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
	22CI	A. BUILDING: _____ B. WING _____	04/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRENADA REHABILITATION AND HEALTHCAF	1966 HILL DRIVE GRENADA, MS 38901

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M 000	Initial Comments The State Agency (SA) determined during an annual recertification survey, conducted from 4/8/19 to 4/11/19, the facility was not in compliance with the Mississippi Regulations for Minimum Standards for Institutions for Aged or Infirm with deficiencies cited at M500, M610, and M620. The facility held a license for 137 beds and census was 93 at the time of survey.	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	M 500		5/11/19

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M 500	Continued From page 1 medical record), is afforded the opportunity to participate in the planning of his medical 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	M 500		

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M 500	Continued From page 2 facility accept his written delegation of this responsibility to the facility for any period of time 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	M 500		

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M 500	Continued From page 3 unopened, unless medically contraindicated (as documented by his physician or nurse 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 Resident and staff interview, the facility failed to provide postal mail services on Saturdays for one (1) of six (6) residents who attended the Resident Council meeting. This had	M 500	The Administrator met with Resident #43 on 5/02/2019 to discuss the plan to ensure residents receive mail on Saturdays. The nursing supervisor will check mail on Saturdays and deliver to the residents and log that it was delivered. Resident #43	

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M 500	Continued From page 4 the potential to affect all residents in the facility who received mail. Findings include: During Resident Council Meeting on 04/09/2019 at 10:00 AM, Resident #43 stated that mail was not delivered on Saturdays. An interview, on 04/09/2019 at 10: 45 AM, with Resident #43, confirmed that she does not get her mail on weekends. The Resident stated that she receives a lot of mail at the facility but that she never receives any mail on Saturday even if she is looking for mail that day. The resident stated, "You may as well not look for it on Saturday because you are not getting it." An interview, with the Activity Director on 04/09/2019 at 11:10 AM ,revealed that the Front Office staff goes to the mail box and brings the mail in the facility, and the Activity Director and the Activity Assistant deliver the mail to the Residents. The Activity Director stated that on weekends the postal carrier sometimes brought the mail in the facility and staff on duty would give the mail out to the residents. The Activity Director confirmed that the postal carrier does not always bring the mail in the facility, and if the postal service carrier does not bring the mail in the facility on the weekend, it does not get delivered until Monday. An interview, with the Business Office Manager on 04/09/2019 at 11:25 AM ,confirmed that the Business Office normally goes to the mail box and brings the mail in the facility and the activity department normally delivers the mail to the Residents. The Business Officer Manager stated	M 500	stated "ok, that sounds good but I don't get much mail anyway." All residents have the potential to be affected. No residents were affected by the alleged deficient practice. Staff was in-serviced on 4/19/2019 by the Staff Development Coordinator to ensure residents are receiving mail on Saturdays. Beginning 4/15/2019 the Administrator will audit the log signed by the nurse supervisor weekly for four (4) weeks, then monthly for three (3) months to ensure mail is being checked and delivered on Saturdays. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly by the Administrator for three (3) months for review and recommendations. The Administrator is responsible for on-going monitoring and compliance.	

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M 500	Continued From page 5 that if they are expecting something to come in the mail on the weekend, they would call the facility and have a staff member to go get the mail and bring it into the facility for the on-duty staff to deliver. The Business Office Manager confirmed that the mail is not always brought in the facility on weekends. The Business Officer Manager stated that if the mail is not brought in the facility on the weekend, the Business Office staff would go get the mail on Monday and either the Business Office staff or Activity staff would deliver the mail to the residents on Monday. An interview, with the Administrator, on 04/09/2019 at 12:15 PM, confirmed that it is the Business Office responsibility to go to the mailbox to get the mail and bring it in the facility, and the Activity Department delivers the mail to the residents. The Administrator confirmed that the Business Office staff and Activity Department staff would know if the mail is not always delivered on the weekend.	M 500		
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:	M 610		5/11/19

