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
	34CC	A. BUILDING: _____ B. WING _____	02/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE NURSING CENTER	1100 WEST DRIVER LAUREL, MS 39440

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M 000	Initial Comments The State Agency (SA) conducted an annual recertification survey from 02/24/2020 to 02/27/2020. During the survey, the SA determined the facility was not in compliance with the Minimum Standards of Operation for Institutions for the Aged or Infirm. The SA cited state statutes at M615, M620 M635, and M655. At the time of the survey, the facility had a census of 119, and held a license for 126 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 observation, interviews, record review and facility policy review the facility failed to provide wound care in a manner to prevent the possible spread of infection for two (2) of three (3) residents observed for wound care, Resident #84 and Resident #52. Findings include: Resident #84 Review of facility's "Clean Dressing Change" policy, dated 01/30/2020, revealed the purpose was to provide wound care in a manner to decrease the potential for infection and/or cross-contamination. The policy revealed the following steps included in the clean dressing	M 615	Statements contained herein are intended for purposes of compliance with federal and State laws regarding responses to Statement of Deficiencies. The language herein is not intended to be used as an admission against the facility nor is it intended to be used by any third party. It is solely for the purposes of compliance with participation requirements of Medicare and Medicaid. M615 1) For Resident #84, and Resident #52, a 1-1 in-service was provided to Licensed Practical Nurse (LPN) #1 and Registered Nurse (RN) #1 by the Director of Nursing	4/1/20

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

Electronically Signed | 04/16/20

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M 615	Continued From page 1 change: Procedure: ...5) Perform hand hygiene and put on clean gloves, 6) ensure the area is as clean as possible, place a barrier cloth or pad next to the resident to protect the bed linens and bed site, 7) remove soiled dressings and discard, 8) perform hand hygiene and don clean gloves, 9) clean the wound as ordered, 10) discard soiled gauze and gloves, 11) perform hand hygiene and don clean gloves, 12) apply ointments/creams and dress the wound as ordered. During an observation, on 02/25/2020 at 1:44 PM, Licensed Practical Nurse (LPN) #1/Treatment Nurse provided wound care treatment for Resident 84's Stage 4 sacral wound, with assistance from Registered Nurse (RN) #1/Assistant Director of Nursing (ADON). LPN #1 removed the soiled dressing, discarded the soiled dressing, and then cleaned the wound with gauze and normal saline. RN #1 then measured the sacral wound. After the measurements were obtained by RN #1, LPN #1 applied the Mesalt dressing to the wound bed and covered the wound with the Aquacel foam dressing. LPN #1 failed to clean her hands or change gloves after removing the dirty dressing and cleaning the wound. LPN #1 also failed to clean the wound a second time, after the wound measurements were taken by the RN #1. During an interview, on 02/27/2020 at 10:03 AM, the Director of Nursing confirmed, during wound care, the nurse must change her gloves, when going from dirty to clean. The DON stated that not doing so, would be an infection control concern. On 02/27/2020 at 10:32 AM, during an interview with RN #1, she stated when any wound care treatment was done, the nurse should always change her gloves after removing the dirty/soiled	M 615	(DON) on 02/28/20. The in-service included providing wound care in a manner to prevent the possible spread of infection consistent with professional standards of practice to promote healing. 2) All residents with Pressure Ulcers have the potential to be affected. A 100% audit for residents with Pressure Ulcers was conducted by the DON on 02/28/20. Facility identified six (6) residents with Pressure Ulcers. Only Residents #84 and #52 were affected. 3) The Clean Dressing Change policy was reviewed by the Quality Assessment and Assurance (QAA) Committee on 03/11/20, and was approved with no changes. A new policy was developed and approved by the committee at that time titled Wound Assessment policy which gives guidance for wound measurement, assessment and documentation. An in-service with LPN #1 and RN #1 was conducted on 03/11/20, by the DON regarding the Wound Assessment policy, and proper procedures for clean dressing changes and wound care. LPN #1 and RN #1 were observed for proper procedure for wound care and measurement during clean dressing change. Observation was conducted on 03/11/20, by the DON via return demonstration and completion of competency checklist. 4) The Director of Nursing (DON), or the	

