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
	81YC	A. BUILDING: _____ B. WING _____	C 02/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YALOBUSHA COUNTY NURSING HOME	630 SOUTH MAIN STREET WATER VALLEY, MS 38965

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M 000	Initial Comments The State Agency (SA) conducted two (2) Complaint Investigations (CI) at the facility on 2/24/25 for CI MS #27341 and CI MS #27548. 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 regarding CI MS #27548 for Accidents and Hazards and cited M 640. The SA found the facility to be in compliance regarding CI MS #27341 with no deficiencies cited. At the time of survey the facility had a census of 81 residents and was licensed for 122 beds.	M 000		
M 640	45.21.8 Accidents Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies. This Statute is not met as evidenced by: Level III Based on staff and resident interview and record review the facility failed to provide adequate supervision to reduce the risk of an accident/hazards when a resident with behaviors of wandering did not have any increased supervision/monitoring put in place resulting in the physical assault of a resident for one (1) of four (4) residents reviewed for accidents. (Resident #1) Findings include:	M 640	Resident #1 was placed on one-on-one monitoring on all shifts as of January 5,2025 and upon his return from Geri-Psych on January 20,2025 and continues at this time. All residents have the potential to be affected A 100% audit of all residents by the Director of Nursing was conducted on February 24, 2025, to assess the need for increased staff monitoring or supervision. No other residents were found to require an increase in monitoring/supervision. An	3/17/25

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M 640	Continued From page 1 Review of a document on facility letterhead provided by the Administrator revealed, "The facility does not have a policy that addresses resident supervision." Record review of the Facility Reported Incident revealed on 1/5/25 at approximately 8:00 - 8:30 PM, Resident #2 reported to Licensed Practical Nurse (LPN) #4 that Resident #1 "came in my room and was rumbling through my shirts and I told him to go on and he hit me in my face and then he did it about six more times." Resident #2 was unable to recall what time the incident occurred. On assessment by the Director of Nursing (DON) there was slight discoloration to inner corner of right eye and minimal swelling to right side of face around resident ' s right eye. CT of head and CT of Maxillo-facial were obtained on 1/6/25 revealing a nondepressed right nasal bone fracture. Resident #1, the aggressor in the situation had 1:1 sitter at bedside from 7PM-7AM for monitoring, scheduled daily. This was added after incident of wandering in the evening hours. Resident #1 was care planned for cursing staff, refusing care, attempting to hit staff and chasing staff. Resident #1 has an active diagnosis of severe dementia with behavioral disturbances. Resident #1 ' s cognition is severely impaired, her has poor decision making, and cannot recall events or retain safety information. There had been no previous incident of agitation with or aggression toward other residents. Resident #1 was transported to a behavioral health inpatient facility on 1/6/25. During an interview with the DON on 2/24/25 at 10:20 AM regarding a facility reported incident related to Resident #1 and Resident #2, she stated it was determined through staff and	M 640	Inservice was conducted on February 28, 2025, by the Staff Education Nurse for all nursing staff regarding reporting resident incidents and behaviors such as wandering and aggression towards other residents/staff immediately for increased staff supervision and monitoring. All residents will be reviewed daily for the need of increased staff supervision by the Director of Nursing or Registered Nurse Supervisor for four weeks beginning on February 24, 2025, then weekly for eight weeks. The Director of Nursing shall bring audit findings to the Quality Assurance Meeting on March 14,2025 then monthly for three months	

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M 640	Continued From page 2	M 640		

resident interviews, and investigation that Resident #1 wandered into Resident # 2's room on 1/5/25 and hit Resident #2 in the face several times resulting in Resident #2 sustaining a right nasal bone fracture.

Record review of a Progress Note for Resident #1 documented by the DON revealed, late entry for 1/5/25: resident noted to have increased agitation, wandering, pacing and rummaging. It was reported by several residents that Resident #1 was in their room on 1/5/25. (Resident #3) reported that Resident #1 was in her room, raised his hand at her and yelled at her. It is noted that Resident #1 went into (Resident #2's room) and afterwards it was reported that (Resident #2) had slight discoloration and swelling to the right inner eye and eyebrow. (Resident #2) stated that the resident hit him in the face.

During an interview with Resident # 2 on 2/24/25 at 10:30 AM, he confirmed that he remembered Resident #1 coming into his room and hitting him. He stated, "It was right after suppertime; he started going through my clothes, and I kept telling him to go on, and then he hit me about six (6) times in the face. He had come into my room many times before but would leave when told this is not your room. "

Record review of a computer tomography (CT) of the face for Resident #2 related to facial swelling dated 1/6/25 revealed a right nasal bone fracture.

During an interview with Resident # 3 on 2/24/25 at 10:45 AM she stated that on 1/5/25 around 5:15 PM to 5:30 PM, Resident #1 came in her room. She stated, "I kept telling him it was not his room. He raised his hand and acted like he was going to hit me and then walked out of the room."

