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
	42GA	A. BUILDING: _____ B. WING _____	10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN AGE NURSING HOME	2901 HIGHWAY 82 EAST GREENWOOD, MS 38930

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M 000	Initial Comments The State Agency (SA) conducted a licensure survey at the facility 10/16/17 to 10/19/17. During the survey, the SA determined the facility was not in compliance with State Licensure Regulations for the Aged or Infirm, and cited State Statutes at M635 and M640. The facility is licensed for 150 beds and the census at the time of survey was 127.	M 000		
M 635	45.21.7 Gastric feeding Gastric feeding. Residents who are eating alone or with assistance are not fed by a gastric tube unless their clinical condition indicates that the use of a gastric feeding tube is unavoidable. The residents who are fed by a gastric tube receive the treatment and services to prevent complications or to restore if possible, normal eating skills. 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 administer medications through a Percutaneous Endoscopic Gastrostomy (PEG) tube separately, to ensure comparability and to help prevent clogging, for two (2) of seven (7) medication observations (Residents #15 and #16). Findings include: Review of the facility "Administration of Medication via Asiatic/Gastrostomy Tube", policy, with a revision date of 7/19/15, revealed no	M 635	M635 1. Resident #15 was assessed by Director of Nursing on 10/19/17 for adverse effects of not administering medications separately through a Gastrostomy (PEG) tube. Resident #16 was assessed by Director of Nursing on 10/19/17 for adverse effects of not administering medications separately through a Gastrostomy tube. 2. All residents receiving medications through a Gastrostomy (PEG) tube have	11/16/17

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M 635	Continued From page 1 directions that instructed staff to administer medications separately unless the resident is on fluid restriction. The policy revealed instructions that medications can be administered in a single medication administration if medications are compatible. Review of Mosby's Pocket Guide to Nursing Skills and Procedures, Perry and Potter, eighth edition, revealed under: Oral Medications: Nasogastric Tube Administration: Crush each tablet into a fine powder. Dissolve each tablet in separate cup of 30 milliliter (ml) of warm water. (Fine powder dissolves more easily, reducing chance of occluding feeding tube). To administer more than one (1) medication, give each separately, and flush between medication with 15 to 30 ml of water. (Allows for accurate identification of medication if dose is spilled. In addition, some medications may be incompatible). Resident #15: During a medication pass observation, on 10/16/17 at 3:45 PM, Licensed Practical Nurse (LPN) #2 administered medication to Resident #15. LPN #2 prepared Resident #15's medication at her medication cart in the hall outside the resident's room. LPN #2 placed the Vitamin C and Methenamine HiPP in a small bag and crushed together and placed in a five (5) ounce plastic cup and mixed with 30 cubic centimeters (cc)'s of water. LPN #2 then poured the Potassium and ProStat in separate medication cups. LPN #2 flushed the PEG with 60 cc's of water, administered the crushed medications in a cup with water, administered the Potassium, ProStat, added some water to the Prostat due to it was thick and not draining down the syringe and ended with a flush of 50 cc's of water, all via the PEG. LPN #2 crushed	M 635	the potential to be affected by not administering medications separately. 3. Enteral Tube Medication Administration policy was revised 11/9/17 to include administering medications separately through a gastrostomy (PEG) tube. In-service training initiated 11/9/17 by the Director of Nursing for Registered Nurses and Licensed Practical Nurses on revised Enteral Tube Medication Administration policy. Nurses will be in-serviced on revised policy prior to working. Newly hired Registered Nurses and Licensed Practical Nurses hired on or after 11/9/17 will be checked off on orientation checklist for administer crush meds separately. 4. Quality Assurance Committee reviewed deficiencies and possible corrective action 10/25/17 To ensure corrective action is achieved and sustained, three (3) med pass observations will be conducted weekly for 12 weeks by Unit Manager of medication administration through a Gastrostomy (PEG). Peg Tube Medication Observation checklist will be used to monitor compliance. The audits will be presented to the Quality Assurance Committee quarterly at a minimum or as often as needed to assure continued performance.	

