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
	79CH	A. BUILDING: _____ B. WING _____	02/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILKINSON COUNTY SENIOR CARE	116 SOUTH LAFAYETTE STREET CENTREVILLE, MS 39631

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M 000	Initial Comments The State Agency (SA) conducted a recertification survey and a complaint investigation (CI) MS #18551 at the facility from 2/7/22 through 2/11/22. During the survey, the SA determined the facility was not in compliance with Mississippi Regulations for Minimum Standards for Institutions for the Aged or Infirm and cited M615. CI MS#18551 was not substantiated however deficiencies were cited related to foley catheter care and the residents care plan. The SA returned to the facility on 2/24/22 for Complaint Investigation (CI) MS #18514. The complaint was not substantiated for neglect.	M 000		
M 615 SS=D	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: Based on observation, interviews, record review and facility policy review, the facility failed to anchor catheter tubing during catheter care to minimize movement or prevent possible friction or trauma and failed to ensure a catheter leg strap was in place for one (1) of three (3) catheter care observations. Resident #9. Findings Include: Review of the facility policy, "Catheter Care Policy", dated 8/20 revealed "It is the policy of this facility to ensure that residents with indwelling	M 615	A. The facility failed to anchor catheter tubing during catheter care to minimize movement or prevent possible friction or trauma and failed to ensure a catheter leg strap was in place for one (1) of three (3) catheter care observations. Resident #9. A catheter leg strap was applied 2-8-2022 by the Director of Nursing to anchor catheter tubing. The nursing assistant was in-serviced on 2-8-2022 by the Director of Nursing on the facility□s policy on catheter care.	3/24/22

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M 615	Continued From page 1 catheters receive appropriate catheter care...Compliance Guidelines: ... 12. ... wipe the catheter making sure to hold and secure the catheter in place to not pull on the catheter..." Resident #9 Observation on 02/08/22 at 01:22 PM, of catheter care with Certified Nursing Assistant (CNA) # 2 revealed CNA #2 failed to secure the tubing on the catheter while providing catheter care. CNA #2 held the sides of the penis and pulled the tubing outward and did not hold the tubing secure. Resident #2 jumped when CNA #2 pulled on the tubing. Resident #9 also did not have a catheter leg strap in place to anchor the tubing to prevent friction. During an interview on 02/08/22 at 01:52 PM, with CNA #2, confirmed she failed to secure the tubing while cleaning the tubing. CNA #2 said she did not realize that she caused tension and friction by pulling and tugging on the catheter. CNA #2 said she didn't realize she could pull the catheter out causing trauma to the meatus. Record review of the Admission Record revealed Resident #9 was admitted to the facility on 08/09/2021 with diagnoses included Paraplegia and Neuromuscular Dysfunction of Bladder. Record review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/16/21 revealed Resident #9 had a Brief Interview for Mental Status (BIMS) score of 15 indicating Resident #9 is cognitively intact. During an interview on 02/08/22 at 01:55 PM, with the Director of Nursing (DON) confirmed CNA #2 failed to follow the facility policy. The DON said	M 615	B. The potential exists to affect 67 residents. C. All certified nursing assistants were in-serviced on 2-24-2022 by the Director of Nursing on the facility□s policy on catheter care. In-service training included observation of each nursing assistant performing the procedure. On 2-24-2022, a validation checklist was completed by the Director of Nursing for each individual observed to determine if the individual was performing the procedure correctly. Findings were reviewed with each nursing assistant. Corrective action was provided as needed. D. The Director of Nursing Services, or Assistant Director of Nursing Services, will complete weekly Validation Checklists of nursing assistants performing Catheter Care for two (2) times per week (8) consecutive weeks to ensure nursing assistants are performing Catheter Care in accordance with our facilities Practice Guideline beginning on 3-1-2022. Validation Checklists will be reviewed in the weekly Quality Assurance meetings starting on 3-1-2022 by the Quality Assurance Performance Improvement Committee. Necessary changes will be made to maintain sustained compliance.	

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M 615	Continued From page 2 CNA #2 should have made sure Resident #9 had a leg strap on to keep the catheter from causing friction or trauma. The DON also confirmed by the CNA not securing the catheter tubing, it could cause friction and or trauma to the meatus and increase the possibility for infections. The DON said the staff has been in-serviced on the correct way to provide catheter care. Record review of a facility record titled, "In-service Training" dated 9/30/21, revealed CNA #2's name was listed on the sign in sheet. Catheter care and Perineal care was included in the in-service. Level II Based on observation, staff interviews, record review, and facility policy review, the facility failed to clean a pressure wound in a manner to prevent the possible spread of infection for one (1) of four (4) pressure wound care observations. Resident #54 Findings Include: Record review of the facility's policy, "Clean Dressing Change", undated, revealed "It is the policy of the facility to provide wound care in a manner to decrease potential for infection and/or	M 615		

