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
	DB23	A. BUILDING: _____ B. WING _____	07/25/2019

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DUNBAR VILLAGE TERRACE	725 DUNBAR AVE BAY SAINT LOUIS, MS 39520

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M 000	Initial Comments The State Agency (SA) conducted an annual recertification survey along with a complaint survey, CI MS #15942 from 7/23/19 to 7/25/19. Complaint CI MS #15942 was related to Admission, Transfer, and Discharge Rights. During the survey, the SA did not substantiate the complaint, and no deficiencies were cited related to the complaint. 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 statutes M 620 and M815. The census was 62 at the time of the survey entrance, and the facility held a license for 70 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 observation, record review, facility policy review, and staff interview, the facility failed to provide proper catheter care to prevent the possibility of trauma to the bladder for one (1) of two (2) residents observed for catheter care. (Resident #34) Findings include:	M 620	1. Resident #34 was assessed by the Director of Nurses (DON) on 7/25/19 to ensure no distress or negative side effects evident due to failing to provide proper catheter care to prevent the possibility of trauma to the bladder. Certified Nurse Assistant (CNA) #2 counseled by the DON on 7/24/19 to ensure catheter securement device and proper catheter care for Resident #34. Registered Nurse (RN) #2/Assistant Director of Nurses (ADON) placed catheter securement device on	9/4/19

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M 620	Continued From page 1 Review of the facility's document, "Giving Indwelling Catheter Care", no date, revealed the seven (7) Equipment List items to be gathered included tape or a leg strap. This document was provided when a facility policy for catheter care was requested. An observation, on 7/24/2019 at 2:21 PM, revealed Certified Nursing Assistant (CNA) #2 provided Resident #34's catheter care. It was observed at that time Resident #34 did not have a catheter strap in place before catheter care began. During the catheter care, CNA #2 put Resident #34 at risk for injury or discomfort, by holding the catheter tubing at the Y connection, instead of close to the meatus. CNA #2 was observed to be cleaning the catheter tubing away from the body in the correct direction. CNA #2 did not provide a catheter strap to Resident #34's thigh/leg to secure the catheter tubing, and prevent tugging or pulling on the tubing. An interview, on 7/24/2019 at 2:28 PM, revealed Certified Nursing Assistant (CNA) #2 confirmed Resident #34 did not have a catheter strap in place. CNA #2 stated, "I should have held the catheter tubing close to the body when cleaning the tubing, so that that the tubing won't pull and hurt the resident or come out." CNA #2 stated, "It must have come off, cause (sic) she usually has one on." Review of Resident #34's Comprehensive Care Plan revealed a Problem/Need at risk for Urinary Tract Infection (UTI) due to Resident #34 having chronic urinary retention and a diagnosis of Neurogenic Bladder disorder. The Onset Date was 6/2/2016. The Approaches included the Certified Nursing Assistants (CNAs) was to check the catheter and ensure the catheter was secured	M 620	Resident #34 on 7/24/19. 2. Any resident can be affected by failing to provide proper catheter care to prevent the possibility of trauma to the bladder. 3. All five residents with catheters were checked to ensure the placement of a catheter securement device by Registered Nurse (RN) on 7/24/19. All Nurses and CNAs were inserviced by the RN beginning 7/25/19 with completion on 8/1/19 on proper catheter care. All Nursing Staff will be inserviced by the RNs upon hire and quarterly thereafter on proper catheter care. Catheter care observations were begun on all CNAs for residents with a catheter by the RNs on 7/29/19 with planned completion on 8/30/19. Observation findings recorded on the Catheter Care Competency Audit Tool. 4. Findings of the Catheter Care Competency Audit Tool will be reviewed and presented to the Quality Assurance and Assessment (QAA) by the DON on 9/4/19 and in one quarter to determine if further action is needed.	

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M 620	Continued From page 2 to the elder's (resident) thigh with a catheter securement device to prevent excessive movement and minimize accidental removal. Review of Resident #34's July 2019 Physician's Orders revealed an order, dated 3/24/2017, for a Foley catheter, for a diagnosis of Neuromuscular Dysfunction of the Bladder. The order stated that the catheter was also ordered due to a diagnosis of Urinary Retention. The order included instructions for catheter care to ensure that the catheter did not malfunction or was accidentally removed. Further review of the July 2019 Physician's Orders revealed an order, dated 10/26/2017, for catheter care, as well as the instruction that the catheter was to be secured to Resident #34's thigh with a catheter securement device to prevent excessive movement and minimize accidental removal. During a follow-up observation on 7/24/2019 at 4:29 PM, with Registered Nurse (RN) #2/Assistant Director of Nursing (ADON), it was revealed there was no catheter strap or securing device in place for Resident #34's catheter tubing, who was lying in bed, in her room. An interview at this time with the Assistant Director of Nursing (ADON) confirmed Resident #34 did not have a securing device for the catheter tubing. The ADON stated that a securing device for the catheter tubing helps to prevent tugging and possible pain and injury, if the catheter came out. The ADON stated that the tubing should be held closer to the body to prevent injury or preventing the dislodgement of the catheter, during care. During an interview, on 7/25/2019 at 8:56 AM, Registered Nurse (RN) #1/Care Plan and Minimum Data Set (MDS) Coordinator confirmed securing the catheter tubing close to the body	M 620		

