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	21GC	A. BUILDING: _____ B. WING _____	10/10/2024

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M 000	Initial Comments The State Agency (SA) conducted an annual recertification survey at the facility from 10/07/2024 through 10/10/2024. 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 M815.	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 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	M 500		11/8/24

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M 500	Continued From page 1	M 500		

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 facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law;

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M 500	Continued From page 2 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 unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical	M 500		

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M 500	Continued From page 3 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, interviews, record review, and facility policy review, the facility failed to ensure a resident's right to be free from physical restraints by not identifying and documenting the use of a chest harness as a restraint for one (1) of fourteen (14) sampled residents. Resident #38	M 500	1. On 10/8/2024, Resident # 38 was assessed for the use of a postural trunk control device using the pre-restraining evaluation, informed consent form and restraint elimination form related to impaired mobility and upper body trunk control as a result of medical diagnosis of Spastic Quadriplegic Cerebral Palsy and Dandy-Walker Syndrome. New orders	

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M 500	Continued From page 4 Findings Include: A review of the facility's policy titled "Use of Restraints," revised April 2017, revealed: "Restraints shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully... When the use of restraints is indicated, the least restrictive alternative will be used for the least amount of time necessary, and ongoing re-evaluation for the need for restraints will be documented. Physical restraints are defined as any manual method or physical or mechanical device, material, or equipment attached to the resident's body that the individual cannot remove... If the resident cannot remove a device in the same manner in which the staff applied it, given the resident's physical condition, and this restricts his/her typical ability to change position or place, that device is considered a restraint." A record review of Resident #38's medical record revealed there was no documentation regarding the use of a restraint. On 10/08/24 at 3:50 PM, during an interview with the Administrator, she explained that Resident #38 wore the support straps across her body while sitting in her wheelchair due to her medical condition. The Administrator stated that the facility did not consider the support device, which was a harness, as a restraint. She further explained that if a resident does not have the mental capacity to understand or remove the restraint, it was not considered a restraint by the facility. The Administrator confirmed that Resident #38 could not remove the harness without staff assistance. On 10/09/24 at 7:30 AM, in an observation, Resident #38 was observed sitting in her	M 500	were received for Postural trunk control device while up in wheel chair with resident observations every 30 minutes and the device released every 2 hours x 15 minutes for safety and socialization. The comprehensive care plan was developed to reflect the use of the postural support device. 2. On 10/8/2024 the Director of Nurses (DON), Quality Assurance (QA) Nurse, and the Registered Nurse (RN) Supervisor assessed all 56 Residents and one (1) Resident was identified as having the potential to be affected. 3. To protect Residents from similar occurrences the Staff Development Nurse provided education on 10/9/2024 to five (5) Licensed Practical Nurses (LPN) and five (5) Registered Nurses (RN) and twelve (12) Certified Nurse Aides (CNA) regarding the need for assessments to reflect the indication and use for postural support devices, physicians order to apply such device with sufficient monitoring, and care planning to include resident specific interventions for resident safety. All other direct care staff are scheduled for in-service training on 10/23/2024 and 10/25/2024. On 10/17/2024, the quality assurance (QA) committee met and reviewed the policy for Physical Restraints and no changes were recommended. A new policy and procedure for Upper Body Harness was also reviewed and implemented by the QA committee and signed by the Medical Director. 4. An audit tool will be completed by the	

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M 500	Continued From page 5 wheelchair with a cloth cross-body strap support on her upper chest. On 10/09/24 at 7:38 AM, during an interview, Licensed Practical Nurse (LPN) #1 stated that the resident wore the straps across her body when she was in her wheelchair to provide support. LPN #1 reported that Resident #38 was placed in her wheelchair for two (2) hours in the morning and then placed back in bed for two (2) hours, continuing this cycle throughout the day. LPN #1 added that the straps had been used since the resident was admitted to the facility. On 10/09/24 at 7:40 AM, during an interview, Certified Nursing Assistant (CNA) #2 confirmed that the straps were placed across the resident's chest to prevent her from falling out of the chair. CNA #2 also confirmed that Resident #38 could not remove the straps on her own. On 10/09/24 at 11:05 AM, in an interview, the Director of Nursing (DON) acknowledged that Resident #38 was unable to remove the harness from her wheelchair without staff assistance. The DON confirmed that the facility had not previously identified the strapping device as a restraint. The DON explained that, moving forward, the facility would conduct pre-restraint evaluations, obtain physician's orders, secure consents from the resident's representative, and ensure proper documentation. Additionally, the DON committed to providing in-service training to staff on identifying and documenting restraints. A record review of the "Admission Record" revealed that the facility admitted Resident #38 on 04/19/19 with diagnoses including Spastic Quadriplegic Cerebral Palsy.	M 500	DON, QA Nurse or the RN Supervisor to monitor and ensure residents with postural support devices are supported with the accurate documentation required for regulatory compliance. Initial monitoring began 10/15/2024 and will be completed weekly x 4 weeks then monthly x 3 months. Audit logs were reviewed by the QA committee on 10/17/2024. The QA committee will review audit logs again on 11/6/2024 and then will be reviewed monthly x 3 months to ensure compliance is sustained.	