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M 615	Continued From page 2 dressing and cleaning the wound. RN #1 stated this was an infection control concern. During an interview, on 02/27/2020 at 11:15 AM, LPN #1 confirmed she had not cleaned her hands and changed her gloves, between removing the soiled dressing and cleaning the wound. LPN#1 stated that she knew this could cause the wound to become infected. A review of Resident #84's Care Plan revealed a focused problem for Pressure Ulcers, with a care plan goal of area will remain free of infection. Interventions included to clean wound to sacrum area with normal saline, pat dry, apply Mesalt to wound bed and cover with Aquacel foam daily until resolved. Review of the "Face Sheet" revealed, Resident #84 was admitted by the facility on 03/08/2019, with diagnoses to include Heart Failure and Essential Hypertension. Resident #52 A review of the facility's "Clean Dressing Change" policy, dated 01/30/2020, revealed, to place a barrier cloth or pad next to the resident, under the wound if possible to protect the bed linens and the body site. Cleanse wound as ordered, taking care to not contaminate other skin surfaces or other surfaces of the wound. Review of the facility's "Pressure Injury Prevention and Management Policy", dated 01/30/2020, revealed, the purpose was for prevention of avoidable pressure injury and promotion of healing of existing pressure injuries. Monitoring included to measure the wound and implement the initial treatment per physician's order or the skin care protocol. The policy revealed the Treatment Nurse and of Wound	M 615	Quality Assurance Infection Preventionist (QA-IP) will audit two (2) wound care treatments and measurements weekly for three (3) consecutive months to ensure residents with wounds are provided with wound assessment and care consistent with professional standards of practice and according to facility policy and procedure. Audit reports will be reviewed by the Quality Assurance (QA) Committee monthly until such time substantial compliance has been achieved as determined by the committee. The QA committee will make any recommendations or changes if needed to ensure compliance.	

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M 615	Continued From page 3 Nurse would modify interventions as needed as new risk factors are identified, resident goals or preference change, or for non-healing when appropriate. A review of Resident #52's Physician Orders, revealed an order, with a start date of 11/01/2019, to clean the left heel with normal saline, pat dry, apply Nickel thick Santyl, cover with Aquacel Extra, and cover with heel foam. Secure with Kerlix and tape daily. An order dated, 01/23/2020, revealed, to clean the wound to right ischium with normal saline, pat dry, apply Puracol to wound bed, cover with Aquacel foam daily until resolved. During an observation, on 02/26/2020 at 2:15 PM, Licensed Practical Nurse (LPN) #1 entered Resident #52's room to provide wound care to the left heel. LPN #1 placed a barrier on the bed, under Resident #52's left foot. LPN #1 removed the dirty dressing from Resident #52's left heel, and laid the unclean left heel onto the barrier. Blood tinged drainage was noted on the barrier under the resident ' s heel. LPN #1 picked Resident #52's left heel up off of the barrier and began to clean the heel. LPN #1 cleaned the right side of the left heel wound in a circular motion with a normal saline gauze and discarded the gauze, LPN #1 then cleaned the left side of the heel wound in a circular motion with a normal saline gauze and discarded the gauze. LPN #1 placed the cleaned heel wound back onto the soiled barrier. LPN #1 picked up the resident's left heel and using a clean gauze, she patted the wound dry. LPN #1 placed the left heel back onto the dirty barrier. Registered Nurse (RN) #1 was handed a paper measuring tape by LPN #1, who did not have gloves on at the time. RN #1 measured the wound and placed the heel back	M 615		

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M 615	Continued From page 4	M 615		

onto the dirty barrier. RN #1 removed her gloves, used hand foam and applied gloves. RN #1 picked Resident #52's left heel back up, and took a Q-tip applicator to measure the depth of the wound. RN #1 placed the left heel wound back onto the dirty barrier. LPN #1 picked the resident ' s heel up from the barrier and applied the dressing to the wound and secured it with Kerlix and tape. The wound was not cleaned after RN #1 measured the wound and before a clean dressing was placed onto the left heel wound.

