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
	49WM	A. BUILDING: _____ B. WING _____	10/20/2020

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WINONA MANOR HEALTH CARE AND REHABILITATIC	627 MIDDLETON ROAD WINONA, MS 38967

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M 000	Initial Comments State Agency (SA) conducted a COVID-19 Infection Control (FIC), along with complaint(s), MS #17222, MS #17064, and MS #17104 from 10/18/2020 to 10/20/2020. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in the Minimum Standards for the Aged or Infirm. SA substantiated CI MS #17222 and cited M-735 related to medical records management. The SA did not substantiate MS #17064 related to staffing and MS#17104 related to quality of care, with no deficiencies cited. No deficiencies were cited related to the COVID-19 Focused Infection (FIC) survey. At the time of the survey, the facility had a census of 78, with a license for 116 beds.	M 000		
M 735	45.25.1 Medical Records Management Medical Records Management. 1. A medical record shall be maintained in accordance with accepted professional standards and practices on all residents admitted to the facility. The medical records shall be completely and accurately documented, readily accessible, and systematically organized to facilitate retrieving and compiling information. 2. A sufficient number of personnel, competent to carry out the functions of the medical record service, shall be employed. 3. The facility shall safeguard medical record information against loss, destruction, or unauthorized use. 4. All medical records shall maintain the following	M 735		11/18/20

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M 735	Continued From page 1 information: identification data and consent form; assessments of the resident's needs by all disciplines involved in the care of the resident; medical history and admission physical exam; annual physical exams; physician or nurse practitioner/physician assistant orders; observation, report of treatment, clinical findings and progress notes; and discharge summary, including the final diagnosis. 5. All entries in the medical record shall be signed and dated by the person making the entry. Authentication may include signatures, written initials, or computer entry. A list of computer codes and written signatures must be readily available and maintained under adequate safeguards. 6. All clinical information pertaining to the residents stay shall be centralized in the resident's medical records. 7. Medical records of discharged residents shall be completed within sixty (60) days following discharge. 8. Medical records are to be retained for five (5) years from the date of discharge or, in the case of a minor, until the resident reaches the age of twenty-one (21), plus an additional three (3) years. 9. A resident index, including the resident's full name and birth date, shall be maintained. This Statute is not met as evidenced by: Based on record review, staff interview and policy review, the facility failed to develop, implement, review or revise a comprehensive person-centered wound care plan for four (4) of	M 735	* A root Cause Analysis (RCA) was completed on 11/09/20 by QAPI committee and based on the findings the facility failed to ensure residents plan of	

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M 735	Continued From page 2 four (4) residents reviewed with wounds (Residents #1, #2 #3 and #4). Findings include: Review of the facility's "Plans of Care" policy, revised 09/25/2017, revealed, "Policy: An Individualized, person-centered plan of care will be established by the interdisciplinary team (IDT) with the resident and/or resident representative(s) to the extent practicable and updated in accordance with state and federal regulatory requirements. The plan of care is to be maintained as part of the final medical record. Procedure: Develop a comprehensive plan of care for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. Develop and implement an Individualized Person-Centered Baseline plan of care within 48 hours of admission that includes, but not limited to, initial goals based on the admission orders, physician orders, dietary orders, therapy services, social services, PASARR recommendations, if applicable, and other areas needed to provide effective care of the resident that meets professional standards of care to ensure that the resident's needs are met appropriately until the Comprehensive plan of care is completed...Review, update and/or revise the comprehensive plan of care based on changing goals, preferences, and needs of the resident and in response to current interventions...The interdisciplinary team shall ensure the plan of care addresses any resident needs... Note: The resident's plan of care encompasses many documents that are part of the resident's clinical record including, but not limited to, structured care plan documents, MARS	M 735	care for resident # 3 and #4,and failed to ensure resident plan of care was updated to reflect the current medical conditions of resident #1 and #2. The facility failed to develop a comprehensive plan of care that included measurable objectives for wounds. * All residents residing in the facility with wounds have the potential to be affect by this deficient practice. Quality observation of current care plans was conducted by the RN MDS nurse on 10/20/20 to reflect Quality observation of current wounds and ensure wounds are treated per physician orders. * Re-education was conducted by the Director of Clinical Services (DCS) on 10/28/20 with emphasis on care plans, skin assessments and documentation. Nurses notes and 24 hour reports are to be reviewed daily 5X a week during the clinical meeting for new orders and/or concerns Care plans to be update as needed to indicate changes. * Quality Improvement monitoring to be conducted by the Director of Clinical Services or designee 5 times per week X 2 weeks then 3X weekly for 4 weeks, then monthly to ensure care plans are accurate. Findings are to be reviewed at monthly QAPI meeting for 3 months then quarterly.	

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M 735	Continued From page 3 (Medication Administration Records), TARS (Treatment Administration Records), physician orders, flow records, and/or legal documents that would drive the plan of care for the individual resident." Resident #1 Review of Resident #1's "Order Summary Report" dated 10/19/2020, revealed and order to "Clean left lateral ankle with wound spray, pat dry, apply Santyl ointment to affected areas. Apply Calcium Alginate to affected areas, cover with 4x4 gauze and cover with Optifoam adhesive dressing daily until healed. Review of Resident #1's care plan for his left lateral ankle wound, initiated on 06/22/2020, revealed, "I have a stage 2 pressure ulcer to my left ankle..." Review of Resident #1's "Order Summary Report" dated 10/19/2020, revealed and order to "Clean right lateral ankle with wound spray, pat dry, apply Santyl ointment to affected areas. Apply Calcium Alginate, cover with 4x4 gauze, then cover with Optifoam adhesive dressing daily until healed. Review of Resident #1's care plan for his right lateral ankle wound, initiated on 07/10/2020, revealed, "I have a stage 2 pressure ulcer to my right ankle..." On 10/19/2020 at 2:10 PM, during an interview with the wound treatment nurse/Licensed Practical Nurse (LPN) #1, regarding using a debriding agent on stage 2 pressure ulcers, revealed she indicated the wounds on his left and right lateral ankles were no longer stage 2 pressure ulcers and were now stage three (3)	M 735		