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M 500	Continued From page 6 A record review of the "Quarterly Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 07/24/24 revealed that Resident #38's cognitive skills for daily decision-making were severely impaired. The resident required a staff interview for cognitive status.	M 500		
M 815	45.29.1 Safe Food Handling Procedures Safe Food Handling Procedures. Food shall be prepared, held, and served according to current Mississippi State Department of Health Food Code Regulations. This Statute is not met as evidenced by: Level II Based on observation, staff interview, record review, and facility policy review, the facility failed to follow proper sanitation and food handling practices to prevent the possible outbreak of foodborne illnesses, as evidenced by a foreign object observed in the sugar bin for one (1) of four (4) kitchen observations. Findings Include: A review of the facility's policy titled "Storage of Canned and Dry Food," revised 10/17, revealed, " ...The facility ensures the quality, nutritive value, and safety of canned and dry food through accepted storage practices. Procedure: 1. Dry storage is designated for the storage of dry goods such as single-service items, canned goods, and packaged or containerized bulk food ...2. The dry storage room is a clean, dry area free from contaminants ...10. Dry food products such as flour, cornmeal, sugar, etc., are removed from	M 815	1. On 10/7/2024 Dietary Staff removed foreign object (hard crystalized object) from storage bin filled with sugar used for sweet tea the remaining sugar was emptied into the trash by Dietary Aide. The storage bin was washed, sanitized and left to air dry. The Dietary Supervisor refilled the storage bin with sugar on 10/8/2024. 2. On 10/8/2024 all Resident□s beverage preferences were reviewed by Dietary Manger (DM) and determined nineteen (19) of fifty-six (56) Residents having the potential to be affected. 3. To protect Residents from similar occurrences the (DM) in-serviced/educated six (6) of ten (10) dietary employees on inspection of dry storage bins daily and all storage bins to be cleaned and sanitized weekly as indicated on cleaning schedules on 10/7/2024. The remaining four (4)	11/8/24

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M 815	Continued From page 7 their original packaging and stored in bins. These bins are cleaned and sanitized according to the facility's cleaning schedule ..." On 10/07/24 at 10:36 AM, during an observation and interview of the dietary department, the State Agency (SA) observed what appeared to be a rock (foreign object) in the sugar bin. Dietary Staff #1 and Dietary Staff #2 confirmed during an interview that the foreign object was in the sugar bin. Dietary Staff #1 stated that she did not know how the object got into the sugar, but she explained that all staff members are responsible for checking the sugar. Dietary Staff #2 stated that she had used sugar from the second bin in the kitchen to make tea for the residents but was unsure how the object entered the sugar and emphasized that everyone who uses the dry goods should examine the products. During an interview on 10/08/24 at 2:00 PM, Dietary Staff #2 reported that she had dumped the contaminated sugar the previous day, cleaned the container, and refilled it halfway. Dietary Staff #2 also confirmed that residents could become ill from consuming food contaminated with foreign objects. During an interview on 10/08/24 at 2:55 PM, the Administrator expressed her expectations for staff to examine all food before serving it to residents. She further stated that it is the staff's responsibility to ensure that all food is sanitary and free from foreign objects for the residents, and she expects all staff members to examine dry goods. A record review revealed the facility conducted an in-service training on 03/25/24. The kitchen staff was trained to check containers of sugar, flour,	M 815	employees were in-serviced/educated on 10/9/2024 per the (DM) prior to performing duties. This in-service will be a part of the orientation process for all newly hired dietary employees. On 10/17/2024 the Quality Assurance (QA) committee reviewed policies and procedures on dry food storage with no changes recommended. 4. Audit tool will be completed by the (DM), the Quality Assurance (QA) Nurse, or the Administrator to monitor and ensure dry food storage is free from contaminants. Initial monitoring began 10/14/2024 and will be completed weekly x 4 weeks then monthly x 3 months. Audit logs were reviewed by the QA committee on 10/17/2024. The QA committee will review audit logs again on 11/6/2024 and then will be reviewed monthly x 3 months to ensure compliance is sustained.	

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M 815	Continued From page 8 and cornmeal, clean and sanitize containers, and refill them. Staff members signed to confirm their understanding and agreement.	M 815		