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
	45CM	A. BUILDING: _____ B. WING _____	07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON CO NH	1421-A EAST PEACE STREET/P. O. BOX 488 CANTON, MS 39046

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M 000	Initial Comments The State Agency (SA) conducted a State Licensure survey along with a complaint survey, MS 16017, from 7/23/18 through 7/25/18. During the survey, the SA determined the complaint survey was unsubstantiated with no deficiencies cited related to the complaint. The facility, however, did not meet the licensure requirements for the State Minimum Standards for the Aged and Infirm. The SA cited M610 and M640. The facility was licensed for 96 beds and had a census of 93 during survey.	M 000		
M 610	45.21.2 Activities of daily living Activities of daily living. Each resident shall receive assistance as needed with activities of daily living to maintain the highest practicable well being. These shall include, but not be limited to: 1. Bath, dressing and grooming; 2. Transfer and ambulate; 3. Good nutrition, personal and oral hygiene; and 4. Toileting. This Statute is not met as evidenced by: Based on observation, staff interview, family interview, resident interview, record review, and facility document review, the facility failed to provide nail care for Resident #25, and #71, and shave facial hair for Resident #36 and #59, for four (4) of 19 sampled residents. Findings Include: A review of an untitled document provided by the	M 610	A. Residents #25 and #71 were shaved on 07/25/19 by their assigned Certified Nursing Assistant. Residents #36 and #59 were provided nail care on 07/25/19 by their assigned Certified Nursing Assistant. B. Ninety-three (93) residents on the day of survey had the potential to be affected by the deficient practice. C. Nursing staff will be inserviced by the Director of Nurses on 08/23/19 to observe	8/23/19

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

Electronically Signed | 08/19/19

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M 610	Continued From page 1 facility on 07/25/19, revealed it was the protocol of the facility to have personal care, hygiene, and grooming needs met for all residents to include caring for fingernails and shaving. Resident #36 An observation and interview on 07/23/19 at 10:15 AM, revealed Resident #36 in her room lying in bed watching television. The resident appeared clean but had visible patches of chin hair curled up that extended approximately one (1) centimeter (cm) from the surface of her face. Resident #36 stated she liked for the chin hair to be shaved off. She stated the staff had shaved the chin hair in the past. She stated she could not recall when it was last done, but guessed it was more than two (2) weeks ago. An observation on 07/23/19 at 4:16 PM, revealed Resident #36 in her room in bed with chin hair present. Resident's eyes were closed and she was breathing deeply. An observation and interview on 07/24/19 at 08:39 AM, revealed Resident #36 sitting up in bed in her room. Resident #36 stated the chin hair was bothersome to her and she preferred for it to be shaved. Resident #36 stated she had never refused it to be shaved and staff had never asked her if she wanted it shaved. Review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/08/19, revealed resident had a Brief Interview of Mental Status (BIMS) of 12, indicating she had moderate cognitive impairment, and needed extensive assistance with one (1) person physically assisting her with personal hygiene.	M 610	any nail care needs or facial hair removal on bath days and as needed. Nail care will be provided by the Certified Nursing Assistants except for diabetics, whose nail care will be provided by the Licensed Practical Nurses. Shaving of facial hair will be provided by the Certified Nursing Assistants. D. The Registered Nurse Supervisor will do weekly checks beginning 08/08/19 for nail care and facial hair for three (3) months. Any problems noted will be reported to the Quality Assurance Committee for recommendations/changes.	

