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
	25MA	A. BUILDING: _____ B. WING _____	05/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTAN NURSING AND REHABILITATION	4540 MANHATTAN RD JACKSON, MS 39206

(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 a recertification survey from 05/20/19 to 05/23/19. During the survey the SA determined the facility was not in compliance with the Minimum Standards for The Institutions For The Aged And Infirm. The SA cited the state statute M620. The census at the time of the survey entrance was 169, and the facility was certified for 180 beds.	M 000		
M 620	45.21.4 Urinary incontinence Urinary incontinence. Residents with urinary incontinence shall be assessed for need of bladder retraining program. An indwelling catheter will not be used unless the resident ' s clinical condition indicates that catheterization is necessary. These residents shall receive treatment and services to prevent urinary tract infections. Level II Based on observation, staff interview, record review, and facility policy review, the facility failed to provide catheter care in a manner to prevent possible cross contamination/Urinary Tract Infection (UTI), for one (1) of three (3) residents reviewed with catheters. Resident #173. Findings include: On 5/21/19 at 10:10 AM, an observation revealed Certified Nursing Assistant (CNA), assisted by CNA #2, provided Resident #173's catheter care#173 was lying in bed with an indwelling urinary catheter to gravity drainage. Both CNAs washed their hands and applied clean gloves. CNA #1 wiped the resident's perineal area in a	M 620	- Resident #173 had no complications related to the indwelling urinary catheter care on 5/21/19 during survey. The DNS assessed resident #173 on 5/21/19. There were no negative effects from the care rendered on 5/21/19. CNA #1 was counseled 1:1 on 5/21/19 by the DNS on proper indwelling urinary catheter care with a return demonstration and following the PCG. - All residents who have an indwelling urinary catheter have the potential to be affected. The CCPs/PCGs for seven (7) residents with indwelling urinary catheters were reviewed by the DNS on 5/28/19. No negative findings were identified.	6/21/19

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M 620	Continued From page 1 downward motion on each side of the resident's groin areas, and down the middle of the resident's vaginal area. While CNA #1 held the catheter tubing at the distal end farthest away from the meatus, she wiped the catheter tubing towards the meatus two times, and after CNA #2 told her "not that way", CNA #1 then wiped the catheter tubing away from the meatus area twice. CNA #1 held the catheter tubing with her left hand at the distal end from the meatus, while using her right hand to wipe towards the distal end away from the meatus. After completion of the catheter care, both CNAs applied the resident's clean brief, positioned her up in bed onto her left side, and covered her up. CNA #1 disposed of the soiled linens and other items. On 5/22/19 at 12:05 PM, an interview with CNA #1, revealed when she started to wipe the catheter tubing she wiped in the wrong direction. She stated she wiped towards the vagina area, and should have wiped away from the vagina. She stated the resident could have gotten an infection. CNA #1 stated she held the catheter away from her body (referring to Resident #173) and should have held it closer to her body (referring to Resident #173) so the tension would not have been there. On 5/22/19 at 12:15 PM, an interview with CNA #2, revealed the CNA was wiped in the wrong direction and that could cause a bacterial infection. She also stated when CNA #1 was holding the catheter tubing closer to her (referring to Resident #173) and wiping the tubing (referring to the catheter tubing), that could have caused the catheter to be pulled out. 05/22/19 1:45 PM, an interview with the Director of Nurses (DON), revealed CNA #1 wiped the	M 620	- Beginning 5/25/19 to 6/10/19 the Director of Nursing Services/Assistant Director of Nursing Services/Staff Development Nurse in-serviced all Nurses and Certified Nursing Assistants (CNAs) on proper indwelling urinary catheter care to prevent possible urinary tract infection (UTI). The Director of Nursing Services/Assistant Director of Nursing Services/Staff Development Nurse completed Nurse and CNA competency check-offs for indwelling urinary catheter care 6/14/19. - Beginning 6/3/19 the Director of Nursing Services/Assistant Director of Nursing Services/Staff Development Nurse performed daily observations of one (1) CNA over three shifts performing proper indwelling urinary catheter care, for three (3) weeks, Monday through Friday. Any problems identified will be reported to the Quality Assurance Committee (QAC) by the DNS. The QAC will make recommendations for continued observations.	

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M 620	Continued From page 2 catheter tubing in the wrong direction, she got nervous, and yes, that's definitely a problem, and can cause infection. The DON also stated she has to hold it (referring to the catheter tubing) closer to the catheter insertion site when wiping it. On 5/22/19 at 3:28 PM, an interview with the Staff Development Nurse, revealed she (referring to CNA #1) should have held the catheter tubing close to the meatus area and wiped away from the meatus area. She also stated CNA #1 should have anchored the catheter tubing close to the meatus end so there would be no pulling on the tubing. Review of the May 2019 physician's orders revealed an order, dated 03/10/19, for a 16 FR (French) Foley catheter with a 5cc (five cubic centimeter) balloon to gravity drainage. May change as needed for occlusion, leakage or dislodgement. Record Foley output every shift. Review of the Face Sheet revealed Resident #173 was admitted by the facility, on 02/09/16, with the included diagnoses: Pressure Ulcer of Sacral Region, Stage 4, Overactive Bladder, Pressure Ulcer Right Buttock Stage 3. A record review of the most recent Quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 04/04/19, revealed Resident #173's Urinary Bowel and Bladder Continence was checked "not rated", resident had a catheter (indwelling, condom, urinary ostomy, or not urine output for the entire 7 (seven) days of observation. it was resident had a catheter.	M 620		