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
	25CR	A. BUILDING: _____ B. WING _____	08/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HILL NURSING CENTER	927 COOPER RD JACKSON, MS 39212

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M 000	Initial Comments The facility was licensed for 87 beds, and had a census of 71 at the time of survey The State Agency (SA) conducted a licensure survey from 07/30/19 to 08/01/19. During the survey the SA determined the facility was not in compliance with the Minimum Standards for The Institutions For The Aged And Infirm. The SA cited the state statutes M500 and M700. The census at the time of entrance was 55, and the facility was certified for 60 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	M 500		9/3/19

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M 500	Continued From page 1 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 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;	M 500		

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M 500	Continued From page 2 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; 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	M 500		

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M 500	Continued From page 3 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 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	M 500	F-500	

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M 500	Continued From page 4 Based on observations, staff interview, record review, and facility policy review, the facility failed to protect the residents from abuse for five (5) of six (6) residents reviewed for abuse, Residents #10, #24, #27, #28, and #60. the facility also failed to protect Resident #24's property from unauthorized use of funds for one (1) of 21 residents reviewed for misappropriation of funds. Findings include: Review of the facility's policy, titled "Abuse/Neglect Reporting-Resident", no date, revealed each resident in this facility has the right to be free from verbal, sexual, mental, physical abuse, including corporal punishment, involuntary seclusion and/or misappropriation of property, Abuse is willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. This includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychosocial wellbeing. Physical Abuse includes but is not limited to hitting, slapping, pinching, and kicking. It also includes controlling behavior through corporal punishment. Review of the facility's policy titled, "Preventing Resident Abuse", dated April 2013 revealed: "Our facility will not condone any form of resident abuse and will continually monitor our facilities (sic) policies, procedures, training programs, systems, etc. to assist in preventing resident abuse. Our abuse prevention/intervention includes but is not limited to assessing, care planning and monitoring residents with needs, and behaviors that may lead to conflict or neglect and involve qualified psychiatrists and other mental health professionals to help the staff	M 500	1. On 6/6/19, Resident # 124 was immediately placed on one-on-one basis until transferred to Geri-Psych Unit on 6/6/19 at 5:33pm. Resident # 124 did not return to facility. On 7/28/19, the Administrator, Staff Development Nurse and Director of Nursing (DON) conducted an in-service on Abuse/Neglect/Reporting/Misappropriation . No employee will be allowed to work until In-serviced. On 7/31/19, Resident # 24 was transferred to Geri-Psych Unit for treatment. Resident returned 8/4/19, to a different room, with follow-up appointments for outpatient treatments. On 8/15/2019, Resident #60 was transferred to a separate hall. On 8/29/2019, the Quality Assurance (QA) Committee, consisting of Administrator, Medical Director, Director of Nursing/Infection Control Preventionist (DON), Social Services Director, Wound Care/Licensed Practical Nurse (LPN), Minimum Data Set (MDS)/Admissions Coordinator, Environmental Supervisor, Unit One Manager/ Registered Nurse (RN), Unit Two Manager/Registered Nurse (RN), Dietary Manager, Minimum Data Set (MDS) Coordinator, Medical Records Clerk/Licensed Practical Nurse (LPN), Therapy Supervisor, reviewed the policies for Preventing Resident Abuse, Abuse Investigation Reporting, Resident Rights and Resident to Resident Altercations with no recommended changes to the policy at this time. 2. All 71 Residents have the potential to be affected by this deficient practice. The	

