

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 18HC	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/02/2019
NAME OF PROVIDER OR SUPPLIER HATTIESBURG HEALTH & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 514 BAY STREET HATTIESBURG, MS 39401		
(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 a Complaint Investigation (CI) MS #16382, from 11/12/19 to 12/02/19, related to allegations of Quality of Care (QOC) and Abuse issues. The SA substantiated misappropriation of money for Resident #9, and physical abuse for Resident #16. During the survey, the SA determined the facility was not in compliance with State Licensure Regulations for the Aged or Infirm, and cited State Statutes at M500. The facility's census during survey was 169, and the facility is licensed for 184 beds.	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	M 500		1/7/20

Mississippi State Department of Health

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

TITLE

(X6) DATE

Electronically Signed

12/24/19

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M 500	Continued From page 1 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, 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;	M 500		

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M 500	Continued From page 2 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; 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	M 500			

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M 500	Continued From page 3 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 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, interview, record review,	M 500	1. Licensed Practical Nurse, reported to Director of Nurses verbal report of possible misappropriation of property on	

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M 500	Continued From page 4 and policy review, the facility failed to ensure residents were free from misappropriation for one (1) of six (6) residents reviewed for Abuse/Misappropriation, Residents #9. A Certified Nursing Assistant (CNA) accepted money from Resident #9. The facility also failed to protect Resident #16 from resident to resident abuse. Findings include: Review of the facility's "Investigating Incidents of Theft and/or Misappropriation of Resident Property" policy, dated April 2017, revealed residents have the right to be free from theft and/or misappropriation of personal property. A review of the facility's "Protection of Residents during Abusive Investigations" policy, dated April 2017, revealed: "Our facility will protect residents from harm, reprisal, discrimination or coercion during investigations of abuse allegations." Resident #9 Review of a facility document, "Employee Warning Report", dated 10/15/19, signed by CNA #1 and the Administrator, revealed CNA #1 accepted \$10.00 on 10/9/19, from a resident (Resident #9). Upon notification of CNA #1 accepting money from a resident, CNA #1 was called in to meet with the Administrator and Director of Nursing (DON), prior to her work schedule. The \$10.00 was immediately refunded to the resident by the facility. The document revealed CNA #1 was placed on Administrative suspension. Review of a written statement, dated 10/15/19, signed by CNA #1, revealed she knew it was against company policy to accept anything from	M 500	10/15/19. Certified Nursing Assistant #1 was called in on 10/15/19 upon report of exchange of money with resident. CNA #1 was placed on administrative suspension on 10/15/19, while investigation was completed. Resident funds were reimbursed by facility on 10/15/19, and then employee reimbursed facility on 10/15/19. CNA #1, stated understanding of facility policy and procedure of accepted gifts per her statement dated 10/15/19. Reported to State Department of Health and Attorney General's office 10/16/19 with written report submitted on 10/18/19. On 10/15/19, upon report of a resident of resident altercation. Both residents were immediately assessed by Physician Assistant while Resident #15 was placed on, one on one monitoring. Resident #16, was noted with right eye swollen, to which x-rays obtained revealed no evidence of fracture or dislocations. Resident #15 was assessed and no injuries were noted at that time. One to one monitoring was initiated by 5:00pm on 10/15/19 at the direction of, Director of Nurses. Director of Nurses informed all staff on unit including facility supervisors of one to one status and policy at 4:45pm on 10/15/19. On 10/15/19 social Services conducted interviews with all residents in the section of CNA #1 and none were identified as giving any funds or items to staff. 2. 172 residents were identified as being at risk from this deficient practice. On 10/15/19, DON identified only Resident	

