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
	51JA	A. BUILDING: _____ B. WING _____	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
J G ALEXANDER NURSING CENTER	25112 HIGHWAY 15 UNION, MS 39365

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M 000	Initial Comments The State Agency (SA) conducted an annual recertification survey and Complaint Investigation (CI), MS #26987, at the facility from 01/27/25 through 01/30/25. The SA investigated CI MS #26987 for resident abuse, quality of treatment, and restraints related to a fracture of unknown origin. There were no citations related to the complaint investigation. 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, M645 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	M 500		2/22/25

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M 500	Continued From page 1 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; 6. may manage his personal financial affairs, or is	M 500		

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M 500	Continued From page 2 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 with persons of his choice, may join with other residents or individuals within or outside of the	M 500		

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M 500	Continued From page 3 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 Based on observations, interviews, record reviews, and the facility policy review, the facility failed to honor residents' rights and dignity by not	M 500	1) a. On 01/29/2025, facility Ward Clerk removed all signage related-to resident care for Resident #5, Resident #39, and	

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M 500	Continued From page 4 honoring requests for a second bed rail as an enabler and by posting signs at the head of the bed related to resident care for three (3) of 16 sampled residents: Resident #5, Resident #39, and Resident #54. Findings include: A review of the facility's "Resident Rights Policy" revised in 09/2022 revealed, "... Facility will ensure the resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. Facility will treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance and enhancement of their quality of life, recognizing each resident's individuality. The facility will protect and promote the rights of each resident ..." Resident #5 On 01/28/25 at 10:51 AM, Resident #5 requested to speak with the State Agency (SA). During the interview and observation, the resident explained that she had only one bed rail on the right side but had requested another on the left. She was told that the state removed bed rails. Resident #5 stated she needed both rails to assist with turning and to feel safer at night following an elective hip replacement. The SA observed one half-bed rail on the right side of the bed. The resident explained that she used a recliner on the left side to assist with turning, which was unsafe, and she feared rolling out of bed. On 01/28/25 at 01:25 PM, during an interview, Certified Nurse Aide (CNA) #2 stated that Resident #5 had repeatedly requested an	M 500	Resident #54. (Exhibit 550A) b. On 01/28/2025, facility Physical Plant Manager installed bed rails for Resident #5, Resident #39, and Resident #54. (Exhibit 550B) 2) All facility residents have potential to be affected by the same deficient practice. 3) a. On 2/3/2025, Quality Assurance (QA) revised policy/procedure(s) related to ensuring improper signage remains unposted from resident rooms and ensuring all residents who prefer bed rails have access to the same. (See Exhibit 550C) b. On 1/31/25, facility Staff Development Coordinator conducted an all-staff quarterly in-service related-to ensuring improper signage remains unposted in resident rooms and ensuring all residents who prefer bed rails have access to the same. (See Exhibit 550D) 4) a. On 01/30/2025, facility Resident Services Coordinator began completing Resident Bed Rail Preferences Form for all residents, to be conducted on admission and quarterly thereafter in order to ensure that all residents who prefer bed rails receive the same. (See Exhibit 550E) b. On 1/30/2025, Director of Nurses (DON) began completing monthly Resident Room Audits to ensure that zero improper signage related-to resident care is posted in resident rooms. (See Exhibit 550F) c. Beginning no later than 2/21/2025 Quality Assurance (QA) will meet and	

