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
	75VT	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BLUFFS REHABILITATION AND HEALTHCARE C	2850 PORTER'S CHAPEL ROAD VICKSBURG, MS 39180

(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 re-certification and complaint survey at the facility from 6-13-22 to 6-16-22. The complaints were MS # 19056, MS # 18799, MS # 18800, MS # 18803 and MS # 18607. The SA was not able to substantiate any of the complaints. The SA determined the facility was not in compliance with the Minimum Standards for Institutions for Aged or Infirm regulation and cited M655 related to a Peripherally Inserted Central Line not being flushed according to the professional standards of practice. The facility was licensed for 107 beds and had a census of 94 at the time of the survey.	M 000		
M 655	45.21.11 Special needs Special needs. Each resident with special needs shall receive proper treatment and care. These special needs shall include, but are not limited to injections; parenteral and enteral fluids; colostomy, ureterostomy, ileostomy care; tracheostomy care; tracheal suction; respiratory care; foot care; and prostheses. This Statute is not met as evidenced by: Level II Based on observation, interviews, record review and facility policy review the facility failed to administer Peripherally Inserted Central Catheter (PICC) flushes in accordance with professional standards of practice for one (1) of two (2) resident's reviewed for PICC line care. Resident #82 Findings Include: Review of the facility's policy, "Chartwell Flushing	M 655	M655 1. On 6/15/22 Resident #82 physician orders were obtained and followed by Director of Nursing regarding Peripheral Inserted Central Catheter (PICC) line care to include flushing standards. On 6/15/22 Resident #82 was evaluated and assessed by the Director of Nursing for any adverse reactions related to deficient practice. no concerns identified.¿On 06/15/22 Consulting Nurse Practitioner #1 was interviewed by the State Department	7/22/22

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M 655	Continued From page 1 Guidelines" (undated) revealed, "Adults...Type of Device...Central line: RN (Registered Nurse) Bedside PICC (Peripherally Inserted Central Catheter)...Flush Solution and Volume...Heparinized Saline (Heparin) 100 units/ml (milliliter) (5 ml)...Frequency and Documentation...Daily OR after each use..." On 06/14/22 at 03:13 PM, in an interview with Resident # 82, she stated she had an appointment with her infectious disease doctor earlier today and she believed she may require intravenous (IV) antibiotics based on the outcome of labs that were obtained at the appointment. The State Agency (SA) observed a double lumen PICC line to her right upper arm. On 06/15/22 at 11:20 AM, in an interview with Resident # 82, she stated that when she went to the her appointment yesterday, the practitioner had difficulty drawing blood from the PICC line. The PICC line was placed sometime last month before she went to the hospital. She remarked that the PICC line had not been flushed by the facility staff since she received antibiotics last month (May 2022). A record review of the "Admission Record" revealed Resident # 82 was originally admitted by the facility on 10/11/2017. She had a recent admission date of 5/5/2022, with diagnoses including Metabolic Encephalopathy and Paraplegia. A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/3/22 revealed Resident #82 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated she is cognitively intact.	M 655	of Health representative for any adverse reactions related to deficient practice. No adverse reactions were identified. On 6/20/22 Facility Nurse Practitioner #2 assessed Resident #82 for any adverse reactions due to PICC line care with no concerns identified. Director of Nursing received education¿on¿6/15/22 by¿Corporate Clinical¿Specialist regarding PICC line policies and procedures to include entering, receiving, and reporting of Intravenous orders. 2. On 6/15/22 all current residents were audited by the Director of Nursing to ensure any Residents receiving IV therapy have PICC line protocols followed and being met. No concerns were identified. There are¿two (2)¿residents who had physician orders for PICC and are¿at risk related to this deficient practice.¿ 3. On 6/16/22 facility Licensed Nurses were in-service¿by Director of Nursing regarding transcribing and following physician orders on PICC line requirements and notification of Registered Nurse as needed with required flushes. A Quality Assurance Performance Improvement meeting was held with the Medical Director and the Interdisciplinary team on 6/16/22 to discuss requirements for PICC care and flushes. ¿ Clinical standards meetings are held on 6/29/22	

