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
	24GC	A. BUILDING: _____ B. WING _____	03/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOYINGTON HEALTH AND REHABILITATION	1530 BROAD AVE GULFPORT, MS 39501

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M 000	Initial Comments The State Agency (SA) conducted a licensure survey from 3/5/19 through 3/8/19. During the survey the SA determined the facility was not in compliance with the Minimum Standards for the Aged and Infirm. The SA cited M 615 and M 620. At the time of the survey, the census was 143 and the facility held a license for 180 beds.	M 000		
M 615	45.21.3 Pressure sores Pressure sores. Residents with a pressure sore shall receive necessary treatment and service to promote healing and prevent the development of new pressure sores. Residents without pressure sores will not develop pressure sores unless the residents' clinical condition indicates they were unavoidable. This Statute is not met as evidenced by: Level II Based on observations, staff interview, record review, and facility policy review, the facility failed to provide wound care in a manner to promote healing for three (3) of six (6) resident wound care observations: Resident #2, Resident #57, and Resident #133. Findings Include: A review of the facility's policy titled, "Pressure Ulcer Treatment," dated September 2018, revealed that it is the purpose of this facility's procedure to provide guidelines for the treatment of pressure ulcers to facilitate healing and to prevent further deterioration. The Pressure Ulcer Treatment procedure outlined certain steps in the procedure as follows: Put on exam gloves, loosen	M 615	Corrective Action: Risk Manager (RM) in-serviced Registered Nurse (RN) #3 on 3/8/19 on providing wound care in a manner to promote healing and prevent infection. These in-services included hand washing and cleaning of equipment during wound care treatments. Residents #2, #57, and #133 were assessed by the Director of Nursing (DON) on 3/11/19 for negative outcomes due to the cited deficiency. No negative outcomes were noted. Identification of others with potential to be affected: Rounds were made by the DON on 3/11/19 to identify any residents affected	4/30/19

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

Electronically Signed | 04/10/19

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M 615	Continued From page 1 tape and remove dressing, remove gloves, then wash hands, and now put on clean gloves. Observe the pressure ulcer, dress the pressure ulcer with the prescribed dressing, discard all disposable items into designated container, and remove gloves and discard into designated container. Wash hands. Resident #2 An observation, on 03/06/2019 at 8:46 AM, revealed Resident #2's wound care was provided by Registered Nurse (RN) #3. RN #3 performed the wound care on three (3) separate pressure wounds: A Stage 4 pressure wound to the left (L) Ischium, a Stage 4 pressure wound to the right (R) Ischium, and a Stage 4 pressure wound to the sacral area. RN # 3 performed the wound care to both the Stage 4 pressure wounds to the (L) Ischium and (R) Ischium, without incident. During the wound care on the Stage 4 pressure wound to the sacral area, RN #3 discarded the soiled four by four gauze used for cleaning the wound, and then continued with the wound care by applying two (2) out of three (3) dressing ropes into the wound bed without washing her hands. After applying the second dressing rope, it was then that RN #3 removed her gloves, washed her hands, put on new gloves, and then continued to apply the third dressing into the wound. During an interview, on 03/07/2019 at 11:00 AM, Registered Nurse (RN) #3 confirmed she did not wash her hands after she discarded the soiled gauze from cleaning the sacral wound, and before she applied the first two (2) medicated rope dressings. RN #3 stated she remembered washing her hands before she applied the third medicated rope dressing. RN #3 stated, "I didn't realize I didn't wash my hands, because I usually	M 615	as a result of the cited deficiency. There were no residents with wounds identified with negative outcomes. To ensure deficient practice does not recur: Hand washing during wound care will be observed by DON, Risk Manager (RM), Unit Managers, or Staff Development Coordinator (SDC) three times per week for four weeks and one time per week thereafter until compliance is achieved. Wound care treatments will be observed by DON, RM, Unit Managers, or SDC three times per week for four weeks and one time per week thereafter until compliance is achieved, to ensure supplies and equipment are sanitary. In-services were initiated by RM on 3/11/19 to 100% of Nursing Staff on proper hand washing and sanitation of supplies/equipment procedures during wound care. New hires will be in-serviced on cited deficiency during orientation by SDC or Orientation leader. Quality Assurance: Effective 3/11/19, a Performance Improvement Plan was initiated by the DON and RM to monitor outcomes of the cited deficiency. Any deficiencies will be documented and submitted by the DON at the monthly Quality Assurance meeting for further review or corrective action.	

