STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255050	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) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey at the facility from 2/20/23 through 2/22/23. During the survey, the facility was found to not be in compliance with the requirements of participation in Medicare and Medicaid. The SA cited F686 and F726. The facility had a census of 44 and was licensed for 55 beds.	F 000		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: 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:	F 686	POC F686 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	3/24/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 03/06/2023

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F 686	Continued From page 1 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 ..." 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 into the wound bed, removed it and used	F 686	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 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	

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F 686	Continued From page 2	F 686		

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

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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F 686	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. Record review of the "Face Sheet" revealed Resident #11 was admitted by the facility on 10/14/2022 and had diagnoses including 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.	F 686		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that	F 726		3/24/23

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F 726	Continued From page 4 licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure a licensed nurse had the specific competencies and skill set to stage pressure wounds for two (2) of two (2) residents reviewed for pressure wounds. Resident #11 and Resident #13. Findings Include: A review of the facility's policy, "Competency of Nursing Staff", revised October 2017, revealed, "Policy Statement ...2. In addition, licensed nurses and nursing assistants employed (or contracted) by the facility will:.. b. demonstrate specific competencies and skill sets deemed necessary to care for the needs of residents, as identified through resident assessments and described in the plans of care ...Policy Interpretation and Implementation 1. The staff development and training program is created by	F 726	F726 On 2/22/2023, Resident #13 wound to Right top of Right Lateral foot was reclassified to a Stage Three Pressure Injury wound per Director of Nurses and RN#1. Pressure injury wounds were assessed for proper staging per RN#1 and Consultant completed on 02/27/2023. Two wounds were reclassified to proper staging. All residents with pressure injury wounds 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 that included proper staging and wound	

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F 726	Continued From page 5 the nursing leadership ...and is designed to train nursing staff to deliver individualized, safe, quality care and services for the residents 2. The following factors are considered in the creation of the competency-based staff development and training program ...c. Specialized skills or training needed based on the resident population ...4. Competency in skills and techniques necessary to care for residents' needs may include but is not limited to competencies in areas such as ...h. Skin and wound care ..." A review of the "Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual Version 1.17.1" dated October 2019 revealed, " ...Definition Stage 2 Pressure Ulcer Partial thickness loss of dermis presenting as a shallow open ulcer ...without slough ..." Review of the manual also revealed, " ...Once a deep tissue injury has opened to an ulcer, reclassify the ulcer into the appropriate stage ..." Resident #11 Record review of the "Wound Assessment Report" for Resident #11, dated 2/16/23, revealed Resident #11 had a Pressure Ulcer with the "Wound Location" of "Left Buttock; Stage 2 pressure". The pressure ulcer was listed as a "Stage 2" with measurements that indicated the length of the ulcer as 0.10 cm (centimeters), width of 0.20 cm, and depth of 8.30 cm. The wound bed was listed as having 10% slough (non-viable tissue) and the assessment was electronically signed by Registered Nurse (RN) #1 on 2/16/23. On 2/21/23 at 1:35 PM, the State Agency (SA) observed wound care for the left buttock pressure ulcer for Resident #11, with Registered Nurse	F 726	assessment procedures with review of policy "Pressure Ulcers/Injuries Overview and National Pressure Injury Advisory Panel Pressure Injury Stages". On February 23, 2023, the Quality Assurance Committee consisting of the facility's 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 met and reviewed the policy "Pressure Ulcers/Injuries Overview" with no recommended changes at this time. The Director of Nurses will reassess all new wounds for proper staging once weekly x 8 weeks. This weekly reassessment began on February 26, 2023. Any issues noted will be corrected immediately and reviewed with Quality Assurance committee for four months beginning March 9th, 2023. This monitoring will be documented on a "Wound Stage Assessment and Monitoring" log.	

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(RN) #1. RN #1 measured the pressure ulcer depth as 6 cm, which is uncharacteristic of a "shallow open ulcer".

Record review of the "Face Sheet" revealed Resident #11 was admitted by the facility on 10/14/2022 and had diagnoses including Hypertension, Encephalopathy, and Senile Degeneration of Brain.

Resident #13

Record review of the "Wound Assessment Report" for Resident #13, dated 2/16/23, revealed Resident #13 had a Pressure Ulcer with the "Wound Location" of "Right Top of Foot: Right Lateral Foot". The pressure ulcer was listed as an "Unstageable due to suspected deep tissue injury (DTI)". Review of the "Notes" section revealed, "Healing unstageable wound; new measurements are: approx. (approximately) 2.2 cm in length; 1.5 cm in width; 0.3 cm in depth. Wound bed is pink". The assessment was electronically signed by RN #1 on 2/16/23.

On 2/22/23 at 10:07 AM, during an observation of wound care for Resident #13 with RN #1, she measured the wound as 1.3 cm length, 2.4 cm width, and 0.3 cm depth. The wound was opened, and muscle and granulated tissue were visible in the wound bed. The open wound was not characteristic of a deep tissue injury.

A record review of the "Face Sheet" revealed Resident #13 was admitted by the facility on 5/21/20 and had diagnoses including Functional Quadriplegia and Contracture, Left Knee.

On 12/22/23 at 10:26 AM, during an interview

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with RN #1, she stated that she previously worked in an acute care hospital for 17 years, in which she did not have the responsibility of staging pressure ulcers. She became employed at the facility at the end of September 2022 as the treatment nurse. Her job duties include performing treatments, conducting skin assessments, and completing weekly wound assessments for residents with pressure ulcers. The Infection Preventionist provided her training and worked with her during her orientation. She stated she had asked about possibly becoming wound care certified because she felt as though she would "feel better and be more confident" when staging wounds. She confirmed that she did not change the stage of the Stage 2 pressure ulcer for Resident #11 after it had progressed to include a depth of 9 cm. She stated the wound parameters were so small that she was unable to visibly assess the wound bed, so she left it staged as it was. She confirmed that she continued to classify the pressure injury for Resident #13 as an unstageable DTI even after it had opened up because she thought the nurse consultant had told her that she "couldn't downstage" the pressure injury.

On 12/22/23 at 11:00 AM, in an interview with the Director of Nursing and the Infection Preventionist (IP), the DON stated that she had "taken for granted" that RN #1 would know how to stage wounds accurately. The DON and the IP acknowledged that wound care staging and assessments required a certain skill set and that RN #1's work history had been in an acute care setting in which there were specialized staff who were responsible for staging pressure wounds. The DON stated that there are so many nuances involved in staging pressure ulcers and cover a

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F 726	Continued From page 8 broad area. She confirmed that Resident #11's wound should have been staged as a Stage 4 as the wound progressed and became deeper and verified that a Stage 2 was not accurate. The DON stated that Resident #13's wound should have been reclassified once the wound became opened. She stated she would have classified his wound as a Stage 4. She confirmed that is it her responsibility to oversee the work of RN #1. 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.	F 726		