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
	55PI	A. BUILDING: _____ B. WING _____	12/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PICAYUNE REHABILITATION AND HEALTHCAF	1620 READ ROAD PICAYUNE, MS 39466

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) conducted a State Licensure survey from 12/26/18 through 12/28/18. During the survey, the SA determined the facility did not meet the licensure requirements for the State Minimum Standards for the Aged and Infirm. The SA cited M500 and M620.	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 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	M 500		1/18/19

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M 500	Continued From page 1 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 facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law;	M 500		

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M 500	Continued From page 2 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 unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical	M 500		

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M 500	Continued From page 3 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 staff interview, record review and facility policy review, the facility failed to ensure the residents rights to receive Foley catheter and pericare in a manner to prevent the possibility of tauma to the meatus and a Urinary Tract Infection (UTI), for (2) of (3) catheter care observations, for Residents #39, and #48	M 500	1. Certified Nursing Assistant (C.N.A)#2 received one to one education on December 27, 2018 from the Staff Development Coordinator on requirements of catheter care performance and failure to secure the catheter near the entrance of the meatus to prevent possible trauma and following the care card. On December 27, 2018	

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M 500	Continued From page 4 Findings include: Review of the facility's, "Comprehensive Care Plan Policy", revised 12/2016, revealed a comprehensive, person-centered, care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The Interdisciplinary Team (IDT) in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. The care plan interventions are derived from thorough analysis of the information gathered as part of the comprehensive assessment. The interdisciplinary team includes a nurse aide who has responsibility for the resident. Review of Resident #39's Care Plan revealed a Focus for alteration in elimination as evidenced by an indwelling Foley catheter with an initial date was 02/06/2018. The Goals included the resident would be free from signs and symptoms (s/s) of infection during this 90 day review period. The target date was 02/06/2019. The Interventions included: Foley catheter (cath) care every (Q) shift and as needed (PRN) every shift for cath care. During Resident #39's catheter care observation, on 12/27/18 at 10:46 AM, Certified Nursing Assistant (CNA) #2 failed to secure the catheter near the entrance of meatus to prevent possible trauma. CNA #2 pulled the tubing outward from the meatus with a wet wipe. During an interview, on 12/28//2818 at 1:33 PM, Care Plan Nurse/ Registered Nurse (RN) #1	M 500	C.N.A. #1 received one to one training rom (SDC) on catheter care performance and failure to prevent recontamination by wiping front to back and failure to secure the catheter near the entrance of the meatus to prevent possible trauma and following the care card. Resident #48 and #39 were assessed by the Nurse Practitioner (NP) on 12/28/2018; no issues identified. 2. All residents have the potential to be affected. On December 28, 2018 an audit of residents with catheters was initiated by the Director of Nursing (DON) and Assistant Director of Nurses to ensure no negative issues related to catheter care; no negative issues identified. 3. On December 28, 2018 return demonstrations were initiated and are ongoing for Certified Nursing Assistants to include cleaning and securing of catheter tubing, by Staff Development Coordinator. On February 19, 2019 Information Quality Healthcare, RN (IQH representative) will conduct education on catheter care procedures and goals to prevent trauma and/or infection with nursing staff. Nursing and CNA staff were in-serviced on December 31, 2018 by Staff Development Coordinator regarding peri care, catheter care, anchoring of tubing,dental care of residents and residents rights. 4. Beginning the week of December 31, 2018, audits of catheter care observations will be conducted by Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, or supervisor to	