On 02/26/2020 at 2:28 PM, during an observation of wound care to Resident #52's right ischium, LPN #1 put on gloves and placed a barrier under the left buttocks of the resident to protect the linen when cleaning the wound. LPN #1 obtained a normal saline gauze, wiped the wound once with the gauze in the middle of the wound and discarded the gauze. LPN #1 took a second normal saline gauze and wiped in the middle of the wound again. LPN #1 took the third gauze and patted the wound dry. LPN #1 handed RN #1 a measuring tape. RN #1 measured the wound by touching the tape to the wound. RN #1 obtained a Q-tip and placed it into the wound for depth measurement. LPN #1 obtained the Puracol and applied it to the wound bed by pressing it into the wound bed with her gloved fingers. Wearing the same gloves, LPN #1 applied Aquacel Foam dressing to the right ischium, and fastened the brief back onto Resident #52. LPN #1 proceeded to pull the bed covers over Resident #52, wearing the same gloves. LPN #1 did not re-clean the wound after RN #1 measured the wound and before the clean wound treatment and dressing was applied.

During an interview, on 02/27/2020 at 10:42 AM, LPN #1 stated she remembered placing Resident

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M 615	Continued From page 5 #52's left heel back on the dirty barrier pad after she cleaned the wound. LPN #1 revealed she remembered the resident ' s heel being placed on the dirty barrier on and off through the wound care process. LPN #1 stated that she remembered RN #1 placing Resident ' s left heel on the barrier after she measured the wound. LPN #1 stated that she went ahead and dressed the wound without re-cleaning it. LPN #1 further stated this could have caused an infection especially since Resident #52 had a history of infection in that left heel wound from September 2019. LPN #1 stated that she knew better and she should have recleaned the wound after RN #1 measured the wound and prior to dressing the wound. During an interview regarding Resident #52's ischium wound care, LPN #1 stated she remembered cleaning Resident #52's ischium and afterwards, RN #1 measured the wound. LPN #1 stated she dressed the resident's ischium without cleaning the wound again, after RN #1 had measured it. Both were cross contamination and had the potential to cause infection. Record review of Resident #52's Physician orders, revealed Resident #52 had been prescribed Augmentin 500/125 milligrams (mg) one (1) by mouth three times a day for seven (7) days for heel infection back on 09/11/2019. During an interview, on 02/27/2020 at 11:00 AM, RN #1 revealed LPN #1 should have re-cleaned the Resident #52's left heel wound after she measured the wound and before dressing the wound. RN #1 stated she remembered Resident #52's heel touching the dirty barrier several times throughout the wound care process. RN #1 revealed LPN #1 did not re-clean Resident #52's left heel nor the ischium wound. RN #1 stated with the wound not being re-cleaned after she	M 615		

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M 615	Continued From page 6 measured the wound, and after the left heel retouched the dirty barrier, it could have caused an infection. RN #1 further stated that it was definitely a cross contamination issue. RN #1 revealed Resident #52 had a previous infection in his left heel. RN #1 stated after LPN #1 cleaned Resident #52's right ischium wound, she measured the wound, and LPN #1 then dressed the wound without cleaning it again. RN #1 revealed the wound procedure to the right ischium was cross contamination as well. During an interview, on 02/27/2020 at 11:10 AM, the DON stated LPN #1 not cleaning Resident #52's wounds again, after they were measured by RN #1, was not proper procedure. She stated the left heel touching the dirty barrier, time and time again throughout the wound care process, was an infection control issue. The DON stated Resident #52 had a history of infection in his left heel and this was definitely an infection control and cross contamination issue. The DON further stated LPN #1 not cleaning the resident ' s ischium after RN #1 measured it and before she dressed the wound, was not proper procedure. The DON stated it was an infection control issue. Review of the facility's "Face Sheet" revealed, Resident #52 was admitted on 06/05/2017, with diagnoses which included Osteomyelitis of Vertebra, Sacral, and Sacrococcygeal region and Diabetes Mellitus with Unspecified Complications. A review of the admission "Departmental Notes" for Resident #52, dated 06/05/2017, revealed Resident #52 was admitted to the facility with an unstageable wound to the left heel, which measured at 1.8 x 3.7 x 0 centimeters (cm), and a Stage 4 wound to the sacrum measuring at 11 x 9.5 x 3.0 cm.	M 615		