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M 735	Continued From page 4 pressure ulcers. The physician had ordered Santyl to eat away the slough on the wound beds. Review of Resident #1's handwritten physician's order, dated 08/04/2020 revealed an order to "turn resident side to side every 2 hours" due to a pressure ulcer on his gluteal cleft/sacrum. Review of Resident #1's current wound care plans revealed, neither care plan for his left or right ankle wounds had been updated to reflect the current stage of the wounds, nor had any of his wound care plans been updated with the specific order to turn Resident #1 from side to side every two (2) hours. On 10/20/2020 at 9:00 AM, during an interview with the MDS (Minimum Data Set)/Care Plan Nurse, the Director of Nursing (DON), and the Assistant Director of Nursing (ADON), confirmed Resident #1's left and right ankle wounds were now stage 3 pressure ulcers. They also verified his comprehensive care plan had not been revised to reflect the changes of staging, nor the specific order to "turn side to side every 2 hours". Resident # 1 was admitted to the facility on 05/08/2020 with diagnoses of Traumatic Brain Injury, Seizures, Atrial Fibrillation, Hypertension, Gastroesophageal Reflux Disease, Anxiety, Muscle Spasms, Neurogenic Bladder, Aphasia, and Constipation. Resident #2 Review of Resident #2's "Order Summary Report" dated 10/19/2020 revealed an order to "Cleanse SDTI to left heel with wound cleanser, pat dry with 4 x 4's, paint with betadine, apply and, wrap with kerlix and secure with tape daily".	M 735		

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M 735	Continued From page 5 Review of Resident #2's care plan revealed, "I have an STDI to my Left Heel...Interventions: Cleanse STDI to left heel with NS, Pat Dry, Swab with Sureprep and Pad with Optifoam dressing daily." Further review of Resident #2's "Order Summary Report" revealed an order to "Clean left outer knee stage 2 with wound cleanser, pat dry with 4x4's, apply calcium alginate and bordered dressing daily." Review of Resident #2's care plan revealed, "I have an abrasion to my left outer knee...Interventions: Clean with NS, Pat dry, swab with Sureprep and pad with Optifoam daily". On 10/20/2020 at 9:00 AM, during an interview with the MDS/Care Plan Nurse, the DON, and the ADON, they indicated Resident #2's wound care plans had not been updated and revised to include the new treatment order for Betadine to his SDTI on his left heel, and the wound on his left outer knee was no longer an abrasion, but had become a stage 2 pressure ulcer. The wound care plan for his left knee had not been revised and updated to reflect the change. Resident #2 was admitted to the facility on 01/17/2019 with the diagnoses of Cerebral Vascular Accident, Dementia without Behaviors, Anemia, Hyperlipidemia, Gastostomy Tube, Constipation, Gastroesophgeal Reflux Disease, Neurogenic Bladder, Hypertension, Diabetes, and hemiplegia of the Left side. Resident #3 Review of Resident #3's "Order Summary	M 735		

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Report", dated 10/19/2020, revealed an order to "Cleanse SDTI (Suspected Deep Tissue Injury) to right heel with wound cleanser, pat dry with 4 x 4's (gauze), paint with betadine, apply ABD (abdominal) pad, wrap with Kerlex and secure with tape daily."

Review of Resident #3's current comprehensive care plans revealed, no care plan present for the SDTI wound of the right heel.

On 10/20/2020, at 9:00 AM, during an interview with the MDS (Minimum Data Set)/Care Plan Nurse, the DON (Director of Nursing), and the ADON (Assistant Director of Nursing), they indicated the SDTI had been identified the week prior, and a wound care plan for the SDTI of the right heel had not been initiated yet.

Resident #3 was initially admitted to the facility on 12/04/2009 and had a readmission on 12/25/2019. Her diagnoses included Multiple Sclerosis, Encephalopathy, Dementia, Hypertension, Depression, Osteoarthritis, Dysphagia, Gastroesophageal Reflux Disease, Glaucoma, and Constipation.

Resident #4:

Review of Resident #4's "Order Summary Report", dated 10/19/2020, revealed an order for "Cleanse unstageable to right upper buttock with NS (Normal Saline), pat dry, apply Santyl and Calcium Alginate and cover with a dry dressing daily and PRN (as needed)".

Review of Resident #4's current comprehensive care plans revealed no care plan present for the unstageable wound to his right upper buttocks.

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M 735	Continued From page 7 On 10/20/2020, at 9:00 AM, during an interview with the MDS (Minimum Data Set)/ Care Plan Nurse, the DON (Director of Nursing), and the ADON (Assistant Director of Nursing) indicated the wound had been identified a few weeks prior, and no comprehensive care plan had been initiated for it yet. Resident #4 was initially admitted to the facility on 08/02/2019, with a readmission date of 08/27/2020. His diagnoses included Hypoxic Ischemic Encephalopathy, Cardiomyopathy, Atrial Fibrillation, Diabetes, Hyperlipidemia, Tracheostomy, Right Sided Above the Knee Amputation, Gastrostomy Tube, Cerebral Vascular Accident, Neurogenic Bladder, Constipation, Athrosclerotic Heart Disease, Chronic Respiratory Failure, and Anemia.	M 735		