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M 610	Continued From page 6 Level II Based on observation, interview, and policy review, the facility failed to ensure Activities of Daily Living (ADL) care was provided for two (2) of 27 residents reviewed, Resident #21 and Resident #69, as evidenced by long, dirty and/or jagged fingernails, and Resident #21 was in need of a shave and oral care. Findings include: A review of the facility's policy titled," Activities of Daily Living (ADL), Supporting" revealed Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal, and oral hygiene. Appropriate care and services will be provided for the residents who are unable to carry out ADL's independently, with the consent of the resident and in accordance with the plan of care , including appropriate support and assistance with hygiene (bathing, dressing,grooming, and oral care). Resident #21 An observation, on 04/08/19 at 12:54 PM, revealed Resident #21 to have long fingernails with black colored material under the nails and noticeable facial hair. An observation, on 04/09/19 at 12:55 PM, revealed Resident #21 sitting in the dining room waiting for lunch. Resident #21's fingernails continued to be long and dirty. Resident #21 stated he didn't have anybody to cut them. Resident #21 stated the staff had not offered to cut his nails and he would like to have them cut. Resident #21 also had foul mouth odor and a	M 610	The Assistant Director of Nursing trimmed and cleaned Resident #21's finger nails, provided mouth care, and assisted Resident #21 in being shaved on 4/10/2019. The facility Nurse Practitioner trimmed Resident #69's toe nails on 4/9/2019. Fifteen (15) dependent residents, thrity-eight (38) extensive assist residents, thirty-one (31) limited assist residents, and ten (10) residents needing supervision by staff for activities of daily living (ADL) care have the potential to be affected. No resident was affected by the alleged deficient practice. Nursing staff was in-serviced on 4/19/2019 by the Staff Development Coordinator on performing ADL care to the residents with the emphasis on ensuring nail care is provided, mouth care is provided, and residents are shaved. Nursing staff new hires will be trained upon hire on providing indwelling catheter irrigation and ensuring catheter bags were positioned in a manner for urine to flow per gravity. Beginning 4/12/2019 the Director of Nursing/Assistant Director of Nursing will audit fingernails, toe nails, mouth care, and residents being shaved three (3) times a week for four (4) weeks, then weekly for four (4) weeks, then monthly for three (3) months to ensure Activities of Daily Living care is being provided. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly by the Director of Nursing for three (3) months for review	

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M 610	Continued From page 7 large amount of whitish material coated along his lower gums and teeth. Resident #21 also stated he would like to be shaved. He stated he was used to shaving every day. An observation, on 04/10/19 11:00 AM, with the Director of Nursing (DON), confirmed Resident #21's fingernails where too long and they needed cleaning. She confirmed he needed shaving and that his mouth needed care. Resident #69 An observation on 4/9/19 at 9:05 AM, revealed Resident #69 to have long jagged toe nails on both feet. Interview on 4/9/19 at 9:06 AM, with Resident #69, revealed she would like to have her toe nails trimmed. She stated the nurses are supposed to do them, but you have to ask them to. Interview on 4/10/19 at 11:05 AM, with the DON, revealed Resident #69's toe nails were too long and jagged. She stated they needed cutting and they could cause skin tears and possibly infections. The DON stated the staff should know to do ADL care for residents during general care the resident gets.	M 610	and recommendations. The Administrator is responsible for on-going monitoring and compliance.	
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.	M 620		5/11/19

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M 620	Continued From page 8 Level II Based on observation, interview, record review, and policy review, the facility failed to ensure the Foley catheter bags were positioned in a manner for urine to flow per gravity, and not back into the resident's bladder, which could cause infection/trauma . This affected two (2) of 14 residents with a catheter, Resident #59 and Resident #69. The facility also failed to ensure sterile technique while irrigating the Foley catheter for Resident #59. Findings include: Review of the facility's policy titled, "Catheter Care, Urinary," revised September 2014, revealed it's purpose was to prevent catheter-associated urinary tract infections. Number (#) 3, under Maintaining Unobstructed Urine Flow, revealed the urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder. Review of the facility's policy titled, "Catheter Irrigation, Open System," revealed the purpose of this procedure is to maintain patency of the catheter. Equipment and supplies necessary when performing this procedure include sterile irrigation tray, alcohol wipe, and a sterile drape. Steps in the procedure include #6. to put on sterile gloves, and; #10. Disconnect the catheter from the drainage tubing. Cover the end of the drainage tubing with the sterile protector cap, and; #13. Remove the protector cap, clean the end of the drainage tubing with the alcohol wipe, and reconnect tubing to the catheter.	M 620	The Assistant Director of Nursing (ADON) trimmed and cleaned Resident #21's finger nails, provided mouth care, and assisted Resident #21 in being shaved on 4/10/2019. Certified Nursing Assistant (CNA)#2 placed Resident #59's catheter bag on the side of the bed lower than the level of the bladder on 4/9/2019. Certified Nursing Assistant #2 was one-to-one in-serviced by the Director of Nursing on 4/9/2019 on following the resident's care plan to have the catheter bag lower than the level of the bladder. Licensed Practical Nurse (LPN)#1 was one-to-one in-serviced by the Director of Nursing (DON) on 4/10/2019 for following the resident's care plan related to catheter irrigation via sterile procedure. The facility Nurse Practitioner trimmed Resident #69's toe nails on 4/9/2019. Residents who are dependent on staff for activity of daily living care (ADL), fourteen (14) residents with indwelling catheters and two (2) residents with orders for indwelling catheter irrigation have the potential to be affected. No residents were affected by the alleged deficient practice. Nursing staff was in-serviced on 4/19/2019 by the Staff Development Coordinator to ensure residents are receiving services according to care plans including providing ADL care, maintain indwelling catheter drainage bags at a level below the bladder and following sterile procedures during indwelling catheter irrigation per physician orders. Beginning 4/12/2019 the Director of	