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M 620	Continued From page 3 when cleaning, is correct. Review of the Face Sheet revealed Resident #34 was admitted by the facility, on 5/20/2016, with diagnoses to include Cerebral Infarction and Neuromuscular Dysfunction of Bladder.	M 620		
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 observations, staff interviews, and facility policy review, the facility failed to maintain the kitchen in a manner to prevent cross contamination and food borne illness related to two (2) uncleaned hand towels sitting on the tray line during tray line temperature checks, failed to clean the thermometer with an alcohol pad after each food temperature item was checked, and failed to wear hair nets for two (2) of five (5) kitchen observations. Findings include: A review of the facility's policy dated 1/13 and titled "Food Service Operational Standards for Purchasing, Cooking, and Storage revealed, the facility stores, prepares, distributes, and serves food under sanitary conditions to prevent the spread of food borne illness and to reduce those practices that result in food contimination and compromised food safety. On 7/23/19 at 9:44 AM an initial tour of the	M 815	1. No known negative effects to any residents due to not maintaining the kitchen in a manner to prevent cross contamination and food borne illnesses. Dietary Staff #2 counseled by Dietary Manager on 7/24/19 on cross contamination of food contact surface. Dietary Staff #1 counseled by Dietary Manager on 7/24/19 on proper hand washing during food preparation. Certified Nursing Assistant (CNA) #1 was counseled by the Dietary Manager on 7/24/19 on proper hair restraint policy to include hand washing. Dietary Staff #5 and Dietary Staff #6 were counseled by Dietary Manager on 7/24/19 on proper hair restraint policy. 2. Any resident can be affected by not maintaining the kitchen in a manner to prevent cross contamination and food borne illnesses. 3. An inservice on proper handwashing and hair restraints was begun by Certified	9/4/19

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M 815	Continued From page 4 kitchen revealed, a freezer for foods other than meats temperature was 6 degrees and a freezer for meats was 5 degrees. The vegetable cooler was 10 degrees and the refrigerator was 40 degrees. The ice cream cooler was -15 degrees, and the chest cooler was 6 degrees. The initial tour conducted with Dietary Staff member #1. On 7/23/19 at 11:49 AM an observation of Dietary Staff #2 revealed, the tray-line temperature checks of the mashed potatoes temperature was 187. Dietary Staff #2 then wiped the thermometer with a non-clean, dingy white hand towel that she had sat on the tray-line before checking the temperature of the green beans which were 181 degrees. The tomatoes mixed with zucchini were 197 degrees, white rice was 190 degrees, gumbo was 183 degrees, chopped meat at 173 degrees and after checking the chopped meat, Dietary Staff #2 wiped the thermometer with a dingy white hand towel that was sitting on the tray-line, the gravy was 194 degrees. Dietary Staff #2 had sat 2 dingy white hand towels on the tray-line while she was checking the temperature of the foods. On 7/23/19 at 11:59 AM an observation of Dietary Staff #3 revealed, the tray-line temperatures of beef stew was 197 degrees, gumbo was 183 degrees, white rice was 192 degrees, tomatoes and zucchini was 200 degrees, green beans was 197 degrees, mechanical soft beef meat was 173 degrees, mashed potatoes was 192 degrees, and brown gravy was 190 degrees. On 7/24/19 at 11: AM an observation of Dietary Staff #2 revealed, the tray-line temperatures were ham and beans at 187 degrees, rice at 177 degrees, gravy at 183 degrees and she used the same alcohol prep to wipe the mashed potatoes	M 815	Dietary Manager (CDM) on 7/25/19 to all staff with completion on 8/2/19. An inservice on Hazard Analysis and Critical Control Point (HAACP) guidelines, biological hazards and chemical hazards was presented to all dietary staff on 8/6/19 by (Name of Food Supplier) representative who is a Registered Dietician (RD)/Licensed Dietitian Nutritionist (LDN). An inservice on kitchen cloths, personal hygiene, handwashing, food safety and sanitation, and taking accurate food temperatures was presented to all dietary staff on 8/14/19 by CDM. Larger signs were placed outside of the kitchen entrance doors stating Dietary Staff Only on 8/6/19 by the CDM. The door code to the kitchen doors was changed by the Maintenance Director on 8/13/19 in which the dietary staff was directed by the CDM to not give code to non-dietary staff members. The Registered Dietitian (RD) and the CDM will monitor compliance with maintaining the kitchen in a manner to prevent cross contamination and food borne illnesses by doing weekly unannounced inspections on dietary staff beginning 8/12/19 with completion on 9/3/19. The findings of the inspections will be recorded on the Food Service Manager Self-Inspection Checklist. 4. Findings of the Food Service Manager Self-Inspection Checklist will be reviewed and presented to the Quality Assurance and Assessment (QAA)Team by the CDM on 9/4/19 and in one quarter to determine if further action is needed.	

