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
	02AC	A. BUILDING: _____ B. WING _____	C 01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MS CARE CENTER OF ALCORN COUNTY, INC-SNF	3701 JOANNE DRIVE CORINTH, MS 38834

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M 000	Initial Comments The State Agency (SA) conducted an annual re-certification survey with one (1) complaint investigation (CI) MS # 27465, at the facility from 1/28/25 through 1/30/25. During the survey, the SA determined the facility was not in compliance with the requirements of the Mississippi Regulations for Minimum Standards for Institutions for the Aged or Infirm. The SA identified non-compliance and cited M 500 for CI MS #27465 related to Abuse and Neglect. The SA also cited M 815 and M 955. The census at the time of the survey was 90 and the facility is licensed for 119 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	M 500		2/24/25

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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 III	M 500	1. Resident A was assessed for pain by the medication nurse, Licensed Practical	

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M 500	Continued From page 4 Based on record reviews, staff interviews and facility policy review, the facility failed to ensure a resident's right to be free from abuse and neglect as required for one (1) of 20 residents reviewed. Resident A. Findings Include: Review of facility policy " Freedom from Abuse, Neglect and Exploitation" revised October 2022 revealed "Policy Statement: All residents of this facility have the right to be free from neglect...Residents must not be subject to abuse by anyone...Practices of omitting part of resident care or neglecting resident and misappropriation of property is to be considered as leading to abuse and should be investigated and treated as abuse." A record review of the "Grievance/Complaint Report" documented by Social Services on 10/22/24 revealed that Resident A reported that staff was rude to him and refused to give him his medications, stating it was "bad for him" and that he "did not need it." He further reported that staff threw his call light on the floor, refused to assist him onto the bedside commode, and that he was scared. A record review of the "Record of Complaint" documented by the Director of Nursing (DON) on 10/21/24 indicated that Resident A's responsible party stated that the night shift nurse was rude and hateful. The resident expressed a desire to discharge home, stating he felt unsafe and was not receiving proper care at night. The investigation found that the resident's pain was left untreated, and staff interviews revealed examples of misconduct toward resident by the nurse. The immediate corrective actions at the	M 500	Nurse with a pain score of "2" on 10/21/24 at 9:58 am. Licensed Practical Nurse #3 was terminated on 10/23/24 at 10:00 am by Director of Nursing for improper conduct after investigation. License Practical Nurse #3 was not allowed to work in facility during investigation. Abuse report for resident A was submitted untimely to the State Agency by the Administrator on 1/30/25 at 2:57 p.m. Was reported to the Mississippi Attorney General on 1/30/25 at 3:13 p.m. by the Administrator, and reported to the MS Board of Nursing on 1/30/25 by the Director of Nursing 2. All residents who receive pain medication and has a less than adequate nurse have the potential to be affected by this situation. 3. a. All nurse staff were in-service on 2/11/25 on Pain Assessment and Management Policy by Staff Development Nurse. b. Attorney General investigator in-service all staff on 2/16/25 on Abuse. c. Resident's Right Policy was reviewed by Administrator on 2/18/25 and no revisions were necessary. d. All staff was inserviced on What is Abuse (Hand-in-Hand) Module 2 on 2/6/25 by Staff Development Nurse e. Employee Questionaire Related to Recent Survey Corrections is being done for 9 employees per day beginning on 2/14/25 and then weekly X1 month to ensure nursing staff knows what to do if a resident complains of pain by Director of Nursing and reported to Quality	

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M 500	Continued From page 5 time of the incident included the termination of the night shift nurse, relocating the resident to a different hall per his request, and in-servicing staff on professional conduct, abuse, and neglect. A record review of the "Witness Statement" documented by the Physical Therapy Assistant (PTA) on 10/21/24 revealed that Resident A stated he wanted to leave the facility. The resident became emotional and expressed fear, stating he had no defense and could not protect himself. He also reported that no one answered his call light, that staff threw it on the floor, and when he asked for it back, they refused, telling him he did not need it. During an interview with the PTA on 1/29/25 at 9:25 AM, she confirmed that her statement accurately reflected what Resident A had reported to her on 10/21/24. A record review of a "Witness Statement" documented by Licensed Practical Nurse (LPN) #2 on 10/22/24 revealed that she heard LPN #3 yelling, "Shut up!" down the hall on 10/19/24 while Resident A was calling for help. She also stated that LPN #3 said she was not going to give Resident A anything for pain because he could not have a bowel movement. During an interview and record review of the "Grievance/Complaint Report," "Record of Complaint," and "Witness Statements" on 1/29/25 at 9:28 AM, the Social Services/Grievance Official agreed that Resident A's complaint constituted an allegation of abuse and neglect. In an interview with the DON on 1/29/25 at 10:05 AM, she stated that when she arrived at work on 10/21/24, she was reviewing nursing notes and	M 500	Assurance. Exhibit #3 4.a. All residents with pain will have Comprehensive Care Plan for Pain Audit performed to ensure they are currently receiving their pain med timely when requested. Comprehensive Care Plan for Pain Audit will be done on 15 residents by chart audit and verbal resident interviews beginning on 2/14/25 then weekly X 2 weeks, then monthly X 2 months, then quarterly by Director of Nursing and submitted to Quality Assurance committee. Exhibit #7 b. The Quality Assessment and Assurance Committee will meet on 2/21/25 then monthly X 3 months to review findings and make recommendations and changes as needed to ensure continued compliance.	

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M 500	Continued From page 6	M 500		

found documentation by LPN #3 that Resident A had yelled that he had requested pain medication over an hour ago. The DON further stated that, while in the Assistant Director of Nursing's (ADON) office, the resident's son reported that the previous evening, the resident had requested pain medication, but the nurse told him he did not need it due to stomach issues. The DON later spoke with the resident in the therapy department, where he confirmed he had not received his pain medication the previous night and expressed fear of LPN #3 due to her loud and rude behavior. The DON stated that during her investigation, she received reports from LPN #2 that LPN #3 had been loud and cursing in the hallway. When she interviewed LPN #3, the nurse admitted to withholding the pain medication because the resident was constipated. The DON informed her that this was not a valid reason to deny medication. The nurse was subsequently terminated. However, the DON stated she could not substantiate the allegations that staff had taken or ignored the resident's call light and that after review of the camera footage at that time you could see a CNA going in and answering his call light that night. The DON agreed that this incident was an allegation of abuse and neglect.

In an interview at 10:12 AM on 1/29/25 with the Administrator he confirmed that the "Grievance Investigation" was an allegation of abuse.

A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/22/24 revealed that Resident A had a Brief Interview for Mental Status (BIMS) score of 15, indicating that he was cognitively intact.

A record review of the Admission Record revealed that Resident A was admitted to the

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M 500	Continued From page 7 facility on 10/1/24 with diagnoses including Left-sided Maxillary Fracture, Left-sided Fracture of the Medial Orbital Wall, Multiple Left-sided Rib fractures, other Physical Fracture of the Lower End of the Radius, and Unspecified Pain. Resident A was discharged home on 10/26/24.	M 500		