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
	53SM	A. BUILDING: _____ B. WING _____	C 07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STARKVILLE MANOR HEALTH CARE AND REHABILI1	1001 HOSPITAL ROAD STARKVILLE, MS 39759

(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 complaint investigations (CI) MS #25350, CI MS # 25510, and CI MS #25714 at the facility from 7/1/24 through 7/2/24. During the survey, the SA determined that the facility was not in compliance with the Mississippi Regulations Minimum Standards for Institutions for the Aged or Infirm for CI MS #25510 resident rights related to personal funds and cited M 500. The SA found the facility to be in compliance for CI MS #25350 and CI MS #25714 related to abuse and cited no deficiencies. The census at the time of the survey was 110 residents with a bed capacity of 119 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	M 500		8/5/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53SM	A. BUILDING: _____ B. WING _____	C 07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STARKVILLE MANOR HEALTH CARE AND REHABILI1	1001 HOSPITAL ROAD STARKVILLE, MS 39759

(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 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, 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,	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53SM	A. BUILDING: _____ B. WING _____	C 07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STARKVILLE MANOR HEALTH CARE AND REHABILI1	1001 HOSPITAL ROAD STARKVILLE, MS 39759

(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 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; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care;	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53SM	A. BUILDING: _____ B. WING _____	C 07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STARKVILLE MANOR HEALTH CARE AND REHABILI1	1001 HOSPITAL ROAD STARKVILLE, MS 39759

(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 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 choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level II	M 500	1.Root Cause Analysis was conducted by	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53SM	A. BUILDING: _____ B. WING _____	C 07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STARKVILLE MANOR HEALTH CARE AND REHABILI1	1001 HOSPITAL ROAD STARKVILLE, MS 39759

(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 Based on resident and staff interviews and facility policy review, the facility failed to ensure a resident's personal funds were available for use on the same day as requested for two (2) of five (5) residents reviewed for personal funds. Resident #2 and Resident #3 Findings include: Record review of facility policy titled, "Resident Trust Fund - Cash Disbursements", with revision date of 2/6/24, revealed, "Cash disbursements from the Resident Trust Fund petty cash box will be disbursed in accordance with state and federal regulations." The policy also revealed, "Procedure: Upon request of a Medicare/HMO/Other Payer/Private resident: Must provide up to $100 on the same day requested; Over $100, must be provided within 3 business days; The resident must sign the withdrawal receipt at the time of disbursement, not the request. Upon request of a Medicaid resident: Must provide up to $70 on the same day requested; Over $70, must be provided within 3 banking days; The resident must sign the withdrawal sheet at the time of disbursement, not the request. Note: If the Business Office Manager is not in the Center, the Executive Director should be made aware of the request and ensure that the request is processed timely." During an interview on 7/1/24 at 2:15 PM, Resident #3 revealed there had been several times he was unable to get his money from the front office due to the facility not having enough money available. He revealed his check would be available on 7/3/24 and he had plans for 7/4/24 and he was already concerned that his	M 500	the Quality Assurance Performance Improvement (QAPI) Committee on 07/02/2024. Based on findings, the facility failed to ensure resident's personal funds were available for use on the same day as requested for resident #2 and resident #3. On 7/02/2024 Business Office Manager ran a withdrawal transaction report in order to determine the amounts usually requested by residents. On 7/02/2024 Business Office Manager sent in a request to increase the trust fund petty cash from $750 to $1,200. 2. All residents have the potential to be affected by this deficient practice who have a resident trust fund account. 3. Education with all staff who disburse resident trust funds was conducted and completed on 7/01/2024 by Executive Director. 4. Quality Assurance Improvement (QAPI) meeting was held on 7/02/2024 to ensure resident's personal funds are available on the same day as requested. On 7/02/2024, the Executive Director will conduct ongoing quality monitoring to ensure resident's personal funds are available for use on the same day as requested, 4 times weekly for 4 weeks, then 3 times weekly for 3 weeks, then weekly for 4 weeks, then monthly for 3 months. On 7/30/2024, a QAPI meeting will be conducted to review our findings from our Quality Monitoring to ensure all solution is sustained. We will review all finding from our Quality Monitoring on the last Tuesday of each month during the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53SM	A. BUILDING: _____ B. WING _____	C 07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STARKVILLE MANOR HEALTH CARE AND REHABILI1	1001 HOSPITAL ROAD STARKVILLE, MS 39759

(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 funds would not be available when he asks for them on 7/3/24. During an interview on 7/1/24 at 2:18 PM, Resident #2 revealed he had asked for his money on several occasions, and it was not given to him on that day. He stated he had been told that the facility ran out of money and he would have to wait until the next day. Resident #2 stated he tells the Business Office Manager when he needs money and it is usually about $25 every 2-3 weeks and the Receptonist will deliver the money, but sometimes it is not till the next few days. An interview with the Business Office Manager on 7/1/24 at 3:40 PM, revealed the facility kept $750 in a locked box for the residents to have access to their money. She stated if the amount requested by the resident was less than $50, the money would be given at that time, but if over $50 was requested, the facility would need to know in advance so they could obtain the funds. She revealed there were times, especially at the first part of the month when the residents' checks came in and many residents requested their money, that there were times when the facility did not have enough money available for all the residents requesting their money and those residents had to wait until the next day to obtain their funds. During an interview on 7/1/24 at 3:45 PM, the Receptionist stated the residents requested their money from her. She revealed the facility had $750 each day to provide the residents who requested money. She acknowledged she had been in this position since 5/20/24 and there had been several times that the $750 was given out and other residents still wanted their money, but they had to wait until the next day to get theirs.	M 500	QAPI meeting by the QAPI Committee in the monthly meeting for 6 months to ensure our solutions are sustained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53SM	A. BUILDING: _____ B. WING _____	C 07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STARKVILLE MANOR HEALTH CARE AND REHABILI1	1001 HOSPITAL ROAD STARKVILLE, MS 39759

(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 An interview with the Social Worker on 7/2/24 at 8:20 AM, revealed she was one of the staff members who served as a witness and verified the amount of money obtained by each resident. She stated there had been multiple times that money was not available for each resident that was requesting it and those residents had to wait until the next day to receive their money. During an interview on 7/2/24 at 10:00 AM, the Administrator acknowledged there were times when the facility did not have enough money available for each resident who requested their money and they had to wait until the next day to receive their money. She confirmed amounts below $50 should be available the day of request, but larger amounts would take three (3) days to receive. She confirmed the facility failed to keep an adequate amount of money for the residents' use available and it was their right to have their money available. She confirmed this was the residents' money and needed to be available on request as the regulations require. Record review of Resident #2's "Admission Record" revealed the resident was admitted to the facility on 12/28/23. Record review of Resident #2's Minimum Data Set (MDS) dated 4/4/24 revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact. Record review of Resident #3's "Admission Record" revealed resident was admitted to the facility on 3/18/22. Record review of Resident #3's MDS with ARD of 5/7/24, revealed a BIMS score of 15 which	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53SM	A. BUILDING: _____ B. WING _____	C 07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STARKVILLE MANOR HEALTH CARE AND REHABILI1	1001 HOSPITAL ROAD STARKVILLE, MS 39759

(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 7 indicated the resident was cognitively intact.	M 500		