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M 500	Continued From page 5 manage difficult or aggressive residents. Review of the facility's policy titled, "Reporting Abuse to Facility Management" with no date, revealed: "It is the responsibility of our employees, facility consultants, Attending Physicians, family members, visitors, etc. to promptly report any incident or suspected incident of neglect or resident abuse, including injuries of unknown source and theft or misappropriation of resident property to facility management". Review of the facility's policy, titled Investigating Incidents of Theft and/or Misappropriation of Resident Property. The policy statement revealed all reports of theft or misappropriation of resident property shall be promptly and thoroughly investigated. The policy Interpretation and Implementation revealed the residents have the right to be free from theft and/or misappropriation of personal property. Misappropriation of resident property, " is defined as deliberate misplacement, exploitation, or wrongful, temporary or permanent use of resident's belongings or money without resident's consent. Our facility will exercise reasonable care to protect the resident from property loss or theft, including: Implementing policies that strictly prohibit, and pursue to the full extent of the law, staff, staff or employee theft or misappropriation of resident property. Resident #10 Review of the facility's Resident Incident Report revealed an incident occurred, on 06/06/2019 at 8:46 AM, involving Resident #10 and Resident #124. The report stated Resident #124 entered Resident #10's room and began rummaging through her things. Resident #10 told Resident #124 to get out of her room, but instead he hit her	M 500	facility Director of Nursing (DON) or Administrator will monitor all incidents for appropriate interventions and follow through beginning 8/2/19. 3. The facility Director of Nursing or Administrator will review and monitor all incidents. These will be logged daily and reviewed weekly in the High Risk Meetings to ensure appropriate interventions are in place. Any incident will be recorded on the Incident Monitoring Log for three months to ensure compliance. The Social Services Director will attend the Resident Council meeting every month beginning August 27, 2019 for six (6) months to note any issues of neglect, misappropriation of property and Resident Rights. Beginning on 9/09/19, Social Services Director will interview five (5) cognitively intact Residents per week for six (6) weeks for any issues with abuse, neglect, or misappropriation of property and documentation on the resident. 4. Any concerns will be addressed immediately by the Administrator and findings will be brought to the Quality Assurance Committee quarterly for compliance and recommendations.	

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M 500	Continued From page 6 on the side of her face with an open hand, knocking her back on her bed, and causing her eyeglasses to turn sideways. The Immediate Post-Incident Action stated Resident #124 was placed on one on one (1 on 1) supervision and taken to his room. Resident #10 was taken to an office and observed by a nurse. Orders were received to send Resident #12 to a Geri-Psych facility. The Incident Investigation section revealed the interviewed witness, (Certified Nursing Assistant (CNA) #1, stated the resident hit the female resident with an open hand to the left side of her face. The resident (Resident #124) fell to the floor after attempting to also hit the nurse who tried to intervene. An observation, on 07/31/19 at 1:53 PM, revealed Resident #10 was sitting on the bed reading a book. Resident #10 was alert and oriented, speech was clear, and she was able to make her needs known. During an interview, on 07/31/19 at 2:20 PM, Resident #10 revealed Resident #124 came in her room rambling through her stuff. Resident #10 said she told Resident #124 to get out of her room. Resident #10 said #124 punched her on the left side of her face. Resident #10 said Resident #124 hit her so hard she fell on the bed and it turned her glasses sideways. During an interview, on 07/31/19 at 2:21 PM, Certified Nursing Assistant (CNA) #1 said she was walking down the hall and overheard Resident #10 say get out of my room. She saw Resident #124 punch Resident #10 on the left side of her face. Resident #10 fell to the bed. Resident #124 started rambling through Resident #10's night stand. CNA #1 said she attempted to redirect Resident #124, but Resident #124 started	M 500		

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swinging at CNA #1. CNA #1 went to the door and yelled for Licensed Practical Nurse (LPN) #5 to assist her. Resident #124 started swinging at LPN#5. CNA #1 went to get the Director of Nurses (DON) and the Assistant Director of Nurses (ADON). Resident #124 kept swinging at LPN #5 until he fell on the floor. CNA #1 said Resident #124 was sent out to the Geri Psych Unit, that Resident #124 did not return to the facility.

During an interview, on 07/31/19 at 2:29 PM, LPN #5 said CNA #1 yelled for help. LPN #5 said she came to the room and asked Resident #124 to come out of Resident #10's room. Resident #124 refuse to be redirected. Resident #124 started swinging at her. CNA #1 went to get the DON and ADON. Resident #124 kept swinging until he fell on the floor. LPN #5 said Resident #124 was sent to Geri Psych.

