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
	16WH	A. BUILDING: _____ B. WING _____	06/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK OF COLLINS	1315 SOUTH FIR AVE COLLINS, MS 39428

(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) conducted a recertification and a Complaint Investigation CI MS #18764 and CI MS# 18383, at the facility from 6/5/22 through 6/8/22. During the survey, the SA determined the facility was not in compliance with the Mississippi Regulations for Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements and M615, M640, and M815 was cited.	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: Based on observations, interviews, record review, and facility policy review, the facility failed to prevent the development of an avoidable pressure ulcer on a resident with an immobilization brace for one (1) of three (3) facility acquired pressure ulcers reviewed. Resident #30 Findings Include: Review of the facility's policy, "Prevention and Treatment of Skin Issues" with a latest review date of 8/21 revealed, "Policy: It is the policy to properly identify and assess residents whose clinical conditions increase the risk for impaired skin integrity, and pressure ulcers; to implement preventative measures; and to provide appropriate treatment modalities for wounds	M 615	-Resident #30 splint was discontinued on 03/24/2022 by Treatment Nurse. Resident #30 was re-assessed on 06/08/2022 by Director of Nursing and a body audit completed with no additional skin issues or concerns noted. -All residents with splints have the potential to be affected. -An in-service was initiated on 06/07/2022 with facility Registered Nurse, Licensed Practical Nurses, Certified Nursing Assistants and Temporary Nurse Aides by Staff Development Nurse. Topics reviewed included Prevention and Treatment of Skin Issues. Body audits were completed on residents with splints on 06/08/2022 by	7/5/22

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M 615	Continued From page 1 according to industry standards of care ...C. monitoring of skin integrity. The skin will be observed daily during care by the nursing assistants. If any skin concerns are noted, they are to be reported immediately to the designated nurse verbally and via the kiosk in electronic facilities ..." On 06/06/22 at 11:33 AM, the State Agency (SA) observed wound care for Resident #30 performed by the Director of Nursing (DON). The SA observed two wounds to the resident's right heel. Record review of Resident #30's "Departmental Notes" dated 3/21/22 at 2:44 PM revealed, "Pressure Ulcer//Right Heel// ...New DTI (Deep Tissue Injury), which appears to be from the brace resident must wear on her leg. The metal part was under the heel and medial side where the DTI was located." Record review of the facility's "Pressure Ulcer Evaluation for Unavoidable/Avoidable Status" dated 3/21/22 revealed Resident #30 was evaluated for clinical conditions and pressure ulcer risk factors with formal and clinical assessments on 3/18/22. Risk factors for development and or delayed healing of pressure ulcers were indicated as "cast or non-removable device". Record review of the "Wound Assessment Report" dated 3/18/22, revealed an "Assessment Occasion" as "New Wound." The stage and the type of pressure area was indicated as "Unstageable" and "Suspected Deep Tissue Injury". The location of the pressure injury was the right heel and measurements were recorded as 5.50 CM X 2.80 CM. The wound report "Notes" revealed, "New DTI appears to be from	M 615	Director of Nursing. No new skin issues were identified at time of audits on 06/08/2022. Orders were received for all active residents with splints on 06/08/2022 by Medical Records Nurse to check under splint for signs of skin breakdown. There were no non-removable devices ordered for residents at time of audit on 06/08/2022. -The facility Director of Nursing and/or Treatment Nurse will complete an additional body audit weekly times four weeks on residents with splints beginning on 06/08/2022 until substantial compliance is attained. A quality Assurance Committee meeting was held on 06/27/2022 to review this corrective action plan. The Quality Assurance Committee members present on 06/27/2022 were Facility Administrator, Facility Director of Nurses, Facility Medical Director, Facility Infection Preventionist, Dietary Manager, Environmental Services Supervisor, MDS Nurse, Accounts Manager, Admission Coordinator, Social Services, and Medical Records Nurse. The facility Quality Assurance Committee Meeting shall be held monthly for 2 months until substantial compliance is attained. Areas of concern will be carried the the Quality Assurance Committee for corrective action to include in-service training, and/or disciplinary action.	

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the brace resident has to wear on her leg. The metal part was under the heel and on the medial side where the DTI is located".

During an interview on 06/06/22 at 12:15 PM, with Resident #30, she said she fell at home, fractured her knee, and came to the facility to receive therapy. She did not know her foot was pressing against the medal on the brace and had caused a wound.

