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
	24DW	A. BUILDING: _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PASS CHRISTIAN HEALTH AND REHABILIATION CEN	538 MENGE AVENUE PASS CHRISTIAN, MS 39571

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M 000	Initial Comments The State Agency (SA) conducted a Complaint Investigation (CI), MS #28011, at the facility on 3/6/25. CI MS #28011 was investigated for neglect, resident safety, and unwitnessed falls. 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. The facility remains out of compliance from a previous complaint survey conducted from 2/5/25 through 2/7/25.	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	M 500		3/21/25

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M 500	Continued From page 1 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 given at least a quarterly accounting of financial	M 500		

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M 500	Continued From page 2	M 500		

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 facility to work for improvements in resident care,

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M 500	Continued From page 3 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 staff interview, record review, and facility policy review, the facility failed to notify the medical provider until the next day that Resident	M 500	1) A root cause analysis was conducted by the Interdisciplinary Team and based on findings the Director of Nursing provided education to Licenses Practical Nurse #2. Resident #1's Nurse Practitioner was	

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M 500	Continued From page 4 #1, who was prescribed apixaban (an anticoagulant medication), had a fall for one (1) of three (3) sampled residents (Resident #1). Findings include: A review of the facility's policy titled "Notification of Change in Condition," revised 12/16/2020, revealed, " ...Policy: The Center to promptly notify the Patient/Resident, the attending physician, and the Resident Representative when there is a change in the status or condition. Procedure...The nurse to notify the attending physician and Resident Representative when there is a(n): Accidents ..." A record review of the "Admission Record" revealed the facility admitted Resident #1 on 5/22/24 with current diagnoses including Muscle Weakness. A record review of the facility's fall investigation, dated 2/18/25 at 5:42 PM, revealed Resident #1 had a fall in the dining room and the Nurse Practitioner (NP) was not notified until the following day on 2/19/25. A record review of the facility's "Change in Condition (SBAR)" form, dated 2/18/25 at 5:42 PM, which was the time of the fall, revealed " ...C. Review and Notify 1. Primary Care Clinician Notified ...2. Date/Time notified ...3. Recommendation of Primary Clinician ..." were blank with no indication of physician notification of the fall and/or change in resident's condition. A record review of the Medication Administration Record (MAR) for February 2025, revealed Resident #1 was administered Apixaban (anticoagulant medication) two times daily for the	M 500	notified on 02/19/2025 regarding the fall that occurred on 02/18/2025. 2) All Residents with falls or at risk of falls have the potential to be affected by this alleged deficient practice. 3) Education with the Executive Director and Director of Nursing was conducted on 03/12/2025 by the Regional Director of Clinical Services on notification of fall or accident of a Resident to the attending physician or Nurse Practitioner, promptly. Notification will be documented in the Electronic Health Record. Education with the Licensed Nurses was conducted on 03/12/2025 and finished on 03/14/2025 by the Director of Nursing on notification of fall or accident of a resident to the attending physician or nurse practitioner, promptly. Notification will be documented in the Electronic Health Record. 4) Quality Monitoring will be conducted starting 03/07/2025 by the Director of Nursing, Medical Records Clerk or Unit Manager twice weekly x 4 weeks then weekly for 2 months to ensure notification to Attending Physician or Nurse Practitioner was made promptly post fall or accident. All findings will be reported to the Quality Assurance and Performance Improvement Committee starting 03/20/2025 and then monthly for 3 months.	

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M 500	Continued From page 5 month of February. A record review of the "Discharge Instructions" from the local Emergency Department (ED), dated 2/19/25, revealed Resident #1 had a diagnosis of "Fall; Left hip pain; Low back pain." On 3/6/25 at 12:45 PM, an interview with License Practical Nurse (LPN) #1 confirmed that Resident #1 was found sitting on the floor attempting to get up on 2/18/25. She assisted the residents' nurse (LPN #2) with an assessment and then assisted the resident to her wheelchair and took her to her room. On 3/6/25 at 1:00 PM, in an interview, the Director of Nurse (DON) confirmed on 2/18/25 Resident #1 had a fall, and the medical provider was not notified until the following day on 2/19/25. She confirmed that it is the facility's policy to notify the medical providers following any type of fall. On 3/6/25 at 1:15 PM, during an interview with the NP, she confirmed that she was notified on 2/19/25 of Resident #1's fall that occurred on 2/18/25. She stated after she was notified, she requested the resident be sent to a local ED for evaluation and treatment. She confirmed if she had been notified immediately after the fall, she would have ordered the resident to be sent to the ED at that time. On 3/6/25 at 1:45 PM, during an interview, LPN #2 confirmed that she was Resident #1's nurse at the time of the fall she did not report the fall incident to the NP on 2/18/25, following the incident.	M 500		