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
	07CH	A. BUILDING: _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRUCE COMMUNITY LIVING CENTER	176 HIGHWAY 9 SOUTH BOX 1280 BRUCE, MS 38915

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M 000	Initial Comments The State Agency (SA) conducted an annual recertification survey at the facility from 12/12/23 through 12/14/23. During the survey, the SA determined that the facility was not in compliance with the Mississippi Regulations for Minimum Standards for Institutions for the Aged or Infirm and cited M500 related to resident rights for advance directives. The census at the time of the survey was 31 with a bed capacity of 35.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or	M 500		1/19/24

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M 500	Continued From page 1 nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial	M 500		

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M 500	Continued From page 2	M 500		

transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law;

7. is free from mental and physical abuse;
8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint;
9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract;

10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs;

11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care;

12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care,

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M 500	Continued From page 3 and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level II Based on staff interviews, record review, and facility policy review, the facility failed to have an informed consent for code status signed for two	M 500	1. On 12/14/23 Social Service Director contacted resident #3 and Resident #4 Responsible Representative to complete updated facility advanced directives and code status forms to honor resident and	

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M 500	Continued From page 4 (2) of 16 sampled residents reviewed. Resident #3 and Resident #4 Findings include: Record review of facility policy titled, "Advance Directives", dated 11/22, revealed, "The resident has the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment. Advance directives are honored in accordance with state law and facility policy." The policy also revealed, "Do Not Resuscitate (DNR) - indicates that, in case of respiratory or cardiac failure, the resident or legal guardian, health care proxy, or representative (sponsor) has directed that no cardiopulmonary resuscitation (CPR) or other life-sustaining treatments or methods are to be used." Resident #3 Record review of Resident #3's electronic Order Summary Report revealed an order dated 1/15/18 for "DNR". Record review of Resident #3's handwritten "Physician Orders" dated 6/8/23, revealed an order for "DNR". Record review of Resident #3's medical records revealed there was no signed consent by Resident #3 or Resident #3's Resident Representative that indicated the ordered DNR status was consented to. An interview with the Administrator on 12/13/23 at 8:15 AM, revealed the facility failed to have a signed code status or advance directive for Resident #3 to indicate the resident's or the resident representative's wishes for end-of-life	M 500	representatives code status. On 12/14/23 Social Services Director was able to update code status forms according to the wishes of the Resident and Responsible Representative. 2. This alleged deficient practice has the potential to affect all residents. Social Service Director and Administrator performed an audit of all advanced Directive forms on 12/15/23. 3. On 12/14/23 Administrator in-serviced Social Service Director on policy for Advanced Directives, and Code Status during Admission Process. On 1/03/24 Administrator in-serviced Social Service Director on Resident Rights Policy and Procedure. On 12/15/23 Administrator and Social Service Director audited all current medical records to ensure correct code status was implemented by the facility, issues were corrected immediately. Starting 12/15/23 all current resident medical records were audited to ensure a copy of the Advanced Directives was placed on the medical record for all current residents, issues identified, and Responsible Representative and/or Power of Attorney were notified and requested to review and sign advanced directives with date certain by 01/18/2024. Medical Director was also made aware of all findings. 4. On 12/15/23 Administrator to review all new admission and change in status weekly x 4 weeks, bi-weekly x 2 weeks, monthly x 4 months to ensure the correct code status and advanced directive are	

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M 500	Continued From page 5 care. She stated the facility had been in the process of developing a new form that would be consistent throughout the facility, but they realized several residents did not have a signed consent to indicate the resident's or the representative's wishes, only the electronic order and the signed physician order. She confirmed the residents' and the representatives' wishes needed to be honored and the code status needed to be discussed and verified by a signed consent to ensure proper care was given. An interview with the Social Services Coordinator on 12/13/23 at 3:05 PM, revealed she was responsible for having the advance directive and/or code status filled out on admission, as well as reviewing during each care plan meeting. She confirmed that Resident #3's code status form "just slipped through the cracks", and therefore, it was not done. She confirmed the facility failed to have a consent signed to ensure the resident and family wishes were honored. Record review of Resident #3's "Admission Record" revealed the resident was originally admitted to the facility on 3/7/17 and the most recent admission was 4/6/22. Resident #3's diagnoses included Chronic Obstructive Pulmonary Disease, Cognitive Communication Deficit, Hypertension, and Paroxysmal Atrial Fibrillation. Record review of Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 9/14/23 indicated a Brief Interview for Mental Status (BIMS) of 0, which indicated the resident was severely cognitively impaired.	M 500	accurately reflected in the resident chart and orders. Any issues will be immediately corrected. The administrator will report results of the audit to the Quality Assurance Performance Improvement Committee (QAPI) monthly x 6 months starting on 01/18/24 (January QAPI meeting date with MD).	

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M 500	Continued From page 6 Resident #4 Record review of Physician Orders documented order for Resident #4 dated 09/25/23 for DNR and signed by physician. Record review of Resident #4's Scanned Electronic Medical Records revealed that there was no signed consent for DNR (Do Not Resuscitate) status or Advanced Directive. An interview with the Administrator on 12/13/23 at 8:18 AM, revealed the facility failed to have a signed code status or advance directive for Resident #4 to indicate the resident's or the resident representative's wishes for end of life care. She stated the facility had been in the process of developing a new form that would be consistent throughout the facility, but they realized several residents did not have a signed consent to indicate the resident's or the representative's wishes, only the electronic order and the signed physician order. She confirmed the residents' and the representatives' wishes needed to be honored and the code status needed to be discussed and verified by a signed consent to ensure proper care was given. Record review of Resident #4's Admission Record documented Admission Date of 09/28/2022 with the following diagnoses to include: Peripheral Vascular Disease, Cognitive Communication Deficit, Gout, Benign Neoplasm of Unspecified Adrenal Gland, and History of Falling. Record review of the MDS with an ARD of 11/03/23 revealed Resident #4 had a BIMS score	M 500		

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M 500	Continued From page 7 of 03 indicating the resident was severely cognitively impaired.	M 500		