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M 500	Continued From page 5 revealed she expected the CNAs to follow professional standards while providing care. RN #1 confirmed the CNAs failed to follow the care plan by not securing the tubing while providing the catheter/peri care. During an interview, on 12/28/18 at 2:37 PM, CNA #2 confirmed she failed to secure the tubing near the meatus. CNA #2 stated she was nervous, and forgot. A review of the Face Sheet revealed Resident #39 was admitted by the facility, on 07/27/2018, with diagnoses which included Pressure Ulcer of Right Buttocks, Acute Cystitis with Hematuria and Acute Kidney Failure. A review of Resident #39's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/01/2018, revealed Resident #39 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident was mildly cognitively impaired. Resident #48 Review of Resident #48's Care Plan revealed a Focus for alteration in elimination as evidenced by an indwelling Foley catheter with an initial date of 08/01/2017. The Goals included the resident would be free from s/s of infection duriing this 90 day review period. The Target date was 02/12/2019. Interventions included provide catheter care every shift and as needed. During an observation of Resident #48's catheter/pericare provided by CNA #1, on 12/27/18 at 1:24 PM, CNA #1 took a wet wipe, and failed to clean from front to back. CNA #1 cleaned the peri area in a circular motion which	M 500	ensure the catheter care is completed accurately by return demonstration of all of the C.N.A.s performance of catheter care following regulatory guidelines. Audits/observations will be conducted weekly times four (4) weeks then monthly times two (2) months, then quarterly thereafter. Negative findings of the return demonstrations will be addressed immediately and a performance improvements plan implemented. A report of audits will be brought to the Monthly Quality Assurance Performance Improvement committee, monthly times three months for further recommendations by the Director of Nursing. The Director of Nursing is responsible for monitoring and compliance.	

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M 500	Continued From page 6 caused contamination to the clean areas over the peri area. CNA #1 also failed to secure the tubing at the entrance of the meatus while cleaning the catheter tubing. CNA #1 grabbed the tubing at the meatus, and pulled it outward. During an interview, on 12/28//2818 at 1:33 PM, the Care Plan Nurse/RN #1 revealed she expected the CNAs to follow the professional standards while providing care. RN #1 confirmed the CNAs failed to follow the care plan by not cleaning from front to back, and not securing the tubing while providing catheter/peri care. During an interview, on 12/27/18 at 2:59 PM, CNA #1 confirmed she failed to clean from front to back. CNA #1 stated she was nervous, and could not think straight. CNA #1 said she was trained to wipe from front to back. CNA #1 also said she was trained to secure the tubing prior to cleaning it to prevent the catheter from coming out. CNA #1 stated the resident could receive an infection by not wiping front to back. A review of the Face Sheet revealed Resident #48 was admitted by the facility, on 05/13/1916, with diagnoses which included Pressure Ulcer of Sacrum, Urinary Tract Infection. A review of Resident #48's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/07/2018, revealed Resident #48 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated the resident was mildly cognitively impaired.	M 500		
M 620	45.21.4 Urinary incontinence Urinary incontinence. Residents with urinary	M 620		1/18/19

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M 620	Continued From page 7 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 provide catheter care in manner to prevent trauma to the meatus, and a Urinary Tract Infection (UTI) for two of three catheter care observations, for Residents #39 and #48. Findings Include: A Review of the facility's policy titled, "Catheter Care, Urinary" revealed the purpose of this procedure is to prevent infection of the resident's urinary tract. Ensure that the catheter remains secured with a leg strap to reduce friction and movement at the insertion site. For the female: Use a washcloth with warm water and soap to cleanse the labia. Use one area of the washcloth for each downward, cleansing stroke. Change the position of the washcloth with each downward stroke. Next, change the position of the wash cloth and cleanse around the urethral meatus. Do not allow the wash cloth to drag on the resident's skin or bed linen. With a clean washcloth, rinse with warm water using the above technique. Use a clean wash cloth with the warm water and soap to cleanse and rinse the catheter from insertion site to approximately four inches outward. A Review of the facility's inservice titled, State Readiness: handwashing, pericare, foley ,ADLs	M 620	1. Certified Nursing Assistant (C.N.A)#2 received one to one education on December 27, 2018 from the Staff Development Coordinator on requirements of catheter care performance and failure to secure the catheter near the entrance of the meatus to prevent possible trauma and following the care card. On December 27, 2018 C.N.A. #1 received one to one training rom (SDC) on catheter care performance and failure to prevent recontamination by wiping front to back and failure to secure the catheter near the entrance of the meatus to prevent possible trauma and following the care card. Resident #48 and #39 were assessed by the Nurse Practitioner (NP) on 12/28/2018; no issues identified. 2. All residents have the potential to be affected. On December 28, 2018 an audit of residents with catheters was initiated by the Director of Nursing (DON) and Assistant Director of Nurses to ensure no negative issues related to catheter care; no negative issues identified. 3. On December 28, 2018 return demonstrations were initiated and are ongoing for Certified Nursing Assistants to include cleaning and securing of catheter tubing, by Staff Development Coordinator. On February 19, 2019 Information Quality	