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M 615	Continued From page 3 cross contamination...12. Cleanse the wound as ordered, taking care to not contaminate other skin surfaces or other surfaces of the wound (i.e clean outward from the center of the wound) ...". On 2/9/22 at 10:20 AM, the State Agency (SA) observed wound care to Resident # 54's right heel by Licensed Practical Nurse (LPN) #2 and assisted by Registered Nurse (RN) #3. During the observation, LPN #2 cleaned the wound with gauze and wiped in a circular motion from the center of the wound outward two times, using the same gauze. LPN #2 then disposed of the gauze and obtained clean gauze and repeated the same cleaning motion, wiping in a circular motion multiple times with the one gauze. On 2/9/22 at 10:45 AM, in an interview with LPN #2, she confirmed she should have used the gauze one time and disposed of it, and not used the gauze multiple times when cleaning the wound. She verified that her actions could have caused the resident to acquire a wound infection. On 2/9/22 at 10:55 AM, in an interview RN #3, she agreed LPN #2 should not have cleaned the wound multiple times with the same gauze. She stated LPN #2 should have wiped one time, disposed of the gauze, and used a clean gauze when cleaning the wound. She confirmed the resident could have acquired a wound infection due to LPN #2's failure to clean the wound appropriately. On 2/10/22 at 2:25 PM, in an interview with RN #2/Assistant Director of Nursing (ADON), she confirmed LPN #2 did not clean the wound correctly and her actions could have caused Resident #54 to acquire a wound infection.	M 615		

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M 615	Continued From page 4 On 2/10/22 at 2:50 PM, in an interview with the Director of Nursing (DON) she confirmed LPN #2 did not clean the wound correctly and LPN #2's actions could have caused Resident #54 to acquire a wound infection. On 2/10/22 at 4:55 PM, in an interview with RN #4/ Infection Control Nurse, stated LPN #2 did not clean the wound correctly and her actions could have caused Resident #54 to acquire a wound infection. Record review of Resident #54's "Admission Record" revealed the facility admitted her on 1/3/22, with diagnoses including Pressure ulcer of right heel stage 3, Pressure ulcer of sacral region stage 3, and Pressure ulcer of right buttock stage 3. Record review of the "Order Summary Report" with active orders as of 2/11/2022 revealed Resident #54 has a current physician order with an order date of 2/10/2022 to "Cleanse wound to right heel with Dakins, apply Dakins and Santyl moistened gauze, wrap with Kerlix and tape in place daily and prn (as needed) until healed.	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	M 620		

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M 620	Continued From page 5 Based on observation, interviews, record review and facility policy review, the facility failed to anchor catheter tubing during catheter care to minimize movement or prevent possible friction or trauma and failed to ensure a catheter leg strap was in place for one (1) of three (3) catheter care observations. Resident #9. Findings Include: Review of the facility policy, "Catheter Care Policy", dated 8/20 revealed "It is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care...Compliance Guidelines: ... 12. ... wipe the catheter making sure to hold and secure the catheter in place to not pull on the catheter..." Resident #9 Observation on 02/08/22 at 01:22 PM, of catheter care with Certified Nursing Assistant (CNA) # 2 revealed CNA #2 failed to secure the tubing on the catheter while providing catheter care. CNA #2 held the sides of the penis and pulled the tubing outward and did not hold the tubing secure. Resident #2 jumped when CNA #2 pulled on the tubing. Resident #9 also did not have a catheter leg strap in place to anchor the tubing to prevent friction. During an interview on 02/08/22 at 01:52 PM, with CNA #2, confirmed she failed to secure the tubing while cleaning the tubing. CNA #2 said she did not realize that she caused tension and friction by pulling and tugging on the catheter. CNA #2 said she didn't realize she could pull the catheter out causing trauma to the meatus. Record review of the Admission Record revealed	M 620		

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M 620	Continued From page 6 Resident #9 was admitted to the facility on 08/09/2021 with diagnoses included Paraplegia and Neuromuscular Dysfunction of Bladder. Record review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/16/21 revealed Resident #9 had a Brief Interview for Mental Status (BIMS) score of 15 indicating Resident #9 is cognitively intact. During an interview on 02/08/22 at 01:55 PM, with the Director of Nursing (DON) confirmed CNA #2 failed to follow the facility policy. The DON said CNA #2 should have made sure Resident #9 had a leg strap on to keep the catheter from causing friction or trauma. The DON also confirmed by the CNA not securing the catheter tubing, it could cause friction and or trauma to the meatus and increase the possibility for infections. The DON said the staff has been in-serviced on the correct way to provide catheter care. Record review of a facility record titled, "In-service Training" dated 9/30/21, revealed CNA #2's name was listed on the sign in sheet. Catheter care and Perineal care was included in the in-service.	M 620		