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
	41TM	A. BUILDING: _____ B. WING _____	C 09/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF TUPELO	2273 SOUTH EASON BOULEVARD TUPELO, MS 38804

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M 000	Initial Comments CI MS #18027-Substantiated S/S=D PAST Non-Compliance On 09/07/2021-09/08/2021 the State Agency (SA) conducted an onsite complaint investigation, CI MS #18027, for alleged verbal abuse of a resident by a Certified Nursing Assistant (CNA) that had occurred on 08/27/2021. The SA substantiated the allegation of verbal abuse and cited a deficiency at M500 with the Scope and Severity at a "D" level at Past Non-Compliance (PNC). The SA cited Past Non-Compliance and determined that the facility was in substantial complaince with the requirements of The Aged and Infirmed as of 08/30/2021. The facility had substantiated and corrected the deficiency of alleged verbal abuse prior to the SA entering the facility on 09/07/2021. The faclility was licensed for 120 beds on 09/07/2021 and the census was 84.	M 000		
M 500 SS=D	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,	M 500		8/30/21

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M 500	Continued From page 1 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 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	M 500		

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M 500	Continued From page 2 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 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;	M 500		

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M 500	Continued From page 3 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 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	M 500		

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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:
CI MS #18027-Substantiated

Based on record review, staff interviews, resident interviews, and policy and procedure review, the facility failed to prevent the verbal abuse of one (1) of five (5) residents reviewed for abuse and neglect. Resident #1 reported that he was verbally abused by Certified Nursing Assistant (CNA #1).

The facility policy and procedure titled: "Abuse, Neglect, Misappropriation, Exploitation Policy" dated Janurary 2019, read, Purpose: To protect and prevent abuse, neglect, exploitation, misappropriation of resident property and to ensure reporting and investigation of alleged violations (to include injuries of unknown source, mistreatment and involuntary seclusion) in accordance with Federal and State Laws.

Interview with the Administrator on 09/07/2021 at 10:30 A.M. revealed that the facility did not receive the report from the resident's family until Friday 08/28/2021 at 9:45 A.M. The alleged event occurred at approximately 9:30 P.M. on Friday 08/27/2021. The resident never told any of the staff at the facility about the incident. On Saturday 08/28/2021 resident (Res. #1) told his ex-wife that he had been physically assaulted and verbally abused by his CNA. The ex-wife is a registered nurse and she immediately assessed the entire body of (Resident #1) and found no sign of physical assault. She then reported it to the unit supervisor and the nurse supervisor immediately assessed Res #1 through a

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complete body audit and reported the incident to the administrator and acting Director of Nursing (DON). The facility immediately called CNA #1, and suspended her from work until the investigation was completed. The facility conducted in-services to staff on 08/28/2021 concerning abuse and neglect and continued the in-services until all staff had attended. The facility had an emergency Quality Assurance (QA) meeting on 08/30/2021 and another on 09/02/2021. The investigation and statements from all parties were conducted by the DON and ADM. Psychosocial assessments were conducted daily with Resident #1 by the Social Worker and documented in the progress notes. The physician and the family were notified of the incident on 08/28/2021 immediately after the resident reported the incident. The facility assessed the other residents of the facility that were assigned to CNA #1 on the evening shift of 08/27/2021. No other resident was found to have knowledge of any incidents between CNA #1 and Resident #1. The facility reported the allegation to the State Agency (SA) on 08/28/2021 immediately following the residents assessments. All measures to prevent, protect, investigate, report, and educate were taken by the facility on 08/28/2021. The Administrator stated that she had to terminate CNA #1 because the witness was very creditable and had given a written statement that she heard CNA #1 use profane language in the presence of Resident #1 and Resident #1 has continued to give the same account of the events without waiver since it occurred on 08/27/2021.

Record review of the facility investigation contained statements from Resident #1, and CNA #2 that witnessed the incident and the same events and statements were outlined by both

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CNA #2 and Res#1. The termination letter in CNA #1's personnel record verified that CNA #1 was terminated on 09/03/2021. CNA #1's last date of work was 08/27/2021 verified by her timecard for that day.

Interview on 09/07/2021 at 10:55 A.M. with the Social Worker (SW) revealed that she was told about the incident on 08/28/2021 by the RN Supervisor. The SW contacted the Responsible Party (RP) of Resident #1, and informed her of the alleged incident. The SW stated that she has visited with Resident #1 daily since the incident occurred on 08/27/2021 and stated that Resident #1 has not had any signs of distress or behaviors of any type. The SW stated that Resident #1 was cognitively intact and has a Brief Interview for Mental Status (BIMS) score of 14.

The SA reviewed the resident council minutes and the grievance logs for the past three months (July-September 2021) with no other reports of abuse documented.

