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
	61MA	A. BUILDING: _____ B. WING _____	01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JNH-MADISON INN	3550 HIGHWAY 468 WEST PO BOX 207 BLGS 28 &34 WHITFIELD, MS 39193

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M 000	Initial Comments The State Agency (SA) conducted an annual recertification survey from 01/21/2020 to 01/23/2020. The SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm. The SA cited the state statute M635. At the time of the survey, the census was 65, and the facility held a license for 85 beds.	M 000		
M 635	45.21.7 Gastric feeding Gastric feeding. Residents who are eating alone or with assistance are not fed by a gastric tube unless their clinical condition indicates that the use of a gastric feeding tube is unavoidable. The residents who are fed by a gastric tube receive the treatment and services to prevent complications or to restore if possible, normal eating skills. This Statute is not met as evidenced by: Level II Based on observation, record review, and staff interview, the facility failed to prevent the risk of aspiration for a resident with a Percutaneous Endoscopic Gastrostomy (PEG) tube, as evidenced by, the Certified Nursing Assistant (CNA) placing Resident #49's head of bed (HOB) flat, without notifying licensed nurse to hold/stop a continuous feeding pump, during incontinent care, for one (1) of five (5) care observations for residents with PEG tubes. Findings include: Review of the Perry and Potter Nursing Skills and Procedures - Eighth Edition, copyright 2015, revealed: Enteral Nutrition via a Gastrostomy or	M 635	A. How the corrective action(s) will be accomplished for those resident found to have been affected by the deficient practice; Resident #49 was assessed by the Director of Nurses on 1/22/2020 and was found to have no negative outcomes from the certified nursing assistant, (CNA) placing the head of the bed flat during incontinent care. Care plan of resident #49 was reviewed with CNAs #1 and #2 by the Minimum Data Set nurse on 1/23/2020, regarding the resident's individualized needs and importance of not lowering the head of the bed until the feeding pumps are turned off.	3/4/20

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M 635	Continued From page 1 Jejunostomy Tube - Elevate the head of bed to a minimum of 30 degrees (preferably 45 degrees). Rationale - Elevated head helps prevent pulmonary aspiration. A review of Resident #49's revised physician orders, dated 11/18/2019, revealed an order for Diabetic Source at 70 cubic centimeters per hour (cc/hr) with 30 cc/hr water flush. Review of Resident #49's comprehensive care plan revealed a problem to address the risk of aspiration related to the use of the feeding tube, with an onset date of 0418/2015, and target date of 04/02/2020. Approaches included to elevate the HOB 30-45 degrees at all times. An observation of Resident #49's incontinent care, on 01/22/2020 at 2:29 PM, revealed Certified Nursing Assistant (CNA) #1 lowered the head of the bed (HOB) to flat position. CNA #1 and CNA #2 failed to notify the nursing staff to stop the feeding pump before or during incontinent care. The pump was noted to be infusing Diabetic Source at 70 cc/hour. CNA #1 placed Resident #49's HOB back after performing incontinent. During an interview, on 01/22/2020 at 2:50 PM, CNA #1 and CNA #2 stated they had completed yearly competency checks, which included incontinent care. The CNA revealed they were not to touch the feeding pump, so they didn't turn it off. CNA #1 stated she was taught not to let the HOB down completely, but could provide care. CNA #1 confirmed she did let Resident #49's HOB down, while the feeding pump was running, during the resident's incontinent care. An interview on 01/23/2020 at 1:33 PM, with the	M 635	B. Identification of other residents having the potential to be affected was accomplished by the same deficient practice; The facility has determined on 1/23/2020 by the census that eleven residents with Percutaneous Endoscopic Gastrostomy,(PEG) tubes have the potential to be affected by the deficient practice. C. Measures/systemic changes made to ensure that the deficient practice will not recur; The nursing staff that includes, (licensed practical nurses, registered nurses and certified nursing aides) was in-serviced/educated on the facility'□s policy and procedure for Percutaneous Endoscopic Gastrostomy tube care 01/23/2020 by the Director of Nurses (DON). The nursing staff was in-serviced/educated on the facility□s Care Plan Policy and procedure on 1/23/2020 by the DON. Care plan of resident #49 was reviewed with CNAs #1 and #2 by the Minimum Data Set nurse on 1/23/2020, regarding the resident'□s individualized needs and importance of not lowering the head of the bed until the feeding pumps are turned off. All certified nursing assistants were in-serviced on the facility'□s Perineal Care policy on 01/23/2020 by the DON. In-service training included observation of each certified nursing assistant performing the procedure on residents with PEG	