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M 610	Continued From page 2 An interview on 07/24/19 at 03:43 PM, with Licensed Practical Nurse (LPN) #2, revealed all residents in the facility received a bed bath everyday if they didn't have a shower/whirlpool bath. LPN #2 stated during baths all personal hygiene needs should be completed including nail care, grooming, and shaving. LPN #2 stated the Certified Nursing Assistants (CNAs) should record tasks performed on the Activities of Daily Living (ADL) sheet electronically. LPN #2 stated the CNA Coordinator was responsible for checking to make sure the tasks were completed. An interview and observation on 07/25/19 at 09:18 AM, with CNA #1, of Resident #36, revealed the resident had curled chin hair. With Resident #36's permission, CNA #1 extended the chin hairs from the curled position to straight. The chin hair was estimated to be approximately one (1) inch long. CNA #1 stated the hair appeared to not have been shaved for at least two (2) weeks. CNA #1 stated that she had been regularly assigned to Resident #36, but had not really paid attention to the resident's chin hair. CNA #1 confirmed it was her responsibility to assist the resident with bathing and personal hygiene which would include shaving. CNA #1 stated she didn't remember doing it, but if she had she would have recorded it on the kiosk (electronic documentation instrument). CNA #1 demonstrated on the kiosk how the tasks performed were recorded, and the tasks did include an area to mark for shaving. There was no shaving recorded for the months of June 2019, or July 2019. A review of a print out, provided by the facility, titled "Nail Care Report", revealed a column under Personal Hygiene with a task of "shaving/hair removal". The column did not have any mark to	M 610		

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M 610	Continued From page 3 indicate completion of shaving/hair removal from 06/01/19 through 07/24/19 for Resident #36. Resident #59 An observation on 07/23/19 at 09:58 AM, revealed Resident #59 in her room lying in bed. The resident was not verbally responsive. The resident had a patch of curled hair visible on the right side of her chin, approximately one (1) cm from the surface of her chin. A review of Resident #59's most recent quarterly MDS, with an ARD of 5/28/19, revealed Resident #59 was totally dependent on staff to take care of personal hygiene needs. An observation on 07/24/19 at 10:09 AM, revealed Resident #59 sitting in the dayroom near the nurse's station in a gerichair. The resident's chin hair glistened in the sunlight as it shone through the window, visible from the nurse's station, approximately 20 feet away. An interview and observation on 07/25/19 at 09:23 AM, with CNA #1, of Resident #59, revealed the resident had curled chin hair. In order to measure the hair, CNA #1 extended the chin hairs from the curled position to straight and estimated the hairs to be approximately one (1) inch long. CNA #1 stated it had probably been at least a couple of weeks since the hair had been shaved, but she was unsure. CNA #1 stated that she had been regularly assigned to Resident #59 and had not noticed the chin hair. CNA #1 stated that she really hadn't paid attention. CNA #1 confirmed it was her responsibility to assist the resident with bathing and personal hygiene, which would include shaving. CNA #1 stated she didn't remember doing it, but if she had, she would have recorded it on the kiosk.	M 610		

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M 610	Continued From page 4 An interview on 07/25/19 at 03:50 PM, with Resident #59's brother (FM #2), revealed before Resident #59 got sick she was a person who prided herself on her appearance. FM #2 stated the resident would not want to have facial hair present and would want it to be shaved or plucked out. A review of a print out, provided by the facility, titled " Nail Care Report", revealed a column under Personal Hygiene with a task of "shaving/hair removal". The column did not have any mark to indicate completion of shaving/hair removal from 06/01/19 through 07/24/19. Resident #71 An observation and interview on 07/24/19 at 03:25 PM, revealed Resident #71 lying on his left side in bed. The resident's fingernails appeared approximately 0.75 cm from the nail bed, with build up of brown and reddish brown substance under the nails of both hands. Resident #71 stated the CNA told the nurse that his nails needed to be cut this morning, but the nurse came in and said she didn't think they needed to be cut. Resident #71 stated the substance was food built up. The resident stated he wasn't sure how long it had been since they had been cleaned, but buildup was thick and hard. A review of Resident #71's Quarterly MDS, with an ARD of 06/07/19, revealed the resident had a BIMS score of 9, which indicated the resident had moderate cognitive impairment and the resident was totally dependent on staff to complete personal hygiene needs. The resident required the assistance of 1 (one) staff person to assist with personal hygiene.	M 610		

