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
	24LA	A. BUILDING: _____ B. WING _____	C 12/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW NURSING CENTER	16411 ROBINSON ROAD GULFPORT, MS 39503

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M 000	Initial Comments The State Agency (SA) conducted a complaint survey at the facility from 12/18/19 to 12/31/19 for CI MS #16447, CI MS #16472 and CI MS #16466. The SA was able to substantiate CI MS #16447 and CI MS #16472 related to careplans, pain management during pressure ulcer wound care, and falls. These areas were identified at harm levels. The SA was not able to substantiate CI MS #16466 related to incontinent care and staffing. During the survey the SA determined the facility was not in compliance with the Minimum Standards for The Institutions For The Aged And Infirm. The SA cited the state statute M625 and M640. The census at the time of entrance was 91, and the facility was certified for 105 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 observation, staff interview, record review, and facility policy review, the facility failed to assess Resident #4's level prior to providing wound care and during the wound care provided by Licensed Practical Nurse (LPN) #1. The failure to assess Resident #4's pain levels resulted in the resident expressing signs of pain during the treatment such facial grimacing, moaning, and	M 615	* On 12/18/19 at approximately 3:15 PM, Resident #4 was given as needed PRN Tylenol by Licensed Practical Nurse (LPN) #3. ** All residents with wounds have the potential to be affected by this same deficient practice. *** Beginning 01/07/20 at 9:30 AM and	2/28/20

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M 615	Continued From page 1 verbalization of pain. This was identified for one of three (1 of 3) resident wound care observations. Findings include: A review of the facility policy titled, "Clean Dressing Change" not dated, revealed the following procedure to perform a clean dressing change included: Explain to Resident that you are about to perform a dressing change on them, explain the procedure and evaluate pain level, administer pain medication if needed. During a wound care observation, on 12/18/19 at 2:55 PM, Licensed Practical Nurse (LPN) #1 and Certified Nursing Assistant (CNA) #1 entered Resident #4's room to provide wound care to a Stage III pressure ulcer to the Sacrum. Licensed practical Nurse (LPN) #1 did not assess Resident #4's pain level before performing wound care. Resident #4 told LPN #1 before she started the wound care that his wound was hurting. Resident #4 exhibited facial grimacing as well as verbally complaining of pain. LPN #1 proceeded with the wound care treatment telling Resident #1 that she would be finished soon and she would tell the Medication Nurse to give him something for pain. Resident #4 moaned several times during the wound care and voiced he was hurting. Resident #4 yelled out and flinched when LPN #1 cleaned the sacral wound. LPN #1 continued wound care without any pain assessment or pain medication. Review of December 2019 Physician's Orders revealed an order, dated 12/13/19, to clean the sacral ulcer with Normal Saline, Pat dry, Apply Hydrogel and Collagen mix to wound bed and cover with silicone foam border every 48 hours and as needed.	M 615	ending on 01/16/20 at 8:30 AM, 10 Registered Nurses (RNs) and 36 LPNs were in-serviced on the Pain Policy by the Director of Nursing (DON). Beginning 01/24/20 at 6:00 PM and ending on 01/31/20 at 5:00 PM, all 10 RNs and 36 LPNs have been educated with documentation by a Certified Wound Care RN from an outside vendor. All nurses will be given a skills assessment by this Certified Wound Care RN by February 7, 2020. All new hire LPNs and RNs will be educated the Pain Policy and on wound care upon hire and will be required to pass a skills assessment within 30 days of date of hire. Every wound care order now includes a pre-wound care pain scale special requirement that requires the nurse to put in a numerical response before they can sign off on the Treatment Administration Record (TAR). This requirement prompts the nurse to offer pain medication to the resident. **** The Quality Assurance Nurse (QA) nurse will monitor two wound care treatments per week beginning on 01/30/20 for three months for pain management by reviewing documentation and by conducting resident interviews regarding their pain. The QA nurse will bring their findings to the monthly QA meeting for review and recommendations.	

