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
	76ME	A. BUILDING: _____ B. WING _____	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MS CARE CENTER OF GREENVILLE	1221 EAST UNION STREET GREENVILLE, MS 38703

(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 an annual recertification survey at the facility from 2/3/25 through 2/5/25. During the survey, the SA determined that the facility was not in compliance with the Mississippi Regulations for Minimum Standards for Institutions for the Aged or Infirm and cited M 500 for resident rights. The census at the time of the survey was 70 with a bed capacity of 90 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 nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his	M 500		3/17/25

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M 500	Continued From page 1	M 500		

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 transactions made on his behalf should the

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M 500	Continued From page 2	M 500		

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, and send and receive his personal mail

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M 500	Continued From page 3 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 resident and staff interviews, record reviews, and facility policy reviews, the facility failed to honor a resident's rights to make her own healthcare decisions for end-of-life care for	M 500	1. Address how corrective action(s)will be accomplished for those residents found to have been affected by the deficient practice; "Resident #3 Advanced directive was reviewed and signed by resident with corrections at residents request 2/12/25	

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M 500	Continued From page 4 one (1) of 24 residents reviewed for advanced directives. Resident #3 Findings include: Record review of the facility policy titled, "Advance Directives" with a revision date of 9/2022 revealed The resident has the right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. ...Facility will inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment at the resident's option and to formulate an Advanced Directive." Record review of the "Physician Statement of Status of Mental Capacity of Resident" dated 1/23/24 revealed that the physician checked "Competent," revealing that the resident was able to make her own decisions. Record review of the "DNR (Do Not Resuscitate)/Full Code Request and Consent" form dated 1/23/24 revealed Resident #3 had not signed her consent form and that it was signed by a family member. In an interview on 2/04/25 at 3:00 PM, Resident #3 revealed she could make her own decisions, and when she was admitted to the facility, no one talked with her about her end-of-life wishes. She revealed her niece had already signed all the paperwork and she did not sign her own Advance Directive. She stated, "I had my legs cut off, not my brain," and revealed no one had gone over the paperwork with her. An interview on 2/04/25 at 3:31 PM, with the	M 500	2.Address how the facility will identify other residents having the potential to be affected by the same deficient practice; "All residents have potential to be affected by stated deficiency; Residents with BIMS of 10 or greater or deemed competent have been audited by the Admissions Nurse and their Advance directives signed by residents with corrections if requested on 2/12/25 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The policy on Request/reuse/discontinue treatment: Formulate Advance Directive was reviewed by Administrator with Admissions Nurse on 2/6/25 and no revisions were necessary. "Facility will continue to include residents deemed competent or with BIMS over 10 in the admissions process and during their care plan conference on advance directives. Advance directives will be discussed weekly during care plan meetings with resident and change as resident requests 4.Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system." Audits started on 2/18/2025 and will be conducted weekly x 4 weeks during care plan then 2 times a month for 3 months by Admissions nurse or Social department. Findings will be reported at QAPI on March 14, 2025	

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M 500	Continued From page 5 Admission Nurse revealed that she met with the family and had the paperwork signed prior to the resident's admission. She revealed that their physician also sees the resident prior to admission and deems the resident competent or non-competent in determining whether they can sign their own paperwork. She revealed Resident #3 was deemed competent; however, the niece signed the Advance Directive instead of the resident. She revealed that Resident #3 was able to make her own decisions and should have been given the opportunity to make her own decisions regarding her Advance Directive. An interview on 2/05/25 at 9:40 AM, the Administrator revealed that if a resident is able and competent to sign their own advance directive, the facility should go over the paperwork with the resident and allow them to sign. Record review of the Admission Record revealed Resident #3 was admitted to the facility on 01/23/2024 with medical diagnoses that included Hypertensive Heart Disease with Heart Failure, Cerebral Infarction, Acquired absence of right leg below the knee, and Acquired absence of left leg above the knee. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/6/25, revealed, under section C, a Brief Interview for Mental Status (BIMS) summary score of 15, which indicated Resident #3 was cognitively intact.	M 500	followed by monthly meetings for 3 months and the need for continued audits will be determined based on findings. 5. Indicate the date(s) the corrective action(s) will be completed Survey March 17, 2025	