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M 635	Continued From page 2 Director of Nursing (DON), revealed she stated, the facility's policy was for staff to notify the nurse, to turn off the tube feeding during care, to decrease the risk of aspiration. The DON revealed both CNAs had received training related to caring for residents. The facility did not provide a copy of the training records for CNA #1 or CNA #2. The facility failed to provide of a policy related Peg Tube care and procedures. A review of the facility's "Identification and Summary Sheet" for Resident #49, revealed the facility admitted the resident on 04/18/2016 with diagnoses which included of Dysphagia - Peg Tube. Based on observation, record review, staff interview, and facility policy review, the facility failed to ensure proper care of enteral tube during resident care for one (1) of five (5) resident care observed, Resident #49. Finding include:	M 635	tubes beginning 01/23/2020 until 02/22/2020. A Validation Checklist was completed on 2/22/2020 for each individual observed to determine if the certified nursing assistants were performing the procedure correctly by having the nurse turn the pump off prior to incontinent care. Findings were reviewed with each certified nursing assistant. D. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented,and the corrective action evaluated for its effectiveness. This POC is integrated in the QA system. Care plans in accordance with the care plan review schedule will be reviewed weekly starting 1/26/2020 with the nursing staff by the Minimum Data Set nurse and Director of Nurses. The DON, or Registered nurse starting 1/26/2020 will complete weekly Validation Checklists of certified nursing assistants performing perineal care on residents with Peg tubes to ensure the feeding pump is turned off by a nurse and the head of bed is lowered prior to incontinent care weekly for four (4) consecutive weeks then monthly for two (2) months. Findings of this audit will be discussed and monitored by the Nursing Home Administrator, (NHA.) The NHA will report findings, the progress and effectiveness of	

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M 635	Continued From page 3 A review of Resident #49's physician orders revealed an order for Diabetic Source at 70cc/hr with 30cc/hr water flush. A review of Resident #49's comprehensive care plan revealed a care plan related to the risk of aspiration related to the use of the feeding tube with a target date of 4/2/20. One of the approaches listed was to elevate HOB 30-45 degrees at all times. An observation on 01/22/20 at 02:29 PM for incontinent care on Resident # 49 with Certified Nursing Assistant (CNA) #1 and CNA #2. CNA #1 used the remote to the bed and laid the head of the bed (HOB) down flat for Resident #49's care. Neither CNA notified the nursing staff to stop the feeding before or during care. Diabetic Source was running by feeding pump at 70cc/hour. CNA #1 let the HOB back up for Resident #49 after performing incontinent care and positioned resident before leaving. An interview on 01/22/20 02:50 PM with CNA #1 and CNA #2 said they had yearly competency checks which included incontinent care. They said that they were not to touch the feeding pump so they did not turn it off. CNA #1 said she was taught to not let the HOB down completely and could do the care. CNA #1 confirmed she did let the HOB down during Resident #49's care. An interview on 01/23/20 at 01:33 PM with Director of Nursing (DON) said the policy of the facility was to notify the nurse to turn off the tube feeding during care to decrease the risk of aspiration. She said both had training related to the care of residents.	M 635	the corrected actions to the Quality Assurance Performance Improvement (QAPI) committee meeting each month, should systemic changes not be effective, the QAPI committee will investigate and determine further action(s) to be implemented.	

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M 635	Continued From page 4 The facility did not provide a copy of the training for CNA #1 or CNA #2. A review of Resident #49's facility "Identification and Summary Sheet" revealed an admit date of 4/18/16 with a diagnosis of Dysphagia.	M 635		