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
	81YC	A. BUILDING: _____ B. WING _____	11/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YALOBUSHA COUNTY NURSING HOME	630 SOUTH MAIN STREET WATER VALLEY, MS 38965

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M 000	Initial Comments The State Agency (SA) conducted an annual recertification and licensure survey from 11/4/19 through 11/7/19. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for the Aged or Infirm, and cited State Statutes at M610, M620, and M945. At the time of the survey, the census was 111, and the facility held a license for 122 beds.	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 observation, staff interview, resident interview, record review, and facility policy review, the facility failed to ensure the resident had clean, trimmed fingernails, Resident #44, one (1) of 109 residents reviewed for nail care. Findings include: Review of the facility's "Policy and Procedure for Nail Care", not dated, revealed toenails and	M 610	Bullet One: Resident #44's fingernails were assessed by RN treatment coordinator on November 5, 2019 at 2:45 p.m. The following was observed: nails on the right hand were jagged and 3 nails were long with a dark substance under them. The thumbnail on the left hand was long. Nail care was provided at the time of assessment by the RN treatment coordinator. No concerns were identified related to resident's nails being long, jagged with a dark substance under them.	12/10/19

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

Electronically Signed | 11/25/19

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M 610	Continued From page 1 fingernails are to be kept trimmed and neat. Resident #44 On 11/04/19 at 2:22 PM, observation of Resident #44 revealed the resident in bed and awake. Observation of Resident #44's fingernails revealed on the right hand all the nails needed filing and trimming. The fingernails on the right hand were jagged; three (3) were approximately 1/4 inch long and a dark brown substance was observed under the nails of three (3) fingers. The left hand was splinted. The thumb nail was long and curled in at the sides, putting pressure into the skin on the sides; no skin breakdown was noted. A dark substance was noted under the thumb nail. All nails on the left hand needed trimming and/or filing. On 11/5/19 at 11:45 AM, an observation of Resident #44's fingernails revealed the nails were long, jagged and dirty. Review of the November 2019 Physician's orders revealed an order dated 8/3/16, for Resident #44, to provide nail care as needed, and an order on 7/20/18, for nail care monthly. On 11/5/19 at 2:30 PM, an interview with Certified Nursing Assistant (CNA) #1 confirmed Resident #44's fingernails needed to be cleaned and trimmed. CNA #1 stated the Treatment Nurse was responsible for trimming and filing resident fingernails in the facility, and the CNAs should clean resident fingernails if needed. CNA #1 stated she did not know why Resident #44's were in the shape they were. On 11/5/19 at 2:40 PM, interview with Registered Nurse (RN) #1 confirmed she is the Treatment Coordinator and stated any nurse or CNA could	M 610	Bullet Two: This has the potential to affect every resident who receives Activities of Daily Living (ADL) Care in the facility. A 100% fingernail audit was conducted on each resident in the facility on November 5, 2019 by the RN treatment coordinator, LPN restorative nurse, LPN medical records nurse and RN infection control nurse. On November 6, 2019, the facility policy was modified to implement nail care weekly. An Ad-Hoc Quality Assurance (QA) meeting was held with the DON, medical director and administrator to approve the policy revision on November 6, 2019. On November 6, 2019, each residents' medical record and care plan were modified by LPN supervisor and LPN restorative nurse to reflect the policy change. Bullet Three: All nursing staff were in-serviced by the DON beginning November 5 through November 21, 2019, on the updated policy and procedure regarding resident nail care. Bullet Four: The DON or RN treatment coordinator shall monitor 100% of all residents' fingernails, to ensure nails are trimmed, filed and clean, weekly times 4 weeks, beginning November 13, 2019. The DON or RN treatment coordinator shall bring the findings of the assigned audits to the quality assurance committee quarterly and as needed.	

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M 610	Continued From page 2 clean resident fingernails. She confirmed the Treatment Nurses were responsible for trimming and filing all resident fingernails. RN #1 confirmed Resident #44's fingernails needed care, which would include cleaning, trimming and filing. On 11/5/19 at 2:45 PM, interview with the acting Director of Nursing (DON) confirmed Resident #44's fingernails needed trimming and filing, along with cleaning. The DON confirmed Resident #44's nails were dirty, jagged and long. The DON confirmed the Treatment Nurse was responsible for nail care and Resident #44 had an order written on 7/20/18, for nail care monthly. The DON stated any nurse or CNA should clean any resident's fingernails when needed. The DON revealed she would have the Treatment Nurse check all of the resident's nails and perform any needed care. On 11/07/19 at 9:51 AM, interview with the DON stated the CNAs nor nurses kept the fingernails trimmed and filed like they should have for Resident #44. Record review of the Quarterly Minimum Data Set with an Assessment Reference Date of 8/30/19, revealed in section G, Resident #44 was coded for total dependence for assistance by one (1) staff member for personal hygiene.	M 610		
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	M 620		12/10/19