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M 500	Continued From page 5 additional bed rail, as had other residents. The management was notified, but residents and staff were informed that only one bed rail was allowed. CNA #2 confirmed that Resident #5 used the existing bed rail for turning and getting out of bed. After her hip surgery, Resident #5 required a stand-up lift and had difficulty moving in bed with only one bed rail. On 01/28/25 at 03:40 PM, Licensed Practical Nurse (LPN) #1 confirmed that Resident #5 had only one bed rail, similar to most residents. According to LPN #1, upper management instructed staff that no resident could have two bed rails due to SA regulations. Resident #5 struggled to get out of bed post-hip replacement and continued to request two bed rails but was denied. On 01/29/25 at 04:10 PM, during an observation of Resident #5's transfer from a wheelchair to bed with the Therapy Director and CNA #3, staff used a stand-up lift. The resident demonstrated upper body strength while using the lift. Positioned on the left side of the bed, Resident #5 stated that an additional bed rail would assist with transfers. The Therapy Director confirmed that Resident #5 had requested another bed rail but was denied. A review of Resident #5's "Admission Record" indicated admission on 12/05/22 with diagnoses including Other Chronic Pain and Presence of Neurostimulator. A review of Resident #5's "Annual Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 11/15/24 indicated a Brief Interview for Mental Status (BIMS) score of 12, signifying intact cognition. Section GG showed no upper extremity impairment, and the resident required	M 500	receive the data related to all pertinent audit(s) and in-services on a monthly basis for at least three months, and determine pertinent corrective measures as well as the continued frequency of relevant audit(s) and in-services based upon findings and results achieved.	

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M 500	Continued From page 6 supervision or touch assistance with transfers. A review of Resident #5's "Bedrails Consent" signed by her daughter on 08/01/24 did not specify the use of only one bedrail. The consent form had "Yes" checked under the question, "Do you choose to use bedrails on your bed while in the facility?" Resident #54 On 01/27/25 at 01:41 PM, during an observation and interview, the SA observed Resident #54 in bed with one bed rail up. The resident asked why he did not have four bed rails like he had in the hospital. On 01/28/25 at 02:50 PM, Registered Nurse (RN) #5 explained that the facility only allowed one bed rail unless deemed necessary. Resident #54 had only had one side rail since admission, and no residents were allowed four bed rails. On 01/28/25 at 03:00 PM, during an interview, Resident #54 stated he had been at the facility for nearly a year and had requested another bed rail to assist with turning. He was informed that only one was allowed. The resident denied upper arm weakness and continued to request a second bed rail for assistance. On 01/29/25 at 03:30 PM, during an interview, the Director of Nursing (DON) stated that the facility limited bed rails to one per resident for safety reasons but lacked documentation supporting this decision. She was unaware of requests from Resident #5 or Resident #54 and confirmed that alternative positioning aids had not been considered.	M 500		

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M 500	Continued From page 7 A review of Resident #54's "Admission Record" indicated admission on 02/21/24 with diagnoses including Osteomyelitis of the Vertebra and Rheumatoid Arthritis. A review of Resident #54's Quarterly MDS with an ARD of 11/28/24 revealed a BIMS score of 14, indicating intact cognition. Section GG indicated no extremity impairments and the resident required supervision or touch assistance with transfers. A review of Resident #54's "Bedrails Consent" dated 02/21/24 did not specify the use of only one bedrail. The form had "Yes" checked under the question, "Do you choose to use bedrails on your bed while in the facility?" Resident #39 On 01/27/25 at 11:30 AM, the SA observed Resident #39 in bed with signage posted at the head of the bed, including: "Enhanced barrier," "Oral care," "Turning schedule - keep heels floated," and "Keep head of bed up at all times." A proper name was included on the signs. On 01/28/25 at 03:00 PM, CNA #5 confirmed that the signage had been in place for an extended period and contained resident care instructions. On 01/29/25 at 02:20 PM, the Administrator and DON confirmed that signage related to personal care should not be displayed on walls, as it violated Resident #39's dignity. The DON stated she was unaware of the postings and confirmed the signs would be removed. Both the Administrator and DON stated they expected all staff to honor residents' rights and avoid posting personal care instructions publicly.	M 500		

