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
	70RH	A. BUILDING: _____ B. WING _____	C 02/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REST HAVEN HEALTH AND REHABILITATION	103 CUNNINGHAM DRIVE RIPLEY, MS 38663

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M 000	Initial Comments The State Agency (SA) conducted a complaint investigation (CI) MS00023705 and CI MS #24072 at the facility from 2/7/24 through 2/8/24. During the survey, th SA determinded that the facility was not in compliance with the Minimum Standards of Operation for Institutions for the Aged or Infirm. The SA identified non-compliance and cited M500 for CI MS #23705 and CI MS #24072 for verbal abuse from a staff member toward a resident.	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	M 500		3/1/24

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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 transactions made on his behalf should the

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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, and send and receive his personal mail

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M 500	Continued From page 3 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 observation, staff and resident interview, record review and facility policy review, the facility failed to resolve resident's grievances regarding allegations of verbal abuse from the	M 500	1. On 2/8/2024, grievances were reported by Resident #1, Resident #2, Resident #5, Resident #6, and Resident #7. The reported grievances stated that Certified Nursing Assistant (CNA) #1 talked and treated them inappropriately.	

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M 500	Continued From page 4 staff for five (5) of 10 residents reviewed for unresolved grievances. Residents #1, Resident #2, Resident #5, Resident #6 and Resident #7. Findings Include: Review of the facility policy titled "Grievance/Concern/Comments" with a revision date of 12/2021 revealed under "Standard ...Residents and their family members may voice grievances to the facility or other agency/entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal The facility will make prompt efforts to resolve grievances." Resident #1 During an observation and interview on 2/7/24 at 7:40 PM, with Resident #1 revealed there was one Certified Nurse Assistant (CNA) that had talked ugly to her and other residents. She stated one night recently she was sleeping, and her arm hit the top of her overbed table and knocked a drink off and spilled it on the floor. She revealed that when she used her call light and CNA #1 came to her room. She told her what had happened and the CNA told her that she told her she wasn't cleaning that up. CNA #1 went and got a towel and brought it back and told her to get up and clean it up. She stated that she could not get herself out of bed to do that and that made her cry. She revealed CNA #1 did end up cleaning the spill. She stated she reported this incident to the Administrator and the Director of Nurses (DON). Record review of Resident #1 "Admission Record" revealed the resident was admitted to the facility on 12/31/23 with a medical diagnosis that included Urinary Tract Infection.	M 500	As a result of these allegations reported on 2/8/2024, Certified Nursing Assistant (CNA)#1 placed on suspension pending investigation on 2/8/2024. Certified Nursing Assistant (CNA) #1 was terminated on 2/9/2024, as a result of the investigation findings. Resident #1, Resident #2, Resident #5, Resident #6, and resident #7 grievances were investigated and resolved. The Director of Nursing interviewed each resident again on 2/9/2024 with no new concerns or grievances to report. 2. On 2/9/2024, the Administrator and Director of Nursing (DON) identified and interviewed a total 26 of 43 residents who had the ability of being interview regarding the reporting of Certified Nursing Assistant (CAN#1) allegedly treating them inappropriately. All residents have the potential of being affected by this practice of not resolving grievance in a reasonable manner. 3. The administrator and Director of Nursing interviewed 26 residents to note any additional grievances. No other grievance was reported at the time. The Administrator and Director of Nursing were in-serviced on 2/28/2024 by the Corporate Compliance Officer on the facility's standard, Grievance Concern Comment Standard. Additional education on the Grievance Concern Comment Standard was provided to 7 of 7 dietary staff, 6 of 6 housekeeping staff, 2 of 2 maintenance staff, and 18 of 18 nursing department staff by the Nurse Educator. On 2/9/2024 the QAPI committee reviewed the "Grievance Concern Standard and no recommended changes	

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M 500	Continued From page 5 Record review of Resident #1's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/17/24 revealed in Section C a Brief Interview for Mental Status (BIMS) score of 15, which indicates the resident is cognitively intact. Resident #2 During an interview and observation on 2/8/24 at 8:45 AM, with Resident #2 he stated the only problem he has had was with CNA #1 on the night shift, is that she is young. Resident #2 stated ," I just don't think she knows how to talk to people, because she talks short and ugly to people at times." He revealed that normally the day shift makes his bed, but one day they forgot, and he was trying to make it up around 6:30 PM that night and had asked CNA #1 to help him. He stated that she told him she was passing snacks, and it would have to wait. He stated that he asked her if passing snacks was more important than helping him get his bed made so he could lay down and as she walked out of his room she said, "Make it yourself". Record review of Resident #2's "Admission Record" revealed the resident was admitted to the facility on 8/8/23 with medical diagnoses that included Unspecified Combined Systolic (Congestive) and Diastolic (Congestive) Heart Failure. Record review of Resident #2's MDS with an ARD of 11/14/23 revealed in Section C a BIMS score of 15, which indicates the resident is cognitively intact. Resident #5	M 500	were made to the standard. All new hire employees will receive training on Grievance Concern Comment Standard upon hire, annually and as need basis. The grievance concern log will be maintained by Social Services Director. Logs will be reviewed at least monthly by the Quality Assurance Performance Committee. 4. The Director of Nursing or the Social Service Director will conduct four resident interviews weekly for 30 days beginning 2/9/2024 and then monthly for three months to ensure compliance with the Grievance Concern Comment Standard. Any concerns noted will be logged immediately and reported to the Facility Administrator for evaluation and correction in compliance with reporting requirements. The findings of the interviews will be reported to Quality Assurance Committee beginning 2/29/2024 and then monthly times 3 months. The interviews will be reviewed by the Interdisciplinary Team and Quality Assurance Committee which consists of the Administrator, Director of Nursing, RN Supervisors, Dietary Manager, Nurse Educator, Medical Records Nurse, Social Service Director, Activity Director, and Medical Director to ensure compliance with reporting alleged reportable incidents. The QA Committee will make necessary recommendations as needed.	

