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
	02AC	A. BUILDING: _____ B. WING _____	06/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MS CARE CENTER OF ALCORN COUNTY, INC	3701 JOANNE DRIVE CORINTH, MS 38834

(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) determined during an annual recertification survey, conducted from 6/17/19 to 6/20/19, the facility was not in compliance with the Mississippi Regulations for Minimum Standards for Institutions for Aged or Infirm with deficiencies cited at M615. At the time of the survey the census was 106, and the facility held a license for 125 beds.	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: Level II Based on observation, staff interview, and record review, the facility failed to ensure a bed cradle was used as a preventive measure for a resident at risk for recurrent skin breakdown for one (1) of six (6) residents reviewed for pressure ulcer/injury. Resident #51. Findings include: Record review revealed a physician's order for a foot cradle to foot of the the bed with an order date of 4/25/19, for Resident #51. An observation, on 06/19/19 at 10:45 AM,	M 615	" The bed cradle ordered for resident #51 was installed by to help prevent further skin breakdowns by nursing staff on 06/19/2019. " All residents with orders for the use of a bed cradle to assist in the prevention of pressure ulcers could be adversely affected by this deficient practice. " QAPI nurse will conduct daily audits to verify the use of bed cradles 5 days a week for 90 days, document the results on facility worksheet and provide copies to the DON/ADON upon completion. Nurses and certified nursing assistants were	7/31/19

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M 615	Continued From page 1 revealed pressure ulcer care to the Resident #51's left great toe was performed by Registered Nurse (RN) #1. No concerns noted with the wound care. The ulcer was healed. The skin at the site was dark pinkish in color and fragile. The RN applied skin prep to the area. She stated they were doing this as a preventative measure and the resident should have a metal bed cradle on her bed to keep the weight of her covers off her toe. RN #1 confirmed there was no bed cradle on Resident #51's bed. RN #1 stated she felt Resident #51 got the pressure area on her left great toe due to pressure from heavy covers over her feet. RN #1 located Resident #51's bed cradle underneath the sink counter in the Resident's room. RN #1 cleaned the dust and lint from the cradle with a wipe and placed it on the resident's bed. An interview, on 6/20/19 at 8:20 AM, with Certified Nurses Assistant CNA #1, revealed care to be given by CNA's is documented in their computers. She stated the bed cradle for Resident #51 should be listed under the equipment section. Review of the computer screen indicated Resident #51 was to have a bed cradle to the foot of her bed. CNA #1 stated she was not sure why the bed cradle was not on the bed. She stated she just didn't notice it. CNA #1 confirmed the bed cradle intervention was documented in the computer. An interview, on 6/20/19 at 8:26 AM, with Licensed Practical Nurse (LPN) #1, confirmed Resident #51 had an order dated 4/25/19, for a bed cradle to her bed. LPN #1 stated the bed cradle should be on the bed. An interview, on 6/20/19 at 8:41 AM, with the Director of Nursing (DON), confirmed Resident	M 615	inserviced on 07/31/2019 by facility nurse trainer on the use of bed cradles ordered for residents to assist in the prevention of pressure ulcers on residents as ordered by physician. Audit will include the use, orders issued for the use of and care plan documentation related to implementation and use of bed cradle to help prevent skin breakdowns. " Results of QAPI nurse audits of bed cradle orders, care plan and use, will be provided to the facility Quality Assurance Committee for review and action if necessary	

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M 615	Continued From page 2 #51 should have had the bed cradle on her bed to help prevent any further breakdown to her toe.	M 615		