| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 255286 | A. Building<br>B. Wing | 06/20/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Pine View Health and Rehabilitation Center | 1304 Walnut St<br>Waynesboro, MS 39367 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>47873<br><br>Based on observation, staff interview, and record review, the facility failed to ensure a resident's right to a dignified experience, as evidenced by not providing a privacy covering for a urinary drainage bag for one (1) of nine (9) residents with an indwelling catheter. (Resident #17)<br><br>Findings include:<br><br>On 6/16/24 11:35 AM, during an observation, Resident #17 was lying in bed and a urinary catheter drainage bag was hanging from the right side of the lower bed. The urinary drainage bag was not covered and the urine in the bag was visible from the hallway.<br><br>On 6/17/24 at 9:15 AM, in an interview and observation with Registered Nurse (RN) #2, she confirmed Resident #17 had an indwelling catheter and the drainage bag was not covered, making the urine visible. RN #2 explained the visible urine was a dignity issue for the resident.<br><br>On 6/18/24 at 9:15 AM, in an interview with the Director of Nursing (DON), she revealed urinary drainage bags should have a privacy covering because it was a dignity issue for the resident.<br><br>Record review of the Admission Record revealed the facility admitted Resident #17 on 10/19/23 with current Paraplegia and Neuromuscular Dysfunction of Bladder.<br><br>Record review of the Order Listing Report revealed Resident #17 had a Physician's Order, dated 5/10/24, for a Foley (Indwelling) catheter. |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure each resident receives an accurate assessment.<br><br>43283<br><br>Based on staff interview, record review and facility policy review, the facility failed to accurately code a Minimum Data Set (MDS) regarding anticoagulant medication for one (1) of 18 residents reviewed. Resident #10<br><br>Findings include:<br><br>A record review of the facility's policy MDS with a revision date of 09/25/2017 revealed Policy: The center conducts initial and periodic standardized, comprehensive and reproducible assessments .Procedure .Each person completing a section or portion of a section of the MDS signs the Attestation Statement indicating its accuracy .<br><br>Record review of the Quarterly MDS with an Assessment Reference Date (ARD) of 05/15/24 indicated Resident #10 received anticoagulant medication for seven (7) days during the look back period.<br><br>Record review of Resident #10's .Order Review Batch Update revealed she had Physician's Orders for Aspirin 81 milligram (mg) (non-steroid anti-inflammatory medication) and Plavix Tablet 75 mg (anti-platelet medication). There were no orders for anticoagulant medications.<br><br>On 06/19/24 at 2:00 PM, during an interview with the MDS Nurse/Licensed Practical Nurse (LPN) #1, she confirmed the MDS with an ARD of 05/15/24 for Residents #10 was inaccurately coded because she did not receive anticoagulant medications.<br><br>On 6/19/24 at 2:15 PM, during an interview with the MDS Coordinator/Registered Nurse #1, she explained the facility completes a scrub report prior to submitting the MDS. She confirmed Resident #10's MDS was coded in error and missed on the review.<br><br>On 6/19/24 at 3:20 PM, during an interview with the Director of Nursing (DON), she confirmed the MDS was coded inaccurately for Resident #10, and she expected all MDS assessments to be coded accurately.<br><br>Record review of the Admission Record revealed the facility admitted Resident #10 on 11/02/2006 with diagnoses including Hemiplegia and Hemiparesis. |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>43283<br><br>Based on staff interview, record review, and facility policy review, the facility failed to implement a Nurse Practitioner's (NP) recommendation for a specialty mattress for a resident with a pressure ulcer (PU) for one (1) of three (3) residents reviewed with PUs. Resident #32<br><br>Findings include:<br><br>A review of the facility's policy Skin and Wound with revision date of 01/24/2022 revealed Policy: To provide a system for .implementing resident centered interventions to promote skin health, prevention, and healing of pressure injuries .<br><br>A record review of a timeline provided by the facility of Resident #32's PUs revealed Resident #32 acquired a deep tissue injury (DTI) (a type of pressure injury) to the right and left heel and a left lateral heel DTI on 03/11/24. On 04/02/24, Resident #32 acquired a sacrum wound that was a Stage II PU. She received a specialty (air) mattress on 05/22/24.<br><br>Record review of Resident #32's Progress Note Details of the wound care NP revealed 4/30/24 . Will order patient air mattress . 5/14/24 .patient has not received air mattress .5/21/24 .The patient has not received the air bed .<br><br>A record review of the 5-Day (Reentry from an acute hospital) Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/30/24 revealed Resident #32 was severely cognitively impaired and had three (3) unstageable pressure wounds and indicated there were no pressure devices for her bed or chair coded in Section M for skin conditions.<br><br>A record review of the Customer Portal maintenance list revealed Resident #32 received an APM2 (type of specialty air mattress) and pump on 5/22/24.