STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255289	A. BUILDING _____ B. WING _____	**03/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RIVER CHASE VILLAGE	**5090 GAUTIER VANCLEAVE ROAD GAUTIER, MS 39553**

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)
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review the facility failed to follow the care plan related to catheter/incontinent care for three (3) of four (4) care plans reviewed, Resident #28, Resident #14, and Resident #35. Findings include: Review of the facility's Comprehensive Care Plans policy, revised July 29, 2019, revealed: An individual comprehensive care plan that includes measurable objectives and time frames to meet the resident's medical, nursing, mental, and psychological needs is developed for each resident. Resident #35 A review of Resident #35's care plan, revealed, a focused problem, with an onset date of 03/01/2019, related to the resident's [DIAGNOSES REDACTED]. Interventions included to provide catheter care every shift and clean the urinary penile catheter. During an observation of Resident #35's catheter care, on 03/11/2020 2:25 PM, Certified Nursing Assistant (CNA) #3 washed the catheter tubing in a downward motion, away from the body, without securing the catheter tubing two (2) times. CNA #3 washed around the head of the penis multiple times, using the same area of the soapy washcloth. CNA #3 rinsed the catheter tubing in a downward motion again, without securing the tubing for three (3) wipes. CNA #3 dried the catheter twice without securing the catheter tubing. CNA #3 failed to apply a leg strap or device to secure the catheter after the care was completed. CNA #3 confirmed Resident #35 did not have a leg strap in place for the urinary catheter, therefore it was not secured. On 03/11/2020 at 2:30-2:40 PM, during an interview with CNA #3, she confirmed Resident #35 should have had a leg strap on to prevent pulling on the catheter. CNA #3 stated, the catheter could be pulled out causing damage. CNA #3 confirmed she wiped multiple times when washing the head of the resident's penis, used the same area of the cloth, and pulled on the catheter without securing the tubing during washing, rinsing and drying the catheter. CNA #3 stated this could cause damage and an infection. CNA #3 confirmed she did not provide catheter care and apply a leg strap for Resident #35, per the care plan. CNA #3 stated the care plans are located on the Kiosk for each resident. A review of the facility's Face Sheet revealed, Resident #35 was admitted by the facility, on 12/15/2017, with [DIAGNOSES REDACTED]. Resident #28 Review of Resident #28's care plan, revealed a focused problem, with an onset date of 03/21/2019, related to the resident being at risk for a Urinary Tract Infection [MEDICAL CONDITION] due to being occasionally incontinent of bowel and bladder. The goal and target date revealed the resident would be kept clean and dry with no evidence of UTI by 04/20/2020. Interventions included to check every two hours and as needed (prn), and keep clean and dry using good pericare. During an incontinent care observation for Resident #28, on 03/10/2020 at 11:07 AM, CNA #1 used one (1) pair of gloves to pull down the covers, let down the bed, and then provide incontinent care. CNA #1 wiped Resident #28's vaginal area, using a new disposable wipe each time, from top to bottom on the left and right side, but failed to wipe down the middle of the vagina. CNA #1 wiped multiple times using the same area of the wipes. CNA #1 repositioned Resident #28, and adjusted the covers with the soiled gloves after cleaning feces. On 03/11/2020 at 4:15 PM, during an interview with the Director of Nursing (DON), she revealed the facility had on-going training for incontinent care and catheter care. The DON stated all catheters should have a catheter strap to secure the catheter to prevent