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
	24GG	A. BUILDING: _____ B. WING _____	C 05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GULFPORT CARE CENTER	11240 CANAL ROAD GULFPORT, MS 39503

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M 000	Initial Comments The State Agency (SA) conducted Complaint Investigations (CI), MS #24570, CI MS #24603, and CI MS #24912, at the facility from 4/30/24 through 5/2/24. The SA investigated CI MS #24570 related to abuse and CI MS #24912 related to resident rights and no deficiencies were cited related to these CI's. The SA investigated the Facility Reported Incident (FRI) CI MS #24603 related to verbal abuse and determined the allegations did not rise to the level of verbal abuse, however, the resident was not treated with respect and dignity. During the survey, the SA determined the facility was in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements based on the facility's implementation of corrective actions on 3/25/24 prior to the SA's entrance on 4/30/24 and M500 was cited as Past Non-Compliance (PNC) related to CI MS #24603.	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	M 500		5/13/24

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M 500	Continued From page 1 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 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,	M 500		

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M 500	Continued From page 2	M 500		

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;

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;

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M 500	Continued From page 3 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 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	M 500		

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M 500	Continued From page 4 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, facility investigation, and policy review, the facility failed to treat a resident with respect and dignity during care for one (1) of four (4) residents sampled. Resident #2 Findings included: A review of the facility's policy titled, "Resident Rights Policy," reviewed 12/23, revealed, "Every resident in this facility has the right to: ...12. Be treated courteously, fairly and with the fullest measure of dignity..." A review of the facility's investigation revealed there was an allegation of verbal abuse reported to the facility on 3/22/24, by Resident #5, the roommate of Resident #2. Resident #5 reported that a Certified Nurse Aide (CNA) had verbally abused her roommate while providing care. Resident #5 reported that a CNA told Resident #2 that "she needed to get her 'expletive' up and go the bathroom," when the resident had an "accident" in the bed. On 4/30/24 at 10:45 AM, during an interview with the Social Services Director (SSD), she confirmed that on 3/22/24, Resident #5, the roommate of Resident #2, informed her that during the early hours of 3/22/24, a CNA told Resident #2 to "get her 'expletive' up and get into the bathroom." The SSD revealed that once she received this information, she immediately informed the Administrator and they began their investigation.	M 500	Past Non-Compliance, No POC needed	

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M 500	Continued From page 5 On 4/30/24 at 11:00 AM, during an interview with Resident #2, she confirmed that about a month ago, during the early morning hours, she urinated on herself and called out for help. The nurse checked on her, then the CNAs entered her room, and one CNA told her something not nice and "spoke ugly." On 4/30/24 at 1:00 PM, during an interview with the Director of Nurses (DON), she confirmed Resident #5 is alert/oriented and if she reported that a staff member was disrespectful to another resident, then she would have to say "it did happen". Resident #5 was clear on what she heard on 3/22/24, and her statement had not changed. The DON confirmed "staff should not talk to residents in a disrespectful way." On 5/1/24 at 11:10 AM, during an interview with the Administrator, she confirmed that during her investigation, both Resident #2 and Resident #5 reported that a staff member used inappropriate language when addressing Resident #2. The Administrator acknowledged that her investigation revealed the CNA that the residents described, was CNA #1. The Administrator acknowledged that the language used by CNA #1 was disrespectful but was not threatening. As this was the second time that CNA #1 had been accused of being discourteous to residents, she was terminated from her employment at the facility. The Administrator stated that after the recent incident, the facility had an emergency Quality Assurance Performance Improvement (QAPI) meeting to discuss the event and what measures needed to be implemented. As a result, in-services were conducted regarding resident rights and abuse/neglect.	M 500		

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On 5/1/24 at 1:00 PM, an interview with Resident #5 confirmed that about a month ago, in the early morning hours, her roommate, Resident #2, used the bathroom on herself, it was a big mess, and it went onto the floor. Two (2) CNAs came in to clean her up but one of the CNAs, who had a head wrap on, stated, "get your 'expletive' up and get into the bathroom." Resident #5 stated they took her roommate to the shower to clean her up and brought her back to her room. Resident #5 confirmed that she informed the Social Worker the next day of what took place earlier that morning.

A review of the personnel file for CNA #1 indicated she had received training on the Vulnerable Adults Act and Resident's Rights and signed an acknowledgment of receiving training on 4/21/22, upon hire, then annually and throughout the year.

Record review of the "Facesheet," for Resident #2, revealed the facility admitted the resident on 12/9/22, with current diagnoses of Altered Mental Status and Chronic Kidney Disease.

Record review of the " Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 3/4/24, revealed Brief Interview for Mental Status (BIMS) score is 15, which indicated the resident was cognitively intact.

Record review of the "Quarterly MDS," for Resident #5, with an ARD of 2/22/24, revealed a BIMS score of 15, which indicated the resident was cognitively intact.

Based on the facility's implementation of corrective actions on 3/25/24, the State Agency (SA) determined the deficiency to be Past

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M 500	Continued From page 7 Non-Compliance (PNC), and the deficiency was corrected as of 3/25/24, before the SA's entrance on 4/30/24. Validation: On 5/2/24, the SA validated through staff interviews, record review, and facility policy review the facility began an immediate investigation when the incident occurred. A review of the emergency QAPI meeting minutes revealed the facility held a QAPI meeting on 3/25/24, the Medical Director attended via phone. The SA verified through an interview with the DON and Social Services Director that they attended the QAPI meeting to discuss the situation, and the facility policies related to violation of the resident rights were discussed, and no changes were needed. The QAPI meeting concluded that the Plan of Correction was to in-service all staff, suspend the employee, and interview all residents with a Brief Interview for Mental Status (BIMS) score over 12, to determine if any resident experienced any violation of their resident rights. The SA reviewed in-service sign-in sheets that began on 3/22/24 related to resident rights and abuse/neglect. The Administrator and DON conducted in-services in which they had every employee sign the policies on resident rights and abuse/neglect. On 3/22/24, the SA verified the facility reported resident abuse to the SA and the Attorney General Office (AGO) on 3/22/24.	M 500		