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M 635	Continued From page 2 medications together and administered them together, did not flush with water between the crushed medications, the Potassium or the ProStat. The facility admitted Resident #15 on 10/5/07, with diagnoses which include Anxiety, Alzheimer's Disease and Gastrostomy Status. Review of the Quarterly Minimum Data Set (MDS) for Resident #15, with an Assessment Reference Date (ARD) of 9/5/17, revealed a Brief Interview of Mental Status (BIMS) score of 7, which indicated severely impaired mental status. Section K revealed Resident #15 has a feeding tube. Resident #16: An observation on 10/16/17 at 4:36 PM, revealed Licensed Practical Nurse (LPN) #4 administered medications to Resident #16 through her PEG tube. LPN #4 combined Warfarin Sodium 3 milligrams (mg), one (1) tablet, Vitamin C 500 mg, one (1) tablet, and 30 milliliters (ml) of Pro T Gold (a protein supplement), into one (1) cup and administered them through the PEG tube. She did not administer them separately with a flush in between each medication. Record review of Resident #16's Face Sheet revealed the resident was admitted to the facility on 12/19/12, with diagnoses of Unspecified Convulsions, Type 2 Diabetes Mellitus, Aphasia, Hypertension, Gastrostomy Status, and Cerebral Infarction. Review of the annual MDS with an ARD of 9/5/17, revealed Resident #16 had a BIMS score of zero (0), indicating severely impaired cognitive skills for daily decision making.	M 635	Quality Assurance Committee reviewed Plan of Correction 11/9/17	

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M 635	Continued From page 3 During an interview, on 10/18/17 at 3:00 PM, the Director of Nursing (DON) confirmed medications through a PEG should be given separately and flushed with water between each one, with the exception if a resident had fluid restrictions. The DON confirmed Resident #15 and #16 did not have an order for fluid restriction. The DON revealed she thought that having an order that allowed medications to be mixed would be enough to allow them to be administered together. An interview with the Pharmacy Consultant on 10/18/17, at 11:09 AM, revealed that he was aware of the regulation requiring all PEG medications to be administered separately and that he felt this was a gray area. He stated that his understanding was that it was suggested, not required, while in the gray area before the new regulations were released. He stated that it is also his understanding that as long as the Facility Policy covered the administration of the medications together, it would be acceptable. When asked if he had reviewed all residents with PEG tube medications to ensure the medications were compatible, he stated "No", that he does a general review monthly.	M 635		
M 640	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.	M 640		11/16/17

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M 640	Continued From page 4 This Statute is not met as evidenced by: Level II Based on observation, Staff interview and facility policy review the facility failed to store hazardous chemicals in a manner to prevent the potential injury to residents as evidenced by two (2) of Five (5) chemical storage areas unlocked and two (2) of three (3) housekeeping carts unlocked. Findings include: Review of facility's "Hazardous Chemical Storage Policy", dated 04/15, revealed hazardous chemicals shall be maintained in a safe, clean and locked location when not in use. Hazardous chemicals will be maintained in a locked storage area at all times. Hazardous chemicals in use shall remain under direct control by facility personnel while in common traffic areas. Hazardous materials placed on "cleaning carts" shall be locked in the provided container after each use or not when in direct use by facility personnel. Observation on 10/16/16 at 11:40 AM, revealed an unlocked Housekeeping Supply closet. This closet door had a napkin stuffed into the door jamb to prevent it from locking. The unlocked closet contained one (1) 33.8 ounce bag of lotion soap (for a dispenser) and one (1) can of enforcer insect spray. The supply closet was in close proximity of the nurse's station, where it was in direct view of the staff at the station. There were no residents observed wandering in the area or attempting to get into the supply closet. Review of the Safety Data Sheet for the "Purge III metered flying insect killer" (date 6/2/15) revealed	M 640	M640 1. Housekeeping supply closet door lock on green wing was replaced 10/16/17. No resident was affected. Blue wing storage room was locked and sign placed on door to keep door locked at all times by pushing the L (Lock) button. The Huskey SV Disinfectant was removed until an auto lock could be secured and installed. No Resident was affected. Housekeeper #5 received 1:1 in-service education on 10/16/17 by the Housekeeping Supervisor on Locking of Housekeeping carts and no personal items on cart. No Resident was affected. Housekeeping #2 received 1:1 in-service education on 10/16/17 by the Housekeeping Supervisor on Locking of Housekeeping cart. No Resident was affected. 2. All residents have the potential to be affected by hazardous chemicals not stored in a manner to prevent injury. All housekeeping supply closet locks were checked for proper functioning 10/16/17. Key pad auto lock was installed on blue storage room door 11/3/17.	