pulling on the catheter. The DON revealed by not securing the catheter, this could lead to trauma and pain, as well as cause an infection for the residents. The DON confirmed the staff should only wipe once with the cloth, then use another area of the cloth. The DON also confirmed that at no time should staff place any soiled linen bags or trash bags on the floor. The DON stated the staff should provide care with clean gloves only, not after they have touched anything, and not to pull up the covers with soiled gloves, especially after cleaning a bowel movement (BM). The DON stated this could contribute to the transmission of infections. On 03/12/2020 at 2:40 PM, during an interview with Registered Nurse (RN) #1, she revealed the care plan was for all staff to follow and is individualized for the needs of each resident and their preferences. RN #1 confirmed all catheters should have a leg strap to prevent trauma and infection, as well as comfort for the resident. RN #1 stated all CNAs are expected to provide care per the resident's care plan. A review of the facility's Face Sheet revealed, the facility admitted Resident #28, on 12/22/2014, with [DIAGNOSES REDACTED]. Resident #14 Review of Resident #14's care plan, revealed, a focused problem, with an onset date of 04/18/2019, related to the resident having an indwelling catheter due to her [DIAGNOSES REDACTED]. Interventions included to check catheter to ensure it is secured to the resident's thigh with catheter securement device to prevent and/or minimize accidental removal, monitor catheter tubing for kinks or twists in tubing, position catheter tubing below level of bladder, provide foley catheter care every shift, and record output at end of every shift. On 03/11/2020 at 11:42 AM, during an observation of catheter care for Resident #14, CNA #4 failed to hang the catheter on the bed frame. Resident #14's catheter dangled at the bedside during the catheter care. CNA #4 stated, It looks like the catheter is pulling, but she continued with the care. CNA #4 pulled the catheter tubing to clean the left and right side of the perineal area. CNA #4 pulled the tubing away from the meatus without securing the tip to prevent tension. During the catheter care, CNA #4 asked Resident #14 if she was hurting her, and the resident stated, I can take it. During an interview, on 03/11/2020 at 3:11 PM, CNA #4 confirmed she failed to secure the catheter tubing while providing care. CNA #4 stated she thought she had placed the catheter on the bed frame. CNA #4 further stated she knew something was wrong, because the catheter was pulling. CNA #4 confirmed that by pulling on the catheter, this could cause trauma to the meatus/bladder and/or urinary tract infections [MEDICAL CONDITION]. During an interview, on 3/11/2020 at 3:15 PM, RN #1 stated the expectations are for the CNAs to follow the care plan by avoiding tension, while providing catheter care, to prevent trauma and/or infection. On 3/11/2020 at 3:30 PM, during an interview with the Director of Nursing (DON), she confirmed CNA #4 did not follow the care plan by causing tension while providing catheter care. Review of the facility's Face Sheet revealed, Resident #14 was admitted by the facility, on 09/28/2018, with [DIAGNOSES REDACTED]. The Admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/06/2019, revealed, Resident#14 had a Brief Interview of Mental Status (BIMS) score of 13, which indicated cognitively intact.
F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, the facility failed to provide care in a manner to prevent infection and trauma to the meatus during catheter/incontinent care for three (3) of four (4) incontinent observations, Resident #28, Resident #14, and Resident #35. Findings include: Review of the facility's Indwelling Urinary

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

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.

