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
	24GC	A. BUILDING: _____ B. WING _____	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOYINGTON HEALTH AND REHABILITATION	1530 BROAD AVE GULFPORT, MS 39501

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M 000	Initial Comments The State Agency (SA) conducted a licensure survey for complaint investigation (CI) MS #15951 and CI MS #16039 from 8/27/2019 to 8/29/2019. The SA substantiated CI MS #15951 related to failure to prevent the development of a pressure ulcer for Resident #3, who was admitted by the facility on 02/06/19, with a Stage 3 pressure ulcer to the sacrum. Resident #3 was identified high risk for developing pressure sores at the time of admission. The Stage 3 sacral pressure ulcer healed on 02/21/19. However, the facility failed to perform weekly body audits, skin observations and/or assessments from the time the sacral pressure ulcer healed on 02/21/19 to 05/09/19. The facility identified an unstageable pressure ulcer to Resident #3's sacral area on 05/09/19. Resident #3 required hospitalization on 05/22/19 for Wound Infection, Urinary Tract Infection (UTI) and Sepsis, and the need for debridement of the wound. Due to the facility's failure to perform the weekly body audits, skin observations and assessments to prevent and/or identify skin alterations Resident #3 suffered harm. Resident #3 did not return to the facility after her discharge from the hospital on 06/04/19. Resident #3 was admitted to another facility. CI MS #15951 also addressed concerns with Resident #3's fluid and meal intake, incontinent care, and turning/positioning. Per Resident #3's closed record review, the SA did not substantiate these concerns during the survey as evidenced by observations of other residents identified with these same concerns, record review and interviews. The SA determined the facility was not in compliance with State Licensure Regulations for the Aged or Infirm, and cited State Statutes at M615. The SA did not substantiate CI MS #16039	M 000		

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M 000	Continued From page 1 regarding the administration of pain medications in a timely manner. The SA determined the complaint was not substantiated by record review and interviews. The SA did not cite any deficiencies related to CI MS #16039. The facility's census on 8/29/19, was 137 residents. The the facility is licensed for 180 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 III Based on record review, staff interview and facility policy review, the facility failed to perform weekly body audits to monitor, assess and prevent the reoccurrence of a pressure ulcer. The facility identified Resident #3 at high risk for pressure ulcers on admission, 02/06/19, due the presence of a Stage 3 sacral pressure ulcer. As a result, Resident #3 suffered harm due to the facility's identification of an unstageable sacral pressure ulcer, on 05/09/19, which required hospitalization for wound infection and debridement of the wound. This concern was identified for one (1) of six (6) wound care plans reviewed.	M 615	M0615 1. Resident #3 was discharged from the facility on 5/22/19. 2. Skin checks/body audits were completed by the Director of Nursing (DON) and Assistant Director of Nursing (ADON)September 4, 2019 for the entire facility population to ensure all wounds had been addressed and are receiving treatment. 3. Education was provided to all nursing staff on the importance of completing accurate skin checks, as well as performing routine licensed weekly skin observations on September 4, 2019 by the DON and ADON. Education was provided	10/29/19