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M 615	Continued From page 2 Review of the December 2019 Medication Administration Record (MAR) revealed no Tylenol was administered on December 18th before, during or after the wound care. The last dose of Tylenol was documented on 12/13/19 at 6:45 AM. Review of the December 2019 Physician's Orders revealed an order, dated 11/7/19, for Acetaminophen (Tylenol) 325 milligrams (mg), two (2) tabs by mouth (po) every four (4) hours as needed (PRN) for pain. During an interview, on 12/18/19 at 3:55 PM, LPN #1 revealed she should have waited to do the wound care and offered him some pain medication. She stated she normally would any other time, but she got nervous. During an interview, on 12/18/19 at 5:12 PM, Registered Nurse (RN) #2/Assistant Director Of Nurses (ADON) stated LPN #1 should have stopped the wound care and offered Resident #4 some pain medication. During an interview, on 12/18/19 at 3:25 PM, LPN #3 revealed she was Resident #4's medication nurse and LPN #1 did not tell her that Resident #4 needed pain medication. During an interview, on 12/18/19 at 5:15 PM, the Medical Director stated Resident #4 had an as needed pain medication available to him when needed. The Medical Director stated the nurses could always call him when needed to address Resident #4's pain level. He stated he was always concerned with controlling the pain level of his residents. Review of the Face Sheet revealed the facility	M 615		

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M 615	Continued From page 3 admitted Resident #4 to the facility 10/22/19 with a diagnosis of End Stage Renal Disease with Dialysis, Peripheral Vascular Disease and Type II Diabetes. Review of Resident #4's Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/24/19, revealed the resident was assessed a high risk for developing pressure ulcers. Resident #4 was admitted with one (1) stage I, two (2) stage II, and two (2) unstagable pressure ulcers. The pain assessment revealed Resident #4 was receiving as needed pain medication. Resident #4's Basic Interview for Mental Status (BIMS) score was 12, which indicated mild cognitive impairment. Review of Resident #4's 5-Day MDS, with an ARD of 11/12/19, revealed the resident was still assessed as high risk for developing pressure ulcers, and was re-admitted with a stage III pressure ulcer. Resident #4 received as needed pain medications. The BIMS score was 9, which indicated moderate cognitive impairment.	M 615		
M 640	45.21.8 Accidents Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies. This Statute is not met as evidenced by: Level III Based on interview, record review, facility policy	M 640	* On 12/18/19 all Time Codes for Physician Orders were corrected to prompt for every two hour check and	2/28/20

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M 640	Continued From page 4 review, and the facility investigation review, the facility failed to provide adequate supervision to monitor/check Resident #7's self-release safety belt and as a result Resident #7 fell and sustained a fractured right hip. This concern was identified for for one (1) of four (4) residents with self-release belts observed. Findings include: A review of facility policy titled "Accident and Supervision Policy", not dated, revealed that each resident is to receive adequate supervision and assistive devices to prevent accidents which includes implementing interventions to reduce hazards and risks. Specific interventions will be implemented to try and reduce a resident's risk from hazards including documenting interventions and ensuring that the interventions are put into action. A review of facility policy titled "Policy for Restraints", not dated, revealed that applying a restraint for patient safety requires additional care, observation and management by the medical staff to ensure patient safety. Resident's with restraints should be checked every 30 minutes and have the restraint removed and the resident repositioned every two (2) hours. Review of the facility's incident Investigation, dated 12/20/19 at 8 AM, revealed resident was observed by Activity Staff pulling on her catheter tubing. Activity Aide stayed with resident and took her to her assigned nurse, who transported the resident to her room, left her in the doorway to go get someone to assist putting the resident to bed. When the nurse returned, the resident was on the floor on her left side in front of the bathroom door with her feet up in the wheelchair. The resident	M 640	release on the Treatment Administration Record (TAR) for self-release belts. ** All residents with self release belts have the potential to be affected by this deficient practice. *** Time Codes for Physician Orders for check and release of self-release belts will automatically transfer to the TAR for the nurse to document every two hours that they have checked and released the belt. Beginning 01/07/20 at 9:30 AM and ending on 01/16/20 at 8:30 AM, 10 Registered Nurses (RN's), 36 Licensed Practical Nurses (LPN's) and 46 Certified Nurses Aides (CNA's) were in-serviced on the Accidents and Supervision Policy and the Resident Alarms Policy by the Director of Nursing (DON). Beginning 01/07/20 at 9:30 AM and ending on 01/16/20 at 8:30 AM, 10 RNs, 36 LPNs and 46 CNAs were in-serviced on the Total Care Plan Policy by the DON. Beginning 01/07/20 at 9:30 AM and ending on 01/16/20 at 8:30 AM, 10 RNs and 36 LPNs were in-serviced on the Following Physician's Orders Policy by the DON. **** The Quality Assurance (QA) nurse will monitor three residents per week beginning on 01/30/19 for two hour check and release of restraints by reviewing documentation and resident interview. The QA nurse will bring these findings	

