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
	27BN	A. BUILDING: _____ B. WING _____	C 12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUMPHREYS CO NURSING CENTER	500 CCC ROAD BELZONI, MS 39038

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M 000	Initial Comments The State Agency (SA) conducted an annual recertification survey and complaint investigation (CI) MS #25847 at the facility from 12/10/24 through 12/12//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 M610, M620 and M1570. The SA found the facility to not be in compliance related to CI MS #25847 and cited M500 related to resident rights and M610 related to activities of daily living. Census at the time of the survey was 45 and the facility held a license for 60 residents.	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	M 500		1/10/25

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M 500	Continued From page 1 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, 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	M 500		

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M 500	Continued From page 3 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	Resident #30 was informed of his right to purchase a recliner chair on 12/12/2024	

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M 500	Continued From page 4 Based on observation, resident and staff interviews, record review, and facility policy review, the facility failed to honor a resident's rights for one (1) of 24 sampled residents. Resident #30. Findings include: Record review of the facility policy titled "Resident's Rights Policy" with a revision date of 12/23, revealed, "Every resident in this facility has the right to: ... 8. Receive a prompt response to all responsible requests and inquiries. ... 21. Have his/her own clothing and possessions as space allows. An interview and observation on 12/10/24 at 12:00 PM with Resident #30 revealed he was sitting upright in his wheelchair and stated that he had requested to purchase a recliner for his room. He revealed that the staff told him he could not get one because he could fall out of it. He stated that it just made no sense to him. He admitted that the staff usually put him to bed after lunch, and he usually stays there until the next day. He said that he would rather sit in a recliner rather than sit in his wheelchair all day or be in bed so long. During an interview and observation on 12/11/24 at 9:45 AM, revealed Resident #30 sitting upright in his wheelchair in his room. He admitted that he had a fall in the past and the staff told him they were afraid he would fall out of the recliner, but he is aware that he cannot walk alone or get up without a staff member. He stated, "I wanted the recliner so I could recline it back, relax in my room, and enjoy watching TV and resting instead of being in a wheelchair all day. "	M 500	by Social Services Director. The ordering was in process. An In-service on Resident Rights Policy was performed by Administrator with Director of Nursing, Social Services, Therapy, and Administrative Assistant in attendance on 12/12/2024. This deficient practice has the potential to affect forty-five out of forty-five residents. The Director of Nursing initiated an in-service with all employees on 12/13/2024 on the Resident Rights Policy. This in-service on Resident Rights will be continued thereafter upon hire, annually, and as needed with all employees. The Social Services Director will begin on 12/23/2024 monitor the compliance of Resident Rights Policy by monitoring Grievance Reports, monthly Resident Council Reports, and interviewing three residents once a week for four weeks, then two residents once a week for four weeks, and then one resident once a week for four weeks. Results of these audits will be reported to the facility quality assurance committee. A Quality Assurance Committee Meeting was conducted on 12/12/2024 with the Administrator, Director of Nursing Infection Preventionist, Medical Director, Accounts Manager, Medical Records, Social Services Director, Assessment Nurse, Nurse Case Manager, Therapy Director and the Housekeeping Supervisor. A follow-up Quality Assurance Committee Meeting will be conducted again on 1/9/2025 and then monthly for two months and then quarterly thereafter. Administrator will report any recuring	

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M 500	Continued From page 5 In an interview on 12/11/24 at 11:25 AM, Licensed Practical Nurse (LPN) #1 revealed she was aware that the resident had requested a recliner for his room, but the Director of Nurses (DON) said it was a safety issue since he could slide out of his chair, and they told the residents wife that he could not have the recliner because it was a safety issue. During an interview on 12/11/24 at 1:40 PM, the Rehab Director revealed she was unaware that the resident had requested a personal recliner for his room and since he wasn't on her caseload she hadn't evaluated him. She revealed she does not feel like it would be a safety issue for the resident, as he doesn't try to get up without assistance from his wheelchair. She revealed that the resident pretty much stays in his wheelchair all day long and stated that she "understands him wanting a recliner to rest in at times." During an interview on 12/11/24 at 1:50 PM, the Human Resources staff member revealed she was aware that Resident #30 had requested a recliner for his room; she said she was going to order him one from the furniture store but had to have approval first. She revealed the DON told her not to order it. During an interview on 12/11/24 at 2:00 PM, the DON confirmed that Resident #30 did request a recliner for his room but that she did not think it would be safe because he has had seizures, and his trunk control is lacking. She stated that she based her decision to refuse him the recliner on her "just knowing him". She confirmed that she did not do an assessment on the resident nor confer with therapy services regarding the resident's request. She admits that it is the	M 500	problem to the monthly meetings of the Quality Assurance Committee. The Administrator will take necessary corrective action as necessary to ensure compliance is resolved and the Quality Assurance Committee is in agreement with compliance.	