Interview on 09/07/2021 at 12:40 P.M. with Resident #1 revealed that on a Friday (08/27/2021) he had been at therapy and the therapist rolled him back to his room at approximately 3:30 P.M. Resident #1 told the therapist that he needed to use the toilet and she told the resident to wait at the door of the bathroom until she could get his Certified Nursing Assistant (CNA) to come help him. He waited for approximately 3 hours for help and no one came. He did not use his call light system to summon help because he was waiting in his wheel chair like the therapist had asked him to do. He stated that the CNA, whose name he could not recall, came in his room mad. She went in to the bathroom area and wet a towel and came and

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wiped his "behind" area with the wet towel and then balled it up and threw it at him hitting him in the head with the wet dirty towel. Resident #1 stated that the wet towel hit him with great force and hurt his neck and face. The CNA was telling Resident #1 that he could help himself and he told her he was paralyzed and could not roll over by him self and could not use his left arm. The CNA was rough placing Resident #1 in the bed and she pushed him with her hand real hard in the middle of his back with such force it nearly tossed him off the bed and pushed him into the side rail. The CNA told Resident #1 to roll over on his side and he again told her he could not roll by him self and she replied "I am not your slave and I am not your Bitch" you must be from the old days when things were different and she was not going to be treated like a slave. Resident #1 stated that he told the CNA that race had nothing to do with anything and that he was not referring to the old days or to anything, he was trying to tell her that he needed help and was not able to do things for himself because he had no use of his left side. He stated that the CNA then backed away telling him that she was going to report him to the office, and she left the room. Resident #1 stated that his cell phone/ipad was not charged and he was unable to make a call until the next day and he called his ex-wife and she reported the incident for him. Resident #1 denied being afraid, Resident #1 denied feeling unsafe. Resident #1 stated that this was an isolated event at this nursing home.

An observation and interview on 09/07/2021 at 1:00 P.M. of Resident #1 revealed a small built male sitting in a wheel chair with left sided atrophy of the left arm and left leg. His right leg was nervously shaking up and down rapidly as he talked to the SA. Resident #1 denied feeling

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anxious, denied feeling unsafe, and denied being fearful of his surroundings. Resident #1 was cognitive and presented with clear thoughts and good command of English language. He was able to recall the events of the alleged incident in the same order as he had reported to the Administrator on 08/28/2021. His story of the events of the incident of 08/27/2021 had not changed.

Record review of Resident #1's Brief Interview of Mental Status (BIMS) revealed a BIMS score of 14, which indicated that he was cognitively intact. Resident #1's face sheet revealed that he had a history of a Cerebral Vascular Accident (CVA) with left sided paralysis of upper and lower extremities.

Interview on 09/07/2021 at 1:00 P.M. with CNA #2 who witneseed the incident stated that currently she is working the 3-11 shift, but had worked most all shifts and has been a CNA at the nursing home for 34 years. CNA #2 stated that when she arrived in the room on 08/27/2021 to help place Resident #1 in the bed that CNA #1 had placed Resident #1 in the bed by herself. CNA #2 was the partner of CNA #1 on that shift and had been for several months. They work in teams to comply with the facility procedures of two (2) person assistance. CNA #1 stated that Resident #1 was already in the bed when she arrived to the room and she heard CNA #1 saying "I am not your slave or a bitch. I am on my way to call the supervisor to report." CNA #1 left the room and CNA #2 assumed that CNA #1 was reporting the incident because Resident #1 was upset. CNA #2 confirmed her written statement that she gave to the Administrator on 08/28/2021. CNA #2 stated that CNA #1 should not have talked to the Resident #1 in that tone and should not have said

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what she heard her say. CNA #2 stated that she had never witnessed CNA #1 talk like that before and had no knowledge of any incidents prior to this one. CNA #2 stated that she had worked with CNA #1 for months and there had never been any problems. CNA #2 confirmed that they had been in-serviced regularly on abuse and neglect. CNA #2 confirmed that the facility in-serviced the staff on abuse and negelect and tone of voice starting on Saturday 08/28/2021.

Interview on 09/07/2021 at 1:18 P.M. with Responsible Party (RP) revealed that Resident #1 had been in another Nursing Home prior to coming to this facility and had been assaulted by a CNA while there. The RP stated that Resident #1 was paralyzed on his left side and had two (2) strokes that left him disabled and unable to fully care for himself. She stated that she talked to the Social Worker about the alleged incident but was not given details. The RP stated that the facility had contacted her about the alleged incident on Saturday 08/28/2021. The RP stated that the ex-wife of Resident #1 had come to the facility on 08/28/2021 to assess Resident #1 and to report the alleged incident for Resident #1 after he had phoned her and told her what had occured.

Interview on 09/07/2021 at 4:20 P.M. with Nursing Supervisor (RN #1). She stated that she worked 10:00 A.M.-6:00 P.M. Monday-Friday but was working on Saturday August 28, 2021, when the ex-wife of Resident #1 told her that he had been physically assaulted by CNA #1. RN #1 stated that Resident #1 had not reported the incident to any one at the facility. The incident was first learned about on 08/28/2021 at 9:45 A.M. when the ex-wife reported this to RN #1. RN #1 immediately assessed resident and found no signs of physical abuse. RN #1 immediately

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began in-services with staff at the facility and called the acting DON and ADM to report the alleged incident. The investigation was begun and assessments were completed on Saturday 8/28/2021. The alleged incident was called in to the State Agency at 12:00 P.M. on Saturday 8/28/2021, approximately one and a half hours after it was reported to the RN #1 Supervisor. RN #1 called CNA #1 and told her that she was on suspension and was not to return to the facility until the investigation was completed and she was notified by the facility.