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M 615	Continued From page 2 wash my hands before and after each time I apply the rope dressing into the wound." RN #3 stated not washing your hands is an infection control concern. A review of Resident #2's Order Summary Report for Active Orders as of 03/08/2019, revealed an order, dated 03/05/19 and start date of 03/06/19, to cleanse wound to sacrum with normal saline, pat dry, apply skin prep to peri-wound. Fill wound with alginate extra rope wound dressing, cover with 4x4 gauze, and cover with super absorbent dry dressing daily and as needed (PRN) every day shift. Review of Resident # 2's Electronic Treatment Administration Record (ETAR), dated March 03/01/2019-03/31/2019) 2019, revealed the following treatment been provided for the sacral wound: Cleanse wound to sacrum with Normal Saline (NS) and pat dry, apply skin prep to peri-wound, Fill wound with alginate extra rope wound dressing, cover with four by four (4x4) gauze, and cover with super absorbent dry dressing daily and as needed (PRN) every day shift. During an interview, on 03/07/2019 at 11:15 AM, the Director of Nursing (DON) revealed RN #3 should have washed her hands after she cleaned the sacral wound, and before she applied the medicated rope dressing. The DON stated, "If your hands are not washed, that it is an infection control concern." An interview, on 03/07/2019 at 1:54 PM, with Licensed Practical Nurse (LPN) #1/Care Plan Coordinator, revealed it was her expectation that the nurse would provide the wound care treatment, without risking the possible spread of	M 615		

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M 615	Continued From page 3 infection. An interview, on 03/07/2019 at 3:32 PM, with Registered Nurse (RN) #2/Infection Control Nurse, said during the wound care provided on Resident #2, RN #3 should have washed her hands after cleaning the wound, and prior to the packing of the wound with the rope dressing. Review of Resident #2's Discharge Minimum Data Set (MDS), dated 02/14/19, revealed a Basic Interview for Mental Status (BIMS) score of 15, which indicated no cognitive impairment. Further review of the MDS revealed Resident #2 was coded for the presence of two (2) Stage 3 pressure wounds. Review of Resident #2's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/19/18, revealed a Basic Interview for Mental Status (BIMS) score of 15, which indicated no cognitive impairment. Further review of the MDS revealed Resident #2 was coded for two (2) Stage 4 pressure wounds. Review of the Face Sheet revealed Resident #2 was admitted by the facility on 03/05/2013, and readmitted on 01/21/2015, with diagnoses to include Paraplegia and Pressure Ulcer to the left and right buttocks. Resident #57 An Observation, on 03/07/19 at 10:15 AM, revealed Registered Nurse (RN) #3/Wound Care Nurse, performed wound care to resident #57 sacrum with the assistance of Certified Nursing Assistant (CNA) #3. RN #3 placed a red bag on resident's bed to the right side of the resident's right leg. RN #3 removed the old dressing and discarded the dressing in the red bag. RN #3	M 615		

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M 615	Continued From page 4 washed her hands, gloved, and began to clean the wound. RN #3 cleaned the wound, and patted it dry. RN #3 applied Santyl to the wound bed with a Q-tip applicator, and covered the wound with a silicone dressing. RN #3 wore the same gloves that she had on while cleaning the wound to apply the Santyl and clean dressing to the wound. RN #3 failed to remove her gloves, wash her hands, and re-glove after cleaning the wound and before applying the Santyl and the clean dressing to the wound. During an interview, on 03/07/19 at 10:48 AM, RN #3/Wound Care Nurse, stated, "I knew what I did when I did it. I didn't change gloves and wash my hands after cleaning the wound and before I applied the Santyl and the clean dressing. It could be an infection control issue". Review of Resident #57's Electronic Treatment Administration Record (ETAR), dated March 2019, revealed the daily wound care treatment to the sacrum was provided daily as follows:. Clean sacrum with Normal Saline (N/S), Pat dry, and apply Santyl in a thin layer. Pack with gauze and cover with silicone dressing daily and PRN. An interview, on 03/07/19 at 3:22 PM, with RN #2/ Infection control nurse, revealed, "RN #3 should have removed her gloves, washed hands and re-gloved before placing the Santyl and bandage on the clean wound". "I see that as an infection control Issue". An interview, on 03/07/19 at 3:44 PM, with the Director of Nursing (DON) revealed, "the nurse not changing her gloves and washing her hands after cleaning the wound and before applying Santyl and the dressing is an infection control issue".	M 615		