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M 640	Continued From page 5 was assisted to bed with the help of the nurse and aide. The Charge Nurse assessed the resident for injuries. The injuries observed were skin tears to the left elbow and hand, and the right knee. The Responsible Representative (RR) and Medical Doctor (MD) were notified. The Assistant Director of Nurses (ADON) was also notified. The resident's catheter was changed. The resident was out of bed and propelling self in wheelchair around the facility the remainder of the day. On 12/11/10 7 on the 7 AM to 3 PM shift, the resident complained of pain in right knee. The Charge Nurse and MD were notified, and a new order was received for an xray of the right knee and hip. Received the xray report stating a fracture to the right hip. Resident was sent to the hospital for further evaluation. Review of the facility's Neurological Flow Sheet revealed neuro checks were started on 12/20/19 at 8:15 AM and completed on 12/11/19 at 3 PM. Review of the hospital's Emergency Department (ED) Physician Note, dated 12/11/19 at 4:46 PM, revealed Resident #7 presented to the Emergency Room (ER) today after a fall out a wheelchair last night. Patient does not ambulate. The right complete hip xray, on 12/11/19 at 5:39 PM, revealed a Displaced, Angulated Right Femoral Introtrochanteric Fracture. Resident #7 required a Right Open Reduction Internal Fixation surgery to repair the hip during her hospital stay. During an interview, on 12/30/19 at 6:22 AM, Licensed Practical Nurse/LPN #2/Quality Assurance (QA) Nurse stated Resident #7 could not undo her safety belt on command, but she could undo it when she felt like it. LPN #2 stated during their investigation she discovered Registered Nurse (RN) #2/Assistant Director of	M 640	to the monthly QA Meeting for review and recommendation.	

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M 640	Continued From page 6 Nurses (ADON) told her when she got to work at 7AM that morning she checked Resident #7's self-release belt and it was on and functioning properly. LPN #2 stated RN #2 told her Resident #7 was agitated in the dining room and the Activity Director took her to LPN #5 and LPN #5 stated she pushed Resident #7 in her wheelchair just inside the door of her room and left her to go get someone to assist her to place the resident in her bed. When she returned, she found Resident #7 lying on her left side in front of the door. LPN #2 stated LPN #5 revealed to her that she did not check the belt when she placed Resident #7 by the door. During an interview, on 12/30/19 at 7:41 AM, Licensed Practical Nurse (LPN) #5 stated the Activity person brought the Resident #7 to her on the morning she fell stating that Resident #7 seemed agitated and was pulling at her catheter. She stated she pushed Resident #7 down to her room and placed Resident #7 in the doorway of her room. LPN #5 stated she just pushed her inside the doorway of her room and did not check to see if her seat belt was on or even if it was working. LPN #5 stated that she just assumed it was on Resident #7. LPN #5 stated she walked out of the room to go get help to lay Resident #7 down in the bed and when she went back into Resident #7's room, she was lying on the floor on her left side. LPN #5 stated the belt was suppose to alarm if it was unhooked and she didn't hear it alarm. LPN #5 stated the seat belt was not hooked on Resident #7. LPN #5 stated she didn't know Resident #7 well enough to know if she could take the belt off by herself or not. Review of the December 2019 Physician's Order for Resident #7 revealed an order for a self-release alarm belt while in the wheelchair.	M 640		

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M 640	Continued From page 7	M 640		

Check every 30 minutes for proper functioning and release every 2 hours and as needed (PRN) for toileting and repositioning. The Physician's Orders revealed Resident #7 with diagnoses of repeated falls and Dementia.