Interview on 09/08/2021 at 10:30 A.M. with the ex-wife of Res #1 revealed that she had been called by Resident #1 on 08/28/2021 early in the morning and he told her that a CNA had assaulted him and had hit him with a wet towel in his face and that the CNA told him that she was not his slave and was not his bitch. The ex-wife stated that she helps Resident #1 with his medical care and comes to the nursing home two (2) to three (3) times a week to assist him with his care. She stated that she and Resident #1 had been divorced for over 30 years and have two (2) daughters together. She reported the incident to the nurse supervisor (RN #1) on 08/28/2021, which was a Saturday and stated that she is a nurse and she assessed the entire body of Resident #1 when he reported the assault and she was unable to find any signs of physical assault. She stated that Resident #1 did not report the incident to the facility or to the staff and he did not know the name of the CNA that was alleged to have verbally abused him and she did not know the name of the nurse supervisor that she reported the incident to on 08/28/2021.

Interview on 09/08/2021 at 11:30 A.M. with

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M 500	Continued From page 11 Certified Nursing Assistant (CNA #1) revealed that she went in to Resident #1's room to check on him and he began cussing at her and aggressively calling her names and telling her that he had been waiting on someone to come help him for over two (2) hours. Resident #1 was sitting in his wheel chair and next to the toilet area. He had not used his call light/system and had not used his personal ipad/cell phone. Resident #1 told CNA #1 that she was a slave and worked for him and that she was a "bitch." CNA #1 stated that when she was trying to reassure Resident #1 that she would be happy to help him, he escalated. CNA stated that Resident #1 did allow her to assist in changing him and when she changed his brief he was not wet. CNA #1 stated that CNA #2 came in to help assist with Resident #1 and CNA #1 left and never went back into Resident #1's room. CNA #1 stated that she was sent home on suspensions until the investigation was concluded. CNA #1 stated that CNA #2 came in to assist Resident #1 after he had called CNA #1 a "bitch and a slave." CNA #1 stated that she had been a CNA since 2008 and had worked at the facility since January 2021 full time and had recently in July of 2021 begun PRN (as needed) employment. CNA stated that this was the first time she had been accused by a resident of verbal and/or physical abuse. CNA #1 denied throwing a wet towel on Resident #1 and denied verbal abuse. CNA #1 stated that she felt that Resident #1 was having flash backs of the incident he had at another facility and that he over reacted. CNA #1 stated that she felt that the alleged incident was a misunderstanding. CNA #1 confirmed that she was suspended and sent home while the facility investigated the incident. CNA #1 stated that while she was out on suspension, she had been terminated on 09/03/2021.	M 500		

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M 500	Continued From page 12 Record reveiw revealed that the facility had called the alleged incident of abuse in to the State Agencies (SA) on 08/28/2021 at 12:00 P.M. Record review revealed that the facility held a Quality Assurance (QA) committee meeting on Monday 08/30/2021 at 10:35 A.M. to discuss the Allegation of Abuse and to review the facility's policy and procedure for Abuse and Neglect. The QA committee did not make any policy and procedure revisions on 08/30/2021 during the QA committee meeting. The QA sign in sheet was obtained and the required committee members all were in attendance including the Medical Director. Record reveiw revealed that the In-services were begun on 08/28/2021 shortly after the incident was reported. The facility In-serviced all staff on Abuse and Neglect and the investigation was completed and all corrections were made by 08/30/2021. Reviewed the resident council meeting minutes for the past three (3) months and reviewed the grievance logs for the past three (3) months. There were no incidents of abuse and/or neglect reported. Record review, observation, and interviews revealed that the facility had followed their policies and procedures for abuse and neglect and investigations. Interviewed all five (5) residents on sample with no concerns voiced no knowledge of any resident abuse. No voiced fears of unsafety. Only concern of verbal and physical abuse was voiced by Res #1.	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41TM	A. BUILDING: _____ B. WING _____	C 09/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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M 500	Continued From page 13 Record review of CNA #1's personnel records revealed no prior disciplinary actions were taken and prior in-services regarding abuse and neglect had been conducted when she was hired on 01/26/21. The facility had substaintied the verbal abuse of Resident #1 by CNA #1 and had terminated CNA #1 while she was out on suspension. CNA #1 was suspended from the facility on Saturday 08/28/2021 and received a termination notice on 09/03/2021. The facility had made all corrections and had fully investigated the incident on 08/30/2021. The facility had followed their policy and procedure for abuse and neglect. The facility was cited as Past Non-Compliance. The facility had corrected the deficiency prior to the State Agency (SA) entering the building on 09/07/2021 to investigate CI MS #18027.	M 500		