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F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) Catheter Care policy, undated, revealed: Providing good catheter care is important because the presence of the catheter in the urethra provides a pathway for bacteria to travel up from the perineum into the bladder. The policy's procedure revealed to use a different area of the wash cloth/perineal wipe after each wipe and to clean four (4) inches of catheter away from the resident, holding the tubing close to the meatus to prevent tension. The policy further revealed, to ensure the catheter tubing is secured to the leg. A review of the facility's Perineal Care policy, undated, revealed, when cleaning a female resident, separate the labia, clean front to back using downward [MEDICAL CONDITION] and use a clean area of the cloth for each downward motion. The policy revealed to wash hands thoroughly and apply gloves prior to beginning care. The policy further revealed the purpose for providing perineal care for the resident was to help prevent skin breakdown, itching, burning, odor and infections, as well as provide comfort to the resident. Resident #35 During an observation of catheter care for Resident #35, on 03/11/2020 at 2:25 PM, with Certified Nursing Assistant (CNA) #3, it was noted Resident #35 did not have a leg strap in place to secure the urinary catheter. During the care, CNA #3 cleaned the catheter tubing downward, away from the body, without securing the catheter tubing two (2) times, and washed around the head of the penis multiple times using the same area of the soapy washcloth. CNA #3 rinsed the catheter tubing downward, away from the body again, without securing the tubing for three (3) wipes. CNA #3 then dried twice, again without securing the catheter tubing. CNA #3 confirmed she had completed the catheter care. CNA #3 failed to apply a leg strap or device to secure the catheter, after the care was completed. Resident #35 did not moan or show signs of discomfort during care. An interview with CNA #3, on 03/11/2020 at 2:30 PM, she confirmed Resident #35 should have had a leg strap on to prevent pulling on the catheter. CNA #3 stated this could cause damage and the catheter could be pulled out, causing damage to his private area. CNA #3 confirmed she wiped multiple times when washing the head of the penis using the same area of the cloth, and pulled on the catheter without securing the tubing during washing, rinsing and drying the catheter. CNA #3 stated this could cause damage and an infection. Review of the facility's Face Sheet revealed, Resident #35 was admitted by the facility, on 12/15/2017, with [DIAGNOSES REDACTED]. Resident #28 On 03/10/2020 at 11:07 AM, during an observation of incontinent care for Resident #28, performed by CNA #1, she stated that she washed her hands, prior to the surveyor entering the room. CNA #1 pulled the covers down on Resident #28, lowered the bed down, using the handle at the foot of the bed, with the same pair of gloves on, prior to providing care. CNA #1 wiped the left and right side of the vagina, going from top to bottom, using a new wipe each time, but failed to wipe down the middle of the vagina. CNA #1 used perineal wash to spray Resident #28's buttocks, then using a disposable wipe, she wiped feces from the anal area, in an upward motion. CNA #1 cleaned the resident's buttocks, using a new wipe, and wiped three (3) times, using the same area of the wipe . CNA #1 obtained a new wipe and wiped upward once, folded the wipe, and proceeded to wipe nine (9) times, using the same area of the disposable wipe. CNA #1 repositioned Resident #28 and pulled the covers up, with the soiled gloves still on. Attempts were made multiple times via phone, to obtain an interview with CNA #1, without success. On 03/11/2020 at 4:15 PM, during an interview with the Director of Nursing (DON), she revealed the facility has on-going training for incontinent care and catheter care. The DON stated all catheters should have a catheter strap to secure the catheter to prevent pulling on the catheter. This could lead to trauma and pain as well as cause an infection for the residents. The DON confirmed the staff should only wipe once with the cloth then use another area of the cloth. The DON also confirmed that at no time should staff place any soiled linen bags or trash bags on the floor. The DON stated the staff should provide care with clean gloves only, not after they have touched anything and not to pull up the covers with soiled gloves, especially after cleaning a bowel movement (BM). The DON stated this could contribute to the transmission of infections. Review of the facility's Face Sheet revealed, the facility admitted Resident #28, on 12/22/2014, with [DIAGNOSES REDACTED]. Resident #14 On 03/11/2020 at 11:42 AM, during an observation of Resident #14's catheter care, revealed, CNA #4, failed to hang the resident's catheter bag on the bed frame. Resident #14's catheter dangled beside the bed during the catheter care. CNA #4 stated, It looks like the catheter is pulling, but continued with the care. CNA #4 asked Resident #14 if she was hurting her, and Resident #14 grimaced, and stated, I