<br><br>On 06/19/24 at 4:30 PM, during an interview with the Director of Nursing (DON), she stated she did not understand or know why Resident #32 did not receive an air mattress after the nurse practitioner ordered it on 4/30/24. She explained she expected the staff to follow the NP's recommendations and to place orders as soon as possible.<br><br>On 06/19/24 at 5:00 PM, during an interview with Licensed Practical Nurse (LPN) #2/Wound Care nurse she confirmed the NP indicated in her progress notes on two (2) different dates that Resident #32 did not have an air mattress in place. She explained she remembered the NP asking about the air mattress, but it was forgotten about or maybe it was on order from maintenance.<br><br>On 06/20/24 at 11:45 AM, during an interview with the Maintenance Director, he explained the facility always had low air loss mattresses in-house. The facility placed orders for new mattresses in November 2023. He explained currently there were four (4) low air loss mattresses that are available for use. He stated he always tries to keep one or two low air loss mattresses available but if the facility did not have any mattresses in house, he could order them and have them available the next day.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 06/20/24 at 2:00 PM, during an interview with the Wound Care NP, she explained when Resident #32 first got the PUs, she mentioned to LPN #2/Wound care nurse a verbal order to get the resident a low air loss mattress and after seeing resident a few more times she mentioned the air loss mattress again. She confirmed that she did not follow up on the reason why Resident #32 did not have a specialty mattress.<br><br>Record review of the Admission Record revealed the facility admitted Resident #32 on 01/03/24 with current diagnoses including of Unspecified Dementia. |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>47873<br><br>Based on observation, staff interview, and record review, the facility failed to maintain proper placement of urinary drainage tubing to prevent the possible spread of infection for one (1) of nine (9) residents with an indwelling catheter. (Resident #17)<br><br>Findings include:<br><br>Review of the facility's policy, Urinary Tract Infections (Catheter-Associated), Guidelines for Preventing, revised 9/2017, revealed, . The purpose of this procedure is to provide guidelines for the prevention of catheter-associated urinary tract infections (CAUTIs) .Steps in Procedure .6 .Do not place the drainage bag on the floor .<br><br>Record review of the Order Listing Report revealed Resident #17 had a Physician's Order, dated 5/10/24, for a Foley (Indwelling) catheter.<br><br>On 6/16/24 at 11:35 AM, during an observation, Resident #17 was lying in bed and a urinary catheter drainage bag was hanging from the right side of the lower bed and the drainage tubing on the floor.<br><br>On 6/17/24 at 9:15 AM, in an interview and observation with Registered Nurse (RN) #2, she confirmed Resident #17 had an indwelling catheter and the drainage tubing was on the floor of the resident's room. RN #2 stated the tubing on the floor was an issue with infection control.<br><br>On 6/18/24 at 9:15 AM, in an interview with the Director of Nursing (DON), she revealed catheters could be a cause of infection and the tubing should not touch the floor. She stated it was the responsibility of all nursing staff to ensure catheter drainage tubing was not touching the floor.<br><br>Record review of the Admission Record revealed the facility admitted Resident #17 on 10/19/23 with current diagnoses that included Paraplegia and Neuromuscular Dysfunction of Bladder. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>48181<br><br>Based on observation, staff interview, and facility policy review, the facility failed to ensure the chemical sanitizer for a low-temperature dishwasher had a concentration of at least 50 parts per million (ppm) for (1) of two (2) dishwasher observations.<br><br>Findings include:<br><br>A review of the facility's policy, Isolation/Infection Control - Non-Disposal Service Ware, Effective Date 11/30/2014, revealed, Policy: Isolation and Infection Control guidelines issued by the Center for Disease Control are followed .Procedure .Low temperature dish machines .use a chemical sanitizer .The required chemical sanitizer concentration is 50 ppm for a chlorine based sanitizer .<br><br>On 6/17/24 at 10:07 AM, during an interview and observation with the Dietary Manager (DM), the low-temp dishwasher Hypochlorite (chlorine) on the dish surface final rinse was below 10 ppm. The DM confirmed the chlorine ppm was registering below 10. The DM explained adequate chlorine levels were important to help with infection control and stated she would call the Maintenance Director regarding the sanitation concentration.<br><br>On 6/17/24 at 10:36 AM, an interview with the Maintenance Director revealed the low-temperature dishwasher chlorine was registering below 10 ppm. He advised he would contact the manufacturer to provide further maintenance and a representative would come to the facility.<br><br>On 6/20/24 at 11:40 AM, an interview with the Administrator, he stated he was aware the low temperature dishwasher chlorine level was below 10 ppm when SA observed the DM test the sanitation on 6/17/24. The Administrator stated he planned to personally in-service the staff on requirements for dishwasher sanitation. |