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M 615	Continued From page 7 A review of the "Wound Healing Progress Report" for Resident #52, revealed, the right ischium wound (unstageable) was identified 08/27/2019 and measured in centimeters at 2.70 x 3.00 x 0.10. As of 02/25/2020, the wound was at a Stage 4 and measured 2.20 x 1.00 x 0.5 cm. A review of Resident #52's "Wound Healing Progress Report" for the left heel wound, revealed the wound reopened on 05/22/2019, and was identified as unstageable and measured at 1.00 x 1.00 x 0.10 cm. As of 02/25/2020, the left heel wound was at a Stage 4 and measured 1.60 x 3.00 x 0.10 cm.	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 infections. Level II Based on observation, interview, record review, and facility policy review, the facility failed to provide incontinent care in a manner to prevent urinary tract infections for three (3) of seven (7) catheter care observations, Resident #15, #87, and #52. Findings include: Review of the facility's "Perineal Care" policy, dated 01/23/2020, revealed the purpose of the	M 620	Statements contained herein are intended for purposes of compliance with federal and State laws regarding responses to Statement of Deficiencies. The language herein is not intended to be used as an admission against the facility nor is it intended to be used by any third party. It is solely for the purposes of compliance with participation requirements of Medicare and Medicaid. M620	4/1/20

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M 620	Continued From page 8 policy is to provide guidelines for providing adequate body hygiene for all resident and to decrease the risk of Urinary Tract Infection (UTI). The facility policy revealed staff must follow Infection Control practices for hand hygiene. The facility policy further revealed, the procedure for perineal care included, if a bowel movement is present, cleanse the resident with disposable wipes, remove gloves and dispose, perform hand hygiene, and don clean gloves. Resident #15 During an observation of Resident #15's incontinent care, on 02/24/2020 at 10:36 AM, provided by Certified Nursing Assistant (CNA) #3 and CNA #4, Resident #15 was lying on her left side and CNA #3 wiped Resident #15's buttocks area from back to front on the last swipe. CNA #3 and CNA #4 turned Resident #15 on her right side, and CNA #4 wiped the resident's buttock area from side to side four (4) times and from back to front two (2) times using the soiled brief and not clean wipes. CNA #3 picked the trash can up off the floor, held it over the resident, leaned forward across the bed. CNA #4 tossed the soiled brief into the trash can. CNA #3 and CNA #4 continued to reposition the resident in the bed without washing their hands or changing gloves. During an interview, on 02/24/2020 at 10:55 AM, CNA #3 stated she was not aware that she had wiped the wrong way during Resident #15's incontinent care, but that it was possible. CNA #3 stated picking up the trash can and not cleaning the resident from front to back, could cause the resident to get an infection. On 02/24/2020 at 11:00 AM, during an interview with CNA #4, she confirmed that she had wiped in	M 620	1) The Certified Nursing Assistants (CNAs) caring for Residents #15, #87, and #52, which were CNAs #1, #2,#3 and #4, were immediately in-serviced by the Director of Nursing (DON) on 02/28/20. The in-service included following the facility policy for perineal and catheter care, including proper hand hygiene procedures. 2) All residents with Urinary Incontinence or indwelling catheters have the potential to be affected. A 100% audit was conducted on 02/28/20, by the DON for residents with Urinary Incontinence and Indwelling Catheters. Facility identified one hundred twenty (120) residents with problems related to Urinary Incontinence and seven (7) residents with an indwelling catheter. Only Residents #15, #87, and #52 were affected. 3) The Hand Hygiene, Catheter Care, and Perineal Care policies were reviewed by the Quality Assessment and Assurance (QAA) Committee on 03/11/20, and approved with no changes. All of the facility CNAs were in-serviced from 02/28/20 through 03/05/20, by the DON regarding the facility policy and proper procedures for hand hygiene, catheter care and perineal care. All CNAs were observed for proper hand hygiene, catheter care, and perineal care. Observation was conducted by the Quality Assurance Infection Preventionist (QA-IP)	