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M 615	Continued From page 2 Findings Include: Review of the facility's policy titled, "Prevention of Pressure Ulcers", dated April 2019, revealed the skin observation schedule would be completed as follows: C.N.A.s (Certified Nursing Assistants) will complete total body observations at minimum on bath days. Charge Nurse will complete weekly skin observations on each resident, "Licensed Nurse Weekly Skin Observation Form". Any residents with wounds will be documented on the Weekly Wound Information Sheet. The Care Plan will be revised/updated. Review of the hospital Emergency Department (ED) notes revealed Resident #3's service time and date was 05/22/19 at 12:59 PM. History of Present Illness: She was sent in because of change in hydration and alertness. Decreased diet and is refusing to take medications, meals, and fluids. Level of consciousness was alert, awake, and aware. Calm and cooperative. Diagnoses included: Wound Infection, Acute Urinary Tract Infection, Acute Renal Failure, Sacral Decubitus Ulcer, Diabetes, and History of Stroke. Review of the hospital Discharge Summary revealed Resident #3 was admitted to the hospital, on 05/22/19, and discharged on 06/04/19. Resident #3 underwent an Excisional Debridement of a 15 cm X 15 cm sacral and bilateral gluteal stage IV (4) decubitus ulcer. Incision and drainage of a left medial abcess. The discharge diagnoses included: Wound infection with Proteus mirabilis and Enterococcus faecalis. Sepsis, unspecified organism. Initial blood culture was positive for Staphylococcus lugdunensis. Repeat blood cultures were negative. Acute Urinary Tract Infection: Urine cultures were	M 615	to all Certified Nursing Assistants (CNAs) regarding their role in pressure ulcer prevention, reporting changes, and the implementation of planned interventions on September 4, 2019 by the DON and ADON. The DON and ADON will monitor the weekly skin checks daily to ensure compliance. 4. Monitoring for ongoing compliance will be completed through audits for all residents with pressure ulcers and altered skin to be conducted weekly beginning October 18, 2019; 8 residents per week, one at a time, for 6 weeks to ensure all residents skin integrity is assessed appropriately. The DON and ADON, Minimum Data Set (MDS) Nurse, Unit Managers, and/or Wound Care Nurses will be responsible for the random audits. All skin assessments will be audited with scheduled Minimum Data Set (MDS) assessments and significant changes. All findings by the Director and Assistant Director of Nursing, Minimum Data Set (MDS) Nurse, Unit Managers, and/or Wound Care Nurses will be discussed in the monthly Quality Assurance and Performance Improvement (QAPI) meeting to review and follow up for any needed changes/recommendations for six months.	

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positive for Kliebsiella pneumonia and Enterococcus faecalis. Sacral Decubitus Ulcer. Acute Renal Failure.

Resident #3 did not return to the facility at the time of discharge from the hospital. Resident #3 was transferred to another facility.

Review of the facility's Progress Notes, dated 05/22/19 at 9:18 AM, revealed the Nurse Practitioner (NP) documented Resident #3 was sent to the hospital Emergency Department (ED) for evaluation.

An interview with Registered Nurse (RN) #1/Treatment Nurse, on 08/29/2019 at 10:00 AM, revealed Resident #3 was admitted with a healing stage 3 sacral pressure ulcer on February 6, 2019. RN #1 said the wound healed on February 21, 2019. RN #1 then stated, a Certified Nursing Assistant reported to her that she needed to check Resident #3's buttocks on 05/09/2019. RN #1 reported she observed a 10 centimeter (cm) by 5 cm unstageable wound to Resident #3's sacral area with a small amount of serosanguineous drainage. RN #3 also stated the wound bed was covered with slough. RN #1 reported the wound got progressively worse. RN #1 revealed she had not seen Resident #3's buttocks since February 22, 2019. RN #1 said the nurses on the floor are responsible for body audits every week. RN #1 stated Resident #3 was considered high risk for the wound to reopen on her sacrum because she was obese, Diabetic, Chronic UTI's (Urinary Tract Infections), and a history of pressure ulcers.

Review of Resident #3's Progress Note, dated 02/21/19 at 5:29 PM, documented by RN #1, revealed the pressure ulcer to the sacrum was

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healed. Treatment orders were discontinued.

Review of Resident #3's Admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/12/19, revealed the resident was admitted with the presence of one (1) Stage 3 pressure ulcer, and was identified as high risk for pressure ulcers. Resident #3's Basic Interview for Mental Status (BIMS) score was 14, which indicated no cognitive impairment. Review of Resident #3's Functional Status revealed she required: Extensive assistance with two persons physical assist with bed mobility, transfers, and toilet use. Total dependence with one person's physical assist with locomotion on and off the unit. Supervision with set up help with eating. Extensive assistance with one person's physical assist with personal hygiene and bathing. Resident #3 was always incontinent of bowel and bladder. Resident #3 had Range of Motion (ROM) impairment to her upper and lower extremities on one side.

