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
	67WC	A. BUILDING: _____ B. WING _____	06/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALTER B CROOK NURSING FACILITY	840 NORTH OAK AVENUE RULEVILLE, MS 38771

(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) determined during an annual recertification survey, conducted from 6/17/19 through 6/20/19, the facility was not in compliance with the Mississippi Regulations for Minimum Standards for Institutions for Aged or Infirm with deficiencies cited at M625. The facility held a license for 60 beds and had a census of 60 residents.	M 000		
M 625	45.21.5 Range of motion Range of motion. Residents with limited range of motion shall receive treatment and services to increase range of motion or prevent further decline in range of motion. This Statute is not met as evidenced by: Level II Based on observation, staff interview, facility policy, and record review, the facility failed to provide services and care of splinting, with a hand roll, to maintain or prevent the resident's decline in range of motion for one (1) of two (2) residents investigated for range of motion, Resident #2. Findings include: Review of the facility's policy titled, "Splinting", not dated, revealed splinting is used to protect joints and surrounding soft tissues. This can be accomplished by maintaining joints at position of rest, preventing positions that contribute to contracture and/or deformity, protecting the system of arches within the hands and feet and increasing or maintaining range of motion (ROM) in the joint.	M 625	1. Resident # 20 care plan was developed and implemented on 12/17/2018 by Licensed Practical Nurse to reflect application of rolled gauze for right hand contracture. Resident # 20 was assessed by Restorative Licensed Practical Nurse on 06/20/2019 showing no harm from gauze not being applied. Director of Nursing applied the rolled gauze to Resident # 20's right hand on 06/20/2019. 2. All Residents have the potential to be affected, especially residents requiring use of gauze roll to prevent contractures. No other Residents were identified during this time. 3. Treatment Nurse was in-serviced on 06/20/2019 by the Director of Nursing on the application of rolled gauze to Resident #20 per Physician Orders for prevention of contractures. Director of Nursing will monitor Residents with roll gauze	7/16/19

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

Electronically Signed | 07/12/19

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M 625	Continued From page 1 Review of Resident #20's June 2019 orders revealed an order dated 12/17/18, to apply rolled gauze to the right hand daily for preventive measures. Observations on 06/17/19 at 10:56 AM and 2:45 PM, 6/18/19 at 10:33 AM and 4:06 PM revealed Resident #20 without any type of hand roll in his hands, which had bilateral contractures. During an interview on 06/18/19 at 4:04 PM, the Occupational Therapist (OT) revealed she understood nursing was placing a gauze roll in the hands of Resident #20 bilateral to prevent further contractures. On 06/18/19 at 04:12 PM, an interview with Certified Nursing Assistant (CNA) #1 revealed she was assigned to Resident #20 and gauze had not been in his hands. CNA #1 revealed she thinks Therapy may be working with Resident #20. On 06/18/19 at 4:25 PM, an interview with Licensed Practical Nurse (LPN) #1 revealed she was the Medication Nurse for Resident #20 and had worked in this position for eight (8) months. LPN #1 stated she couldn't say she'd ever seen a gauze roll in Resident #20's hand. On 06/18/19 at 4:35 PM, an interview and observation with the Director of Nursing (DON) revealed an order for Resident #20, which instructed nursing to apply a gauze roll to the right hand daily for preventive measures and the gauze should have been in Resident #20's right hand. The DON confirmed the gauze roll was not the in Resident #20's right hand.	M 625	applications two times per week for four weeks beginning 06/20/2019 to ensure the applications of rolled gauze are applied. 4. The Treatment Nurse will observe Residents with rolled gauze applications beginning 06/20/2019 and ongoing to ensure that they are being applied. Any concerns will be immediately corrected. The Director of Nursing will continue to audit monthly to ensure that all applications are being applied as ordered by Physician. The Treatment Nurse will forward the results of the audit to the monthly Quality Assurance Committee. The Quality Assurance Committee will determine the frequency and continuation of the audits based upon the results achieved and make recommendations as needed.	

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M 625	Continued From page 2 On 06/19/19 at 11:45 PM, an interview with Licensed Practical Nurse (LPN) #2 revealed she is the Treatment Nurse and responsible for placing the gauze in Resident #20's right hand. LPN #2 revealed she did not know why the gauze was not in Resident #20's hand on 6/17/19 and 6/18/19 unless it fell out. LPN #2 revealed she does not check during the day to see if the gauze has fallen out. Review of Occupational Therapy quarterly screen notes, dated 4/4/19, revealed, under section of equipment comments, that nursing is providing the patient with rolled gauze in bilateral hands to decrease risk of further contracture and skin breakdown.	M 625		