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M 620	Continued From page 9 the wrong direction and did not use a clean wipe to clean Resident #15's buttocks area during the incontinent care. CNA #4 confirmed she had not cleaned her hands or changed her gloves. CNA #4 stated that by not cleaning the right way and not using a clean wipe, this could cause the resident to get an infection. During an interview, on 02/27/2020 at 10:03 AM, Licensed Practical Nurse (LPN) #4/Staff Development Nurse, confirmed wiping from back to front is not the correct way to clean the perineal area when incontinent care is performed. LPN #4 stated the buttocks area should be cleaned with a clean wipe instead of a soiled brief. LPN #4 further stated, cleaning in the wrong direction using only the soiled brief, puts the residents at greater risk for a Urinary Tract Infection (UTI). LPN #4 revealed CNA #3 and #4 had completed and passed an incontinent skills check-off within the last six (6) months. During an interview, on 02/27/2020 at 10:24 AM, the Director of Nursing (DON) confirmed wiping from back to front was not the way perineal/incontinent care should be done. DON stated performing incorrect perineal care would increase the resident's risk for a UTI. Review of the facility's document, "Skills Competency for Catheter Care and Perineal Care", revealed CNA #3 had met the skills competency for perineal care. The document was signed by LPN #4 and dated on 10/18/2019. A review of the "Skills Competency for Catheter Care and Perineal Care" for CNA #4, signed and dated by LPN #4 on 11/27/2019, revealed she met the skills competency for perineal care. Review of the "Face Sheet", revealed, the facility	M 620	and the Treatment Nurse via return demonstration and completion of competency checklist. Observations were conducted from 02/28/20 through 03/06/20. Training on proper hand hygiene procedures, catheter care, and perineal care, as well as competency verification, will be conducted annually at a minimum with all CNAs, and will be included during orientation for newly hired CNAs. 4) The QA-IP and the Staff Development Coordinator will conduct validation checks for three (3) CNAs weekly for three (3) consecutive months to ensure competency performing hand hygiene, catheter care, and perineal care according to facility policy. Any issues identified will be addressed at that time. Audit reports will be reviewed by the Quality Assurance (QA) Committee monthly until such time substantial compliance has been achieved as determined by the committee. The QA committee will make any recommendations or changes if needed to ensure compliance.	

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M 620	Continued From page 10 admitted Resident #15 on 12/02/2016 with diagnoses which included Cerebral Infarction, Type 2 Diabetes Mellitus, and Chronic Kidney Disease. Resident #87 Review of the facility's, "Perineal Care" policy, dated 01/23/2020, revealed, the procedure for performing male perineal care included: If the resident is uncircumcised, the foreskin should be retracted before cleaning and placed back in position after cleaning is complete. Gently, but securely hold the shaft of the penis in one hand. Using a clean disposable wipe, use circular motion and clean the end of the penis down toward the shaft and dispose of the wipe. During an observation of Resident #87's incontinent care, on 02/27/2020 at 10:23 AM, CNA #2 cleaned the resident's groin areas and scrotum, but failed to cleanse Resident #87's penis while providing incontinent care. On 02/27/2020 at 11:08 AM, during an interview, CNA #2 confirmed she failed to pull the skin back and cleanse Resident #87's penis. CNA #2 stated she totally forgot to do it. CNA #2 further stated by not cleaning Resident #87's penis could have caused him to get a UTI. Review of CNA #2's "Skills Competency for Catheter Care and Perineal Care", dated 10/18/2019 and signed by LPN #4, revealed CNA #2 was trained to provide perineal and catheter care for a male resident and had met the skills competency. During an interview, on 02/27/2020 at 11:16 AM, Licensed Practical Nurse (LPN) #3 confirmed	M 620		

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M 620	Continued From page 11 CNA #2's failure to cleanse Resident #87's penis could cause a UTI. On 02/27/2020 at 11:24 AM, during an interview with LPN #4/Staff Development Nurse, she revealed incontinent care training was done upon hire and once a year with return demonstration. LPN #4 stated the penis was the most important part of the perineal area for a male, and should be cleaned appropriately. An interview on 02/27/20 at 3:15 PM, with the DON, revealed, the CNAs are trained to clean the resident's penis when providing incontinent/perineal care. A review of the "Face Sheet" revealed, the facility admitted Resident #87 on 02/18/2019, with diagnoses that included Unspecific Dementia with Behavioral Disturbance, Diabetes Mellitus and Metabolic Encephalopathy. Resident #52 A review of the facility's "Care of Urinary Indwelling and Suprapubic Catheters" policy, dated 01/24/2020, revealed the procedure for performing male catheter care included: "Using a clean disposable wipe, clean the end of the penis using a circular motion an dispose of the wipe. Using a clean disposable wipe, clean the catheter tubing from the area nearest the resident's body away from the body and dispose of the wipe." A review of the "Physician Orders List" for Resident #52, revealed an order, dated 06/06/2017, for a 16 French/10 cubic centimeter (cc) bulb Foley Catheter related to Paraplegia/Neurogenic Bladder.	M 620		