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M 500	Continued From page 6 resident's right to be evaluated for his request to have a recliner. She confirmed that the resident had a Brief Interview for Mental Status (BIMS) score of 15, which indicated that he could make his own decisions. She revealed the resident does sit up in his wheelchair all day and stated that she would rather he lay down in his bed sometimes so he can use his positioning bars to help him turn from side to side, but he doesn't want to do that. She confirmed that she failed to honor his rights by properly evaluating his needs and honoring his request. Record review of Resident #30's "Admission Record" revealed the facility admitted the resident on 4/18/2017 with medical diagnoses that included Hemiplegia and Hemiparesis following Nontraumatic Subarachnoid Hemorrhage affecting Left Non-Dominant Side, and Epilepsy, Unspecified, Not Intractable, without Status Epilepticus. Record review of Resident #30's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 10/31/24 revealed a BIMS score of 15 which indicated the resident was cognitively intact.	M 500		
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; 2. Transfer and ambulate;	M 610		1/10/25

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M 610	Continued From page 7 3. Good nutrition, personal and oral hygiene; and 4. Toileting. This Statute is not met as evidenced by: Level II Based on observation, resident and staff interviews, record reviews and facility policy reviews, the facility failed to provide personal hygiene as evidenced by long, jagged nails with brown substance underneath nails for two (2) of 24 sampled residents. Resident #8 and #30. Findings include: Record review of facility policy titled, "Nail Care", with a revision date of 07/10, revealed, "Purpose ...To promote cleanliness, safety and a neat appearance.." Resident #8 On 12/10/24 at 9:34 AM, observation revealed a left-hand contracture with long nails meeting the inner palm. The right-hand revealed long nails measuring approximately (3/8) three-eighths inches in length with a thick, black substance underneath the nails. On 12/11/24 at 9:36 AM, an observation and interview with the Director of Nursing (DON) confirmed Resident #8 had long dirty nails. She revealed the nurses were responsible for cutting his nails because he was a diabetic. She revealed long nails, and the hand contracture could result in a wound inside the palm, or the resident could scratch himself and cause infection. Record review of Minimum Data Set (MDS) with an Assessment Reference Date (ARD) date of	M 610	Resident #30 had his fingernails trimmed on 12/30/2024. An assessment was performed on 12/30/2024 on resident #30 and found no adverse reactions to the deficiency of not trimming nails. Resident #8 had his fingernails trimmed on 12/11/2024. An assessment was performed on 12/11/2024 on resident #8 and found no adverse reactions to the deficiency of not trimming nails. An order for diabetic nail care has been added to the treatment administration record to be done once a week by a licensed nurse on resident # 8. This deficient practice has the potential to affect forty-five out of forty-five residents. The Director of Nursing will initiate an in-service on 12/12/2024 with all nursing staff on Nail Care Activities of Daily Living Policy & Procedure. The Director of Nursing or Certified Nursing Assistant Class Instructor will perform Nursing and CNA Skills Check Offs with return care demonstration on all direct care Certified Nursing Assistant, Licensed Practical Nurse, & Registered Nurse beginning on 12/13/2024. The Director of Nursing or CNA Class Instructor will monitor the compliance of Activities of Daily Living Compliance Protocols and observe resident care beginning 12/23/2024. The monitoring and observation schedule will be as follows: Seven residents once a week for four weeks, then five residents once a	

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M 610	Continued From page 8 11/13/24 revealed, under section GG, Resident #8 was dependent on staff for personal hygiene. Record review of the "Admission Record" revealed the facility admitted Resident #8 on 3/01/18 with a medical diagnosis that included Hemiplegia and Hemiparesis following Cerebral Infarction. Resident #30 On 12/10/24 at 12:05 PM, an interview and observation with Resident #30 revealed the resident's left hand was contracted. Resident #30 stated that he really needed his nails cut and particularly on his left hand. He revealed that during the day he can keep his hands relaxed but when he goes to sleep it cramps, and his fingernails dig into his palm. The fingernails on the right hand were approximately (approx.) one-half (1/2) inch long with a brown substance noted underneath the nails. Resident #30 was able to extend open the contracted left hand which revealed his fingernails were approximately three fourths (3/4) of an inch long and jagged with a brown substance under the nails. On 12/11/24 at 8:25 AM, an observation revealed Resident #30's fingernails remain unchanged. An interview and observation on 12/11/24 at 11:16 AM, Certified Nurse Aide (CNA) #1 confirmed that Resident #30's fingernails were long and jagged with a brown substance under them, and needed to be cleaned and trimmed. She stated that the CNAs do fingernail care on shower days, but we only do Resident #30's fingernails on one hand. She revealed that the CNAs don't do the fingernails on the stroke hand, the nurses do that hand.	M 610	week for four weeks, and then three residents once a week for four weeks. Results of these audits will be reported to the facility quality assurance committee. A Quality Assurance Committee Meeting was conducted on 12/12/2024 with the Administrator, Director of Nursing Infection Preventionist, Medical Director, Accounts Manager, Medical Records, Social Services Director, Assessment Nurse, Nurse Case Manager, Therapy Director and the Housekeeping Supervisor. A follow-up Quality Assurance Committee Meeting will be conducted again on 1/9/2025 and then monthly for two months and then quarterly thereafter. Administrator will report any recurring problem to the monthly meetings of the Quality Assurance Committee. The Administrator will take necessary corrective action as necessary to ensure compliance is resolved and the Quality Assurance Committee is in agreement with compliance.	

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M 610	Continued From page 9 During an interview and observation on 12/11/24 at 11:25 AM, Licensed Practical Nurse (LPN) #1 confirmed that the residents' nails were long and jagged with a dirty substance under them. She revealed that with them being long and dirty the resident could scratch himself and cause an infection and that the longer fingernails on the left contracted hand could cause a pressure area to develop. She revealed the weekend supervisor usually cuts and cleans Resident #30's fingernails, but his wife has also come in before and cleaned and cut them. Record review of Resident #30's "Admission Record" revealed the facility admitted the resident on 4/18/2017 with medical diagnoses that included Hemiplegia and Hemiparesis following Nontraumatic Subarachnoid Hemorrhage affecting Left Non-Dominant Side, and Epilepsy, Unspecified, not Intractable, without Status Epilepticus. Record review of Resident #30's MDS with an ARD of 10/31/24, revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact.	M 610		