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
	18HC	A. BUILDING: _____ B. WING _____	05/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HATTIESBURG HEALTH & REHAB CENTER	514 BAY STREET HATTIESBURG, MS 39401

(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 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 observation, record review, facility policy review, and staff interview, the facility failed to promote the healing of pressure ulcers for one of five (1 of 5) residents reviewed with pressure ulcers, Resident #89. Findings include: A review of the facility's policy titled "Pressure Ulcers/Skin Breakdown-Clinical Protocol" undated revealed: The physician will authorize pertinent orders related to wound treatments, including pressure reduction surfaces, wound cleansing and debridement approaches, dressings (occlusive, absorbtive, etc.), and application of topical agents. The policy however did not address the events of dressings becoming dislodged, missing, or soiled. An observation, on 05/21/2018 at 11:07 AM, revealed Registered Nurse (RN) #3 removed Resident #89's brief to find there was no dressing on the wound identified as a stage three (3) sacral pressure ulcer. A review of the facility's wound care report titled, "Wound and Skin Status Report", dated 05/10/2018, revealed Resident #89 had a facility	M 615	1) On 05/21/2018, CNA #3 received a 1:1 in-service per Staff Development Nurse on the immediate reporting of dislodged, soiled or missing wound dressing. On 5/21/2018, RN#3/Treatment Nurse completed the physician ordered treatment on Resident #89 and observed no negative findings. 2) Nineteen residents with wound dressings have the potential to be affected by this deficient practice. On 5/21/2018, all resident with wound dressings were observed for dislodgement, missing or soiled dressing per DON and no further wound dressings were identified to be missing, dislodged or soiled. 3) On 6/28/2018, the QA Committee which included Medical Director, Physician #2, Nurse Practitioner, DON, QA Nurse/Infection Control Nurse, Restorative, Corporate Representative and Administrator, reviewed and revised the facility policy and procedure titled "Pressure Ulcer/Skin Breakdown-Clinical Protocol" to include "The nursing staff will follow physician orders for treatment and care of the resident's wounds in accordance with standards of practice and prevention of infection. If wound dressing becomes dislodged, missing, or soiled, the	7/2/18

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

Electronically Signed | 07/05/18

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M 615	Continued From page 1 acquired pressure ulcer with an onset date of 04/20/2017. The facility's wound and skin report revealed treatments for a daily, and an as needed wound care with use of a Promogran dressing. A review of Resident # 89's May 2018 Physician Orders, revealed an order, on 01/05/2018, for a wound care treatment related to a Stage Three (3) pressure ulcer to the coccyx. The treatment order stated the wound was to be cleansed with normal saline, pat dry, apply Promogran or equivalent to wound bed, cover with silicone border foam, and change daily and as needed. During an interview, on 05/21/2018 at 11:12 AM, with RN #3/Treatment Nurse, it was confirmed the dressing for the sacral wound was missing. RN #3 stated no one had reported to her the dressing had come off. RN #3 also stated she would have expected someone to report the missing dressing as soon as it came off. During an interview, on 05/21/2018 11:13 AM, with RN #4/Dementia Care Unit Manager, it was confirmed the dressing for the sacral wound was missing. RN #4 stated the dressing has been known to come off during perineal care and during bathing. RN #4 also stated that the Certified Nursing Assistants (CNAs) are trained to report to a nurse if at any time a dressing is missing or comes off during care. RN #4 stated when a dressing comes off, it should be reported as soon as possible to prevent possible infection. RN #4 stated the CNAs should know the importance of reporting when any dressing comes off, and that maybe an in service is needed to remind them about how important it is to report it. RN #4 also stated no one had reported to her Resident #89's wound dressing was missing, or that it had come off this morning.	M 615	nursing staff will take immediate appropriate actions to promote healing". On 6/28/2018, the QA committee reviewed and revised the facility's policy titled "Wound Care" to include "Dressings that become dislodged, missing, or soiled will be reported immediately to the appropriate staff for correction". On 6/28/2018, the Staff Development Nurse began an in-service for RNs, LPNs, CNAs, Hospice Staff, and Therapy Staff on reporting missing, dislodged or soiled dressing immediately and Policy changes. This in-service was completed on 7/1/18. 4) The facility's QA Nurse will observe 10 wound dressings for dislodgement, soiled or missing per week X 4 months and document on the "Wound Dressing Log". Any issues noted will be corrected immediately. The QA Committee will review and evaluate the "Wound Dressing Log" every month X 4 months and make any recommendations needed to correct negative findings.	

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M 615	Continued From page 2 An interview, on 05/21/2018 at 11:35 AM, with CNA #3, revealed the dressing on Resident #89's sacral wound had come off during the bathing task. CNA #3 stated she was providing care at 5:30 AM on 05/21/2018, and noticed the dressing was dislodged. CNA #3 stated it came off when she removed the brief. CNA #3 also stated it was her intention to report it to the treatment nurse or another nurse, but she got busy and forgot. An interview, on 05/23/2018 10:55 AM, with CNA #4 stated if a dressing for a wound is missing, soiled, or coming off, the CNA is to report it to nursing as soon as possible. CNA #4 stated if the dressing is missing, soiled, or coming off, the wound could get worse or get an infection. An interview, on 05/23/2018 at 11:15 AM, with Licensed Practical Nurse (LPN) #1, confirmed if a dressing was missing, soiled, or dislodged, the expectation would be that it is reported to a nurse as soon as possible. LPN #1 stated it should be reported so it can be redressed to prevent the wound from becoming contaminated, or get infected. During an interview, on 05/23/2018 at 2:05 PM, with the Director of Nursing (DON), it was confirmed when a wound dressing is missing, soiled, or coming off, the CNA is to report the status of the wound dressing to nursing as soon as possible. The DON stated when a wound is left uncovered, it is at risk for an infection. The DON also stated the "as needed" order covers the times that the dressing would need to be replaced, such as when the dressing is missing, soiled, or dislodged. The DON stated there was no actual facility policy that covers the reporting of missing, soiled, or dislodged dressing on wounds.	M 615		

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M 615	Continued From page 3 A review of the Face Sheet revealed Resident #89 was admitted by the facility, on 09/01/2015, with diagnoses to include Diabetes Mellitus and Dementia. A review of Resident # 89's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/29/2018, revealed a Brief Interview of Mental Status (BIMS) score indicating severe impaired cognition.	M 615		