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
	55PR	A. BUILDING: _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL RIVER CO NURSING HOME	305 WEST MOODY STREET POPLARVILLE, MS 39470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) conducted a Complaint Investigation (CI), MS #28951, at the facility from 5/19/25 through 5/20/25. 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 requirement. MS #28951 was investigated for resident safety, physical abuse, and resident rights, and M500 was cited.	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 nurse practitioner/physician assistant in his medical record), is afforded the opportunity to	M 500		6/11/25

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M 500	Continued From page 1 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 transactions made on his behalf should the facility accept his written delegation of this	M 500		

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M 500	Continued From page 2	M 500		

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, and send and receive his personal mail unopened, unless medically contraindicated (as

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M 500	Continued From page 3 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 observation, interview, and record review, the facility failed to ensure a resident was free from the use of a physical restraint when facility staff loosely wrapped a resident's legs in a sheet to prevent the resident from removing his	M 500	1. On May 8, 2025, the tape and draw sheet were immediately removed from the residents bed upon discovery by Licensed Practical Nurse (LPN) #1. An immediate investigation was initiated by the Administrator, Director of Nursing Registered Nurse (RN) and Quality	

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M 500	Continued From page 4 brief for one (1) of three (3) sampled residents. Resident #1 Findings include: A review of the facility policy, "Use of Restraints," revised December 2007, revealed, "...Policy Interpretation and Implementation 1. 'Physical Restraints' are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily...4. Practices that inappropriately utilize equipment to prevent resident mobility are considered restraints and are not permitted, including ...b. Tucking sheets so tightly that a bed-bound resident cannot move ..." A record review of the "Admission Record" revealed the facility admitted Resident #1 on 12/17/24 with diagnoses including Parkinson's Disease. A record review of the Significant Change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/18/25 revealed a Brief Interview for Mental Status (BIMS) score of 5, which indicated the resident's cognition was severely impaired. A record review of the medical record revealed there was no documentation indicating Resident #1 had assessments, interventions, or Physician Orders for the use of a physical restraint. A record review of the "Progress Note" dated 5/8/25 at 6:18 (AM) revealed: "AROUND 5:40 AM ON THIS MORNING 05/08/2025 THIS NURSE ENTERED THIS RESIDENT'S ROOM TO OBTAIN VITALS TO ADMINISTER	M 500	Assurance Registered Nurse (RN). An initial body audit was conducted by LPN #1, with a red area noted, which resolved within one hour. The residents arms and feet were not restricted. Certified Nurse Aides #1 and #2 were suspended pending investigation, and were interviewed by the Director of Nursing. Certified Nurse Aides #1 and #2 stated that the intervention was used because the resident was frequently pulling off his brief and smearing feces. All responsible parties were notified. Education was completed with staff involved in the incident on May 14, 2025 when allowed to return to work, by the Quality Assurance RN related to Residents Rights, Abuse and Neglect, and Use of Restraints. An Ad Hoc Quality Assurance (QA) meeting was held on May 8, 2025, with members of the QA committee. 2. All residents in the facility have the potential to be affected by the deficient practice. 3. Education with all direct care staff was initiated on May 30, 2025 on Resident Rights, Abuse and Neglect, and Use of Restraints by the Education Nurse LPN and Director of Nursing RN. An audit was performed throughout the entire facility to check for improper use of restraints by the QA Nurse RN on May 13, 2025. 4. Monitoring by the Charge Nurses of improper use of restraints, will be completed on three rooms from Station one and Station two, once per week for four weeks beginning on May 23, 2025;	

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M 500	Continued From page 5 MEDICATIONS. ONCE IN THE ROOM, THIS NURSE NOTICED THIS RESIDENT TUGGING AT HIS SHEET ON HIS LOWER EXTREMITIES...THIS NURSE FOUND THAT THE RESIDENT'S LEG HAD BEEN BOUND TOGETHER WITH TAPE...THE RESIDENT RESPONDED SAYING THANK YOU..." The entry was signed by Licensed Practical Nurse (LPN) #1. A review of the facility's investigation revealed that on 5/8/25, LPN #1 reported to the Director of Nursing (DON) that Resident #1 was found with a sheet wrapped around his legs and secured with tape. Certified Nurse Aides (CNAs) stated the intervention was used because the resident was frequently pulling off his brief and smearing feces. The tape was approximately six (6) inches long and placed mid-calf, over the sheet. The resident's arms and feet were not restricted. A red area was noted by the nurse, which resolved within an hour. On 5/19/25 at 6:15 PM, during an observation, Resident #1 was non-verbal, and was laying in his bed with sheets over his lower extremities. His bed was in the low position with a floor mat next to bed. On 5/20/25 at 10:00 AM, during an interview with LPN #1, she confirmed she found Resident #1 with his legs wrapped in a flat sheet and a piece of tape. She immediately removed the tape and sheet and notified the DON. She confirmed she did not leave the items in place for a witness to observe. On 5/20/25 at 10:20 AM, during an interview with CNA #1, she confirmed that she and CNA #2 attempted to prevent the resident from removing	M 500	then monthly for three months thereafter. Findings will be brought forth to the Quality Assurance (QA) Committee for analysis and compliance for four months, beginning on June 11, 2025. 5. Allegation of Compliance Date: June 11, 2025	

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his brief by placing him in a "burrito wrap" using a sheet and secured it with tape. She confirmed he could move his arms and legs, and the tape was not in contact with his skin.

On 5/20/25 at 12:24 PM, during an interview with CNA #2, she explained they wrapped the sheet around the resident's lower body and applied a six (6) inch piece of tape across the sheet to keep him from accessing his brief. She confirmed the intervention was not ordered or approved.

On 5/20/25 at 12:30 PM, during an interview with the Director of Nursing, she confirmed the sheet and tape were applied to control the resident's behavior without a physician's order or care plan intervention. She stated the resident retained full movement of upper extremities and feet. There was no injury observed, and there was a reddened area that resolved within one (1) hour. She confirmed the intervention was deemed a violation of policy but not abuse. The CNAs involved received suspensions and re-education.

On 5/20/25 at 12:45 PM, during an interview with the Administrator, she confirmed the incident was thoroughly investigated and concluded the resident retained the ability to remove the sheet and tape. She emphasized the action was a policy violation, not abuse, and the CNAs were suspended and retrained. She stated the State Agency would have been notified if criteria for abuse had been met.

On 5/20/25 at 1:15 PM, during an interview with Registered Nurse (RN) #1 and the DON present, she confirmed that no bruises, scratches, or skin tears were observed. The healing scabbed area on the right calf had been present before the incident. She confirmed the tape did not touch the

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