Review of The Pressure Ulcer Reports revealed the following: 05/10/19, an unstageable pressure ulcer to Resident #3's sacrum. The wound measured 10 cm x 5 cm. The Pressure Relief Device was to turn every (q) two (2) hours, and the Treatment Plan was Santyl. 05/17/19, 10 cm x 10 cm unstageable pressure ulcer to the sacral area. Acquired 05/09/19. Added a wedge for pressure relief. Santyl continued for Treatment Plan. 05/24/19, 9.8 cm x 9.8 cm unstageable sacral pressure ulcer. Worsened-yes. Air mattress added for pressure relief, and Santyl for Treatment Plan. Each report was signed by RN #1/Treatment Nurse.

Review of the Weekly Wound Information forms revealed the following: On 05/10/19 at 8:53 AM,

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on 05/09/19 an unstageable pressure ulcer was acquired. The wound measured 10 cm x 5 cm with a small amount of serosanguineous drainage. No odor. Slough was present. The peri-wound area was red with excoriation. The Responsible Party (RP), who was identified as "Self", was notified on 05/09/19. The date the MD (Medical Doctor) initially notified or date of most recent status update: 05/07/19. The Progress stated: Resident with new unstageable wound to sacrum. Resident is noncompliant with turning and tends to get irritated when aids/nurses try to turn her. On 05/24/19 at 2:35 PM, continued to identify the unstageable sacral pressure ulcer. Measurements: 9.8 cm x 9.4 cm. Moderate amount serosanguineous drainage. Foul odor when dressing removed. Necrotic tissue to the wound base. Redness to perimeter of the wound. No pain. Progress: Wound to sacrum is being treated with Santyl. 90 % eschar and 10 % granulation. Continue to treat with Santyl at this time. The MD was notified on 05/21/19 of the current wound status. The RP, Self, was notified on 05/22/19.

Review of Resident #3's Treatment Administration Record (TAR) for May 2019, revealed an order, dated
05/10/19, to cleanse the sacrum with NS (Normal Saline). Pat Dry. Apply Santyl to wound. Apply Calmoseptine to periwound. Cover with dry dressing daily and PRN (as needed) for dislodged/soiled dressing every day shift. The order was discontinued on 05/22/19, the date Resident #3 was transferred to the hospital. The TAR also documented an order for the insertion of a 16 F (French) 10 (10 cubic centimeter {cc}) Foley catheter on 05/16/19. Turn q hours, initiated on 02/06/19, with staff initials documenting Resident #3 was turned q two (2) hours while in

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bed from May1st to May 22nd, except for one time on the 1st shift on 05/12/19.

During the interview with the Director of Nursing (DON) on 08/09/2019 at 2:00 PM, she confirmed the facility had not done the weekly body audits for Resident #3. The DON said the floor nurses are scheduled to do body audit on different residents every shift. The DON confirmed there were no body audits done after Resident #3's wound healed in February. The DON also said Resident #3 was identified as a high risk for pressure ulcers because she had just healed from a wound and was unable to turn herself and would refuse to eat or drink at times and allow staff to provide care.

The Certified Nursing Assistants (CNAs) who were assigned to provide Resident #3's care, and the Licensed Practical Nurse (LPN) who was responsible to perform the weekly body audits were no longer employed at the facility. The SA made attempts to contact these former staff members by phone, however the SA was unsuccessful due to the numbers were disconnected or there was no answer, or return call for a message left.

A review of the facility's Face Sheet revealed Resident #3 was admitted by the facility, on 02/06/19, with the included diagnoses Type II Diabetes, Cerebral Infarction, Hemiplegia and Hemiparesis, and Acute Kidney Failure.

A review of Resident #3's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 5/15/2019, revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of 5 which indicated the resident was cognitively impaired. Resident #3's Skin Condition

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M 615	Continued From page 7 revealed the presence of an unstageable pressure ulcer. Further review of the MDS revealed Resident #3's Functional Status: Transfers and locomotion on and off the unit was coded an eight (8), which indicated the activity did not take place. Dressing, bathing and toilet use, Resident #3 was totally dependent, and required one person's physical assist. Eating required supervision and set up help. Personal hygiene required extensive assistance with one person's physical assist. Resident #3 was always incontinent of bowel and bladder. Resident #3. Resident #3 had Range of Motion (ROM) impairment to her upper and lower extremities on one side.	M 615		