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
	25CG	A. BUILDING: _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE FOREST HEALTH AND REHABILITATION	1116 FOREST AVENUE JACKSON, MS 39206

(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 along with five (5) complaint investigations (CI), CI MS #17199, CI MS #17230, CI MS #17351, CI MS #17367, and CI MS #17594 from 3/23/21 to 3/26/21. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Minimum Standards for the Aged or Infirm. The SA did not substantiate CI #17199 for Abuse, Quality of Care and Resident assessment, CI #17230 for Misappropriation of Property, CI #17351 for poor quality of care and dietary services, CI #17367 for poor quality of care and/discharge and CI #17594 for refusing to release a resident's medical records due to lack of evidence with no citations related to the complaint. The SA also cited M490 and M640. The census at the time of the survey was 68 and the facility held a license for 109 beds.	M 000		
M 490	45.17 RESIDENTS RIGHTS RESIDENTS RIGHTS This Statute is not met as evidenced by: Based on observations, interviews, record review, policy review, dietary meal slips, and Resident Rights, the facility failed to honor resident choices related to food preferences for one (1) of 17 residents, Resident #46. Findings include: Review of the facility's Resident's Rights, not dated, revealed the resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident. Review of the facility's "Meal Services policy for	M 490	1. On 3/24/2021 the Dietary Manager reviewed food preferences with Resident #46 to ensure that her likes and dislikes were noted and an alternate food would be offered or if refused by the resident at that time. A new meal ticket care and care plan was updated accordingly. 3/24/2021 2. Residents that receive meal trays from the dietary department have the potential to be affected. 3. On 3/24/2021 the dietary staff to include cooks and dietary aides were in	5/17/21

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M 490	Continued From page 1 Alternate Foods for Food Preferences", not dated, revealed substitutes of similar nutritive value are offered to resident's who refuse food served. The procedure revealed that the dining service department prepares an alternate food choice to be offered to residents who refuse food at meals. The nursing assistant, on observing that a resident is refusing a food, offers the alternate food to the resident. The alternate food is delivered to the resident within 15 minutes of the request. Review of Resident #46's Care Plan, revealed on 8/26/2020, an intervention was initiated to honor Resident' #46's food preferences. Review of the Resident #46's daily meal tickets, dated 3/25/2021, revealed that grits were listed as a dislike for breakfast and macaroni and cheese was listed as a dislike for lunch and dinner. Record of the Admission Record revealed the facility admitted Resident #46 on 1/1/20 with the diagnoses which included End Stage Renal Disease, Congestive Heart Failure, Type II Diabetes, Essential Hypertension, Hemiplegia and Hemiparesis following a Cerebral Infarction. The Quarterly Minimum Data Set (MDS) with the Assessment Reference Date (ARD) of 02/11/2021, revealed Resident #46 had a score of 15 on the Brief Interview for Mental Status (BIMS) indicating Resident #46 was cognitively intact. In an interview with Resident #46, on 03/23/2021 at 4:30 PM, revealed she was not happy with her meals. Resident #46 stated she gets foods that she does not like. On 03/24/2021 at 1:50 PM, in an interview with	M 490	serviced by the dietary manager regarding the facility policy "Alternate foods and preferences" and the requirement to offer substitutes to residents that refusing food and not to serve documented dislikes to residents. On 3/31/2021 observations of meal trays and tickets were started by the dietary manager ensure that dislikes were not served to the residents. 3/31/2021. Residents that received a meal tray were interviewed by dietary manager on 3/24/2021 for food preferences and tray cards and care plans updated as needed. On 5/14/2021 an in-service was provided by the Director of Nursing for nursing staff including certified nursing assistants instructing CNA's that when preparing to deliver the meal tray for residents to review the dislike section on the meal ticket. If a dislike has been served notify Dietary department and request an alternate. Documented Monitoring will be conducted by the dietary manager and nursing staff to include observation of the meal tray and not serving of dislikes foods to the resident. The monitoring tool for the dietary department will be documented on a form titled "Trayline Checklist" for twice weekly x four weeks then twice a month for one ; then monthly, starting on 3/31/2021. The monitoring for nursing will be documented on a form titles "Resident Food Preferences Likes/Dislikes daily for two weeks, then weekly x one month, then monthly for two months, then on a random basis to ensure continuing compliance, started on 5/14/2021. The results of the monitoring will be brought to the daily	

