that appropriate interventions have been put in place to reduce the risk of falls/accidents and that Care Plans have been updated to reflect these interventions. Audited records will be reviewed by the High Risk Committee weekly beginning 11/01/2019 and the Quality Assurance Performance Improvement Committee will review monthly and will make recommendations and changes as needed until such time consistent substantial compliance has been achieved as determined by the Quality Assurance Performance Improvement Committee.	

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M 640	Continued From page 8 dislocation. Review of the Emergency Department form, dated 7/20/19, revealed the reason for visit was shoulder pain-swelling, shoulder dislocation/fall. The final Diagnosis: shoulder dislocation, unspecified subluxation of right shoulder joint. Review of Nurse's Notes, dated 7/20/19 at 11:25 AM, revealed Resident #9 returned to the facility at 8:00 AM with a should immobilizer in place, however the care plan addressed the resident's refusal of the care. An observation on 10/02/19 at 10:55 AM, revealed Resident #9 was transferred with a full body lift and two (2) staff, without difficulty or distress. There was no noted injury to Resident #9. Interview on 10/02/19 at 03:18 PM, with the Director of Nursing (DON), revealed she was not working at this facility when the incident happened with Resident #9. The DON said the check off with the lifts, for CNA #2, could not be located. There was a documented "New Hire Orientation Video Checklist", dated 10/31/18, signed by CNA #2, for a 25 minute video completion for Vander and Vera lifts. Review of facility "Face Sheet" revealed Resident #9 was admitted on 4/14/15, with a diagnosis of dementia, unspecified.	M 640		