

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255312	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/08/2024
NAME OF PROVIDER OR SUPPLIER Union CO Health and Rehab Center, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 1111 Bratton Road New Albany, MS 38652	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>47157</p> <p>Based on observation, staff interview, record review, and facility policy review, the facility failed to promote the dignity of a resident who was observed with a urinary catheter with no privacy bag for (1) one of (5) five residents with catheters. (Resident #26)</p> <p>Findings include:</p> <p>A review of the facility policy titled, Dignity, dated February 2021, revealed Policy Statement: Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction, with life, and feeling of self-worth and self-esteem Policy Interpretation and Implementation .12. a. Helping the resident to keep urinary catheter bags covered.</p> <p>An observation of Resident #26 from the open doorway of her room on 8/5/24 at 10:10 AM, revealed the resident to have a urinary catheter with no privacy bag hanging on the side of the bed facing the doorway.</p> <p>An observation of Resident #26 on 8/05/24 at 12:00 PM, revealed the door to the room to be open, a catheter bag and catheter drainage tube were observed to contain light yellow colored liquid with no privacy bag in use.</p> <p>An observation of Resident #26 on 8/05/24 at 12:02 PM, with Certified Nurse Assistant (CNA) #2 she confirmed the urine in the catheter bag was visible from the resident's doorway and that there was no privacy bag in use for the catheter. She revealed that it was a dignity issue because the bag with urine was visible from the doorway and stated anyone walking by could see it.</p> <p>Review of the Order Summary Report with active orders as of 8/6/24, revealed an order dated 8/2/24 Urinary Catheter .related to Obstructive and Reflux Uropathy</p> <p>In an interview with Licensed Practical Nurse (LPN) #2 on 8/06/24 at 9:27 AM, she revealed all residents with catheters should have a privacy bag in place to keep others from seeing the urine for the resident's dignity.</p> <p>In an interview with the Infection Preventionist on 8/06/24 at 9:33 AM, she confirmed that Resident #26 should have had a privacy bag covering her catheter bag to promote dignity.</p> <p>(continued on next page)</p>

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Admission Record revealed Resident #26 was admitted by the facility on 7/17/20 with diagnoses that included Obstructive and Reflux Uropathy.</p>