On 06/06/22 at 11:34 AM, the SA conducted a telephone interview with Registered Nurse (RN) #2, a former employee who was the wound care nurse. She said she was told by another nurse that Resident #30's right heel was "boggy" which possibly meant the resident's heel had underlying tissue damage. RN #2 said she monitored the area for a few days and notified the doctor, but she was unable to recall the exact date this occurred. RN #2 commented that the resident's immobilizer brace kept sliding down her leg causing the metal bar in the brace to apply pressure to her right heel. RN #2 confirmed the Certified Nursing Assistants (CNAs) could not remove the brace per doctor's order and only the nurse that provided care to the surgical site could remove the device. RN #2 believed Resident #30 developed the pressure injury on her heel from the metal bar on the brace. She stated that as the wound care nurse, she should have requested a physician order to check the pressure points to ensure the resident did not develop a wound from the brace.

During an Interview on 06/07/22 at 11:00 AM, with Licensed Practical Nurse (LPN) # 2, revealed she assisted RN #2 during wound care by holding Resident #30's right foot. LPN #2 said she was holding the residents' foot and noted the

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resident's right heel was red and boggy. LPN #2 said she reported her findings related to the heel to RN #2 and was told that RN #2 was going to monitor the heel for a while. LPN #2 said that approximately one week later, Resident #30's right heel continued to be boggy and had developed a purple discoloration. LPN #2 advised RN #2 that something needed to be done to prevent the resident from having skin breakdown. By the third week, Resident #30's right heel had opened, and wound care orders were received. LPN #2 said she was responsible for the weekly body audits, but she did not document there were any skin issues because she had already told RN #2 and the DON about the condition of Resident #30's heel.

During an Interview on 6/07/22 at 1:00 PM, with the Medical Doctor (MD), he confirmed he was notified that Resident #30 had developed a deep tissue injury on her right heel. He was unaware that the resident's heel was pressing against the metal bar of the brace as it would slide down. He had thought the facility had padded all the pressure points on the resident's leg and heel to prevent pressure ulcers and friction, and he thought the facility was assessing the pressure areas daily.

An interview on 6/7/22 at 1:30 PM, with the Physical Therapy Assistant (PTA) revealed he was asked on 3/28/22 by RN #2 to look at Resident #30's brace to see why it kept sliding down. The PTA said he adjusted the brace which kept the brace in place until it was removed.

Record review of the facility's "Timeline for (Proper Name of Resident #30) Wounds" given to the SA by the DON revealed, "3/7/22 External Fixator with pins was removed and immobilizer

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was placed. 3/14/22 clarification from ortho (Orthopedics) on removal/placement of brace due to pain voiced by resident. Ortho states only loosen for wound care. 3/18/22 Deep tissue injury to right heel developed ..."

During an Interview on 6/7/22 at 2:30 PM with the DON, she confirmed the resident acquired both the unstageable pressure ulcer and the Stage 2 pressure ulcer to the right heel because it had been one (1) wound that developed into two (2) separate wounds. The wound occurred from the metal bar on the brace. She acknowledged there is no documentation showing the facility was monitoring the pressure points daily for pressure injury development underneath the brace. She confirmed it was the wound care nurse's responsibility to make sure the resident's pressure points were checked daily to prevent skin breakdown.

Record review of the "Face Sheet" revealed the facility admitted Resident #30 on 11/10/21, with the diagnoses that included Unspecified Fracture of Right Femur, Muscle Spasm, Muscle weakness, and Diabetes Mellitus.

The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/3/22 revealed Resident #30 had a Brief Interview of Mental Status (BIMS) score of 15 that indicated she was cognitively intact. Review of Section M revealed Resident #30 is at risk of developing pressure ulcer injury and had more than one (1) unhealed pressure injuries.

Review of RN #2's, "Licensed Nurses Orientation Checklist", revealed on 12/8/21 information was covered related to "Policies/Procedures, schedules, documentation" on the Skin

