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 _____	01/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON CO NH	1421-A EAST PEACE STREET CANTON, MS 39046

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M 000	Initial Comments The State Agency (SA) conducted an annual re-certification along with a complaint investigation (CI) MS# 20440 from 1/23/23 to 1/26/23. The SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm related to CI MS #20440 and cited M500. The SA also cited at M 190 Restraints. Census at the time of the survey was 92 and the facility was licensed for 95 beds.	M 000		
M 190	45.2.33 Restraint Restraint. The term "restraint" shall include any means, physical or chemical, which is intentionally used to restrict the freedom of movement of a person. This Statute is not met as evidenced by: Level II Based on observation, staff and resident representative interview, record review and facility policy review the facility failed to ensure residents were free from physical restraints for three (3) of eighteen residents on sample. Resident #25, #31, and #72. Findings include: Record review of the facility policy titled, "Guidelines and Policy" with no revision date revealed under, "Purpose...Physical restraints are defined as any manual method, physical or mechanical device, material or equipment attached to the resident's body that the resident cannot remove easily which restricts freedom of movement or normal access to one's body. The resident must be physically and cognitively able to	M 190	A.1. A new bed rail assessment was completed by the Director of Nursing on 01/25/23 for Resident #31 and the 3/4 side rail was replaced with a half upper side rail for assistance with mobility. A.2. A new bed rail assessment was completed on 01/25/23 by the Director of Nursing for Resident #72 and the bed was replaced by one that has half upper side rails only for assistance with mobility. A.3. Resident #25 has been assessed by the Assessment Nurse and care plan was completed on 01/25/23 for a seat belt as a restraint on her gerichair. B. All residents had the potential to be affected by the deficient practice. C. A bed side rail assessment has been completed on all residents by 02/21/23 by the Assessment Nurse and/or Director of	2/21/23

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M 190	Continued From page 1 self-release device such as Velcro lap-trays or tables, seat belt with Velcro, or snap seat belts, if a resident cannot mentally and physically self-release, then the device is considered a restraint ". Resident #31 An observation on 01/23/23 at 9:00 AM, revealed Resident #31 lying in bed with eyes closed, and three quarter (3/4) siderails up on both sides of the resident's bed with the bed in the lowest position. An interview on 01/25/23 at 8:15 AM, with Certified Nurse Assistant (CNA) #2 revealed she always works the Alzheimer/dementia care unit. She revealed that she thinks all of the residents need side rails to prevent them from falling. She revealed the facility has in-services about siderails and they have told us to make sure they are up and she believes they all need them for safety. She revealed Resident #31 has full side rails up when she is in bed, and she is unaware of any care plan that she is supposed to look at or orders to know who needs full side rails and who does not. An interview on 01/25/23 at 8:25 AM, with Licensed Practical Nurse (LPN) #2 revealed she is the nurse on the Alzheimer's/Dementia care unit. She revealed that full siderails are considered all four (4) split rails and if the bed only has long single rails on each side, then both sides up would be considered full rails. She revealed that the resident's that can let their own siderails down can get full siderails if they request them and they or the family signs a consent. She revealed she is aware that siderails could be	M 190	Nursing to ensure proper side rail use. All wheelchairs and gerichairs were also inspected by the Director of Nursing to ensure no restraint devices were being used without proper assessment, care plan and documentation. All nurses were inserviced by the Director of Nursing on 02/10/23 on the proper use and documentation for physical restraints. D. The Director of Nursing and/or Quality Assurance Nurse will inspect at least 3 beds and/or gerichairs on each hall weekly for three months beginning 01/30/23 for sustained compliance. Any problems noted will be reported to the Quality Assurance and Performance Improvement Committee for at least three months resolution.	

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considered a restraint, a siderail assessment is completed by the Registered Nurse (RN) and LPN on admission and if the resident has any changes in condition. She revealed that if the resident is a fall risk or cannot define the perimeters of the bed, then the staff talk to the resident's family, and if they want full side rails they sign a consent. She revealed that Resident #31 has a long side rail on each side of her bed and both are up when this resident is in the bed.

An interview on 01/25/23 at 8:57 AM, with CNA #3 revealed that some residents have two (2) full rails, and some have 4 half rails. She revealed she does not work the floor often, but when she does, and she sees that a resident has full side rails up then she leaves them up. She revealed if she had to put the resident to bed she determines if the resident needs full side rails based on if the resident can move around by their self. She revealed if the resident can move around on their own, they are at a higher risk of falling out of the bed, so in her judgement they need full side rails.

