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
	09SR	A. BUILDING: _____ B. WING _____	C 11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEARER-RICHARDSON MEMORIAL NURSING HOMI	512 ROCKWELL DRIVE OKOLONA, MS 38860

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M 000	Initial Comments The State Agency (SA) conducted a complaint investigation (CI) MS #26980 at the facility from 11/20/21 through 11/21/24. The SA determined that the facility was not in compliance with the Minimum Standards of Operation for Institutions for the Aged or Infirm and cited M 500 for resident rights. The census at the time of the survey was 67 with a license for 73 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 nurse practitioner/physician assistant in his	M 500		12/6/24

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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 transactions made on his behalf should the

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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, and send and receive his personal mail

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M 500	Continued From page 3 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 III Based on observation, staff and resident interviews, record review, and facility policy	M 500	12/03/2024 the plan of care for Resident #1 has been updated to include; offer/assist to toilet every 30 minutes and upon request, staff to avoid keeping her waiting due to her Huntington's causing her to feel that she needs to move her	

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M 500	Continued From page 4 review, the facility failed to ensure a resident's right to be free from abuse including involuntary seclusion, verbal abuse and unreasonable confinement by staff members physically restraining a resident for one (1) of three (3) residents sampled. Resident #1. Findings include: Record review of facility policy titled, "Abuse, Neglect and Exploitation", dated 3/17/23, revealed, "It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect.., 'Abuse' means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse... Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. ... 'Verbal Abuse' means the use of oral, written or gestured communication or sounds that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability...Involuntary Seclusion refers to the separation of a resident from...his/her room...against the resident's will..." During an interview with the Administrator on 11/20/24 at 9:15 AM, it was revealed that the incident occurred on 10/30/24 around 6:00 PM and was reported by Resident #3 to the Administrator the next morning on 10/31/24. She stated after viewing the video footage and interviewing residents and staff, it was	M 500	bowels frequently. All staff to be inserviced on resident abuse with emphasis on involuntary seclusion by 12/06/2024. Allow resident to go to her room if she desires, can encourage her to stay in public areas but respect her wishes if she choose to go to her room. Upon review of the facility census it was identified that forty-two (42) of forty-three (43) residents could have possibly been affected by the stated deficient practice. On 11/04/2024 Licensed Practical Nurse #1 and Registered Nurse #1 were terminated from employment. Beginning 10/31/2024 through 11/04/2024 the Social Director interviewed 26 residents with a Brief Interview for Mental Status (BIMS) score of 8 or greater on the above identified unit to identify any concerns regarding residents rights and abuse with no negative findings reported. By 12/06/2024 all staff will be in- serviced on the facilities policy Abuse, Neglect and Exploitation with emphasis on the freedom from involuntary seclusion and any physical or chemical restraint not required to treat the resident s medical symptoms by 12/06/2024. As of 11/28/2024 75% of staff have completed the stated in-service. Any staff who has not received the in-service on or before 12/06/2024 will be removed from the schedule until the in-service is completed. Beginning 11/25/2024 and ending 12/06/2024 the Social Director will interview a total of thirty-four Residents that have been identified with a BIMS score of 8 or greater to ensure that they have not personally	