Record review of Resident #124's Comprehensive Care Plan revealed the following Problems/Needs: 05/21/19, Urinary Tract Infection (UTI) infection with increased confusion. The Goal & Target Date was 07/20/19, the UTI will be resolved before the next review date. Approaches included: Orient resident to self, place, and situation due to acute changes in behavior and increased confusion. 10/30/18, Resident has poor short term memory and cannot recall/repeat given words or phrases from memory. The Goal & Target Date was 07/20/19, will continue to function at highest practical level without (w/o) further preventable decline throughout next review date. Approaches included: Encourage him to participate in activities of interest. Provide one on one interaction to provide stimulation for cognitive status awareness. Give him opportunities to

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M 500	Continued From page 8	M 500		

make simple decision for himself and give the time to do so. Provide cues and supervision. 01/30/19. Potential for socially inappropriate behavior r/t his diagnosis of Vascular Dementia with Behavior Disturbances and Unspecified Psychosis. The Goal & Target Date was 07/20/19, will have less than 2 (two) episode of inappropriate behavior per month. Approaches included: Do not argue with resident. Remove resident from public area when behavior is inappropriate. Provide diversional activities as needed Assist resident in avoiding situation that will result in inappropriate behavior. 10/30/1, Potential to become withdrawn. The Goal & Target Date was 07/20/19, will socialize/participate in at least 2 (two) activities a month. Approaches included: Monitor and record mood/behavior changes Q (every) shift. Encourage resident to attend activities with friends. Speak in an understanding non-judge mental tone of voice when communicating with the resident.

Further review of the Resident Incident Reports revealed: On 05/15/18 at 8:20 PM, Resident #124 had a physical altercation with another resident. Resident #124 stated he did not know what the staff member was talking about when he was asked what had happened. The Medical Doctor (MD) was notified, no new orders were received. The Immediate Post-Incident Action revealed the residents would remain separated to prevent further occurrences. On 07/20/18 at 11:00 AM, Resident #124 was punched and knocked down to the floor by another resident. The other resident accused Resident #124 of having his jacket, which he did not. The jacket was checked and found to have Resident #124' name on it. Body audit was done, and Resident #124 was assessed, no bruising was found, and no

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complaints of any pain. The Immediate Post-Incident Action stated the residents were separate immediately and the assailant resident was sent out to Geri-Psych for evaluation. On 05/31/19 at 7:10 PM, Resident #124 punched another resident in the arm. Resident #124 could not remember the incident happening, when he was questioned by the facility staff. A Certified Nursing Assistant (CNA) stated the other resident was trying to get something out of Resident #124's pocket, and he told the other resident to stop, but he didn't, and Resident #124 punched the other resident on the arm. The Immediate Post-Incident Action stated the residents were immediately separated and will remain separated to prevent future occurrences.

During an interview, on 07/31/19 at 3:18 PM, the Administrator confirmed Resident #124 punched Resident #10 in the face. The Administrator said she was trying to find placement for Resident #124 because of his aggressive behavior. The Administrator said she was aware of Resident 124 attempting to fight staff and refusing to be redirected.

Record review of Resident #10's Comprehensive Care Plan, no date, revealed Resident #10 was at risk for high anxiety and has a fear that others around her are upset with her easily evidenced by constantly asking everyone are you upset with me today?" Will repeatedly state I'm sorry for no reason. Interventions included: Encourage resident to participate in daily activities to spend time with friends, Ensure Resident that no one is angry or upset with her to relieve stress, redirect resident if she becomes overly anxious and is on the verge of becoming tearful. Resident #10 has a diagnosis of unspecified Dementia, Unspecified Psychosis, Major Depressive Disorder, and

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M 500	Continued From page 10 Anxiety, resident is often repetitive in questions and has episodes if anxiety, Resident #10 has memory loss and distortion. Resident #10 enjoys special attention and one on one conversations with staff. Resident is at risk for falls related to (r/t) poor safety awareness, depression and anxiety. A review of the Face Sheet revealed the facility admitted Resident #10, on 09/11/2017 with diagnoses, which included the included diagnoses Depressive Disorder, Dementia and Anxiety Disorder. A review of Resident #10's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/8/2019, revealed Resident #10 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. A review of the Face Sheet revealed the facility admitted Resident #124, on 09/11/2017, with diagnoses which included Vascular Dementia, Psychosis and Major Depressive Disorder. A review of Resident #124's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/6/2019, revealed Resident #124 had a Brief Interview for Mental Status (BIMS) score of 5, which indicated the resident was severely cognitively impaired. Resident #28 and Resident #60 Review of the Resident Incident Reports revealed, on 03/19/19 at 8:48 AM, an altercation occurred between Resident #28 and another resident (#60). The CNA (#6) reported a resident (#28) came into the bathroom while Resident #60	M 500		