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M 620	Continued From page 8 (Activities of Daily Living) and abuse revealed CNA #1 and CNA #2 were trained how to provide catheter care in a manner to prevent trauma to the meatus and infection to the urinary tract. Resident #39 During Resident #39's catheter care observation, on 12/27/18 at 10:46 AM, Certified Nursing Assistant (CNA) #2 failed to secure the the catheter tube at the meatus insertion site to prevent possible trauma. CNA #2 pulled the catheter tubing outward from the meatus with a wet wipe. During an interview, on 12/27/18 at 2:09 PM, Licensed Practical Nurse (LPN) #2/Staff Development Nurse confirmed the facility failed to provide catheter care according to the facility policy. LPN #2 also stated the CNAs secure the catheter tubing near the meatus to prevent trauma and to keep the catheter from coming out. During an interview, on 12/28/18 at 2:37 PM, CNA #2 confirmed she failed to secure the catheter tubing near the meatus. CNA #2 stated she was nervous and forgot. Review of the Face Sheet revealed Resident #39 was admitted by the facility, on 07/27/2018, with diagnoses which included Pressure Ulcer of Right Buttocks, Acute Cystitis with Hematuria and Acute Kidney Failure. Review of Resident #39's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/01/2018, revealed Resident #39 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident was mildly cognitively impaired.	M 620	Healthcare, RN (IQH representative) will conduct education on catheter care procedures and goals to prevent trauma and/or infection with nursing staff. Nursing and CNA staff were in-serviced on December 31, 2018 by Staff Development Coordinator regarding peri care, catheter care, anchoring of tubing,dental care of residents and residents rights. 4. Beginning the week of December 31, 2018, audits of catheter care observations will be conducted by Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, or supervisor to ensure the catheter care is completed accurately by return demonstration of all of the C.N.A.s performance of catheter care following regulatory guidelines. Audits/observations will be conducted weekly times four (4) weeks then monthly times two (2) months, then quarterly thereafter. Negative findings of the return demonstrations will be addressed immediately and a performance improvements plan implemented. A report of audits will be brought to the Monthly Quality Assurance Performance Improvement committee, monthly times three months for further recommendations by the Director of Nursing. The Director of Nursing is responsible for monitoring and compliance.	

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M 620	Continued From page 9 Resident #48 During an observation, on 12/27/18 at 1:24 PM, CNA #1 provided Resident #48's catheter/pericare. CNA #1 took a wet wipe and failed to clean from front to back. CNA #1 cleaned the peri area in a circular motion contaminating the cleaned peri area. CNA #1 also failed to secure the catheter tubing at the meatus insertion site while cleaning the catheter tubing. CNA #1 grabbed the tubing at the meatus and pulled the catheter tube outward. During an interview, on 12/27/18 at 2:59 PM, CNA #1 confirmed she failed to clean from front to back. CNA #1 stated she was nervous and could not think straight. CNA #1 said she was trained to wipe from front to back. CNA #1 also said she was trained to secure the tubing prior to cleaning it to prevent the catheter from coming out. CNA #1 stated the resident could receive an infection by not wiping front to back. During an interview, on 12/27/18 at 2:09 PM, LPN #2 confirmed the facility failed to provide catheter care according to the facility policy. LPN #2 also stated the CNAs should clean from front to back, and secure the catheter tubing near the meatus to prevent trauma and the catheter from coming out and prevent infection. A review of the Face Sheet revealed Resident #49 was admitted by the facility, on 05/13/1916, with diagnoses which included Pressure Ulcer of Sacrum, , Urinary Tract Infection. A review of Resident #48's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/07/2018, revealed Resident #48 had a Brief Interview for Mental Status (BIMS)	M 620		

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M 620	Continued From page 10 score of 10, which indicated the resident was mildly cognitively impaired..	M 620		