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M 500	Continued From page 5 determined that the resident was confined to her chair and made to stay in the lobby area and was not allowed to go to the bathroom by two staff members. An interview with Resident #3 on 11/20/24 at 12:25 PM, revealed she was in the lobby area when this incident occurred between Resident #1 and Registered Nurse (RN) #1 and Licensed Practical Nurse (LPN) #1. She stated Resident #1 needed to go to the bathroom and LPN #1 held her in the chair and yelled at her and told her to stay in the chair and that she was not leaving. Then, RN #1 wrapped her arms around resident from behind and held her in the chair. They yelled at her and were telling her that they were going to send her out to the hospital. Resident #1 was moving a lot and trying to get them to let her go. Resident #3 stated, "That really hurt me to see them treat her that way. I had to get out of there because I couldn't watch that." An interview with Resident #2 on 11/20/24 at 12:40 PM, revealed he also witnessed this incident in the lobby, and he reported it the next day. He stated it started when the resident told LPN #1 that she needed to go to her room to go to the bathroom, but LPN #1 told her she had just gone and not done anything, so she was not going back and to stay in her chair. The resident moved her chair towards the door several times, but LPN #1 brought her back to the lobby area each time. LPN #1 told another staff member to close the doors that led from the lobby to the hallway so Resident #1 could not leave. He stated LPN #1 took the resident's hands and held them together in front of the resident and tried to hold her arms on the resident's chest to keep her in her chair. She yelled at the resident to sit down, she was not going to her room, she was	M 500	been affected or observed the stated deficient practice. On 11/26/2024 the Administrator discussed the survey findings with the Resident Counsel attendees and reviewed the facilities policies on Resident□s Right and Abuse, Neglect and Exploitation. Beginning 11/29/2024, the Social Director will be responsible for ensuring that all new hires are educated on resident abuse within 5 days of hire as evidenced by employee signature page from the Abuse, Neglect and Exploitation policy placed in the employees personnel file, with Business Office Manager confirming compliance upon receipt of personnel file. The Quality Assurance Performance Improvement (QAPI) Committee met on 11/27/2024 and developed a Performance Improvement Plan (PIP) regarding resident abuse, reporting and the expectations of staff training. The Quality Assurance (QA) Nurse will be responsible for monitoring effectiveness of PIP beginning 11/27/2024 through the Quality Assurance Performance Improvement (QAPI) program as outlined per review of all new hire records at least one day a month for 3 months to ensure the forms are present in the personnel files. QA to be monitored weekly beginning the week of 11/27/2024 during the weekly QAPI meeting and continuing weekly through 01/31/2024. Any negative findings found will be reported to the Administrator immediately for further action(s). Results of the findings will be discussed by the QA committee including the Medical Director at the next scheduled meeting on	

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M 500	Continued From page 6 going to be sent out, and she was tired of her doing this. At that point, RN #1 came and held the resident from behind with her arms wrapped around the resident's shoulders and the resident's arms were crossed and she held her arms. The resident tried to get them to let go of her and go to the bathroom. He stated it was awful to watch, and he had never seen anything like that before with these nurses or other staff and both of these nurses seemed irritated, and the situation was out of control. An observation and interview with Resident #1 on 11/20/24 at 3:00 PM, revealed the resident sitting in her recliner in her room drinking water from her cup with jerky and uncoordinated movements. Resident #1 had a diagnosis of Huntington's disease; therefore she was extremely difficult to understand, but she continued to repeat each statement until she was understood. She stated she was in the lobby area and needed to go to the bathroom, but LPN #1 would not take her since she had just been. She attempted to propel herself to her room, but LPN #1 stopped her and pushed her back into the lobby. LPN #1 held her in the chair and yelled at her saying she was not going to her room, and she was getting sent to the hospital. Then, RN #1 held her from behind while she was sitting in her chair and would not allow her to move. She stated she had the right to go to the bathroom and to be held down was wrong and she did not like being treated that way. She denied any physical injury but stated she was emotionally bothered, and this made her angry and upset that they did this to her. She stated that the nurses sent her to the Emergency Room (ER) and she told the doctor in the ER that nothing was wrong with her that she just needed to go to the bathroom and they wouldn't allow her too. The resident confirmed that she was	M 500	12/03/2024 and at the regular scheduled meetings on the third Wednesday of each month through 02/28/2024. The Administrator will be responsible for informing the governing body of any negative findings at the meetings scheduled for the third Monday of each month beginning 12/16/2024 through 02/28/2024 The QA Nurse will be responsible for reporting any negative findings at the QA Committee meetings scheduled on the third Wednesday of the month beginning 12/18/2024 through 02/28/2024.	

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returned to the facility later that evening.

During a phone interview on 11/20/24 at 3:45 PM, LPN #1 she stated Resident #1 was in the lobby area and was taken to the bathroom by a Certified Nursing Assistant (CNA) #5 and within a few minutes, she stated she needed to go to the bathroom again. CNA #5 was with another resident, and she informed Resident #1 that it would be a few minutes and the CNA would be back to take her to the bathroom. She stated the resident tried to propel herself to her room and she told her she could not go back by herself due to the risk of a fall. She stated Resident #1 got mad and was hitting and pushing and tried to throw herself out of the chair and she did hold her in the chair to keep her safe. She stated a resident does have the right to fall but she felt that it was her responsibility to keep that from happening if she could. She stated she should not have yelled at the resident or held her when she did not want to be held, but she did this to keep her safe, not to be malicious or mean. She stated she wished the situation had been handled differently, but she just did not want her to fall. LPN #1 confirmed that she was terminated from the facility related to this incident.