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M 640	Continued From page 5 this product is harmful if swallowed or if absorbed through the skin. During an interview on 10/16/17 at 11:40 AM, Housekeeping Staff #1 revealed she did not know how the napkin got lodged in the doorjamb, she did not work the weekend. She stated that the lock was working on her last shift. During an interview on 10/16/17 at 11:40 AM, Registered Nurse (RN) #2 revealed she did not know if the door was unlocked to the Housekeeping supply closet because she never goes in or out of that door. She had not seen residents attempt to go in or out the closet. During an interview on 10/16/17 at 4:00 PM, RN #1 revealed she had worked the previous Saturday and Sunday shift from 8:00 AM to 7:00 PM as Supervisor. She recalled the "Green Hall" Housekeeping closet lock was working fine because she saw Housekeeping staff using the key pad to unlock the door. RN #1 revealed the Housekeeping closet door is supposed to be locked at all times for the protection of the Residents. During an interview on 10/19/17 at 09:30 AM, Maintenance Staff #4 revealed he was notified that morning (10/16/17) the Housekeeping door on Green Hall was broken and would not open with key pad once it was shut. He revealed his department is notified about repair needs that are filled out per staff and he did not receive a work order on this door. On 10/16/17 at 11:50 AM, an observation on the Blue Hall, revealed a housekeeping cart was unlocked, the door open, and keys in the door. Housekeeper #5 was observed walking toward	M 640	3. In-service training for all Housekeeping staff initiated on 10/16/17 by Administrator on storage of chemicals under lock, reporting any malfunction equipment, and no food/personal items on cart. Inservice initiated for all staff 11/1/17 by Administrator on review of Hazard Chemical Storage Policy and reporting equipment issues. 4. Quality Assurance Committee reviewed deficiencies and possible corrective action 10/25/17 To monitor for compliance, the Administrator or designee will complete daily random checks of three (3) Housekeeping Carts Monday through Friday for 4 weeks then three (3) carts a week Monday through Friday for 2 weeks. The audits will be presented to the Quality Assurance Committee quarterly at a minimum or as often as needed to assure continued performance. Storage closets with chemicals have auto locks. To monitor for proper functioning, door checks will be performed daily by patrol staff. Door Checks form will be used to monitor for proper functioning. The Quality Assurance Committee reviewed Plan of Correction 11/9/17.	

