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
	33JD	A. BUILDING: _____ B. WING _____	02/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEFFERSON DAVIS COMMUNITY HOSPITAL ECF	1320 WINFIELD STREET PRENTISS, MS 39474

(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 an Annual Recertification Survey at the facility from 2/20/23 to 2/22/23. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirement and cited M615.	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, interview, record review, and facility policy review, the facility failed to provide care and services consistent with professional standards of practice for a pressure ulcer for one (1) of two (2) pressure wound care observations. Resident #11. Findings Include: Review of the facility's procedure "Wound Care", revised June 2018, revealed, " ...The purpose of this procedure is to provide guidelines for the care of wounds to promote healing ...Steps in Procedure ...7. Use no-touch technique ..." Record review of the "Face Sheet" revealed Resident #11 was admitted by the facility on 10/14/2022 and had diagnoses including	M 615	POC M0615 On 2/22/2023, Resident #11 Right buttock wound was assessed per Director of Nurses for signs or symptoms of adverse effects with none noted. Treatment performed per physician orders using proper technique. All wounds in the facility were assessed for signs or symptoms of infection or decline on 02/23/2023 per Director of Nurses with no issues noted. All residents with pressure injuries have the potential to be affected by this deficient practice. A one on one in-service with RN#1 was initiated on 02/23/2023 and completed on 02/27/2023 by Nursing Consultant. The in-service was per lecture, hand out, and	3/24/23

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M 615	Continued From page 1 Hypertension, Encephalopathy, and Senile Degeneration of Brain. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/19/23 revealed that Resident #11 had severely impaired cognitive skills. A record review of the "Physician Orders" for February 2023 revealed a treatment order with an order date of 1/20/23 for Resident #11 for "Wound care for RT (Right) buttock: Cleanse wound w/(with) wound cleanser. Pack wound w/dry gauze. Cover w/5x5 foam border. Change daily or PRN (as needed) or soilage or dislodgement. DX (Diagnosis): Stage 4 Pressure Ulcer Rt Buttock". A treatment order with an order date of 1/26/23 also revealed, "Wound care orders for RT buttock: for 9 o'clock (position of area as related to the face of a clock) tunneling (passageway of tissue destruction underneath the skin) of wound: cleanse w/wound cleanser. Pack with Opticell AG silver ribbon and dry gauze change on MWF (Monday, Wednesday, Friday) or prn for soilage or dislodgement. Cover w/5x5 foam border Dx: Stage 4 Pressure Ulcer RT Buttock. On 2/21/23 at 1:35 PM, during an observation of wound care of Resident #11 with Registered Nurse (RN) #1/Treatment Nurse, assisted by Certified Nurse Aide (CNA) #1, RN #1 cleaned the wound bed of the Right buttock with wound cleanser. While RN #1 was washing her hands, CNA #1 assisted the resident to turn onto her back, which allowed the clean wound bed to come in contact with the incontinence pad that was soiled with drainage from the wound. Resident #11 was positioned back onto her left side and RN #1 placed a cotton tipped applicator	M 615	hands on demonstration with return demonstration and observations that included proper technique, proper PPE, Hand hygiene, clean barriers, No-touch technique, cross contamination prevention and entire treatment procedures. The policy "Wound Care" was reviewed by the Quality Assurance (QA) Committee on February, 23, 2023 with no recommended changes at this time. The QA committee consisted of Administrator, Medical Director, Director of Nursing, Quality Assurance/Infection Prevention Nurse, Wound Care Nurse, Medical Records Nurse, Administrative Assistant, Activity Director, Minimum Data Set Nurse, Social Services Coordinator, and Therapy Director. The facility Director of Nurses will observe 5 wound treatments per week x 4 weeks starting 2/28/2023, then 3 treatments per week x 2 weeks to ensure care and services are provided consistent with professional standards of practice. This monitoring will be documented on a "Treatment Monitoring/Check Log". Any issues noted will be corrected immediately and discussed for four months in the weekly Quality Assurance meeting beginning Thursday, March 9th, 2023 and continuing through July, 6, 2023.	

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M 615	Continued From page 2	M 615		

into the wound bed, removed it and used measuring paper to measure the depth of the wound. She then took the same cotton tipped applicator and placed it back into the wound to measure the tunneling at 1 o'clock. RN #1 then removed the applicator from that area of the tunneling wound and held it up to the measuring paper to obtain the depth of the tunneling. RN #1 used the same cotton tipped applicator and placed it into the tunneling at 9 o'clock and held it up to the measuring paper to obtain the depth of the tunneling.

On 12/22/23 at 10:26 AM, during an interview with RN #1, she stated that at her previous job, she did not have to stage or measure pressure wounds. She confirmed that during the wound care for Resident #11, she used the same cotton tipped applicator to measure the wound depth, and both wound tunneling and that this could have caused cross contamination of the wound. She said that she was nervous during the observation and did not know why she did not use a different cotton tipped applicator to measure each area of the wound because she had brought several applicators into the room for that very reason. She also verified that CNA #1 allowed the resident's cleaned wound to come in contact with the contaminated incontinence pad and that she did not clean the wound again, but proceeded with packing the wound.

On 12/22/23 at 11:00 AM, in an interview with the Director of Nursing (DON) and the Infection Preventionist (IP), they both confirmed that CNA #1 should not have allowed the resident's cleaned wound to come in contact with the contaminated incontinence pad. They also confirmed that the wound care nurse should have used a different cotton tipped applicator when measuring the

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M 615	Continued From page 3 depth at each tunnel of the wound to avoid cross contamination of the wound. A record review of the facility's document, "Wound care reviewed with (Proper Name of RN #1)", dated 2/1/23 revealed there were no issues identified during RN #1's wound care technique when observed by management staff. The steps reviewed (1-20) did not address measuring or staging wounds.	M 615		