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M 490	Continued From page 2 Resident #46 revealed that she did not enjoy her lunch. She stated that she had received macaroni and cheese and she does not like it. She stated she had told them she does not like macaroni and cheese, but they continue to serve it to her. On 03/24/2021, at 2:00 PM, in an interview with Dietary Employee #1/Dietary Manager regarding resident food preferences, she stated that residents have the opportunity to provide information about their likes and dislikes of certain foods. She stated that these preferences are listed on the resident's dietary meal slips for the dietary servers to use as a guide for preparing the resident's plates. On 03/24/2021 at 2:15 PM, in an interview with Certified Nursing Assistant (CNA) #1, she stated that she had served Resident #46's her lunch tray today. She confirmed that the resident's lunch tray included macaroni and cheese. On 03/25/2021 at 8:15 AM, observed Resident #46 sitting in a wheelchair in room, while waiting to go to dialysis. The resident's breakfast was on the overbed table in front of her. Her grits were uneaten. The resident stated she did not like grits and had asked that she not receive grits for breakfast. The resident stated that when she tells the CNA's that she does not like a food that is served, she does not receive anything else. On 03/25/2021 at 9:00 AM, in an interview the with Dietary Employee #1/Dietary Manager, she stated she was aware that Resident #46 had received the macaroni and cheese yesterday. She stated she was unaware that the resident had received grits this morning for breakfast. The Dietary Manager stated she realizes it is important to serve the residents foods that they	M 490	stand up meeting weekly x 1 month, and then monthly x 1 to Quality Assurance Performance Improvement Committee for review and recommendations, then randomly on an ongoing basis as needed.	

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M 490	Continued From page 3 like. She further stated that if resident's receive foods that they do not like, they will probably not eat, and this can lead to weight loss. On 3/25/2021 at 9:10 AM, in an interview with Registered Nurse (RN) #1/Director of Nursing (DON), stated when residents receive the foods they do not like, it can lead to weight loss and when diabetic residents do not eat, it can cause their blood sugars to drop. The DON confirmed food choices are a part of the Resident's Rights. On 03/24/21 at 2:00 PM, in an interview with Dietary Employee #1/Dietary Manager regarding resident food preferences, she stated residents have the opportunity to provide information about their likes and dislikes of certain foods. She stated these preferences are listed on the resident's dietary meal slips for the dietary servers to use as a guide for preparing the resident's plates.	M 490		
M 640 SS=D	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: Based on interviews, record reviews, facility policy review, the facility failed to supervise Resident #25 as evidenced by testing positive for cannabis on 1/3/21 for one (1) of 17 residents, Resident #25.	M 640	1. The facility Administrator started investigation on 1/6/2021 when positive results of drug screen for opiates and marijuana were reported by hospital on Resident #25. 2. Residents have the potential to be	5/17/21

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M 640	Continued From page 4 Findings include: Review of the facility's policy, "Accidents or incidents investigating and reporting" policy, revealed all accidents involving residents, employees, visitors, vendors, etc., occurring at our facilities must be investigated and reported to the administrator. The purpose of this policy is to ensure the safety of all residents, employees and visitors, investigation into the cause of any incident will be tracked in order to improve care and to prevent future occurrences. A Review of the local hospital pathology report, dated 01/03/21, revealed Resident #25 tested positive for Cannabinoid screen (marijuana) and opiods. A review of the facilities Comprehensive Care Plan, dated 06/29/2019, revealed Resident #25 uses, anti depressant medication, related to Depression. Resident #25 also has a Care Plan for safety concerns, on 01/21/2021, regarding Resident #25 recently testing positive on a drug screen for Opiates and Marijuana use at the local hospital. During an interview on 03/25/21 at 09:46 AM with Resident #25, revealed he was sent to the local hospital in January 2021 because he was nauseated and had tremors. Resident #25 stated he tested positive for marijuana and opiods. Resident #25 stated the Maintenance Man #3 charged him twenty dollars for each Marijuana cigarette. Resident #25 said he purchased three (3) cigarettes from him. A review of the facility's investigation revealed Resident #25 stated the Maintenance Man #3 came to his room while he was on the COVID-19	M 640	affected 3. On 01/06/2021, all staff that had worked the Unit where Resident #25 resided received a drug screen testing for opioids and marijuana. One Certified Nursing Assistant tested positive for marijuana and was terminated on 1/6/21. the accused Maintenance Man #3 was suspended pending investigation on 2/2/21. His drug screen returned negative for opiates or marijuana and was allowed to return to work on 2/23/21, due to the facility being unable to substantiate that he had sold marijuana to Resident#25. On 2/9/21, Maintenance Man #3 was notified by Plant Operations Manager, that he would not be allowed to work on the unit that Resident #25 was occupied. On April 3, 2021, Maintenance Man #3 terminated his employment with the facility. On 5/14/2021 at 12:30 p.m. the facility Administrator, Director of Nursing, Social services Director and social services staff were in-serviced by outside Registered Nurse who is a retired surveyor, nurse consultant, and infection Control Nurse. 4. Any allegation of abuse, neglect, exploitation or mistreatment will be reported to the Administrator immediately to initiate investigation. The state aagency will be notified no later than 2 hours per reporting protocol and facility policy. Violations will be logged on a form titled Adverse Events. An emergency qualilty	