A phone interview with CNA #1 on 11/20/24 at 4:05 PM, revealed she came up on the situation and the resident was yelling that she had to go to the bathroom and RN #1 was holding her from behind. CNA #1 did not witness the resident hitting or kicking but said it appeared to her that she was trying to free herself from being held. She stated she was shocked to see this and did not know what to think about it.

During a phone interview with RN #2 on 11/20/24 at 4:15 PM, it was revealed that she and RN #1

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were having shift report in the office, and they heard a big commotion and yelling so they went out to see what was happening. She stated LPN #1 said the resident was kicking and hitting and she needed help to hold her in her chair, so RN #1 put her arms around her from behind her to keep her from falling from the chair. She heard LPN #1 yelling at the resident that they were going to send her out and to sit down or you are going to fall. She felt they were trying to keep her safe and she did not think they meant for things to be that loud and out of control.

A phone interview with CNA #2 on 11/20/24 at 4:45 PM revealed she had come into the lobby area and the lobby doors were closed and she heard the resident yelling that she needed to go to the bathroom and LPN #1 told her that she had just been to the bathroom and did not need to go again. She stated LPN #1 also cussed and yelled at the resident to calm down and she was not going to put up with this sh**t and that she was being sent out. CNA #2 observed that the resident was not combative but appeared to be trying to get loose from being held. She stated RN #1 was behind the resident and had her arms wrapped around her shoulders. She stated a CNA #3 came up and was holding her hands and talking calmly to the resident and the resident calmed down and RN #1 released her hold. She stated she had never seen anything like that, and the resident did not deserve for her caregivers to treat her that way in her home.

During a phone interview on 11/21/24 at 9:45 AM, CNA #3 revealed the lobby doors were closed and when she walked through, she saw RN #1 holding the resident like a bear hug from behind and RN #1 said the resident had been hitting and kicking. RN #1 asked her to hold the resident's

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hands so she gently placed her hands over the resident's hands, and talked calmly to her and she calmed down and RN #1 released her hold on her. She stated the ambulance came and she was taken to the hospital.

A phone interview with RN #1 on 11/21/24 at 10:00 AM revealed on the evening of the incident, she and the day nurse were in the office for shift change report and they heard a commotion and yelling in the lobby area. She and the day shift nurse went into the lobby area and heard LPN #1 and Resident #1 yelling loudly and LPN #1 told Resident #1 that she needed to calm down and she was going to be sent out to the hospital. LPN #1 told her the resident had been hitting and slapping all day and she asked her to help hold her in the chair so she would not fall out while she did the paperwork for the hospital transfer. She held her from behind around her shoulders like a bear hug to keep her from falling out of the chair and the resident tried to get loose. She stated the resident had a history of fighting and attacking staff and had been to the emergency room before for this. The resident told her she needed to go to the bathroom to poop but LPN #1 said she had already been and did not do anything. CNA #3 came and held her hands and talked to her and she calmed down and she stated she released the bear hug hold on her. The ambulance arrived and she was assisted onto the gurney and was taken to the hospital. She stated with the information she had received, her first concern was to keep this resident and others safe. She stated she made a judgement call based on the information she had received and in hindsight, the situation should have been handled differently and she should not have held her in her chair. She stated when she was in the situation, all she could think of was what to do to prevent a harmful

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fall. RN#1 confirmed that she resigned from the facility, prior to the facility terminating her.

A phone interview with CNA #4 on 11/21/24 at 10:08 AM, revealed that she and CNA #1 came into the lobby and heard the commotion. RN #1 was holding the resident from behind and CNA #3 walked over to talk to the resident. She stated RN #1 and LPN #1 were screaming to "sit down" and "you're not going anywhere." The resident yelled out and tried to get loose, but she did not see the resident kick or hit. As the resident calmed down and got quiet, she said she "just needed to go to the bathroom". The ambulance arrived and she was taken to the hospital.

An interview with RN #3 on 11/21/24 at 10:20 AM, revealed she had worked day shift and Resident #1 was agitated. After she ate her dinner in the dining room, she was taken to the lobby area. She stated LPN #1 was trying to calm her down and stated to the resident, "We're not doing this" and that she is "Going to send her out". She stated she did not see the part of the incident where the resident was being held, but she knew the nurses and she did not believe they meant to cause her harm.