An interview and observation on 01/25/23 at 11:00 AM, with the Director of Nurses (DON) revealed there were 13 beds with ¾ siderails and one (1) bed with full side rails on the 100 hall with 22 total beds. She revealed the facility has been trying to get all new beds with just the upper half rails. She revealed that if a resident's bed had both ¾ side rails up then the resident could not let them down on their own and it could be considered a restraint.

An interview on 01/26/23 at 11:35 AM, with Registered Nurse-Minimum Data Set (RN-MDS) confirmed that Resident #31 has both 3/4 side rails up while she is in bed to help with bed mobility. She revealed the resident is able to

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move herself in the bed independently and needs limited assistance with walking. When the SA asked why the resident would need both 3/4 side rails up while in bed if the resident is able to move herself independently in bed, RN-MDS stated, "I see your point". She confirmed that if a resident had both 3/4 side rails up then the resident could not let them down or get out of their bed.

Record review of the facility restraint in-services revealed CNA #2 and CNA #3 and LPN #1 and LPN #2 had completed restraint in-services in 08/2022.

Record review of Resident #31's Face Sheet revealed the resident was admitted to the facility on 4/20/21 with medical diagnoses that included Unspecified dementia, unspecified severity with behavioral disturbance.

Record review of Resident #31's Physician's Orders revealed an order dated 4/20/21- Siderails, necessary to serve as an enabler to promote independence.

Record review of Resident #31's Side Rail Consent revealed that left and right upper side rails were to be used and was signed by a resident representative on 4/19/21.

Record review of Resident #31's Bedrail/Assist Bar evaluation competed on 01/03/23 revealed that "bed rails are 3/4 rails and are only utilized when resident is in bed for promotion of bed mobility independence. Resident can reposition self in bed."

Record review of Resident #31's MDS with an AR of 01/03/23 revealed under Section C a BIMS score of 00 which indicates the resident is

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severely cognitively impaired, under Section G indicated the resident needed limited assistance with bed mobility, transfer, moving from seated to standing position, walking, moving on and off toilet and surface-to-surface transfer and in Section P that bed rails were not being used,

Resident #72

An observation on 01/23/23 at 7:20 PM, revealed Resident #72 lying in bed with a wood head and foot board and full wooden siderails up.

An observation on 01/24/23 at 8:50 AM, revealed Resident #72 lying in bed with full side rails up.

An observation on 01/24/23 at 3:00 PM, revealed Resident #72 lying in bed with full side rails up.

An observation on 01/24/23 at 5:00 PM, revealed Resident #72 lying in bed with full side rails up and with eyes closed.

An interview on 01/24/23 at 5:10 PM, with Resident #72's Resident Representative revealed she guesses she is ok with the siderails and revealed the staff may have discussed the risk and benefits of side rails, but she cannot remember.

An interview and observation on 01/25/23 at 9:00 AM, with LPN #1 revealed she is the nurse for Resident #72. She revealed that full side rails are a precaution to keep them from falling out of the bed. She revealed if the resident moves a lot in the bed, then they have full side rails. She revealed that Resident #72 does not walk, but she can stand and pivot. An observation at this time with LPN #1 confirmed that Resident #72 has 4 split rails up. She revealed that she is not

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sure why Resident #72 has full side rails, because she should not need them.

An interview and observation on 01/25/23 at 9:15 AM, with CNA #4 confirmed that Resident #72 has full side rails up on her bed. She revealed that Resident #72 has just come out of the stage of walking on her own and now she does not, so she might think she can still get up and that is why her full siderails are up. She revealed that Resident #72 has never tried to get out of bed as far as she knows. She revealed that residents that are total care all have full side rails to keep them from falling. She revealed that siderails can be considered a restraint.

An interview and observation on 01/25/23 at 10:20 AM, with LPN-MDS with RN-MDS present revealed that Resident #72 has a consent on her record for left and right upper rails, signed by her resident representative on admission 11/3/22. An observation with LPN-MDS confirmed that Resident #72 has a bed with 4 half rails and all 4 rails were up. She revealed she would consider the resident a fall risk, but she has never known her to try and get out of the bed. She revealed Resident #72 needs a new bed that goes lower to the floor, and she plans to have it replaced. She revealed that Resident #72's siderail consent does not match what the resident has in use.