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M 615	Continued From page 5 Review of Resident #57's Significant Change MDS, with an ARD of 01/11/19, revealed a BIMS score of 10, which indicated moderate cognitive impairment. Further review of the MDS revealed Resident #57 was coded for an unstageable wound. Resident #133 An observation, on 03/05/19, 4:40 PM, revealed Registered Nurse (RN) #3/Wound Care Nurse provided Resident #133's wound care to the right foot/great toe. RN #3 was assisted by Certified Nursing Assistant (CNA) #3. RN #3 set up the wound care supplies on the over bed table, and then she placed the red biohazard bag on Resident #3, which positioned the right toe wound between RN #3 and the red biohazard bag. After looking over the supplies RN #3 identified she forgot to get scissors from the wound care cart. RN #3 left the room, and returned with the scissors in her bare hands. RN #3 laid the scissors on the tray containing her clean dressings without cleaning the scissors. RN #3 removed the dirty dressing, and discarded it into the red biohazard bag. RN #3 washed her hands and gloved to begin cleaning the wound. RN #3 wiped the wound with normal saline soaked gauze, and discarded the gauze into the red bag. RN #3 got another piece of normal saline gauze, wiped the other side of the wound, and discarded the gauze into the red bag. RN #3 took another piece of the normal saline gauze, wiped the wound, and the normal saline dripped down the side of the foot. RN #3 took the same piece of gauze and reached down to catch the dripping saline and wiped back towards the cleaned wound going from an uncleaned area to a cleaned area, thus wiping dirty to clean. RN #3	M 615		

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M 615	Continued From page 6 did not reclean the wound before attempting to apply the wound vac to the wound. RN #3 washed her hands and gloved, and then picked up the foam that was to be packed into the wound and crossed the cleaned wound over to the red bag and held the foam above the red bag, with the dirty dressing and gauze in it, and began trimming the foam with the uncleaned scissors. RN #3 brought the foam from over the red bag back to the wound, and placed it on the wound. She then reached back over and got the second piece of foam and crossed the clean wound again going to the red bag. RN #3 began trimming the foam over the red bag, and then brought the foam back and placed it on wound. She picked up the end of the wound vac that was to be placed over the foam on the wound. RN #3 placed the wound vac tubing on Resident #133's gown. The end to the tubing was uncapped. RN #3 sealed the part of the wound vac with the dressings cut earlier. She then picked up the tubing from the gown and hooked it to the wound vac itself without cleaning the uncapped tube. Suction was obtained. RN #3 cleaned up her trash, washed her hands, and exited the room. An interview, on 03/05/19 at 5:10 PM, with RN #3/Wound Care Nurse revealed, "I did wipe the wound from dirty to clean and I knew it when I did it." RN #3 stated, "I didn't think about crossing over the wound to the red bag with the foam then bringing it back over and putting it in the wound. I can see where that would be a contamination issue. I cleaned the scissors before bringing them in the room, but I didn't reclean them after bringing them into the room in my hand. I didn't think about that being an issue but I can see where they could be considered dirty being toted in my bare hand. I held the foam above the red bag to trim it, and I wasn't thinking about it being	M 615		

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M 615	Continued From page 7 a contamination issue since I didn't touch it. But with the dirty dressing being in the red bag I can see it being a issue". Record review of Resident #133's Physician Orders revealed the following orders: (1) Right Great Toe Amputation Site: Cleanse with NS (Normal Saline), pat dry, apply Dankins ½ strength wet to dry packing. Cover with 4x4s and wrap with Kerlix PRN (as needed) when wound vac is reapplied. Start Date 02/27/19. (2) Wound vac (negative pressure wound therapy) in place to wound to right great toe amputation site. Apply wound vac at amputation site at 125 mmHg (millimeters of Mercury) Change Q (every) Tuesday and Friday. Start Date 02/26/19. During an interview, on 03/07/19 3:08 PM, RN #2/Infection Control Nurse, revealed wiping the resident's wound from dirty to clean and not recleaning the wound before dressing it would be a infection control issue. RN #2 said RN #3 should not have crossed the leg with the foam to the red bag. RN #2 stated RN #3 shouldn't go across the wound with the wound vac foam because your crossing the clean wound with supplies coming from the over bed table. RN #2 said RN #3 was going back to the clean wound with something dirty after she held it over the red bag. RN #2 also stated the tubing should not have been laid on Resident #133's gown. It should have been on a clean surface or RN #3 should have cleaned it before connecting it to the other capped end of the tube. RN #2 also stated the scissors should have been recleaned before using them since she had transported them in her bare hand. An interview, on 03/07/19 at 3:49 PM, with the Director of Nursing (DON) revealed RN #3's	M 615		