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M 620	Continued From page 3 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 perform catheter care in a manner to prevent the possibility of complications, as evidenced by inadequate cleaning, and failure to secure the catheter during, cleaning for two (2) of five (5) residents with indwelling catheters, Resident #29 and Resident #104. Finding include: Review of the facility's "Urinary Catheter Care" policy, not dated, revealed it is the policy that residents with an indwelling urinary catheter shall be provided with catheter care daily to help prevent infection. The procedure for the female catheter care revealed to cleanse the labia with an antiseptic solution, using a swab or gauze pad, using only one downward stroke at a time. Discard the swab or gauze pad and clean the next area. Next, cleanse around the urethral meatus. Finally, cleanse around the catheter closest to the meatus using the same method. On 11/06/19 at 11:10 AM, an observation of Foley catheter care for Resident #104, provided by Licensed Practical Nurse (LPN) #1, revealed the LPN wiped in a circular motion around the catheter at the labia, with a 4 x 4 gauze soaked with Hibiclens. LPN #1 did not separate the resident's labia during care. LPN #1 did not anchor the catheter near the meatus while wiping outward from the resident to clean the catheter. She then rinsed, using sterile water and 4 x 4 gauze, wiping in the same manner, and she did not anchor the catheter while rinsing. LPN #1 did	M 620	Bullet One: Resident #104 was assessed by the DON on November 6, 2019 at 3: 00 p.m. for any concerns related to LPN #1's failure to adequately separate the labia, failure to secure catheter tubing while wiping and failure to pat area dry during catheter care. No concerns were noted. Resident #29 was assessed by DON on November 6, 2019 at 3:00 p.m. for any concerns related to LPN #1's failure to adequately secure the catheter during catheter care. No concerns were noted. On November 9, 2019, LPN #1 was in-serviced by LPN supervisor on proper procedures of performing urinary catheter care prior to providing any further resident care. On November 6, 2019, at 3:10 p.m. the RN treatment coordinator revisited residents #104 and # 29 and performed catheter care. Bullet Two: This has the potential to affect 5 residents receiving indwelling catheter care within the facility. Bullet Three: All RN's and LPN's providing direct care were in-serviced on proper procedures of performing urinary catheter care by LPN supervisor and DON beginning November 7, 2019, through November 8, 2019. A skills competency check was conducted by DON and LPN supervisor on all RN's and LPN's providing direct care to ensure proper procedures were followed. No concerns of improper care were noted. Bullet 4: The DON or RN/LPN Supervisor	

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M 620	Continued From page 4 not separate the Resident's labia during any portion of the care. LPN #1 did not pat the area dry after rinsing. An interview, on 11/06/19 at 2:38 PM, with the Director of Nursing (DON), revealed not properly cleaning during catheter care can cause skin breaks and increase the risk of infection. She stated not securing the catheter during care could cause pain and possible dislodgement of the catheter. During an interview, on 11/06/19 at 4:20 PM, LPN #1 stated she did not anchor the catheter when she cleaned it from the insertion site outward. LPN #1 confirmed she did not part the labia and adequately clean the resident. She stated she should have held the catheter to prevent pulling and causing discomfort to the resident or dislodging of the catheter. She stated not adequately cleaning around the catheter could allow bacteria to set up and cause infections. An interview on 11/06/19 at 9:35 AM, with the DON, the nurse didn't follow the physician's orders if she didn't pat the area dry after cleansing the catheter. The DON stated the nurse should have anchored the catheter while providing care. She stated this is a standard of practice and should be a part of the nurses general knowledge. Record review revealed LPN #1 had attended an in-service addressing care of urinary catheters on 08/17/19. Resident #29 Observation on 11/06/19, at 2:03 PM, revealed Licensed Practical Nurse #1 (LPN) performed suprapubic catheter care for Resident #29, she	M 620	shall monitor 3 nurses providing catheter care weekly for 4 weeks using a skills competency check beginning November 13, 2019. The DON or RN/LPN supervisor shall bring the findings of the assigned audits to the QA committee meeting quarterly and as needed.	

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M 620	Continued From page 5 cleaned the insertion site and catheter tubing from the insertion site, down the tube, with a 4 x 4 gauze moistened with Hibiclens. She rinsed with sterile water per 4 x 4 gauze. LPN #1 did not pat the area dry per physician order nor anchor the catheter tubing at the insertion site while cleaning/rinsing down the tubing with the 4 x 4. Review of the Physician Order, dated 4/20/19, revealed: Clean catheter insertion site with Hibiclens, rinse with sterile water, and pat dry every shift. During an interview on 11/06/19 at 2:09 PM, LPN #1 stated the catheter tubing should be held at the insertion site to prevent pulling the tube out; because that was considered standard practice. During an interview on 11/06/19 at 2:45 PM, the Director of Nursing (DON) stated not anchoring the tubing could cause dislodgement of the catheter and pain for the resident. She stated not patting the area dry after care would not be following physician orders. Further interview with the DON, on 11/07/19, at 8:45 AM, revealed the facility policy did not include anchoring the catheter tubing during cleaning, but it was a standard of practice and the policy would be updated. Review of the Face Sheet revealed the facility admitted Resident #29 on 4/30/19, with a diagnosis of Unspecified Intracranial Injury and Obstructive and Reflux Uropathy, unspecified. Record review of the Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 8/6/19, revealed that Resident #29 had severely impaired cognitive skills for daily decision making.	M 620		