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M 500	Continued From page 5 residents. CNA #1 documented the resident (Resident #9) offered her money, she declined at first, and then ended up taking the money. She documented her intention was not to leave with the money, but to return it to the resident. She stated it slipped her mind, until she got home and realized she still had the money. CNA #1 documented, "I know company policies is not to accept anything. My intentions was to take it back. I promise." During an interview, on 11/14/19 at 12:00 PM, the Administrator confirmed CNA #1 accepted \$10.00 for her birthday from Resident #9. The Administrator stated CNA #1 she didn't want the resident to cry and think she was ungrateful when she gave it to her, and planned to bring the money back. The Administrator stated CNA #1 returned the money, which was given back to Resident #9. The Administrator stated he disciplined CNA #1 on 10/15/19, (documented in Personnel file), and probably should have fired her, but she had not had any discipline to that nature since her employment at the facility. The Administrator stated they suspended CNA #1 for approximately a week, without pay, until it was investigated properly, and also because it is the facility's policy not to accept gifts of any kind from any resident. During an interview, on 11/14/19 at 12:45 PM, with the Director of Nursing (DON) and review of the investigation, provided by the DON, the DON stated an investigation was initiated on 10/18/19, when CNA #1 allegedly received money from Resident #9. She stated the CNA was suspended, and allowed to return to work, after the investigation and advisement from the Attorney General's office, the incident would not be pursued as a crime. The DON confirmed CNA	M 500	#15 and Resident #16 were involved in altercation. 2 of 172 residents have potential to be at risk from this deficient practice. 3. On 10/15/19 an in-service was conducted by Licensed Practical Nurse, Staff Development, with all staff regarding policy and procedure related to accepted gifts from residents and family. All staff were in-serviced prior to working. On 10/31/19, a QA meeting was conducted and policy and procedure related to Investigation Incidents of theft and or misappropriation of resident property, were reviewed and no changes were suggested. On 10/16/19, Resident #15 was transported to Behavioral Health in patient services. on 10/16/19 DON reviewed policy and procedure on resident to resident altercations with Medical Director and no further changes were made. 4. Reported to State Department of Health and Attorney General's office 10/15/19 with written report submitted 10/18/19. QA Nurse to monitor for employees accepting gifts from residents or family by interviewing 10 residents monthly for 3 months. All findings of staff accepting gifts will be immediately addressed upon notification of QA Nurse by reimbursement and placing staff on administration suspension until investigation complete. No further findings as of 12/23/19. Facility wide in-service on, resident on resident abuse was completed on	

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M 500	Continued From page 6 #1 accepted \$10.00 from Resident #9. During an interview on 11/26/19 at 8:50 AM, Resident #9 revealed that she did give CNA #1 money for her birthday, because she wanted her to have it. Resident #9 stated the \$10.00 was given back to her by the facility. Resident #9 stated she had never given CNA #1 anything before that day. Review of facility document titled "In-service Training for Certified Nurse Aides (CNA)" dated 6/13/19 revealed CNA #1 was in-serviced on abuse and neglect and exploitation of vulnerable adults. Resident #16 Review of an investigative report, dated 10/18/19, revealed on 10/15/19 at 4:30 PM, Resident #15 told the RN he had retrieved the remote from his roommate. The report documented Resident #16 was lying in his bed with a red area over his right eye brow. The report documented the RN Supervisor and the Physician's Assistant (PA) assessed both residents, with swelling and tenderness to Resident #16's right superior orbit of his eye; x-rays were negative for fracture. The report documented Resident #15 was assessed, with no injury, and was placed on 1:1 supervision until transport to the Geri-psych unit on 10/16/19 at 5:15 PM. A review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 9/30/19, revealed Resident #15 had a Brief Interview of Mental Status (BIMS) score of 9, which indicated moderate cognitive impairment. Record review of the Nurses Notes for Resident #15, dated 10/17/19, as a late entry for 10/15/19,	M 500	10/17/19. DON to monitor resident on resident altercations daily for 3 months by review of incident reports and any findings of those not following policy and procedure will be brought to QA for immediate review.	

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M 500	Continued From page 7 by RN #1, revealed Resident #16 (Resident #15's roommate), told a CNA he was hit in the face by Resident #15 twice, because of a TV remote. The note documented the RN assessed both residents and Resident #15 was placed on 1:1 observation, until transported to the behavioral unit. The report documented Resident #15 admitted to hitting Resident #16 due to taking his remote. Record review of a facility document, "Every Shift Monitoring", revealed Resident #15 was placed on 1:1 monitoring, beginning 10/15/19 at 5:00 PM, and the monitoring ended 10/16/19 at 6:00 PM. During an interview, on 11/18/19 at 1:37 PM, the Social Services Director (SSD) stated Resident #15 had been sent to the Geri-Psych unit twice before, for saying inappropriate things to staff members, but he had never been aggressive towards another resident until this happened with Resident #16.	M 500		