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>47157</p> <p>Based on staff interview, record review, and facility policy review, the facility failed to notify the physician before holding a resident's long-acting insulin for (1) one of 14 residents reviewed. (Resident #30)</p> <p>Findings include:</p> <p>Review of the facility policy titled, Change in a Resident's Condition or Status, revised February 2021 revealed Policy Statement: Our facility promptly notifies the attending physician . of changes in the resident's medical/mental condition and/or status</p> <p>Review of the August 2024 Medication Administration Record for Resident #30 revealed Insulin Glargine Solution Pen-Injector 100 unit/milliliters (ml)-Inject 40 units subcutaneously two times a day related to Type 2 Diabetes was not administered on 8/1/24-8/4/24 at 2100 hours (9:00 PM) and 8/5/24 at 0600 hour (6:00 AM).</p> <p>An interview with the Director of Nursing (DON) on 8/07/24 at 9:09 AM, revealed that she spoke with Licensed Practical Nurse (LPN) #4, and she stated that she had held the scheduled insulin Glargine on those days because Resident #30's blood sugars were low and stated she had notified the charge nurse of the blood sugars but did not notify the physician. The DON confirmed that LPN # 4 should not have held the long-acting insulin Glargine without notifying the physician. LPN #4 was not available for an interview during the survey.</p> <p>In an interview with LPN #3 on 8/7/24 at 9:45 AM, she revealed she would notify the physician before holding a scheduled long-acting insulin and stated that the physician would be notified of any changes in the resident's condition.</p> <p>A phone interview with the Nurse Practitioner on 8/7/24 at 10:14 AM, confirmed she was made aware that Resident #30 had recent episodes of low blood sugars at night but confirmed she was not notified that the staff were not giving her long-acting insulin Glargine because of low blood sugars. She revealed the long-acting insulin Glargine would not have affected the low blood sugars, and she should have been notified before holding the insulin because she would have instructed staff not to hold the insulin.</p> <p>Review of the Admission Record revealed Resident #30 was admitted by the facility on 3/29/23 with diagnoses that included Type 2 Diabetes Mellitus.</p> <p>Record review of Resident #30's of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/2/24, Section C revealed a Brief Interview for Mental Status (BIMS) score of 3, indicating the resident was severely cognitively impaired. Section N0350 Insulin Injections : coded received seven injections during the last 7 days.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47158</p> <p>Based on observation, resident, and staff interviews and facility policy review, the facility failed to maintain the building in a safe manner for one (1) of 47 resident rooms observed. (Resident #41).</p> <p>Findings include:</p> <p>Record review of the facility policy titled, Maintenance Service undated, revealed .Policy Interpretation and Implementation 1. The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times .</p> <p>An observation on 8/5/24 at 10:30 AM, of Resident #41's room revealed a 22 inch by 10 inch panel surrounded with a one (1) and one-half (1/2) inch metal frame on the wall that was one (1) inch above the headboard of the resident's bed. A three (3) inch section of the bottom part of the metal frame was noted to be bent and protruding outward from the wall.</p> <p>During an interview on 8/5/24 at 10:32 AM, with Resident #41 stated that the metal frame of the panel had been bent for quite some time, but she could not recall how long.</p> <p>In an interview on 8/5/24 at 10:40 AM, with the Maintenance, he stated that the panel was the door to the sprinkler system controls and that he was not aware that the metal frame was bent. He agreed that the metal frame protruding from the wall was dangerous and could cause an injury to the resident.</p> <p>On 8/5/24 at 11:00 AM, during an interview with Certified Nursing Assistant (CNA) #1, she stated that she did notice that the metal frame of the sprinkler panel was bent, protruding outward from the wall this morning, and she should have notified the Charge Nurse, but she did not. She stated that the bed did have a metal bar to keep the headboard from hitting the wall, but it is only used if the resident has a trapeze bar or equipment that may damage the wall. She denied knowing that the metal bar needed to be down on Resident #41's bed to prevent it from bending the sprinkler panel frame.</p> <p>In an interview on 8/6/24 at 8:45 AM, with the Housekeeper, she stated that she usually cleans Resident 41's room and that she had never noticed the sprinkler panel frame being bent. The Housekeeper also stated that she was not aware of the metal bar on the bottom of the bed that would keep the headboard from hitting the bed, and that no one ever informed her that it needed to be down to prevent Resident 41's headboard from hitting the sprinkler panel frame.</p> <p>During an interview on 8/6/24 at 9:23 AM, the Director of Nursing (DON) stated she was not aware that there was a sprinkler panel located in Resident 41's room or that the metal frame around the panel was bent. She stated she was not aware that the metal bar on the frame of the bed should have been down to prevent the headboard from hitting and bending the sprinkler panel frame. The DON agreed that there was nothing in place to prevent the headboard from bending the metal frame on the sprinkler panel and that it was dangerous and could cause an injury to the resident.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the Admission Record revealed Resident #41 was admitted to the facility on [DATE] with diagnoses that included Cerebral Infarct.</p> <p>Record review of the Quarterly Minimum Data Set Assessment (MDS) with an Assessment Reference Date (ARD) of 6/26/24 revealed, Resident 41's Brief Interview for Mental Status (BIMS) score was 12, indicating that she had moderate cognitive impairment.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>47157</p> <p>Based on observation, staff interview, record review, and facility policy review the facility failed to prevent the possibility of the spread of infection as evidenced by a urinary catheter bag and drainage tubing laying on the floor for (Resident #26) and failure to perform hand hygiene after handling a urinary catheter bag during wound care for (Resident #38) for (2) two of (7) seven care area observations.</p> <p>Findings include:</p> <p>A review of the facility policy titled, Urinary Tract Infections (Catheter-Associated). Guidelines for Preventing, revised September 2017, revealed Purpose: The purpose of this procedure is to guide guidelines for the prevention of catheter-associated urinary tract infections .Steps in the Procedure . 4. Always practice vigilant hand hygiene and standard precautions when handling catheter systems .6. c. Do not place the drainage bag on the floor .</p> <p>A review of the facility policy titled, Changing a Dressing, undated, revealed Procedure Guideline for Changing a Dressing: 1. Perform hand hygiene .14. Dispose of the gloves and soiled dressing . Perform hand hygiene . Apply clean gloves .16. Dispose of gloves and perform hand hygiene .</p> <p>Resident #26</p> <p>In an observation of Resident #26 on 8/5/34 at 10:10 AM, the resident was observed to have a urinary catheter hanging on the right side of the bed, with the bottom of the catheter bag and drainage tubing observed sitting on the floor beside the bed.</p> <p>An observation of Resident #26 on 8/05/24 at 12:00 PM revealed a catheter bag and catheter drainage tube to be sitting on the floor.</p> <p>An observation of Resident #26 on 8/05/24 12:02 PM with Certified Nurse Assistant (CNA) #2 confirmed the bag should not be hanging down touching the floor because it was an infection control concern.</p> <p>In an interview with Licensed Practical Nurse (LPN) #2 on 8/06/24 at 9:27 AM revealed that catheters should not be touching the floor because it increases the risk of the transmission of infection.</p> <p>In an interview with the Infection Preventionist on 8/06/24 at 9:33 AM, she confirmed that Resident #26 catheter bag should never be touching the floor because of what might be on the floor and increases the risk of transmission of infection.</p> <p>Review of the Admission Record revealed Resident #26 was admitted by the facility on 7/17/20 with diagnoses that included Cerebral Infarction.</p> <p>Resident #38</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An observation of wound care for Resident #38 on 8/7/24 at 10:15 AM, with LPN #1 revealed she entered the room, sanitized her hands and applied gloves, she then picked up the resident's catheter bag and sat in on the side of the resident's bed. She then continued setting up the wound supplies on the bedside table on a clean barrier after handling the catheter bag that was laying on the floor. LPN #1 then cleansed Resident #38's wound bed to his sacrum and applied the clean dressing supplies with the same gloves that were placed on her hands when she initially entered the room.</p> <p>In an interview with LPN #1 on 8/7/24 at 10:30 AM, she confirmed she did not perform hand hygiene after handling the catheter bag and cleaning the sacral wound bed. She also confirmed she did not perform hand hygiene before applying the clean dressing to the sacral wound bed. She then revealed by failing to perform hand hygiene, she placed the resident at risk for the transfer of bacteria to the wound and increased the risk for a wound infection.</p> <p>In an interview with the Director of Nursing (DON) on 8/07/24 at 10:32 AM, she confirmed that hand hygiene should have been performed after handling the catheter bag and during wound care. She revealed by not performing proper hand hygiene that it placed the resident at increased risk for infection.</p> <p>Review of the Admission Record revealed Resident #38 was admitted by the facility on 9/29/23 with diagnoses of Pressure ulcer of unspecified buttock, unspecified stage and Neuromuscular dysfunction of bladder.</p> <p>Record review of Resident #38's the Minimum Data Set (MDS) with an Assessment Reference Date of 5/07/24, Section C , revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was severely cognitively impaired Section H0300: was coded Resident #38 had a catheter for last seven days Section M0300 : was coded Resident #38 had one Stage 3 pressure ulcer.</p>		