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
	60QC	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUITMAN COUNTY HEALTH & REHAB LLC	350 GETWELL DRIVE MARKS, MS 38646

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M 000	Initial Comments The State Agency (SA) conducted an annual re-certification survey at the facility from 8/26/24 through 8/29/24. 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 requirements and cited M500 and M610. The census at the time of the survey was 45 and the facility is licensed for 60 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 medical conditions unless medically contraindicated (as documented by a physician or	M 500		10/7/24

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M 500	Continued From page 1 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; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial	M 500		

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M 500	Continued From page 2	M 500		

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 residents or individuals within or outside of the facility to work for improvements in resident care,

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M 500	Continued From page 3 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 staff and resident interviews, record reviews, and facility policy review the facility failed to verify the documented advance directives	M 500	**On 8/27/2024 The Social Service Director, Administrator and Registered Nursing Consultant spoke with resident #148 and explained the difference between Full Code Status and Do Not	

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M 500	Continued From page 4 signed by the Resident Representative (RR) were the preferences of a cognitively intact resident for one (1) of 16 Advance Directives reviewed. Resident #148. Findings Included: Review of the facility policy, titled "Advanced Directives", revealed "...Policy Interpretation and Implementation 1. Upon admission, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate and advance directive if he or she chooses to do so ...4. If the resident becomes able to receive and understand this information later, he or she will be provided with the same written materials as described above, even if his or her legal representative has already been given the information..." Record review of the "Order Summary Report" with active orders as of 8/27/24 revealed an order dated 8/19/24 "Code Status; DNR (Do Not Resuscitate) EFF(effective) 081424." An additional order dated 8/2024 revealed "DNR." Record review of a "Nurse Note" dated 8/7/24 at 6:19 PM revealed " ...States that she is not a DNR ..." Record review of the "Resident/Representative Consent for Cardiopulmonary Resuscitation (CPR)" form, dated 8/7/24, indicated the RR, rather than the resident herself, had signed the document upon admission. The form contained a statement that read, "I understand that CPR constitutes an extraordinary measure and SHOULD NOT be done on this resident..."	M 500	Resuscitate. Advance Directive/Code Status was verified with resident #148, Responsible Representative, and Medical Director. A new copy of Advance Directive/Code Status was placed on the chart by the Social Service Director due to deficient practice for compliance. **All residents have the potential to be affected by this deficient practice **On 8/28/2024 The Administrator in-serviced the Social Service Director and Medical Records Nurse on facility policy of Advance Directives/Code Status and reviewing Advance Directives during admission. On 8/28/2024 Administrator in-serviced licensed nurses and certified nursing assistance on Advanced Directive/Code Status Policy. On 8/29/2024 100% of resident's medical records were audited by Administrator, Director of Nursing, Medical Records Nurse and Social Service Director to ensure correct Advance Directive/Code Status was currently in place in residents' medical record. On 8/30/2024 Quality Assurance Performance Improvement Committee which includes Administrator, Director of Nurses, Charge Nurse, Social Service Director, Infection Preventionist, Medical Records Nurse and Medical Director reviewed Advance Directive/Code Status policy with no recommended changes at this time. **8/29/2024 Administrator to review all new admissions and changes in status weekly times 4 then monthly times 2 Starting on 9/9/2024 with Quality	

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M 500	Continued From page 5 Record review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/14/24 revealed Resident #148 had a Brief Interview for Mental Status (BIMS) score of 15, indicating she was cognitively intact. During an interview on 8/27/24 at 11:30 AM, Social Services stated that the "Resident/Representative Consent for CPR" was signed by the resident's representative at the time of admission and not by the resident. She admitted that she did not discuss CPR with Resident #148 upon admission. Considering Resident #148's BIMS score of 15, which demonstrates cognitive intactness, she agreed that she should have followed up with the resident directly to verify her preferences regarding CPR. In an interview with Resident #148 on 8/27/24 at 12:10 PM, the resident confirmed that no one had discussed CPR with her or asked for her wishes regarding resuscitation. She expressed that depending on the circumstances, she might want CPR performed. A review of the "Admission Record" revealed that Resident #148 was admitted to the facility on 8/7/24 with diagnoses that included Unspecified dementia.	M 500	Assurance Performance Improvement Committee to review monitoring logs completed by Administrator on 10/07/2024 then will review quarterly times 2	
M 610	45.21.2 Activities of daily living Activities of daily living. Each resident shall receive assistance as needed with activities of daily living to maintain the highest practicable well being. These shall include, but not be limited to: 1. Bath, dressing and grooming;	M 610		10/7/24