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M 620	Continued From page 12 During an observation of catheter care, for Resident #52, on 2/26/2020 at 2:28 PM, Certified Nursing Assistant (CNA) #1 wiped the head of the penis in a circular motion twice with the same area of the disposable wipe. CNA #1 obtained a second wipe, and in a circular motion, wiped Resident #52's penis again twice, with the same area of the disposable wipe. Using a new wipe, CNA #1 wiped the left side of the catheter tubing away from the body, and used the same area of the disposable to clean it twice. CNA #1 took another disposable wipe and wiped the right side of the tubing away from the body, using the same area on the wipe twice. CNA #1 did not dry the catheter tubing, penis or groin area after cleaning with the wipes. Upon completing the catheter care, CNA #1 pulled up and fastened Resident #52's brief and pulled the covers back over the resident. CNA #1 did not change her gloves or perform hand hygiene during the entire catheter care process. On 2/27/2020 at 10:50 AM, during an interview, CNA #1 stated she remembered wiping the catheter tubing on the right side of the tubing, twice with the same area of the wipe and the left side as well. She stated that could have caused contamination or an infection. CNA #1 stated she should have wiped only once down the tubing and then discarded the wipe prior to wiping the second time in the same area. CNA #1 confirmed she did not dry Resident #52's penis, groin or catheter tubing before applying his diaper. CNA #1 stated she knew that she should have changed her gloves and washed her hands before pulling Resident #52's covers back over him. During an interview, on 2/27/2020 at 11:10 AM, the DON stated CNA #1 should not have wiped	M 620		

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M 620	Continued From page 13 the same area on the tubing twice with the same area on the wipe. The DON stated she should have wiped the tubing once, discarded the wipe, and then obtained another wipe to continue. The DON further stated CNA #1 should have dried Resident #2 off and the catheter tubing, before applying the brief. The DON stated CNA #1 should have removed her gloves and washed her hands before she pulled the covers back over Resident #52.	M 620		
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, interviews, and facility policy review, the facility failed to label and date enteral feeding bags during three (3) of four observations of two (2) sampled residents with tube feedings, Resident #53 and Resident #83. Findings include: Review of the facility's "Feeding Tube Management" policy, dated 01/30/2020, revealed, the staff should label the enteral formula and tubing appropriately. Resident #53	M 635	Statements contained herein are intended for purposes of compliance with federal and State laws regarding responses to Statement of Deficiencies. The language herein is not intended to be used as an admission against the facility nor is it intended to be used by any third party. It is solely for the purposes of compliance with participation requirements of Medicare and Medicaid. M635 1) On 02/27/20, the Assistant Director of Nurses (ADON) verified the enteral feeding bags for Residents #53 and #83	4/1/20

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M 635	Continued From page 14 A review of Resident #53's active "Physician Orders List" as of 02/27/2020, revealed an order dated, 10/07/2019 for Jevity 1.5 at 45 cubic centimeters (cc) per hour (45cc/hr) with 20 cc water flush every hour for 20 hours per Kangaroo pump. Turn pump off at 12:00 PM and turn back on at 4:00 PM. During an observation, on 02/25/2020 at 8:40 AM, Resident #53's tube feeding bag was not labeled to indicate the date and time of when the bag was hung. At 2:45 PM, Resident #53 was observed in the bed with the head of the bed elevated. The tube feeding bag was still noted to be without a label to indicate the date and time in which the bag was hung. During an observation, on 02/26/2020 at 8:15 AM, Resident #53's tube feeding bag was not labeled and dated to indicate the time the bag was hung. An interview with the Director of Nurses (DON), on 02/27/2020 at 11:25 AM, revealed, tube feedings are required to be labeled and dated when the bags are changed. The DON stated If the tube feeding bags are not labeled and dated, the resident could get the wrong rate. Review of Resident #53's Annual Minimum Data Set (MDS), dated 9/24/2019, revealed, Section K (Swallowing/Nutritional Status), was coded to indicate Resident #53 received nutrition via feeding tube. Resident #83 A review of Resident #83's active "Physician Orders List, as of 02/27/2020, revealed an order dated 10/07/2019, for Jevity 1.0 at 60 cc/hr per PEG continuous feeding tube for 20 hours daily with water flush at 20 cc/hr per Kangaroo pump.	M 635	were labeled and dated correctly. 2) All residents with enteral feeding pumps have the potential to be affected. A 100% audit was conducted by the Director of Nursing (DON) on 02/28/20, for residents with enteral feedings bag sets. Facility identified seven (7) residents with enteral feeding sets. Only Residents # 53 and # 83 were affected. 3) The Feeding Tube Management policy was reviewed by the Quality Assessment and Assurance (QAA) Committee on 03/11/20, and was approved with no changes. All of the facility Licensed Practical Nurses (LPNs) and Registered Nurses (RNs) were in-serviced from 02/28/20 through 03/06/20, by the DON regarding the facility policy and proper procedures for labeling and dating of enteral feeding bags. Training on proper labeling and dating of enteral feeding bags will be reviewed annually at a minimum with all RNs and LPNs, and will be included during orientation for newly hired LPNs and RNs. 4) The Quality Assurance □ Infection Preventionist (QA-IP) or the Treatment Nurse will conduct an audit of all enteral feeding bags weekly for three (3) consecutive months to ensure proper labeling and dating of bags according to facility policy. Audit reports will be reviewed by the	

