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
	76WC	A. BUILDING: _____ B. WING _____	03/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CARE CENTER	1920 LISA DRIVE EXTENDED GREENVILLE, MS 38703

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M 000	Initial Comments A Recertification survey was conducted by Healthcare Management Solutions, LLC on behalf of the Mississippi State Department of Health from 03/25/19 through 03/28/19. During the survey, it was determined the facility was not in compliance with federal requirements at F690, F712, and F908. It is also determined during the survey, that the facility was not in compliance with the Minimum Standards of Operation for Institutions for the Aged or Infirm, state licensure requirements at M620, M680, and M1015. The facility had a census of 50 residents, and held a license for 60 beds.	M 000		
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 Based on record review, interview, and policy review, the facility failed to ensure an individual toileting plan was developed for one (1) of 20 residents, Resident (R) #22, reviewed for incontinence. This deficient practice had the potential to affect the other 46 residents identified by the facility with incontinence out of a total census of 50 residents. Findings include: The facility's "Bowel and Bladder Retraining"	M 620	Resident #22 was started on three (3) day bladder/bowel continence pattern observation by Medical Records Nurse on 4/26/19. The completed bladder/bowel continence pattern was reviewed by the Nurse Case Manager and Director of Nursing on 4/30/19. Resident #22 was placed on a toileting plan based on the reviewed pattern on 5/1/19 by the Director of Nursing. Three (3) of (52) residents were identified by the Director of Nursing on 4/30/19 as having the potential to be affected by the	5/1/19

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M 620	Continued From page 1 policy, revised September 2018, documented the facility would complete a Nursing Data Collection tool upon admission and with each Minimum Data Set (MDS) to determine a resident's candidacy for a retraining program, and use the data collected to develop an individualized toileting plan. The facility did not use the data collected, per their policy, and develop an individualized toileting plan for Resident #22. Resident #22's quarterly MDS assessment with an Assessment Reference Date (ARD) of 01/22/19, documented she was admitted to the facility on 08/28/18, with diagnoses including Hypertension and Dementia. The MDS documented R #22 had a Brief Interview for Mental Status (BIMS) score of 9 out of 15, indicating moderate cognitive impairment, required extensive assistance of one (1) person for toileting, was always incontinent of urine and frequently incontinent of bowel, and had not been tried on a toileting program. On 01/22/19, R #22's "Nursing Data Collection" tool documented a section for a Bowel and Bladder assessment. The form documented she was not on a toileting program and had not been tried on a program. The form documented a bowel and bladder retraining program overall score of 6, which indicated she was a "good candidate" for a retraining program. Review of R #22's "Care Plan" for Activities of Daily Living (ADL), initiated 08/28/18, documented she had a Foley [indwelling urinary] catheter. The care plan intervention had not been discontinued or revised. An additional intervention to toilet the resident upon rising, before and after meals, at bedtime, and as needed was added on 12/23/18.	M 620	deficient practice. Three (3) of (3) residents were screened for bowel/bladder retraining which included the need for a toileting plan and one (1) of (3) residents were placed on an individualized toileting plan as a result of these screenings on 5/1/19 by the Director of Nursing. In-service on the policy titled Bowel and Bladder Retraining with a revision date of 9/18, was conducted on 5/1/19 with nine (9) of (9) Licensed Practical Nurses and two (2) of (2) Registered Nurses by the Director of Nursing. The in-service included that residents admitted with catheters will be screened for retraining when the catheter is discontinued and toileting plans initiated as indicated. The Quality Assurance Committee, which includes the Administrator, Director of Nursing, Medical Director and Department Heads, reviewed the policy titled Bowel and Bladder Retraining on 4/30/19 and did not recommend any changes. Bowel and Bladder screenings of residents completed by nurses will be monitored beginning 5/6/19 by the Director of Nursing and/or Medical Records Nurse weekly for four (4) weeks and monthly for two (2) months. Monitoring will include implementation of toileting plan as indicated on the completed bowel and bladder screenings. Any findings are recorded on the medical record audit form and maintained by the Director of Nursing. The Director of Nursing will present findings to the Quality Assurance committee. The Quality Assurance Committee will address concerns and	