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M 815	Continued From page 5 which were at 150 Brussel sprouts at 187 cup of fruit at 37 chicken pot pie at 198 okra and tomatoes at 192. During the follow up visit on 7/24/19 at 11:34 AM, an observation of Dietary Staff #4 revealed, the thermometer was calibrated to 31.7 degrees. The tray-line temperature checks of, white beans were 173 degrees, Brussel sprouts at 150 degrees, okra tomatoes at 167 degrees, white rice at 164 degrees, chicken pot pie at 183 degrees, brown gravy at 181 degrees, cup of pears at 38 degrees, and mashed potatoes at 174 degrees. While the Dietary Staff #4 was checking temperatures, he dropped a alcohol prep into the brown gravy. Dietary Staff #1 removed the brown gravy from the trayline and had taken it into the kitchen and placed it on a table near where the dishes are washed. She then had gone into the dry storage room area, retrieved a packet of brown gravy, returned to a preparation table, opened the packet of dry gravy, poured the dry brown gravy into a pitcher, ran some cold water into the dry gravy from the sink and stirred it together. Dietary Staff #1 then applied clean gloves but had not washed her hands. She poured the brown gravy mixture into some boiling hot water that was on the stove and discarded the gravy that the alcohol prep had gotten dropped into. Dietary Staff #4 did not wear gloves while checking the tray-line temperatures. On 7/24/19 at 2:17 PM an observation revealed, Certified Nursing Assistant CNA #1 walked into the kitchen without wearing a hair net and did not wash her hands upon entering the kitchen. She then turned around shortly after that and left the kitchen. On 7/24/19 at 2:19 PM an observation revealed,	M 815		

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M 815	Continued From page 6 CNA #1 walked into the kitchen again, wearing a hair net, walked over to the ice chest, opened it up and looked inside of it and had not washed her hands. On 7/24/19 at 2:22 PM an observation revealed, Dietary Staff #7 checked the Quaternary chemical strip with results of at 200 ppm. The ice cream freezer was at -15 degrees, milk cooler at 24 degrees. 07/24/19 02:39 PM an observation revealed, Dietary Staff #5 was wearing a hair net that left the braids in the back of her hair uncovered and Dietary Staff #6 was observed to have a bandana on with part of the hair around the outer parts of her head uncovered and not to have a hair net on. 07/24/19 02:42 PM an interview with Dietary Staff #1 revealed, Dietary Staff #2 should not have wiped the thermometer with a towel because lint could get in the food and because of cross contamination. She stated she (referring to herself, Dietary Staff #1) just did not wash her hands in between removing the contaminated gravy and making the new gravy. She stated CNA #1 should have washed her hands between putting the ice in the cooler. She also stated she should have washed her hands when she entered the kitchen. Dietary Staff #1 stated, both Dietary Staff #5 and Dietary Staff #6 should have had a hair net on and all of their hair should have been underneath the hair net. On 7/24/19 at 5:35 PM an interview with the Dietary Manager revealed, the Dietary Staff #5 should have worn a hair net large enough to restrict all of her hair. She stated Dietary Staff #6 should have had a hair net on with all of her hair restricted as well. The Dietary Manager stated,	M 815		

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M 815	Continued From page 7 CNA #1 should have had a a hair net on when she entered the kitchen the first time and washed her hands and should have washed her hands after entering the kitchen the second time. she also stated Dietary Staff #2 stated, she had gotten nervous and that is cross contamination for Dietary Staff #2 to have hand towels on the tray-line	M 815		