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M 615	Continued From page 5 Program/Wound Care which included body audits, treatments/orders	M 615		
M 815	45.29.1 Safe Food Handling Procedures Safe Food Handling Procedures. Food shall be prepared, held, and served according to current Mississippi State Department of Health Food Code Regulations. This Statute is not met as evidenced by: Based on observation, interviews, record review and facility policy review, the facility failed to discard expired food items, ensure daily temperature logs for the freezer were completed, and failed to label and date refrigerated items for one (1) of four (4) kitchen observations. Findings Include: A record review of the facility's policy" Food Storage Labeling", with a revision date of 05/18, revealed, Policy: The facility will ensure the safety and quality of food by following good storage and labeling procedures Procedure: 1. Labeling ... a. All temperature controlled foods and ready to eat foods that are prepared in the facility and held for longer than twenty-four hours will be labeled. Information included on the label: Name of the Food Date of storage ...3. Rotation ...b. Foods stored in storage units will be surveyed routinely to identify and discard foods that have passed its manufactured use-by date or expiration date... 4. Monitoring storage temperatures ...b. Temperatures in food storage units are monitored daily. C. Documentation of time and temperature is recorded on a Temperature Monitoring Log ..."	M 815	-The facility dietary freezers and cooler were cleaned on 06/05/2022 by dietary staff and expired food discarded accordingly. All food was stored and labeled appropriately on 06/05/2022 by Facility Administrator. Cooler and Freezer temperatures were checked on 06/05/2022 and temperature logs updated accordingly by dietary staff. -All residents have the potential to be affected. -An in-service was initiated on 06/07/2022 with facility Dietary staff by Administrator. Topics reviewed included Food Storage Labeling, discarding expired foods, and maintaining temperature logs. -The facility Director of Dietary Services and/or Facility Administrator will check dietary cooler/freezer for appropriate food storage, labeling and discarding of expired food three times per week for three weeks beginning on 06/09/2022 then weekly for 2 weeks until substantial compliance is attained. The facility Director of Dietary	7/5/22

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M 815	Continued From page 6 On 6/5/22 at 10:22 AM, during an initial kitchen tour and interview with the Head Cook (Dietary #1), the State Agency (SA) observed that the temperature logs for the Milk Box and Ice Cream Box freezers had missing documentation. The SA observed an 8-ounce container in the refrigerator that contained a white liquid substance and was not labeled with the name of the food or the date of storage. The SA observed a 32-ounce container of McCormick Culinary egg shade food color with an open date of 5/28/20 and an expiration date of 12/20. The SA observed an undated clear container with potato salad and coleslaw that had no label containing the name of the food or the date of storage. Dietary #1 commented that she had informed the staff that it is important to check all refrigerators, and freezers for labeled food items and to complete the documentation of the temperature logs daily. She confirmed the food should have been labeled and the temperatures logs should have been completed because this information lets the staff know that the food is good to serve to the residents. Dietary #1 explained that all expired foods should be thrown away so that staff will not use them. She further acknowledged that although the egg shade color had not been used for a long time, it should not have been in the kitchen. On 6/8/22 at 2:45 PM, in an interview with the Administrator, he confirmed that Dietary #1 is in charge of the kitchen while the Dietary Manager is on leave. He acknowledged that staff should be checking for expired food, logging temperatures daily, and labeling and dating foods in the refrigerator so that the residents will not be served expired food. He said that dietary staff should check and record temperatures on the	M 815	Services and/or Facility Administrator will check dietary temperature logs three times per week for three weeks beginning on 06/09/2022 then weekly for 2 weeks until substantial compliance is attained. A quality Assurance Committee meeting was held on 06/27/2022 to review this corrective action plan. The Quality Assurance Committee members present on 06/27/2022 were Facility Administrator, Facility Director of Nurses, Facility Medical Director, Facility Infection Preventionist, Dietary Manager, Environmental Services Supervisor, MDS Nurse, Accounts Manager, Admission Coordinator, Social Services, and Medical Records Nurse. The facility Quality Assurance Committee Meeting shall be held monthly for 2 months until substantial compliance is attained. Areas of concern will be carried to the Quality Assurance Committee for corrective action to include in-service training, and/or disciplinary action.	

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M 815	Continued From page 7 refrigerators and freezers to make sure that the food does not spoil. A record review of the "Daily Freezer/Refrigerator Temperature Log" for the "Month/Year" of 6/2022 with a "Location/Unit Description" listed as "Milkbox Dietary" revealed there was no temperature recorded for 6/4/22. A record review of the "Daily Freezer/Refrigerator Temperature Log" for the "Month/Year" of 6/2022 with a "Location/Unit Description" listed as "Ice Cream Box Dietary" revealed there was no temperature recorded for 6/4/22. A record review of the facility's "In-Service Attendance" revealed Dietary #1 received training on the "Topic" of "Storage Temperatures" on 4/6/22.	M 815		