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M 620	Continued From page 2 On 3/25/19 at 3:44 PM, R #22's representative was interviewed with R #22 present. The representative stated prior to admission to the facility R #22 was continent but had become incontinent since admission to the facility. She stated R #22 had a catheter when first admitted to the facility, but it had been discontinued within a few days. R #22 stated, "I sit here in the afternoon and wonder when they are going to come in and take me to the toilet. I worry about it all the time." On 3/28/19 at 8:28 AM, the Director of Nursing (DON) stated R #22 had a catheter upon admission, but it had been discontinued as soon as the resident arrived. The DON stated the toileting times documented on R #22's care plan were designed to train her body to void at those times, as it was easier on staff if all residents had the same voiding schedule. The DON stated that R #22's care plan was not reflective of an individualized retraining program, or plan of care, and stated she was not aware whether R #22 had been continent prior to her admission and could not tell from looking at the documentation in her record.	M 620	evaluate monitoring monthly for three (3) months then quarterly thereafter. Quality Assurance Committee will make recommendations or changes as needed.	
M 680	45.22.4 Physician visit Physician visit. The resident shall be seen by a physician or nurse practitioner/physician assistant every sixty (60) days. This Statute is not met as evidenced by: Level II Based on policy review, interview and record review it was determined the facility failed to	M 680	Physician for Resident #3 visited resident and wrote progress note on 4/30/19. Physician for Resident #44 visited on 3/9/19, Resident #44 expired on 4/13/19.	5/1/19

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M 680	Continued From page 3 ensure physician visits were conducted at least once every 60 days by their physician for two (2) of 18 sampled residents, Resident (R) #3 and R #44. This deficient practice had the potential to affect the total census of 50 residents in the facility. Findings include: The facility's "Physician Visit Tracking" policy, revised January 2015, documented residents would be seen by their physician every 30 days for the first 90 days of admission, then every 60 days thereafter. The facility failed to ensure physician visits with residents were conducting per the facility policy. The "Progress Notes" documented R #44 was seen by her physician on 08/29/18, 11/3/18, and 03/9/19. The EMR did not document other physician's visits in R #44's electronic or paper medical record. The quarterly Minimum Data Set (MDS) found in R #44's electronic medical record (EMR) with an Assessment Reference Date (ARD), of 02/25/19, documented an original admission to the facility on 08/29/18, and readmission on 02/22/19. On 3/28/19 at 8:50 AM, Director of Nursing (DON) stated R #44 was followed by the facility's Medical Director (MD) #1. The DON stated she was not sure of the process the facility used to track the frequency of MD #1's visits, but suggested the Health Information Manager (HIM) may have more information. On 3/28/19 at 9:16 AM, the Health Information Manager (HIM) reviewed R #44's record and stated she was responsible for filing progress	M 680	Fifty-two (52) of (52) residents could have been affected by this deficient practice. As of 4/30/19, all physicians are compliant with visits. Medical Records sent letters to seven (7) of (7) facility physicians on 4/17/19 reminding them of the federal regulation regarding physician visits. In-service with Medical Records on 4/30/19 by Director of Nursing on policy titled Physician Visit Tracking with revision date of 1/15. The in-service included that the facility Medical Director can see residents if primary physician cannot and that the facility will mail letters to physicians up to one (1) week prior to required visit. Facility Quality Assurance Committee, which includes the Administrator, Director of Nursing, Medical Director and Department heads, met on 4/30/19 and reviewed policy titled Physician Visit Tracking and did not recommend any changes. Beginning 5/6/19, facility Administrator, Director of Nursing and Medical Records will monitor the timeliness of physician visits weekly for (4) weeks and monthly for (2) months with findings recorded on Physician Visit Log. Director of Nursing will present findings to Quality Assurance Committee monthly for (3) months then quarterly thereafter. Quality Assurance Committee will make recommendations or changes as needed.	