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M 655	Continued From page 2 A record review of the "Report of Consultation" for Resident #82 dated 5/13/22 from Consulting Nurse Practitioner (NP) #1 revealed, "Progress Notes/Orders...(3) Schedule for PICC line placement..." A record review of Physician Orders for Resident #82 revealed a physician's order dated 5/13/22 to "Insert PICC line to receive IV antibiotics, one time only...", and "Change PICC line dressing Q (Every) 7 day(s)..." Record review of the "(Proper Name of Contract Service) Documentation Form" with a "Service Date" of 5/13/22, confirmed a double lumen PICC line was inserted to Resident #82's right arm. Record review of a Physician's Order dated 5/13/22 for Resident #82 revealed, "Transfer to ER (Emergency Room) for abnormal ct (Computed Tomography Scan) abd (Abdomen)/pelvis..." Record review of a Nurse's Note for Resident #82 dated 5/14/22 at 1:19 AM revealed, "Resident returned... from hospital at appox. (approximately) 11:25 PM (5/13/22)...PICC line noted to R (Right), upper arm..." Record review of a Nurse's Note for Resident #82 dated 5/22/22 revealed, "...called 911 and on call nurse to send resident to hospital..." Record review of a "History and Physical Report" for Resident #82 from the local acute hospital dated 5/22/22 revealed, "History of Present Illness:...A PICC was placed and she was started on Ivanz at the nursing home where she resides..."	M 655	with interdisciplinary clinical teams to review accuracy of physician orders. 4. Beginning on 6/27/22, the¿Director of Nursing/Medical Records will conduct an audit of all residents with physician orders for Intravenous (IV) therapy to ensure accuracy of orders to include dressing changes and flushes weekly for four (4) weeks, then monthly for three (3) months. The Director of Nursing¿will report findings to the Quality Assurance Performance Improvement committee monthly beginning on 7/27/22 for three (3) months for review and further recommendations. The Director of Nursing is responsible for monitoring and compliance.¿	

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M 655	Continued From page 3	M 655		

Record review of the "Admission Summary" Nurse's Note for Resident #82 dated 5/27/22 revealed, "Resident returned from (Proper Name of Acute Care Hospital) and readmitted...Double lumen PICC line in RUA (Right Upper Arm).

Record review of a Physician's Order for Resident #82 dated 5/27/22 revealed, "Admit/re-admit to the (Proper Name of Long Term Care Facility)...."

Record review of the "Report of Consultation" for Resident #82 from Consulting NP #1 dated 6/14/22 revealed, "Progress Notes/Orders (3) Flush PICC line daily with 10 cc (cubic centimeter) NS (Normal Saline) and 5 cc heparin (when not in use)..."

Record review of a Physician's Order for Resident #82 dated 6/15/22 revealed, "Flush PICC with __5__ cc 100 units/ml Heparin following NS flush after medication administration/blood draw or daily while not in use" and "Flush PICC with 10 cc/ml NS before and after medication administration... or daily while not in use." This order, dated 6/15/22, was entered 32 days after the PICC line was inserted. Review of Physician Orders for May and June 2022 revealed no other orders related to flushing Resident #82's PICC line.

Record review of Resident #82's Medication Administration Record (MAR) for May 2022 lacked any documentation related to flushing the PICC line after it was inserted on 5/13/22.

Record review of Resident #82's MAR for June 2022 revealed documentation related to flushing the PICC line did not occur until 6/15/22, which was 32 days after the PICC line was inserted.

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M 655	Continued From page 4 On 06/15/22 at 3:13 PM, in an interview with the Director of Nursing (DON) and the Administrator, the DON stated that the resident had the PICC line placed at the facility on 5/13/22. The DON transcribed the physician orders and input the orders into the computer system. She did not initiate any flush orders for the PICC line at that time. After the PICC line was inserted, the facility received orders to send the resident to the hospital to have a CT scan. Resident #82 returned from the hospital with a less than 24 hour hospital stay. She was receiving IV medications through the PICC line until she had a change in condition and was sent to the hospital on 5/22/22. When Resident # 82 returned to the facility on 5/27/22, the DON said that she entered the readmission orders into the computer system and she did not enter any flush orders for the PICC line. She stated it was a communication error because another nurse completed the physical assessment and entered the physician orders. Because there were no IV medications or orders listed in the hospital return documentation, it did not trigger her to add the PICC line orders at that time. The DON agreed that the resident could have had a negative outcome related to the PICC line not being flushed. The DON also called Consulting NP #1's cell phone to allow SA to interview her. She stated that as far as she knew there was not a problem with the PICC line not flushing at the visit yesterday (6/14/22).	M 655		