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M 640	Continued From page 6 the housekeeping cart on the Blue Hall. On 10/16/17 at 11:50 AM, an interview with Housekeeper #5 revealed, "I just did it, this is the first time". Housekeeper #5 revealed that she had been employed for six (6) months and "was in-serviced when she started to work about keeping the cart locked. Housekeeper #5 confirmed contents of the cart and revealed that "The purse and water is mine." Observation of the housekeeping cart on Blue Hall, with Housekeeper #5 on 10/16/17 at 11:50 AM, revealed the cart contained the following items and the hazardous information: 1. Sani-wipes (blue lid): hazard precautions causes serious eye irritation 2. Comet Liquid 32 ounces: hazard precautions causes eye irritation 3. Glass cleanser one (1) quart spray: hazardous precautions extremely flammable, may cause skin and eye irritation, may cause respiratory irritation in inhaled 4. Lysol surface disinfectant aerosol 17 ounces: hazardous precautions flammable, may cause eye and respiratory tract irritation 5. Pexory II bath and surface cleaner 32 ounces: hazardous precautions causes skin and serious eye irritation 6. A purse (handbag) 7. Smart Water 2 ounce bottle On 10/17/17 at 10:55 AM, an interview with Housekeeper #3 (Supervisor) revealed, "We in-serviced last week about not putting food, drinks or personal items in the cart. The keys are never to be left in the cart. If the lock is broken they are to tell me and we will replace it. (Name of Housekeeper#5) on the Blue Hall is new but she	M 640		

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M 640	Continued From page 7 should have known better." On 10/17/17 at 11:10 AM, an interview with the facility Administrator revealed, "They (housekeeping) know they are not supposed to have personal items in the carts. The carts are to be locked at all times, no keys in the door. We have had in-services from time to time to cover this." On 10/16/17 at 11:55 AM, a tour of Blue Hall revealed a storage room's door was unlocked and was opened by pushing on the door. Immediately to the right, after entering the door, was a cardboard box that was closed, but not sealed, and contained four (4), one (1) gallon, containers of "Huskey SV Disinfectant". The storage room is on the Blue hall which was currently being remodeled and all the rooms were empty except for two (2) rooms. The resident in room 78 has a BIMS score of 9, could not ambulate and required assistance to be pushed in a wheelchair. The resident in room 97 had a BIMS score of 15, and required limited assistance of one (1) person with ambulation. Record Review of the Safety Data Sheet on "Huskey 800 Neutral Disinfectant Cleaner" revealed may cause skin irritation, serious eye damage and harmful if swallowed. On 10/16/17 at 11:55 AM, an interview with Registered Nurse (RN) #3 revealed she did not know how long the storage room door had been unlocked on Blue Hall. There is a keypad to unlock the door and a button had to be pushed when leaving the room to lock the door. RN #3 revealed she did not make rounds to check locked doors and was not sure who did and the	M 640		

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M 640	Continued From page 8 last person that entered the room must not have locked the door properly. RN #3 revealed she had never seen any resident's entering the storage room. On 10/16/17 at 12:05 PM, an interview with Certified Nursing Assistant (CNA) #1 revealed the storage room door should always be locked and sometimes she finds it locked and sometimes it is not locked. Observation on 10/16/17 at 12:25 PM, revealed an unattended housekeeping cart sitting in the doorway of Room 107 on the Yellow hall with the keys in the door where chemicals were stored. No Residents were in Room 107 at the time of this observation. Housekeeper #2 was seen walking from the end of the Yellow hall towards her cart. Supplies on the cart included: 1. Peroxy II spray, 2. Comet 3. Chlorox wipes, 4. Glass cleaner, 5. Lysol Disinfectant Cleaner 6. Odo-Ban Spray. In an interview, on 10/16/17 at 12:27 PM, Housekeeper #2 confirmed she had left her keys in the cart. She stated she normally locked the cart and put the key in her pocket but she just forgot. Housekeeper #2 stated she had walked to the end of the hall to turn the fan off and was coming right back. Housekeeper #2 confirmed that someone could have gotten supplies off her cart while she was away. There were no residents observed wandering around the hall or near the housekeeping cart. On 10/16/17 at 12:30 PM, an interview with the facility Administrator revealed the facility had an	M 640		

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M 640	Continued From page 9 in-service two (2) months prior on Hazard Communication and the facility's MSDS (Material Safety Data Sheets). On 10/16/17 at 12:54 PM, an interview with the Administrator revealed there had not been any incidents with a resident involving any chemicals or any supplies that should be locked up.	M 640		