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M 680	Continued From page 4 notes into the paper medical record. The HIM stated notes are left in her office and then she is responsible to file them in a resident's record. The HIM said she did not know how the facility tracked the frequency of MD #1's visits. Resident #3: Resident #3's record documented "Physician Progress Notes" on 7/31/18, 11/3/18, and 3/9/19. There were no further "Physician Progress Notes" documented in R #3's electronic or paper medical record. The MDS found in R #3's EMR with an ARD of 12/24/18, documented she was admitted to the facility on 08/02/17, with diagnoses of Diabetes mellitus and Bipolar disorder. On 3/28/19 at 1:47 PM, the Administrator stated he was not aware MD #1 had not been completing compliance visits as required, and the facility would work with him to resolve the issue.	M 680		
M1015	45.35.2 Bathtubs, Showers, and Lavatories Bathtubs, Showers, and Lavatories. Bathtubs, showers, and lavatories shall be kept clean and in proper working order. They shall not be used for laundering or for storage of soiled materials. Neither shall these facilities be used for cleaning mops, brooms, etc. This Statute is not met as evidenced by: Level II Based on policy review, observation, and staff interview, the facility failed to maintain the whirlpool tub chair in safe and clean operating condition. This deficient practice had the potential	M1015	Whirlpool tub seat cushions were replaced by Maintenance and Administrator on 3/28/19. Rough edges on whirlpool tub were caulked on 3/27/19 by Maintenance. Fifty (50) of (52) residents have the	5/1/19

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M1015	Continued From page 5 to affect all 50 residents in the facility. Findings include: A facility policy titled, "Typical Duties of the Infection Preventionist" dated 06/14, documented, "Conduct periodic rounds address/find areas of concern. Identify areas of new or excess concern." The facility's Infection Control Preventionist was not following the policy for periodic rounds in the bath room to check equipment for breaches in infection control and the need for repair. Observation on 03/26/19 at 10:20 AM, of the bath room, revealed the whirlpool tub chair had sharp edges along each side of the chair. There were cut and scratch marks in the slightly raised areas on each side. On 03/27/19 at 11:35 AM, the Director of Nursing (DON) observed the whirlpool tub chair and said she was not aware of the sharp edges on the chair. The DON confirmed the edges were sharp and could be a risk to residents. In an interview on 03/27/19 at 11:40 AM, the Administrator observed the whirlpool tub chair's sharp edges. The Administrator said he was not aware the whirlpool tub chair had sharp edges, but stated the facility would repair the chair by putting some epoxy on the edges.	M1015	potential to be effected by these deficient practices. No residents were affected. Infection Control in-service was conducted by Director of Nursing on 4/2/19 with bath aides. In-service included reporting any fault with equipment to Director of Nursing, Administrator and/or Charge Nurse. Facility Quality Assurance Committee, which includes the Administrator, Director of Nursing, Medical Director and Department Heads, met on 4/30/19 and discussed policy titled Typical Duties of the Infection Preventionist, with revision date of 6/14 and did not recommend any changes. Administrator, Maintenance and/or Director of Nursing will monitor whirlpool equipment through observations weekly for four (4) weeks starting 5/6/19 and monthly for two (2) months. Any concerns will be reported to facility Quality Assurance Committee by the Administrator, Director of Nursing and/or Maintenance monthly for three (3) months and quarterly thereafter. Quality Assurance Committee will make recommendations or changes as needed.	

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M1245	45.41.1 Date of Construction & Life Safety... Date of Construction and Life Safety Code Compliance. 1. Buildings constructed after the effective date of these regulations shall comply with the edition of the Life Safety Code (NFPA 101) effective on the date of construction. 2. Buildings constructed prior to the effective date of these regulations shall comply with Chapter 13 of the Life Safety Code (NFPA 101), 1985 edition. This Statute is not met as evidenced by: Based on observations, the facility failed to maintain a complete manual fire alarm system as directed by NFPA 72 code 1-5.4.6, and NFPA 101 section 9.6. The deficient practice affected two (2) of two (2) smoke compartments in facility on the day of survey. Findings include: On April 2, 2019 at 11:10 AM, observation revealed a "smoke detector" trouble signal on the fire alarm system panel of the facility. It was also revealed the Maintenance Supervisor was unable to reset the fire alarm system to normal status, but the fire alarm system was functioning properly. The finding was acknowledged by the Administrator and Maintenance Supervisor verified this observation during the exit interview on April 2, 2019.	M1245	Administrator notified fire alarm servicing company on 4/2/19 that fire panel was indicating a trouble signal. Fire panel servicing company came and corrected issue on 4/3/19. This deficient practice had the ability to affect 52 of 52 residents. Administrator in-serviced Maintenance Director on 4/29/19 to notify Administrator if there is an issue with fire alarm panel. Fire alarm panel will be monitored weekly for (4) weeks and monthly for (2) months by Administrator. Any concerns will be corrected immediately and reported to facility Quality Assurance Committee monthly for (3) months and quarterly thereafter. This will be completed by 5/3/19	5/1/19