Record review of a facility Consent For Use Of Physical Restraints Or Enabling Device, dated 4/23/18, revealed a self-release alarm belt was ordered for confusion, poor safety and hx of falls.

Review of the Treatment Administration Record (TAR), dated December 2019, revealed self-release alarm belt while in wheelchair, check every 30 minutes for proper functioning and release every two (2) hours and as needed for toileting and repositioning. On 12/9/19 and 12/10/19, the 7 AM to 3 PM shift columns for monitoring/checking the belt every 30 minutes and releasing the belt every two (2) hours was blank.

During an interview with RN #2, on 12/31/19 at approximately 10:00 AM, she revealed she checked the resident's seat belt on arrival to work on 12/10/19 at 7AM and it was on and functioning properly. However, she stated she did not document the belt was checked on the Treatment Administration Record (TAR).

During an interview, on 12/30/19 on 8:10 AM, LPN #1 revealed she saw the Activities Director coming down the hallway with Resident #7 and the Activity Aide told her that Resident #7 was pulling at her catheter and the resident seemed a little agitated. The Activities Director handed her off to LPN #5 and she took Resident #7 to her room and left her at the door to go look for somebody to help her put Resident #7 in her bed. LPN #1 stated she didn't think to look for the

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M 640	Continued From page 8 safety belt because she was just passing Resident #7 in the hallway. LPN #1 stated the day Resident #7 fell, she was doing treatments and it would have been her responsibility to sign the TAR off that the self-release alarm belt was checked. LPN #1 stated she didn't remember checking the safety seat belt at all on the morning that Resident #7 fell. During an interview, on 12/30/19 at 10:55 AM, the Activity Director stated to be honest and thinking back on it, she didn't remember seeing the safety belt on Resident #7 that morning. During an interview, on 12/31/19 at 10:39 AM, the Administrator stated the monitoring of the self-release seat belt was not being done correctly according to the Physician's Order and the TAR for Resident #7 and that she was having the monitoring of the belt corrected immediately. During an interview, on 12/31/19 at 12:21 PM, the Director of Nursing (DON) stated the Medication Nurses are responsible for monitoring the self-release alarm belt and documenting that they have been checked according to physician's orders. The Don stated according to the TAR, the monitoring of the self-release alarm belt was not being monitored per the Physician's Order. The self-release alarm belt not being monitored correctly could have contributed to a fall for Resident #7. During an interview, on 12/31/19 at 12:44 PM, LPN #4/Care Plan Nurse revealed the Medication Nurses are responsible to check for the release of the self-release alarm belt and document accordingly. LPN #4 stated after reviewing the TAR, the physician's order for monitoring the self-release alarm belt was not being followed.	M 640		

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M 640	Continued From page 9 During an interview, on 12/31/19 at 1:17 PM, LPN #2 stated the Medication Nurses or Treatment Nurses on the hall are responsible to document and check the self-release alarm belt. LPN #2 verified that according to the TAR, the self-release belt was not being monitored following the physician's order. Review of the facility's Incident Log revealed Resident #7 had a fall with injury on 12/10/19 at 8:46 AM. The Type of Injury was a skin tear Review of the Face Sheet revealed Resident #7 was admitted by the facility, on 3/26/18, and discharged on 12/16/19. Resident #7 was admitted with the included diagnoses of Hypertension (High Blood Pressure), Unspecified Dementia and Breast Cancer.	M 640		