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M 500	Continued From page 8 On 01/29/25 at 03:20 PM, RN #2 confirmed that one of the names on the signage belonged to a former staff member and acknowledged that resident care instructions should not be posted on the wall. She identified the postings as a dignity issue.	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 observations, interviews, and facility policy review, the facility failed to label and date food stored in the refrigerator and freezer and failed to dispose of expired food for one (1) of four (4) days of kitchen observations. Findings include: A review of the facility ' s "Food Storage Labeling" policy, revised on 10/23, revealed: "...8.a.i. Identify the food item's use-by date or expiration date ... iv. Food in storage units will be surveyed routinely to identify and discard foods that have passed their manufacturer use-by or expiration date ... 2. Refrigerator storage weekly ...." On 01/27/25 at 11:14 AM, during an initial tour with the Dietary Manager (DM), the following observations were made: In Refrigerator #1, one (1) package of sliced ham was opened and	M 815	1) On 1/27/25, Dietary Manager disposed-of the package of sliced ham, bag of bacon bits, the package of sliced roast beef, the unopened packages of sliced roast beef, the bag of shredded cheddar cheese, the fire-braised pork loin, the bag of frozen biscuits, the bag of frozen chicken patties, the package of hamburger patties, the pecan pie, the lemon juice, and properly mopped and cleaned the spilled orange juice. (See Exhibit 812A) 2) All residents have the potential to be affected by the same deficient practice. 3) a. On 1/27/25, the Contracted Certified Dietary Manager made observation of all food items in the dry food storage area, and ensured that all of it was properly labeled, dated, and disposed-of, where	2/22/25

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M 815	Continued From page 9 unlabeled, and a spill of orange juice was observed on the bottom of the refrigerator. In Refrigerator #3, one (1) bag of bacon bits was opened and unlabeled, and (1) package of sliced roast beef with a use-by date of 09/12/24, received on 10/06/24, was opened. Additionally, three (3) unopened packs of sliced roast beef had a use-by or freeze-by date of 11/10/24. A five (5)-lb bag of shredded cheddar cheese was opened and unlabeled. Also, a thawed, unopened fire-braised pork loin with a use-by or freeze-by date of 08/23/24, received on 12/12/24, was observed. The DM confirmed these items were expired and collected them for disposal. In Freezer #1, one (1) bag of frozen biscuits was open and unlabeled. In Freezer #2, one (1) bag of frozen chicken patties and (1) package of hamburger patties was open and unlabeled. A 10-inch pecan pie with an expiration date of 01/24/25 was also observed. In the dry storage room, (1) 48-oz container of Real Lemon Juice was observed opened on 01/05/24 but not stored in the refrigerator, despite manufacturer instructions to refrigerate after opening. On 01/27/25 at 11:20 AM, the DM confirmed the presence of expired and improperly stored food items and collected them for disposal. On 01/30/25 at 11:10 AM, during an interview, the Certified Dietary Manager (CDM) and Registered Dietitian (RD) stated that their expectations for kitchen staff include completing education and training for their positions, following federal guidelines, and adhering to food labeling and handling policies to prevent foodborne illness among residents. On 01/30/25 at 02:00 PM, during an interview, the Administrator revealed that he was aware that	M 815	appropriate. (See Exhibit 812B) b. On 2/3/25, the contracted Certified Dietary Manager conducted monthly in-service training for all dietary staff related-to proper labeling, dating, and disposal of all food items in the dry food storage area. (See Exhibit 812C) 4) a. The Contracted Certified Dietary Manger assigned to the Dietary Manager a weekly audit for three months related-to proper foodservice Label, Date, Dispose, and Cleaning in order to ensure that zero food items are stored in the dry food storage area unless they are properly labeled, dated, and/or disposed-of, and that the floors remain clean. (See Exhibit 812D). b. Beginning no later than 2/21/2025 Quality Assurance (QA) will meet and receive the data related to all pertinent audit(s) and in-services on a monthly basis for at least three months, and determine pertinent corrective measures as well as the continued frequency of relevant audit(s) and in-services based upon findings and results achieved.	

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M 815	Continued From page 10 some items had been out of date but had since been discarded. He explained that the facility added a kitchen in April 2024 because the previous contract with the local hospital's kitchen to service residents ended in May 2024. The Administrator stated there is now a completely different kitchen staff and that he believes the staff is competent. He also noted that the facility changed food providers in November 2024, which may have contributed to expired foods being delivered to the facility.	M 815		