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isolation hall and let him know that he was selling weed. Resident #25 stated he began to buy the Marijuana from Maintenance Man #3 since that time. Resident #25 reported he spent $140.00 (1st time= 30.00, 2nd time =$30.00, 3rd time =$ 30.00, 4th time =$10.00, 5th time = $ 20.00, 6th time = $ 20.00) to the Maintenance Man #3 on Marijuana. Resident #25 stated he has never purchased Marijuana from anyone but him.

During an interview on 03/25/21 at 10:51 AM with The Administrator revealed the facility called in the allegation on 1/6/21. The Administrator stated the hospital called and informed her Resident #25 tested positive for Marijuana. The Administrator stated the facility initiated an investigation completed by the previous Director of Nursing (DON). The Administrator also confirmed the facility failed to report to the local police department or the Attorney General's office of the incident. The Administrator confirmed the facility failed to follow up with sending the completed investigation the the State Agency (SA). The Administrator stated the investigation is still in progress. The facility has not finished the investigation. Resident #25 was interviewed and refused to reveal the persons name he got the marijuana from. The Administrator said he gave them three (3) different employees names before he said he was going to be honest. The Administrator stated Resident #25 said he was afraid Maintenance Man #3 would retaliate. The Administrator stated all the staff was tested that worked on Resident #25's unit. Only one (1) CNA tested positive and was terminated. Maintenance Man #3 was suspended until an investigation was completed. The Administrator stated Maintenance Man #3 said he did not sell marijuana to Resident #25. Maintenance Man #3 did not test positive and was approved to return back to work by the

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cooperate office because the facility could not substantiate he sold the Marijuana to Resident #25. Maintenance Man #3 returned to work on 2/8/21. Resident #25 was informed Maintenance Man #3 was returning back to work because the facility could not substantiate the allegation. The Administrator stated the informed Resident #25 the Maintenance Man #3 would not work on his hall and if he felt unsafe to notify the staff. Resident #25's family was also notified. The family understood the facility was unable to substantiate the complaint.

During an interview on 3/25/21 at 11:00 AM with Social Worker #2, revealed Resident #25 had not been out of the facility with anyone because of the COVID restrictions. Social worker #2 stated Resident #25 received several outside supervised visits. Social Worker #2 also stated Resident #25 received a visit from his Brother-in-law on October 9 and 16. Resident #25's sister visited on October 7, and a visit from his brother on October 30. Social Worker #2 stated the visitors were not allowed to bring items and had to stay six (6) feet away from each other. Social Worker #2 stated the outside visits were allowed from October 2020 to December 2020. The facility canceled outside visits due to an increase in COVID cases. The visits started back March 8, 2021.

During an interview with the Maintenance Man #3 on 03/25/21 at 11:30 AM, he stated he did not sell Resident #25 marijuana. Maintenance Man #3 stated Resident #25 probably got the marijuana from his brother. Maintenance Man #3 stated the resident's room was by the street. The resident's brother came to his room often. Maintenance Man #3 stated the facility drug tested him and he was negative. The Maintenance Man stated he did not talk to Resident #25 often. Maintenance

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M 640	Continued From page 7 Man #3 stated he called the cooperate office and explained he felt the facility accused him of something that was not true. The cooperate office told the Administrator that because they could not prove he sold the marijuana to Resident #25 to allow him to come back to work. During an interview with the facility's Medical Director (MD) on 03/25/21 at 11:45 AM, revealed he was notified that Resident #25 tested positive for opiods and marijuana. The MD stated the use of marijuana and opiods did not cause any harm to the residents physically. The doctor said if the marijuana was laced with some other substance it could cause harm. He does not recommend continued use. The facility admitted Resident #25 on 3/07/18, per the face sheet, with the diagnosis that included Unspecified Nephritic Syndrome with unspecified Morphologic, Intervertebral Disc Degeneration Lumbar region and Depressive disorder. The Admission Minimum Data Set (MDS) with the Assessment Reference Date (ARD) of 01/18/21 revealed Resident#25 had a brief interview of Mental Status (BIMS) of 15 that indicated Resident #25 is cognitively intact.	M 640		