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M 500	Continued From page 6 During an interview and observation on 2/8/24 at 8:30 AM, with Resident #5 revealed some of the CNA's talk ugly to her and one time they cussed at her. Resident #5 stated "but I don't remember their names." Record review of Resident #5 "Admission Record" revealed the resident was admitted to the facility on 7/26/23 with medical diagnoses that included Acute or Chronic Systolic (Congestive) Heart Failure. Record review of Resident #5's MDS with an ARD of 10/30/23 revealed in Section C a BIMS score of 14, which indicates the resident is cognitively intact. Resident #6 During an interview on 2/8/24 at 10:50 AM, with Registered Nurse (RN) #2 revealed that Resident #6 had reported to her last week that CNA #1, the aide on the night shift talks ugly and treats her ugly and that she reported this to the DON and informed the resident that she could talk with the Social Worker about it the next day. During an interview on 2/8/24 at 12:00 PM, with Resident #6 she stated that her only issue has been with CNA #1 on the night shift and that she talks ugly to her and tells her to stay off her call light so much at night. She stated that CNA #1 threatens her and says they will send her to behavioral health if she does not do what they tell her to do. She stated that she has reported this issue to the DON and RN #2 and stated, "Please tell me you are going to do something about this." Record review of a note dated 2/3/24 at 15:26 (3:26 PM) revealed "Type: eMAR-Medication	M 500		

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Administration Note" revealed "(Proper name of CNA #1) and the other girl that works with her. They are thick as thieves, and they always threaten they are gonna get me sent off to behavioral. I don't know why they treat me like they do ...DON was aware ..."

Record review of Resident #6's "Admission Record" revealed the resident was admitted to the facility on 2/16/23 with medical diagnoses that included Type 2 Diabetes Mellitus with other Diabetic Neurological Complications.

Record review of Resident #6's MDS with an ARD of 1/18/24 revealed in Section C a BIMS score of 13, which indicates the resident is cognitively intact.

Resident #7

During an observation and interview on 2/7/24 at 7:50 PM, with CNA #1, CNA #2 and CNA #3 revealed that they were the three CNA's working the night shift and they revealed they have had in-services on abuse. During this interview while in the hallway, Resident #7 was self-propelling her wheelchair and when she passed, she stated to the CNA's, "I need to go to the bathroom." CNA #1 responded quickly to the resident, "Well you're gonna have to wait until I get done talking."

During an interview on 2/7/24 at 8:00 PM, with RN #1, was informed of the manner and tone that CNA #1 had used in response to Resident #7. RN #1 confirmed "that could be verbal abuse to a resident." She stated " That is not an appropriate way to talk to residents."

During an interview on 2/7/24 at 8:05 PM, with CNA #1 she confirmed that she had told Resident

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M 500	Continued From page 8 #7 she would have to wait until she was done talking when the resident asked to be helped to the bathroom. She stated that she did not mean it to sound rude and admits that she has been in-serviced on verbal abuse. She revealed that she had only had one complaint from a resident about her and that one complaint was from Resident #1. She had complained that I had knocked a drink off of her table, but I did not do that. She did it, but I did cleaned it up and I told the Director of Nursing (DON) that I cleaned it up. During an interview on 2/8/24 at 11:40 AM, with Licensed Practical Nurse (LPN)/Social Services confirmed that she had some complaints on CNA #1 talking ugly to the residents and that Resident #7 filed a formal grievance around the first of January that CNA #1 had refused to get her up that morning and talked ugly to her. She stated that on 1/7/24 Resident #2 came to her office to complain about CNA #1, and she asked him if he could wait to let her get the DON and the Administrator in there so they could hear, and he agreed. She revealed that the DON and the Administrator came to her office and the resident revealed that CNA #1 was passing snacks around 6:30 PM and when he asked her to help him make his bed, she told him she was busy passing snacks. She stated that the resident told them that he asked her if passing snacks that early was as important as helping him make his bed and then as she walked out of the room, she rudely told the resident to make it up himself. She revealed that Resident #1 complained to her on 2/6/24 about CNA #1 and that the resident complained that she had accidentally spilled her drink and CNA #1 told her "You going to get that up". She stated that she asked the resident if she wanted to talk with the DON or the Administrator and the resident stated no that she already had,	M 500		

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and they were going to take care of it.