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M 610	Continued From page 5 An observation and interview on 07/25/19 at 09:13 AM, with the resident's sister (FM #1), and Resident #71, revealed the resident's sister often found the resident's fingernails to be dirty when she visited. FM #1 stated she usually tried to clean the nails when she was here. FM #1 stated the build up under the nails was so thick now the resident complained they hurt when she attempted to clean them. FM #1 stated the right hand was more of an issue than the left, because the resident ate with that hand. Resident #71 stated food gets caught under his nails, because his nails are long. Resident #71's nails had dirt under all nails. The resident stated a nurse came to look at the nails and said they didn't need cutting, so he just went along with it. Resident #71 stated if the nails were shorter they wouldn't pick up as much food under them. Resident #71 stated the nails were sore. An interview on 07/25/19 at 09:32 AM, with CNA #2, revealed she was regularly assigned to Resident #71. CNA #2 stated she had attempted to clean the resident's fingernails this morning, but the resident complained they hurt and so she stopped. CNA #2 stated she reported to the nurse and had told the nurse the resident wanted his nails trimmed. CNA #2 declined to answer if she believed the resident's nails should be trimmed, but stated the resident liked to eat finger foods that tended to get under his fingernails. CNA #2 stated she did think if the resident's nails were shorter, they would stay cleaner and be easier to clean. An interview with the CNA Supervisor (LPN #3) on 07/25/19 at 9:51 AM, revealed she expected CNAs to shave hair, clean nails, and assist with all hygiene needs during the resident's daily bath. LPN #3 stated CNAs were expected to shave any	M 610		

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M 610	Continued From page 6 facial hair per the resident's preference or the preference of the resident representative if the resident could not speak for themselves. LPN #3 stated she did periodic spot checks to make sure hygiene tasks were being completed, but did not keep documentation of this. LPN #3 stated that regarding nail care, CNAs were expected to assist the residents in washing hands prior to meals and after meals, which included checking nails, and cleaning as needed, after meals and/or as they check people throughout the day. LPN #3 stated any nursing staff could complete hygiene tasks. LPN #3 stated she had not noticed chin hair on Resident #36 or Resident #59 and had not recently noticed residents having dirty or untrimmed nails. An interview on 07/25/19 at 2:52 PM, with the Administrator and the Director of Nursing (DON), revealed it was expected that staff complete all tasks assigned to them. The DON stated hygiene tasks should be completed during daily baths and as needed and she expected staff to do their job everyday. The DON stated it was the responsibility of nursing staff to complete hygiene tasks and it was expected the tasks be completed per resident preferences. Resident #25 During an interview and observation on /24/19 at 12:00 PM, Licensed Practical Nurse (LPN) #1 confirmed Resident #25 had long, rough, and dirty fingernails. She confirmed Resident #25's right hand index and middle finger had a dark brown substance under the nail. On 07/24/19 at 12:05 PM, an interview with Resident # 25 revealed she always does her own finger nails, the staff does not usually do them. Resident #25 revealed she tried to clean them	M 610		

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M 610	Continued From page 7 when she notices they are dirty. On 07/24/19 at 12:10 PM, an interview with the LPN #1 confirmed Resident #25's fingernails were dirty, long, and rough. LPN #1 revealed that there is no excuse for not keeping her nails clean and smooth. LPN #1 revealed the resident just finished eating and her dirty fingernails could be a source of spreading an infection if not clean for meal times. LPN #1 revealed the Certified Nursing Assistants (CNA) clean and trim non-diabetic fingernails one (1) time a week and they should be cleaned on bath days. LPN #1 confirmed they look like they have not been cleaned or trimmed in a while. On 07/25/19 at 9:00 AM, an interview with the Director of Nursing (DON) revealed she was made aware of Resident #25's fingernails and confirmed they were long and dirty. The DON confirmed that it was everyone's responsibility to clean and trim resident's nails when they are dirty or long. Record review of Resident #25's nail care report revealed from 6/1/19 to 7/25/19, nail care (cleaning/trimming) was provided only one (1) time on 6/20/19. Record review of the MDS for Significant Change, dated 4/18/19, revealed Resident #25 required extensive assistance of one (1) staff for personal hygiene.	M 610		
M 640	45.21.8 Accidents Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate	M 640		8/23/19