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M 635	Continued From page 15 Turn off pump from 10:00 AM to 2:00 PM. Review of Resident #83's care plan, dated 01/27/2020, revealed problem that addressed resident having special dietary needs related to receiving all nutrition via PEG tube. During an observation, on 02/25/2020 at 9:51 AM, Resident #83's tube feeding bag was not labeled, dated, and did not indicate what time the tube feeding bag was hung. During an interview, on 02/27/2020 at 11:41 AM, with Licensed Practical Nurse (LPN) #5, she stated, "When I come in, I do my rounds to check to verify things are labeled because the shift before me changes the tube feeding bags. I did not notice it." Review of Resident #83's Annual Minimum Data Set (MDS), dated 04/25/2019, revealed Section K (Swallowing/Nutritional Status) was checked to indicate Resident #83 received nutrition through tube feeding.	M 635	Quality Assurance (QA) Committee monthly until such time substantial compliance has been achieved as determined by the committee. The QA committee will make any recommendations or changes if needed to ensure compliance.	
M 655	45.21.11 Special needs Special needs. Each resident with special needs shall receive proper treatment and care. These special needs shall include, but are not limited to injections; parenteral and enteral fluids; colostomy, ureterostomy, ileostomy care; tracheostomy care; tracheal suction; respiratory care; foot care; and prostheses. This Statute is not met as evidenced by: Level II	M 655	Statements contained herein are intended for purposes of compliance with federal	4/1/20

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M 655	Continued From page 16 Based on observation, interview, record review, and facility policy review, the facility failed to ensure proper storage of respiratory equipment to prevent the possible spread of infection for three (3) of 3sampled residents, out of a total of 13 residents receiving respiratory care, Resident #35, Resident #38, and Resident #112. Findings include: A review of the facility's "Oxygen Administration Policy", dated 01/29/2020, revealed: "Unused tubing will be stored in a dated plastic bag." Review of the facility's "Infection Prevention and Control Program Policy", dated 01/24/2020, revealed the purpose was to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections. Each department, in partnership with clinical staff, would be responsible for it's role in infection prevention and control and will follow all facility wide infection control policies and procedures. Resident #35 A review of the active "Physician Orders List" for Resident #35, revealed an order dated 06/07/2016, for Oxygen (O2) at 2 liters per minute via Nasal Bi-Prongs (NBP) as needed (PRN) for Respiratory Distress. During an observation, on 02/24/2020 at 9:41 AM, Resident #35's oxygen tubing was lying across the oxygen tank, on the back of the wheelchair and unbagged. The nasal bi-prongs were touching the tank.	M 655	and State laws regarding responses to Statement of Deficiencies. The language herein is not intended to be used as an admission against the facility nor is it intended to be used by any third party. It is solely for the purposes of compliance with participation requirements of Medicare and Medicaid. M655 1) On 02/27/20, the Treatment Nurse changed the oxygen tubing for Residents #35, #38, and #112. The tubing was dated and placed in a plastic bag at that time. 2) All residents using oxygen have the potential to be affected. A 100% audit of all residents using oxygen was conducted by the Treatment Nurse on 02/27/20, to ensure all tubing not in use by the resident at the time was properly stored in a plastic bag. Facility identified fifteen (15) residents with oxygen usage. Only Residents #35, #38, and #112 were affected. 3) The Oxygen Administration policy was reviewed by the Quality Assessment and Assurance (QAA) Committee on 03/11/20. The committee recommended use of a new type of bag for storage of the oxygen tubing when not in use by the resident. The policy was updated and approved with recommended changes on 03/11/20. All of the facility Licensed Practical Nurses (LPNs), Registered Nurses (RNs) and	