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M 615	Continued From page 8 failure not to reclean the scissors before cutting the clean dressing was an infection control issue. The DON stated RN #3 crossing the clean wound with the foam was an infection control issue also. The DON stated RN #3 holding the foam over the red bag to trim it, and then bringing it back to the wound and packing the wound with the foam was an infection control issue. The DON stated RN #3 laying the uncapped tube of the wound vac suction part placed on top of the wound on the resident's gown and not cleaning it before connecting it to the capped end of the actual wound vac was an infection control issue. The DON stated RN #3 should have cleaned her scissors after having them in her hand and before cutting a clean dressing. Review of the Face Sheet revealed Resident #133 was admitted by the facility, on 02/12/19, with the included diagnoses Osteomyelitis, Diabetes Type 2, Generalized Muscle Weakness, and Hypertension. Review of Resident #133's Admission MDS, with an ARD of 02/19/19, revealed a BIMS score of 11, which indicated moderate cognitive impairment. Further review of the MDS revealed Resident #133 was coded for a Stage 2 wound.	M 615		
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	M 620		4/30/19

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M 620	Continued From page 9 infections. Level II Based on observation, staff interview, record review, and facility policy review, the facility failed to provide Resident #51 and Resident #109's catheter care in a manner to prevent the possibility of a Urinary Tract Infection (UTI), for two (2) of five (5) resident catheter care observations. Findings include: A review of the facility's policy titled "Catheter Care, Urinary" dated July 2015 revealed: Equipment and Supplies included pre-moistened wipes. Steps in the Procedure: 1. Wash hands. 17. Clean from the least contaminated to most contaminated area. Review of the facility's policy titled, "Perineal Care", dated December 2017, revealed: Equipment and Supplies included pre-moistened wipes. 18. For Male Resident- Steps in the Procedure - b. Wash perineal area starting with urethra and working outward. (2) Wash and rinse urethral area using a circular motion. f. Instruct, or assist resident to turn on his side. g. Using new washcloth, apply soap or skin cleansing agent or use pre-moistened wipe and wash. h. Using new washcloth, rinse the rectal area thoroughly to include the area under the scrotum, the anus, and the buttocks. If pre-moistened wipes are used, rinsing is not necessary. Resident #51 On 03/07/19 at 2:05 PM, an observation revealed Certified Nursing Assistant (CNA) #1 provided Resident #51's catheter care. CNA #1 entered	M 620	Corrective Action: Risk Manager (RM) in-serviced Certified Nursing Assistant (CNA) #1 on 3/11/19 on proper perineal care procedures, including hand washing, to prevent infection during catheter care. RM in-serviced CNA #2 on 3/11/19 on keeping the catheter bag/tubing below the bladder level to prevent backflow of urine and possible Urinary Tract Infection. Director of Nursing (DON) assessed Resident #51 and Resident #109 on 3/11/19 for negative outcomes due to cited deficiency and no negative outcomes were noted. Identification of others with the potential to be affected: Rounds were made by the DON on 3/11/19 to identify any residents with catheters affected as a result of the cited deficiency. There were no residents with identified with negative outcomes. To ensure deficient practice does not recur: RM initiated in-service to 100% of CNAs on 3/11/19 on proper catheter care and perineal care to prevent risk of infection. On 3/11/19, perineal and catheter care observations were initiated by RM, DON, Staff Development Coordinator, and Unit Managers three times per week for four	