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M 640	Continued From page 3 She confirmed she immediately found the nurse on duty and reported what happened. When asked how she knew who the resident was, she stated because "this was not the first time he had been in my room and the staff told me his name." During an interview on 2/24/25 at 11:00 AM, with Certified Nurse Assistant (CNA) # 1, she confirmed that Resident #1 had been wandering in resident rooms for months. During an interview with CNA #2 on 2/24/25 at 11:50 AM, she confirmed that Resident #1 had been wandering into other resident's rooms for a good while and had to often be redirected to come out of the other resident's rooms. She stated he does have a wander guard but stated that it does not alert staff of him entering other resident rooms. She confirmed she had reported wandering into other rooms numerous times, and confirmed she was unaware of any special monitoring for Resident #1 during the day. During an interview with Licensed Practical Nurse (LPN) #1 on 2/24/25 at 12:00 PM, she stated she works the 7:00 AM-7:00 PM shift and confirmed she was aware that Resident #1 was wandering in and out of other resident rooms all during the day. She revealed the wandering was documented in the resident's Progress Notes and confirmed that the Administration staff was made aware, and they placed him with one-on-one sitters from 7:00 PM-7:00 AM back in November 2024. She also revealed it was difficult to watch Resident #1 and confirmed she felt he needed to have been one-on-one supervision during the day as well. During an interview with CNA #3 on 2/24/25 at 1:20 PM, she confirmed that Resident #1	M 640		

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continuously roamed into other resident's rooms during the day before the incident on 1/5/25. She stated he was not easily redirected and confirmed she had reported the behavior.

During an interview with the DON on 2/24/25 at 1:25 PM, she revealed after review of the Progress Notes for Resident #1 she confirmed that he had been wandering into other resident rooms during the 7:00 AM-7:00 PM shift during the month of December. She then stated that previously she thought the behavior was only occurring at night and had put the resident on 1:1 supervision on the 7PM-7AM shift. She confirmed that the documented wandering into other resident rooms during the day should have already been identified and preventative measures put in place to potentially prevent an incident from occurring. The DON then revealed failing to put interventions in place to increase supervision could lead to the resident or someone else being hurt.

During an interview with the Administrator on 2/24/25 at 1:27 PM, she confirmed that the behavior of wandering in other resident's rooms during the day hours should have been identified and interventions put in place.

During an interview with LPN #2 on 2/24/25 at 1:40 PM, she revealed she works 7:00 AM-7:00 PM shift and confirmed Resident #1 was wandering all day and would go in and out of rooms before the incident. She also confirmed she was unaware of any special increased monitoring before the incident in January 2025 on the 7:00 AM-7:00 PM shift.

During an interview with LPN #3 on 2/24/25 at 3:20 PM she revealed she worked from 7:00

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M 640	Continued From page 5 AM-7:00 PM on the day of the incident 1/5/25. She confirmed that Resident #1 had been constantly wandering in other resident's rooms. She confirmed that she was unaware of any special monitoring of the resident at that time to prevent accidents related to him continually going into other rooms. She also confirmed this behavior had been reported numerous times and documented. During an interview with LPN #4 on 2/24/25 at 3:50 PM, she revealed she worked the night of 1/5/25 7:00 PM-7:00 AM. She revealed Resident #2 reported to her at approximately 8:00 PM-8:30 PM that the "old man" came into his room rumbling through his stuff and hit him several times in the face. Record review of the Progress Notes for Resident #1 revealed from 12/01/25-1/05/25 the 7:00 AM-7:00 PM nurses documented on five (5) days that the resident wandered into other resident rooms constantly. Record review of the "Admission Record" revealed Resident #1 was admitted by the facility on 10/10/24 with a diagnosis of Unspecified Dementia, Severe with Agitation. Record review of Resident #1's Section C of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/18/24 revealed a Brief Interview for Mental Status (BIMS) score was 4, indicating the resident was severely cognitively impaired. Section E0900: Wandering presence and frequency: coded 3.) Behavior of this type occurs daily. Record review of the "Admission Record" revealed Resident #2 was admitted by the facility	M 640		

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M 640	Continued From page 6 on 7/3/24 with a diagnoses that included Protein Calorie Malnutrition, Muscle Weakness and Right Heart Failure. Record review of Resident #2's Section C of the Quarterly MDS with an ARD of 1/7/25 revealed a BIMS score was 5, indicating the resident was severely cognitively impaired. Review of a Quarterly Review progress note for Resident #2 dated 1/6/25 revealed "He is able to make his needs known and decisions for self daily." Record review of the "Admission Record" revealed Resident #3 was admitted by the facility on 1/25/24 with a diagnosis that included a Stress Fracture of the Right Ankle. Record review of Resident #3's Section C of the Annual MDS with an ARD of 1/24/25 revealed a BIMS score was 15, indicating the resident was cognitively intact.	M 640		