Interview with CNA #5 on 11/21/24 at 3:45 PM revealed this was a hard situation to witness. She stated the resident was held in her chair by RN #1 and LPN #1 was cussing and yelling and telling her they were going to send her out to the hospital. She stated the resident was not fighting but was trying to get out of their grip. She stated it seemed like the nurses were frustrated and it turned into a bad situation.

During an interview on 11/21/24 at 11:40 AM, the Director of Nursing (DON) stated they were

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notified of the incident by a resident the day after it occurred. She stated they watched the video and interviewed staff and residents. Resident #1 was cognitive and had the right to go where she wanted to go and no one would want a resident to fall, but a resident has that right. She stated Resident #1 was physically restrained and was kept from going where she wanted to go and doing what she wanted to do, therefore her rights were violated. She stated this incident was troubling to watch on the video and in the time frame they kept her from doing what she chose, the staff could have taken her to the bathroom. She confirmed the resident was verbally abused and was secluded to remain in the chair and was held in the chair by a staff member to prevent her from going to the bathroom.

During an interview on 11/21/24 at 1:45 PM, the Administrator confirmed the resident was cognitive and had the right to make decisions on what she wanted to do and the resident was upset and angry that the staff confined her and kept her from going to the bathroom. She confirmed this violated her rights and that physical restraining of a resident is part of abuse and involuntary seclusion.

On observation of the video with the Administrator on 11/20/24 at 1:40 PM, revealed on 10/30/24 at 6:01 PM, the resident was brought into the lobby. LPN #1 spoke to the resident at approximately 6:03 PM, then redirected her to the lobby in front of the TV at approximately 6:04 and 6:05 PM. At approximately 6:06 PM, a CNA took the resident to the restroom just outside the lobby area and returned to the lobby at approximately 6:14 PM. At approximately 6:20 PM, LPN #1 approached resident again and spoke to her and then about 6:21 LPN #1 redirected her back to the same

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09SR	A. BUILDING: _____ B. WING _____	C 11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEARER-RICHARDSON MEMORIAL NURSING HOMI	512 ROCKWELL DRIVE OKOLONA, MS 38860

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area. At approximately 6:22 PM, Resident #1 began to roll herself backwards and LPN #1 approached and rolled her beside the exit area to B hall and the double doors were closed and LPN #1 appeared to speak with resident and touched her to keep her in place in her chair. At approximately 6:25 PM, RN #1 approached LPN #1 and resident and it appeared they talked and then RN #1 began to hold resident from behind. At 6:30 PM, while RN #1 was still holding resident, CNA #3 approached the resident and appeared to be speaking to the resident, RN #1, or both. At approximately 6:32 PM CNA #3 appeared to lay her hands over the top of Resident's hands and RN #1 released the resident. At approximately 6:33 PM, Emergency Medical Technicians arrived, and the resident was taken to the hospital by ambulance.

The video verified the resident was not allowed to leave the lobby area by LPN #1 and then was held in her chair for almost eight (8) minutes by RN #1 and was not allowed to move from the area. The video verified what the witnesses had stated during their interviews to the State Agency (SA). The video did not have audio but from all the interviews and from the mannerisms of the staff in question it was determined there was yelling in part of this incident captured on the video footage.

Record review of ER notes dated 10/30/24 revealed, " ...presents to the Emergency Department (ED) from the nursing facility due to aggression. Patient is alert and oriented times (x) 4 and states that she just wanted to go to the bathroom, and no one helped her."

Record review of Resident #1's "Admission Record" revealed the facility admitted the resident

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M 500	Continued From page 13 on 1/7/21 with diagnoses that included Huntington's Disease. Record review of Resident #1's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 10/29/24 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 12 which indicated the resident had moderate cognitive impairment. Record review of Resident #2's "Admission Record" revealed the facility admitted the resident on 5/28/21. Record review of Resident #2's MDS with ARD of 11/8/24 revealed the resident had a BIMS score of 15 which indicated the resident was cognitively intact. Record review of Resident #3's "Admission Record" revealed the facility admitted the resident on 12/28/20. Record review of Resident #3's MDS with ARD of 9/24/24 revealed the resident had a BIMS score of 15 which indicated the resident was cognitively intact.	M 500		