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M 620	Continued From page 10 Resident #51's room, applied her gloves, pulled some clean wipes from the wipe container, and begin the catheter care. CNA #1 did not wash her hands prior to donning the gloves and beginning the catheter care. CNA #1 wiped around the catheter near the resident's penis three times using one wipe, and rotated the wipe as she wiped. She then used another wipe to wipe in a downward motion of the resident's groin areas, using a clean wipe for each side. CNA #1 held the catheter tubing near the meatus, and wiped away from the meatus three times. She then repositioned Resident #51 onto his left side and cleaned his buttocks, wiping the buttocks areas in a circular and back and forth motion, using the same wipe to clean the resident's entire buttocks area. CNA #1 failed to wipe Resident #51's buttocks from front to back, or from least contaminated area to most contaminated area. An interview on 03/07/19 at 3:44 PM, with CNA #1 revealed she should have washed her hands before beginning the procedure. She also stated she should have wiped from front to back in an upward motion. An interview on 03/07/19 at 9:29 AM, with Registered Nurse (RN) #7 revealed Resident #51 was very independent, and does not like for the staff to assist him with anything although he needs it. RN #7 stated he does not think Resident #51 has had any Urinary Tract Infections (UTIs), but he does have spasms. He stated the resident has the catheter because he has some Dystonia from his quadriplegia. An interview, on 03/07/19 at 3:49 PM, with the Director of Nursing (DON) revealed CNA #1 should have washed her hands so she does not carry anything in to the resident. The DON stated	M 620	weeks and one time per week thereafter until compliance is achieved. New hires will be trained on perineal and catheter care during orientation by Staff Development Coordinator or Orientation leader. Quality Assurance: Effective 3/11/19, a Performance Improvement Plan was initiated by the DON and RM to monitor perineal care and placement of catheter bags and tubing during catheter care. Any deficiencies will be corrected, and the findings will be documented and submitted by the DON at the monthly Quality Assurance meeting for further review or corrective action.	

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M 620	Continued From page 11 CNA #1 should have wiped in an upward position for infection control purposes. An interview, on 03/07/19 at 3:26 PM, with RN #2 revealed CNA #1 should have washed her hands, gathered her supplies, and placed her supplies on a barrier, and then proceed to perform the catheter care. RN #2 also stated CNA #1 should have used one wipe to wipe each time in an upward position. Review of the Physician Orders, with a start date of 12/21/18, revealed; change Foley Catheter as needed for leakage or blockage. Foley Catheter, check leg anchor every shift and as needed. Foley Catheter care every shift. Foley Catheter size 16 French (FR) to bedside drainage, check for patency every shift and change as needed. Review of Resident #51's most recent comprehensive MDS, with an ARD of 12/19/18, revealed Resident #51 was coded for an indwelling urinary catheter/condom catheter, and not rated for urinary continence. Further review of the MDS revealed a BIMS score of 15, which indicated Resident #51 was cognitively intact. A review of the facility's Face Sheet revealed the facility admitted Resident #51 on 03/13/18 with a diagnosis of Paraplegia. Resident #109 An observation, on 03/07/19 at 8:45 AM, revealed Resident #109 was lying in bed with the head of bed elevated. Further observation revealed Resident #109's catheter bag was lying in the bed with the resident, and the urine was backing up into the tube into the bladder.	M 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24GC	A. BUILDING: _____ B. WING _____	03/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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M 620	Continued From page 12 An observation, on 03/07/19 at 9:00 AM, revealed Resident #109 was lying in the bed with the catheter bag lying in the bed with the resident, and the urine was backing up into the tube into the bladder. An observation, on 03/07/19 at 9:38 AM, with the Director of Nursing (DON) present, and another surveyor revealed Resident #109 was lying in the bed. The catheter bag was lying in the bed with Resident #109, and the urine was backing up in the tubing into the bladder. An interview, on 03/07/19 at 9:40 AM, with the Director of Nursing (DON) confirmed the catheter was lying in the bed with Resident #109. The DON also confirmed the urine was backing up in the tube into the bladder. The DON confirmed this resident has chronic Urinary Tract Infections. Review of Resident #109's Care Plan revealed a Focus for high risk for infection related to having an indwelling catheter due to Obstructive and Reflux Uropathy and Neuromuscular Dysfunction of the Bladder, and History of Urinary Tract Infections (UTIs). Review of the Interventions revealed no intervention for placement of the catheter bag/tubing below the bladder level to prevent backflow of urine and possible UTI. During an interview, on 03/07/19 10:40 AM, Certified Nursing Assistant (CNA) #2 revealed she was looking for a wheelchair because the resident was going out to a doctor's appointment. CNA #2 stated she forgot to move the catheter bag off the bed. CNA #2 said the resident could develop an infection by allowing the urine to back up in the catheter. A review of the Face Sheet revealed the facility	M 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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M 620	Continued From page 13 admitted Resident #109, on 05/06/2016, with diagnoses which included Obstructive and Reflux Uropathy, History of Urinary Tract Infection and Neuromuscular Dysfunction of the Bladder. A review of Resident #109's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/15/2019, revealed Resident #109 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident is cognitively intact. Further review of the MDS revealed Resident #109 was checked for the use of an indwelling catheter, external catheter, or ostomy. Resident #109's Urinary Continence was checked not rated due to a catheter, urinary ostomy, or no urine output during the seven (7) day observation period.	M 620		