During an interview on 2/8/24 at 12:30 PM, with Resident #7 confirmed that CNA #1 told her she would "Have to wait until she was done talking" when she told her she needed to go to the bathroom last night. She stated that CNA #1 was rude but that wasn't the first time, and she is used to it from her. She revealed that she had complained about it to a lot of people, "but it does no good; nothing gets done." She revealed she just don't say anything anymore. She stated that she is supposed to go to the bathroom every 2 hours and usually goes at 4:30,and she has told CNA #1 this. CNA #1 told her that she was not coming straight to her as soon as she came on duty to take her to the bathroom, so she knows to not even ask until around the time she ask last night (around 8 PM). She confirmed that she filed a formal grievance back in January of this year, because the night CNAs that included CNA #1 came in her room around 4 AM and told her if she did not get up right then, then she would have to wait until day shift got there to get up. She stated that she was supposed to get up around 5:30 AM and they never came back to get her up. She confirmed that this had been reported to the Social Worker, Administrator, the DON, and some of the other nursing staff but could not remember their names.

Record review of Resident #7 "Admission Record" revealed the resident was admitted to the facility on 3/13/20 with medical diagnoses that included Type 2 Diabetes Mellitus without Complications.

Record review of Resident #7's MDS with an ARD of 10/30/23 revealed in Section C a BIMS score of 15, which indicates the resident is cognitively

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intact.

Record review of the "Grievance/Concern/Comment Report" dated 1/2/24 revealed a formal grievance was filed regarding CNAs on the night shift not getting Resident #7 out of bed as requested.

During an interview on 2/8/24 at 9:30 AM, with the CNA Supervisor revealed there has been one complaint from a resident back in November 2023 or December about night shift CNA #1 being rude to a resident and that she reported it to the DON and she took care of it.

During an interview on 2/8/24 at 10:00 AM, with CNA #4 and CNA #5 revealed that they normally work day shift but sometimes they have to help and work night shift and that some of the residents complain about a CNA on the night shift that is rude to them but would rather not mention any names. She stated that she thinks that everyone knows it and is sure it has been reported to the DON and the Administrator.

During an interview on 2/8/24 at 1:40 PM, with the DON confirmed that all staff receive abuse in services on hire and annually unless there is an issue and then we can do one anytime in our computer in-service system. She revealed that as far as she knows there has not been an issue in order to have to do an additional abuse in-service. She admitted that she had received a complaint on CNA #1 on 2/6/24, but that was the first complaint she had on the staff member, and she is not aware of any more complaints on other staff regarding talking disrespectfully. She stated that Resident #1 reported an issue to her on 2/6/24 that CNA #1 talked disrespectfully to her. The DON stated she came in last night and

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M 500	Continued From page 11 talked to CNA #1 about that issue around 6 PM. During an interview on 2/8/24 at 2:00 PM, with the Administrator, DON, and LPN/Social Services confirmed they had complaints about CNA #1 talking inappropriately to some of the residents. The Administrator stated that the reports he had from Resident # 1 and Resident #2 just did not seem like verbal abuse to him. Both agreed that the reports of how the CNA spoke to Resident #7 last night and how she said it was inappropriate and disrespectful. The DON confirmed at this time that she had known about the report from Resident #1 and Resident #2. When the State Agency (SA) inquired about Resident #6 and her complaint, the DON stated yes, she came into the office and also had a complaint. The DON verified that she had three (3) residents complain about how CNA #1 talked to them. The Administrator stated that CNA #1 had been talked to last night about the complaint that came in on 2/6/24 with Resident #1. The Administrator stated he was not aware that CNA #1 had told Resident #2 to make his own bed as she walked out of his room, but LPN/Social Services confirmed that he did report that to them. The Administrator confirmed that he was aware of the grievance that Resident #7 had filed about them not getting her up when she wanted to but was not aware that either one of them had told her that if she did not get up now, then she would not get up until day shift got there. He admitted that they would have to do an investigation and more than likely let CNA #1 go. During an interview on 2/8/24 at 2:20 PM, with LPN/Social Services confirmed that Resident #1 complained on 2/6/24, Resident #2 complained on 1/7/24 and Resident #7 filed a formal complaint on 1/3/24.	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	70RH	A. BUILDING: _____ B. WING _____	C 02/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REST HAVEN HEALTH AND REHABILITATION	103 CUNNINGHAM DRIVE RIPLEY, MS 38663

(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 12 Record review of the facility in-services from the last 6 months revealed there was an abuse in-service held in 1/2024 for all staff but was not attended by CNA #1. Record review of CNA#1 employee file revealed that she completed in-services on abuse on 9/25/23 and 12/11/23.	M 500		