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M 945	45.32.4 Food Storage Food Storage. A food-storage room with cross ventilation shall be provided. Adequate shelving, bins, and heavy plastic or galvanized cans shall be provided. The storeroom shall be of such construction as to prevent the invasion of rodents and insects, the seepage of dust and water leakage, or any other source of contamination. The food-storage room should be adjacent to the kitchen and convenient to the receiving area. The minimum area for a food-storage room shall equal two and one-half (2 1/2) square feet per bed and the width of the aisle shall be a minimum of three (3) feet. This Statute is not met as evidenced by: Level II Based on observation, staff interview, and facility policy review, the facility failed to label and date food, stored in the refrigerator and dry storage area, for one (1) of three (3) dietary tours with the likelihood of affecting 103 of 109 residents who receive meals from the kitchen. Findings include: Review of the facility's "Food Storage Policy", not dated, revealed it is the policy of the facility that PHF/TCS foods (leftovers) will be labeled and dated with the date up on which the food was opened/prepared and then discarded within three (3) days of that date, beginning on the day the food was prepared, or a commercial container was opened. During initial tour of the kitchen on 11/04/19 at 10:30 AM, an observation of the refrigerator revealed 13 blueberry muffins covered with	M 945	Bullet One: Thirteen blueberry muffins, 3 donuts, 2 breaded chicken patties, one pancake, one Halloween goody bag with candy and a popcorn ball, approximately 2 cups of shredded cheese, 2 tomato slices, lettuce and white bag containing a Styrofoam dish of food located in the refrigerator and opened bag of two-way chocolate cake mix and open bag of Devil's food cake mix located in dry food storage area were all discarded by the Dietary Manager on November 4, 2019 at 10:30 a.m. Bullet Two: This has the potential to affect 103 residents who receive food prepared by or stored by the facility's dietary department. Bullet Three: All dietary staff were in-serviced beginning November 5 through November 9, 2019, by the Dietary Director regarding the dietary department food	12/10/19

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M 945	Continued From page 7 plastic, not dated, three (3) donuts on a plate, two (2) breaded chicken patties in a zip lock bag, one (1) pancake in a zip lock bag, one (1) decorative Halloween goody bag with candies and a popcorn ball, an opened bag containing approximately two (2) cups of shredded cheese, a zip lock bag with two (2) tomato slices, lettuce in a zip lock bag, and a white bag containing a Styrofoam covered dish with food in it, all not dated. Dietary Staff stated the covered dish belonged to a staff member. Observation, of the dry food storage area revealed an opened bag of two-way chocolate cake mix and an open bag of Devil's food cake mix, with no open date. During an interview on 11/04/19 at 10:45 AM, the Dietary Manager (DM) stated the staff knew they should label and date all foods put in the refrigerator. The DM stated if food items are not labeled and dated, you don't know when to throw it out. She stated if the food was not dated, it might be spoiled, and could make people sick. An observation and interview on 11/04/19 at 10:45 AM, revealed a large plastic container on the bottom shelf in the right hand corner of the refrigerator for staff to place personal items. The DM stated the staff knows not to put personal stuff in the refrigerator with resident food. She stated there is a plastic box with a lid on it in the refrigerator for the staff to put personal stuff in. An interview, on 11/06/19 at 4:10 PM, with the Registered Dietician (RD), confirmed the food in the refrigerator should be labeled and dated. She stated they have talked and talked about this. The RD stated the leftovers should be labeled and dated and to be thrown away after three (3) days. The RD stated she did not want any sickness and food borne illnesses. She stated the	M 945	storage policy and the correct method for covering, labeling and dating food. This in-service also contained proper storage of employee food. Bullet Four: The dietary director or dietary manager shall monitor the refrigerator/coolers, freezer and dry storage daily times two weeks, weekly times four weeks beginning November 4, 2019. The Dietary Director or dietary manager shall bring the findings of the assigned audits to the quality assurance committee quarterly and as needed.	

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M 945	Continued From page 8 staff has a designated area to put personal food items. She stated if their food is not in the right area, there is a risk it could be given to resident. An interview, with the Director of Nursing (DON) on 11/07/19 at 11:40 AM, revealed the facility had five (5) residents who can receive meals in addition to their tube feedings. Record review revealed the facility had a total of 11 residents who receive tube feedings. This resulted in 103 residents receiving food from the kitchen.	M 945		