can take it. CNA #4 pulled the catheter tubing to the left side of the perineal area, and wiped down the right side of the vagina. CNA #4 pulled the tubing to the right side, and wiped down the left side of the vagina. CNA #4 pulled the tubing away from the meatus, without securing the tip to prevent tension. During an interview, on 03/11/2020 at 3:11 PM, CNA #4 confirmed she failed to secure Resident #14's catheter tubing while providing care. CNA #4 stated she thought she had placed the catheter on the bed frame. CNA #4 further stated she knew something was wrong, because the catheter was pulling. CNA #4 confirmed that pulling on the catheter could cause trauma to the meatus/bladder and/or urinary tract infections [MEDICAL CONDITION]. Review of the facility's training records, revealed, CNA #4 attended in-services related to catheter care, on 01/27/2020 and 12/01/2019. During an interview on 3/11/20 at 3:30 PM with the Director of Nursing (DON) said the CNA's are trained to secure the tubing to prevent tension. The DON confirmed CNA #4 could have caused trauma to the meatus/urethra and/ or infections. A review of the facility's Face Sheet revealed, Resident #14 was admitted by the facility, on 09/28/2018, with [DIAGNOSES REDACTED]. The Admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/06/2019, revealed, Resident#14 had a Brief Interview of Mental Status (BIMS) score of 13, which indicated cognitively intact.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation, interview, record review, and facility policy review, the facility failed to label and date opened meats in the meat freezer, for one (1) of two (2) days of observation. Findings include: Review of the facility's, Food Storage policy, dated 2013, revealed, frozen foods should be covered, labeled and dated. All foods will be checked to assure that foods will be consumed by their safe use by dates or discarded. During the initial tour of the kitchen, on 03/10/2020 at 9:12 AM, with the Dietary Manager (DM), revealed, the meat freezer had a bag of chicken breasts opened and not dated. The chicken breasts were frozen together, and were not able to determine the number, but greater than ten (10). A bag of shrimp (undetermined amount), but about one-third (1/3) of a gallon freezer bag full, and 12 cube steak patties were also opened and not dated. An interview with the DM, on 03/10/2020 at 9:24 AM, he confirmed all opened food items should be labeled and dated. The DM stated, I think someone used a dry eraser on the bag of shrimp and the cube steak and it rubbed off, but the chicken breast does not have a visible date or label. The DM stated the staff that opens the bags, are responsible for labeling and dating them. The DM revealed not labeling and dating food items could cause food borne illnesses. During an interview and observation, on 03/12/2020 at 3:04 PM, revealed, the meat freezer contained opened bags of meats that were labeled and dated. The DM stated there was an in-service held on the previous day regarding the labeling and dating of all opened food items.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** Based on observation, interview, record review, and facility policy review, the facility failed to prevent the possible spread of infection during two (2) of four (4) catheter/incontinent care observations Resident #28 and Resident #35. Findings include: Review of the facility's, Standard Precautions policy, revised 01/2020, revealed Standard Precautions are intended to be applied to the care of all residents regardless of the suspected or confirmed presence of an infectious agent. Resident #35 During a catheter care observation for Resident #35, on 03/10/2020 at 2:18 PM, Certified Nursing Assistant (CNA) #3 placed a soiled linen bag on the floor twice, after the care was provided and prior to disposing it in the dirty utility room. During an interview with CNA #3, on 03/10/2020 at 2:25 PM, she confirmed that sitting the soiled linen bag on the floor twice could spread germs. CNA #3 stated she was just nervous. Resident #28 During the incontinent care observation for Resident #28, on 03/10/2020 at 1:45 PM, CNA #1 washed her hands and put on gloves. CNA #1 pulled the covers down, and lowered the bed, using the handle at the foot of the bed, prior to providing incontinent care using the same gloves. After providing incontinent care, which included cleaning feces, CNA #1 repositioned Resident #28 and pulled the covers up, with the same soiled gloves. Numerous attempts were made to contact CNA #1 by telephone for an interview, but attempts were unsuccessful. On 03/11/2020 at 4:15 PM, during an interview with the Director of Nursing (DON), she stated the facility has on-going training for incontinent care and catheter care. The DON confirmed that at no time should staff place any soiled linen bags or trash bags on the floor. The DON stated the staff should provide care with clean gloves only, not after they have touched anything, and not to pull up the covers with soiled gloves especially after

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) cleaning a bowel movement (BM). The DON stated this could contribute to the transmission of infections.