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M 655	Continued From page 17 An observation on 02/25/2020 at 10:46 AM, revealed, Resident #35's oxygen tank was located on the back of the wheelchair and the oxygen tubing was thrown over the oxygen tank and not bagged. The nasal bi-prongs of the oxygen tubing were touching the seat of the wheelchair. During an interview, on 02/27/2020 at 12:30 PM, Resident #35 stated she wore her oxygen every night or whenever she was in the bed. Resident #35 stated that she needed the oxygen sometimes when she was up in her chair. Resident #35 revealed not a day that goes by that she doesn't wear her oxygen. She stated that she has breathing issues and has to have the oxygen. During an interview, on 2/27/2020 at 11:10 AM, the Director of Nursing (DON) stated the oxygen tubing should have been stored in a plastic bag and not thrown across the back of the wheelchair when it was not in use. The DON stated not storing the tubing properly was an infection control issue, with it touching different things on the wheelchair. The DON further stated the facility teaches the staff to store the tubing in plastic bags when it was not being used. Resident #38 A review of the active "Physician Orders List" for Resident #38, revealed, an order dated 08/16/2019, for O2 at two (2) liters per minute via NBP as needed (PRN) for Respiratory Distress. During an observation, on 02/24/2020 at 9:38 AM, Resident #38's oxygen tubing was observed lying across the top of the oxygen concentrator and touching floor. The oxygen tubing was not in a bag.	M 655	Certified Nursing Assistants (CNAs) were in-serviced from 02/28/20 through 03/06/20, by the Director of Nursing (DON) regarding the proper use of oxygen storage bags, and the Oxygen Administration policy, specifically the proper storage of oxygen tubing when not in use by the resident. This information will be reviewed with all LPNs, RNs, and CNAs annually and will be included in orientation for all newly hired nursing staff. 4) The Quality Assurance □ Infection Preventionist (QA-IP) will conduct an audit of all oxygen tubing weekly for three (3) consecutive months to ensure proper storage of oxygen tubing when not in use by the resident. Audit reports will be reviewed by the Quality Assurance (QA) Committee monthly until such time substantial compliance has been achieved as determined by the committee. The QA committee will make any recommendations or changes if needed to ensure compliance.	

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M 655	Continued From page 18 On 02/25/2020 at 8:40 AM, during an observation, Resident #38's oxygen tubing was observed lying across the oxygen concentrator and unbagged. An observation, on 02/26/2020 at 11:13 AM ,revealed Resident #38's oxygen tubing was lying across the concentrator and not in a plastic bag. The oxygen tubing was touching floor. An interview on 2/27/20 at 11:10 AM, the Director of Nursing (DON) stated the oxygen tubing should have been stored in a plastic bag when not is use. She stated the oxygen tubing not being stored properly was an infection control issue. The DON stated the facility taught their staff to put the tubing in plastic bags when it was not being used. Resident #112 Review of the active "Physician Orders List" for Resident #112, revealed an order dated 12/18/2019, for O2 at 2.5 liters NBP PRN for Shortness of Breath (SOB). A review of Resident # 112 ' s care plan, dated 01/22/2020 revealed a problem related to the resident had a diagnosis of Emphysema and Chronic Obstructive Pulmonary Disease (COPD). Interventions included Oxygen at 2 liters per NBP as needed. During an observation, on 02/27/2020 at 9:15 AM, Resident #122 was observed in bed asleep. Resident #112's oxygen tubing was lying on the floor. On 02/27/2020 at 11:26 AM, during an interview, the DON stated oxygen tubing should not be of the floor because it is an infection control	M 655		

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M 655	Continued From page 19 problem. A review of Resident #112's Significant Change (SC) Minimum Data Set (MDS) Assessment, dated 12/31/2019, revealed the resident had a BIMS score of 8, which indicated severe cognitive impairment. The SC MDS Assessment also revealed Section O (Special Treatments, Procedures, and Programs) was checked to indicate the resident was receiving oxygen therapy.	M 655		