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M 620	Continued From page 9 Resident #59 An observation on 04/09/19 at 4:05 PM, revealed Certified Nursing Assistants (CNA) #1 and CNA #2 transferred Resident #59 back to bed utilizing a sling lift. The Resident had a Foley catheter. The Foley catheter was laying on the Resident's lower abdomen during the transfer. After the Resident was placed on the bed, CNA #2 held the catheter bag up approximately one (1) foot over the Resident's thighs before laying it on the bed beside the resident. An interview on 04/11/19 at 11:45 AM, with CNA #2 confirmed the catheter bag was in the resident's lap and she held the catheter bag above the level of the resident's bladder and placed the catheter bag in the bed beside Resident #59 . CNA #2 stated the catheter bag should be kept below the level of the bladder because the urine could back up and that could cause an infection. An observation on 4/10/19 at 10:15 AM, revealed Licensed Practical Nurse (LPN) #1 provided a Foley catheter irrigation on Resident #59. LPN #1 placed an unsterile pad barrier on the resident's over bed table. She then removed six (6) sterile water syringes from their plastic packages, removed the end caps and placed the syringes on the unsterile barrier. LPN #1 donned unsterile gloves and separated the catheter from the tubing without cleaning the area prior to the separation. LPN #1 held the catheter tubing in her left hand, touching the end of the tubing with her unsterile glove while also holding the end of the Foley catheter with her left hand. She inserted each 10 milliliter sterile water syringe into the end of the Foley catheter. LPN #1 then reconnected the catheter and the tubing.	M 620	Nursing/Assistant Director of Nursing will audit fingernails, toe nails, mouth care, and residents being shaved three (3) times a week for four (4) weeks, then weekly for four (4) weeks, then monthly for three (3) months to ensure services are being given per the care plans. Beginning 4/12/2019 the Staff Development Coordinator will audit Foley Catheter irrigation (3) times a week for four (4) weeks, then weekly for four (4) weeks, then monthly for three (3) months to ensure sterile techniques are being used per the care plan. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly by the Assistant Director of Nursing for three (3) months for review and recommendations. The Administrator is responsible for on-going monitoring and compliance.	

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M 620	Continued From page 10 In an interview on 4/10/19 at 11:55 AM, LPN #1 confirmed she should have used sterile technique to irrigate Resident #59's catheter. LPN #1 confirmed she placed the sterile syringes on an unsterile barrier, did not clean the catheter and tubing junction, and did not wear sterile gloves. She stated she probably should have brought a new catheter kit in the room with her. LPN #1 stated she contaminated things and could cause the resident to get an infection. In an interview on 04/11/19 at 2:08 PM, the Director of Nursing (DON) confirmed that the Resident #59's Urinary Tract Infection (UTI) could have been caused by not keeping the Foley catheter bag below the level of the bladder and not using sterile technique for bladder irrigations. Record review revealed a Physician order, dated 04/40/2019, to irrigate Resident #59's Foley catheter with 60 cubic centimeter (cc) of sterile water every shift. Record review revealed lab results, dated 2/25/19, which indicated Resident #59's urine culture grew >100,000 Non-lactose Fermentor, Gram negative Bacilli(A). Review of the facility's McGeer/SHEA/CDC Criteria for Signs /Symptoms of UTI with an Indwelling Urinary Catheter form revealed Resident #69 met the criteria for UTI with Indwelling Urinary Catheter. Resident #69 During an observation of Resident #69 on 4/10/19 at 11:05 AM, with the DON, CNA #3 provided morning care. The observation revealed Resident #69's Foley catheter bag laying in the bed with the resident. The DON removed the bag from the	M 620		

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M 620	Continued From page 11 bed and hung it on the bedside. During an interview, on 4/10/19 at 11:10 AM, CNA #3 confirmed she placed Resident #69's catheter bag on the bed. She stated she didn't always do that. CNA #3 confirmed that the catheter bag should always be below the bladder because the urine can run back and cause an infection. An interview on 04/11/19 at 1:50 PM, with the DON, revealed Resident #69 has not had a Urinary Tract Infection (UTI) in the past three (3) months, which was confirmed by record review.	M 620		