

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 66SR	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/25/2024
NAME OF PROVIDER OR SUPPLIER STONE COUNTY REHABILITATION AND NURSING CT		STREET ADDRESS, CITY, STATE, ZIP CODE 1436 EAST CENTRAL AVENUE WIGGINS, MS 39577		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) conducted an annual recertification survey at the facility from 01/23/2024 through 01/25/2024. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirement and cited M500.	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 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	M 500		2/29/24

Mississippi State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

02/07/24

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 66SR	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/25/2024
NAME OF PROVIDER OR SUPPLIER STONE COUNTY REHABILITATION AND NURSING CT		STREET ADDRESS, CITY, STATE, ZIP CODE 1436 EAST CENTRAL AVENUE WIGGINS, MS 39577		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 500	Continued From page 1 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 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;	M 500		

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 66SR	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/25/2024
NAME OF PROVIDER OR SUPPLIER STONE COUNTY REHABILITATION AND NURSING CT		STREET ADDRESS, CITY, STATE, ZIP CODE 1436 EAST CENTRAL AVENUE WIGGINS, MS 39577		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 500	Continued From page 2 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, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical	M 500		

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 66SR	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/25/2024
NAME OF PROVIDER OR SUPPLIER STONE COUNTY REHABILITATION AND NURSING CT		STREET ADDRESS, CITY, STATE, ZIP CODE 1436 EAST CENTRAL AVENUE WIGGINS, MS 39577		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 500	Continued From page 3 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 interviews, record review, and facility policy review, the facility failed to ensure residents had access to their personal funds on weekends for two (2) of 17 residents reviewed with a personal fund account (Resident #11 and Resident #34). This deficient practice had the potential to affect all 17 residents with a personal	M 500	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility ☐s	

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 66SR	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/25/2024
NAME OF PROVIDER OR SUPPLIER STONE COUNTY REHABILITATION AND NURSING CT		STREET ADDRESS, CITY, STATE, ZIP CODE 1436 EAST CENTRAL AVENUE WIGGINS, MS 39577		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 500	Continued From page 4 trust fund account. Findings include: Review of the facility's policy, "Resident Trust Fund", revised 3/23/23, revealed, " Policy: The resident has a right to manage his or her financial affairs...After Business Hours ... 1. Residents will have reasonable access to their personal funds after business office hours." On 1/24/24 at 1:00 PM, during the Resident Council Meeting, Resident #11, and Resident #34 reported they were not able to withdraw their personal funds on Saturday and Sunday. They explained they were told to ask a certain nurse if they wanted money on the weekend but were unable to recall the nurse's name. Both residents reported they did not have clear information from the facility on how to get their money on the weekend. Record review of the "Open Balance Report", with "Balances as of 1/24/2024", revealed Resident #11 and Resident #34 had a personal trust fund account at the facility. On 1/24/24 at 2:02 PM, an interview with the Business Office Manager (BOM) revealed she worked Monday through Friday and was the only person designated to dispense funds to the residents from their personal accounts. The BOM revealed if a resident wanted money from their account for the weekend, they should get the money on Friday. The BOM stated if a resident requested money from their account on a weekend, she could be contacted by a nurse, and she would come to the facility to dispense the funds. The BOM acknowledged there was no staff member designated to dispense funds to the	M 500	credible allegation of compliance. 1. Immediate actions taken for those residents identified: On January 24, 2024, the Administrator implemented funds to be available every night and weekend effective immediately. On January 24, 2024, residents who have funds were identified through a resident funds audit. Residents with a trust fund have been placed in a binder for management staff to have access to the information. A secure method has been authorized by the administrator to ensure monies are secure and available for residents during the week/weekend. Funds will be available via the 100 hall Nurse outside of normal business office hours. 2. How the facility identified other residents: The facility has determined that all residents have the potential to be affected. 3. Measures put into place/ System changes: The Resident Funds policy has been reviewed and special attention was given to Access to Personal Funds: ¿Residents will have access to petty cash on an ongoing basis and be able to arrange for access to larger funds. Resident requests for access to their funds should be honored by facility staff as soon as possible but no later than: ¿The same day for amounts less than \$100.00 (\$50.00 for Medicaid residents); ¿Three banking days for amounts of \$100.00 (\$50.00 for Medicaid residents) or more. 4. How the corrective actions will be	

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 66SR	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/25/2024
NAME OF PROVIDER OR SUPPLIER STONE COUNTY REHABILITATION AND NURSING CT		STREET ADDRESS, CITY, STATE, ZIP CODE 1436 EAST CENTRAL AVENUE WIGGINS, MS 39577		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 500	Continued From page 5 residents on Saturday and Sunday. On 1/24/24 at 2:07 PM, in an interview with the Administrator, she acknowledged there was no staff member designated to dispense funds to residents on Saturday and Sunday. The Administrator reported the facility once had a system in place to allow the residents to withdraw funds on Saturday and Sunday, whereby a designated nurse would have a locked box on the medication cart with \$100 for residents who wanted to get their money. The Administrator stated the facility stopped this practice because it was seldom used. The Administrator stated her expectation was for residents to have access to their money on the weekends. The Administrator stated she would resume the facility's past practice of designating a nurse to keep a locked box with \$100 on a medication cart in the event resident funds needed to be dispersed on the weekend. Resident #11 A record review of the "Face Sheet" revealed the facility admitted Resident #11 on 07/07/21 with diagnoses that included Parkinson's Disease. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/15/23 revealed Resident #11 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated he was cognitively intact. Resident #34 A record review of the facility's "Face Sheet" revealed the facility admitted Resident #34 on 08/18/21 with diagnoses that included Alzheimer's Disease.	M 500	monitored: Beginning January 29, 2024, the Administrator, Business office Manager, or Assistant Administrator will perform an audit of resident fund availability weekly for eight (8) consecutive weeks to ensure that adequate funds are available for resident fund requests. The results of these audits will be reviewed in the Quality Assurance Meeting on February 29, 2024 and March 28, 2024 or until such a time consistent substantial compliance has been met.	

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 66SR	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 01/25/2024
NAME OF PROVIDER OR SUPPLIER STONE COUNTY REHABILITATION AND NURSING CT			STREET ADDRESS, CITY, STATE, ZIP CODE 1436 EAST CENTRAL AVENUE WIGGINS, MS 39577		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
M 500	Continued From page 6 A record review of the Quarterly MDS with an ARD of 01/19/24 revealed Resident #34 had a BIMS score of 9, which indicated his cognition was moderately impaired.	M 500			