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M 640	Continued From page 8 supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies. This Statute is not met as evidenced by: Level II Based on observation, record review, staff interview, and family interview, the facility failed to implement an intervention (pad side rail) that was discussed with family, to help prevent further injury after a resident had received a prior injury to her hand for one (1) of four (4) residents reviewed for accidents/hazards, Resident #88. Findings include: A review of a facility reported incident dated 07/09/19, revealed the facility reported an injury of unknown source in which no abuse was suspected. Resident #88 sustained an injury of a subtle fracture of the distal radius of her left hand. The facility's investigation concluded it was unknown exactly how the injury occurred, but it was possibly during care, due to the resident's history of kicking, hitting and spitting. The resident also had diagnoses including Parkinson's Disease and degenerative interphalangeal joints. The report documented the care plan was going to be updated and there would be padding put on the side rail of the bed. An observation of Resident #88 and an interview on 07/23/19 at 03:42 PM, with Resident #88's daughter (FM #3), revealed FM #3 was generally pleased with the resident's care, but they were concerned about a fracture that happened on or around 07/02/19. FM #3 stated her sister (FM #4) was notified of the injury on 07/02/19, and an	M 640	A. Padded side rails were added to the left side of the bed for Resident #88 by the Wound Care Nurse on 07/25/19. B. Ninety-three (93) residents on the day of survey had the potential to be affected by the deficient practice. Nine (9) residents currently have padded side rails. C. Nursing staff will be inserviced by the Director of Nursing on 08/23/19 concerning providing interventions to prevent injuries to residents. D. The Quality Assurance Nurse will review incident reports since survey exit to we if any needed interventions were put in to place by 08/22/19 and monitor incident reports beginning 08/22/19 monthly for three (3) months and check to see if interventions were put in place to prevent the incident from reoccurring. Any problems noted will be reported to the Quality Assurance Committee for recommendations/changes.	

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M 640	Continued From page 9 X-ray was performed on 07/03/19, that revealed a fracture to Resident #88's wrist. FM #3 stated she and FM #4 met with the facility Administrator, Director of Nursing (DON), and a nurse from the hospice care provider regarding the injury on July 9, 2019. FM #3 stated the facility suspected the resident hit her wrist on something and determined in the meeting that, as precaution to prevent any further injury, they would pad the side rail. FM #3 stated the side rail had not been padded yet and it was now 07/23/19. Observation revealed there were 1/2 side rails up with no padding and Resident #88 periodically used the side rails to move around in bed. Resident #88 had a splint on her left hand. The bed was positioned against the wall with approximately four (4) inches of space between the wall and the bed rail. At 04:02 PM, the DON approached the doorway to Resident #88's room, during the surveyor interview with FM #3, with a sheepskin pad in her hands and stated she would return shortly to put it on the side rail. An observation on 07/24/19 at 08:30 AM revealed Resident #88's bed had no padding on the side rails. An interview on 07/24/19 at 5:00 PM, with the DON, revealed she was unable to determine the exact cause of Resident #88's injury. The DON stated she couldn't recall how or when the facility decided to put padding on side rails, but did add padding to the rail today. The DON stated she attempted to pad the rails with sheepskin padding yesterday, but it wasn't adequate and could not be secured to the rail. The DON stated the padding could have been added sooner as an intervention to prevent further injury. An interview with the DON and the Administrator	M 640		

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M 640	Continued From page 10 on 07/25/19 at 3:03 PM, revealed there had been a meeting with Resident #88's family on 07/09/19, to discuss the resident's injury. They did recall the discussion of placing padding on the side rails, but they were not sure it was during the meeting with the family. They did not record any minutes of the meeting. They did agree the padding should have been placed and care planned.	M 640		