An interview on 01/25/23 at 10:30 AM, with RN-MDS revealed that she and LPN-MDS does the bedrail assessments on everyone. She revealed that Resident #72 had a bedrail assessment on 12/22/22 due to a significant change in the same bed she currently is in. She confirmed that Resident #72's consent indicates left and right upper side rails and that did not match what the resident currently had in use,

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which was 4 half rails. She revealed that after she completed her bedrail assessment on 12/22/22 she did not get a new consent signed for full side rails.

An observation on 01/25/23 at 1:00 PM, revealed that Resident #72's bed had been changed to a bed that goes lower and has bilateral 3/4 rails and the resident is sitting up in a reclining mobile chair out by the nurse's desk.

An interview on 01/26/23 at 10:35 AM, with the DON revealed that Resident # 72 did not have an order for side rails and if a resident has siderails in use they should have an order.

An interview on 01/26/23 at 11:30 AM, with RN-MDS confirmed that Resident #72's bed was changed and stated, "Her bed was changed because apparently it was not a suitable bed". She also confirmed that the resident did not have an order for siderails but should have.

Record review of Resident #72's Face Sheet revealed the resident was admitted to the facility on 11/3/22 with medical diagnoses that included Chronic obstructive pulmonary disease.

Record review of Resident #72's Physician's Orders revealed there was no order for side rail use.

Record review of Resident #72's "Bedrail/Assist Bar Evaluation" completed 12/22/22 by RN-MDS revealed the assessment was completed due to a significant change. This assessment indicated that the resident had not expressed a desire to have side rails raised and is unable to release bed rails. This assessment revealed under "Evaluation Factors...Bilateral upper and lower

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rails are needed for resident's bed mobility independence and for safety to prevent resident from slipping or rolling onto floor with the diagnosis to be considered with bed rails/assist bar being Unspecified Dementia".

Record review of Resident #72's Side Rail Consent dated 11/3/22 revealed it read "Prior to the completion of the side rail assessment "I request the staff of Madison County Nursing Home to raise the protective side rails indicated below for my safety" and the indicated side rails were marked as left and right upper side rail.

Record review of Resident #72's MDS with an ARD dated of 12/22/22 revealed under Section C that there was a BIMS score of 00 which indicates the resident is severely cognitively impaired; Section G indicated the resident needed limited assistance for moving from seated to standing position and surface to surface transfer and in Section P indicated bed rails were not in use.

Resident #25

An observation on 01/24/23 at 9:51 AM, of Resident #25 sitting in a Geri chair with a black lap belt fastened around her waist.

An observation on 01/24/23 at 11:26 AM, of Resident #25 sitting in a Geri-chair with a black waist belt in place.

An interview and observation on 01/25/23 at 9:20 AM, with LPN #1 confirmed Resident #25 had a lap belt on and was unable to unfasten it. She revealed it's used so she won't slide out of the chair. She revealed she has never witnessed her sliding down in the chair.

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M 190	Continued From page 8 An interview and observation on 01/25/23 at 9:38 AM, the DON confirmed that Resident #25 had a lap belt in place. The DON encouraged Resident #25 to release the belt and Resident #25 was unable to release the belt. The DON then revealed she's not supposed to have this waist belt on. I don't know why she has it on. An interview on 01/25/23 at 10:56 AM, with CNA #1 revealed they have been using the waist belt while the resident was up in the Geri chair to aid in her not sliding down and have been using the belt for a long time. An interview on 01/25/23 at 11:16 AM, with the DON revealed there was no restraint assessment for the waist belt or physician's order or care plan because she wasn't aware it was being used. An interview on 01/25/23 at 2:30 PM, with LPN #1 revealed Resident #25's husband was in today and signed a restraint consent form and wanted to keep the seat belt on her. An interview on 01/26/23 at 10:00 AM, with Resident #25's husband/Resident Representative revealed I'm the one who bought the geriatric chair for her, he revealed the staff would put her safety belt on her to keep her from sliding out of the chair. He revealed he never signed a consent for the belt until he came in yesterday and the nurse told him he needed to sign the form. An interview on 01/26/23 at 12:08 PM, with CNA #1 revealed she has been working in the facility for seven years and the resident has always had the lap belt and everyone knows that she has it. She revealed when I came to work here the aide training me told me the belt needed to be on her	M 190		

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M 190	Continued From page 9 when she is up in the chair, so she doesn't slide out. Review of Resident #25's Face Sheet revealed the resident was admitted to the facility on 11/17/06 with diagnoses that include Hemiplegia following nontraumatic intracerebral hemorrhage affecting the right dominant side. Review of the MDS Section C with an ARD of 10/6/22 revealed a BIMS score of 00 which indicated Resident #25 had severe cognitive impairment.	M 190		