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M 610	Continued From page 6 2. Transfer and ambulate; 3. Good nutrition, personal and oral hygiene; and 4. Toileting. 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 provide Activity of Daily Living (ADL) care related to removal of facial hair (Resident #3) and nail care (Resident #44) for two (2) of 13 sampled residents. Findings Included: Record review of the facility policy titled "Activities of Daily Living (ADL)s" with revision date of March 2018, revealed "Policy Statement: Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene..." Resident #3 An observation on 08/26/24 at 12:14 PM, revealed Resident #3 sitting in her geri chair in the hall and she had scattered white facial hairs above her upper lip and two white chin hairs that were approximately one (1) inch long. An observation on 08/27/24 at 8:45 AM, revealed Resident #3 lying in her room asleep. She had scattered white facial hairs above her upper lip and two chin hairs that were approximately 1 inch long.	M 610	**On 8/27/2024 Nail care was provided for resident #44 by Licensed Practical Nurse. Resident's fingernails were trimmed and cleaned. Resident #3 nail care was conducted by Licensed Practical Nurse. Resident's fingernails were trimmed and cleaned. Certified Nursing Assistant removed facial hair from Resident #3 due to deficient practice for compliance. **All residents have potential to be affected by this deficient practice. **On 8/29/2024 Director of Nursing in serviced all Nursing Staff on ADL Care. On 8/29/2024 Director of Nursing and Charge Nurse audited 100% of all Residents for proper ADL care which included Nail Care and unnecessary facial hair with any issues noted corrected immediately. On 8/30/2024 Quality Assurance Performance Improvement Committee which included Administrator, Director of Nursing, Charge Nurse, Infection Preventionist, a Certified Nursing Assistant and Medical Director reviewed ADL care Policy with no recommended changes at this time. **Starting on 9/9/2024 Director of Nursing and Charge Nurse will monitor 100% of residents daily times 1 week then 3 times weekly times 2weeks then 2 times weekly	

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M 610	Continued From page 7 During an interview on 08/27/24 at 10:27 AM, Certified Nursing Assistant (CNA) #1 revealed that Resident #3's scheduled shower days were Mondays, Wednesdays, and Fridays. She confirmed that Resident #3 had white facial hair on her upper lip and chin and she revealed that her facial hair should have been shaved during her bath the day before. CNA #1 confirmed that her facial hair had not been taken care of. Record review of Resident #3's "Admission Record" revealed that she admitted to the facility on 08/07/2008 with diagnoses that included Huntington's Disease, Dementia, and Heart Failure. Record review of Resident 3's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/31/2024, Section C revealed a Brief Interview for Mental Status (BIMS) should not be conducted because the resident was rarely or never understood. Section GG - Functional Abilities and Goals revealed Resident #3 was dependent in maintaining personal hygiene. Resident #44 During an observation on 08/26/24 at 12:17 PM, revealed Resident #44 sitting up in his wheelchair in his room and his fingernails were long, jagged and had a brown substance underneath them. His fingernails were approximately one-half to three-fourths inch long. Resident #44 revealed that they had not cut his nails in a while and stated, "Sometimes I scratch myself." He also confirmed that the staff did not check his nails every day. During an interview on 08/27/24 at 10:24 AM, CNA #1 revealed that they were supposed to	M 610	times 1 week then weekly times 2 months. Quality Assurance Performance Improvement Committee will review monitoring logs from Director of Nursing and Charge Nurse on 10/7/2024 then quarterly times 2	

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M 610	Continued From page 8	M 610		

provide for the resident's needs such as nail care and shaving facial hair during their bath or shower time. She confirmed Resident #44 had long, jagged nails with brown substance underneath and that his nails should have been addressed yesterday during his shower time. CNA #1 revealed that by not doing nail care could cause the resident to scratch himself, it could cause skin tears and possible infection. CNA #1 revealed that Resident #44 should have gotten his shower yesterday on the evening shift on 08/26/24 and stated that it did not look like his nails had been cleaned or clipped.

On 08/27/24 at 10:30 AM, during an observation and interview with the Registered Nurse (RN) Supervisor, confirmed that Resident #44's fingernails were long, jagged and had brown substance underneath. The RN Supervisor revealed that personal hygiene included nail care, grooming, and facial hair and that the CNAs were supposed take care of these needs during their baths or showers. The RN Supervisor revealed that long, jagged, and dirty fingernails could cause skin tears, abrasions, and she agreed that it could cause infection if nails were not cared for properly. She also agreed that Resident #44's nails were not clipped nor cleaned during his shower he received the day before and stated, "I will get someone on this now."

During an interview on 08/27/24 at 10:40 AM, the Administrator (ADM) revealed that personal hygiene included nail care and shaving facial hair on men and ladies. She revealed that during resident showers, it was the CNAs responsibility to check the residents from head to toe and to take care of any issues that included fingernails and facial hair.

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M 610	Continued From page 9 Record review of Resident #44's "Admission Record" revealed an initial admission date of 03/01/2023 with diagnoses that included Cerebral Infarction, Dysphagia, and Chronic Systolic Heart Failure. Record review of Resident #44's Physician Orders revealed an order with start date of 07/01/2024, to inspect nails daily, clean, and cut as needed. Record review of Resident #44's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/26/2024. Section C - Cognitive Patterns, revealed a Brief Interview for Mental Status (BIMS) Score of 07 which indicated Resident #44 had severe cognitive deficits. Section GG- Functional Abilities and Goals revealed that he was dependent on staff to maintain personal hygiene.	M 610		