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M 500	Continued From page 11 was finishing up their shower. The Resident #60, who was dressing, became very angry and slammed the door in (Name of Resident #28's) face. At this point Resident #28 grew angry, came inside and punched Resident #60. The CNA was able to stop the men from fighting and separate the two individuals. There were no injuries to either party. The Immediate Post-Incident Action stated the two individuals were separated and taken to separate units. Both individuals were interviewed, and witness involved, and assessed both residents for injuries. The Narrative of Investigation stated the incident was investigated and no injuries found. Both residents deny being hit by the other person. Both agreed to stay away from each other, and each stated they do not dislike each other. Review of the facility's Report Information, an investigative document provided by the facility Administrator, dated 03/21/19, revealed an incident occurred on 03/19/19 between Resident #28 and Resident #60. Certified Nursing Aide (CNA) #6 was assisting Resident #60 with getting dressed after he finished his shower then Resident #28 knocked on the door. CNA #6 said patient care, but Resident #28 still opened the door. Resident #60 closed the door on Resident #28 and Resident #28 opened the door again and told Resident #60 that if he closed the door again, he was going to bust his head. Resident #60 closed the door again and that's when Resident #28 opened the door and he was swinging his fist at Resident #60. Resident #60 was swinging back and then landed punches on one another. CNA #6 intervened and started yelling for help. Neither Resident #28 nor Resident #60 received any injuries, no hits to the head. The document stated that the physician was notified, on 03/19/19, for each resident, but neither was seen by a	M 500		

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M 500	Continued From page 12 physician since there was no notice of any signs of injury. The document also revealed that the Resident Representative was notified for both Resident #28 and Resident #60. On 07/31/19 at 3:20 PM, the surveyor attempted to call CNA #6 twice with no answer, and no voice mail set up. Record review of CNA #6's Witness Statement, dated 03/19/19, revealed CNA #6 stated "I was assisting Resident #60 with getting dressed after his shower when Resident #28 knocked on the door. I said patient care, but Resident #28 opened the door. Resident #60 closed the door on Resident #28. Resident #28 opened the door again and told Resident #60 if he closed the door again, he was going to bust his head. Resident #60 closed the door again and that's when Resident #28 opened it up and with his fist closed and swinging at Resident #60. Resident #60 swung back and they both landed a punch on one another. I intervened and started yelling for help. That's when three (3) of my co-workers came and the incident ended". An observation, on 07/31/19 at 4:00 PM, revealed Resident #28 and Resident #60 shared a hall shower with other residents at the facility. An observation, on 08/01/19 at 9:00AM, revealed Resident #28 and #60's rooms were located side by side on the unit with the shower room across the hall from the resident's rooms. Record review of the Face Sheet revealed Resident #28 currently resided in room 212B. Record Review of the Face Sheet revealed Resident #60 currently resided in room 214B	M 500		

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M 500	Continued From page 13 Review of a document provided by the facility revealed Resident #28 was placed in room 212B on admission, 05/16/14. Resident #60 was placed in room 214B on 11/14/18. Record review of the Minimum Data Set (MDS), with an ARD date of 03/21/19, revealed Resident #28 had a Brief Interview of Mental Status (BIM)S score of 15, which indicated no cognitive impairment. Further review of the MDS revealed no concerns with behaviors was identified. Record Review of the MDS, with an ARD date of 03/21/19, revealed Resident #60's BIMS score was 9, which indicated moderate cognitive impairment. Further review of the MDS revealed no concerns with behaviors was identified. An interview, on 07/31/19 at 10:37 AM, with Administrator revealed, "If I remember correctly that's the incident where Resident #28 knocked on the door in the shower room. CNA #6 was in there and she separated them at that time. Basically, we need to make sure the residents know if care is in progress they have to wait. We have two other bathrooms down that hall and some of the residents have bathrooms in their room. The shower room is used by everyone on that unit. We have had no other incidents since then with these two residents. They were separated in the shower that day. I'll have to check and see if anything else was done. I guess I should have got the Psychiatric Nurse Practitioner to evaluate the residents and moved rooms with one of them. To my knowledge, Resident #28 was never seen by the facility's Psych Nurse Practitioner and I believe Resident #60 was not seen by the Psych Nurse Practitioner until June 2019 after the incident".	M 500		

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M 500	Continued From page 14 An interview, on 07/31/19 at 9:10 AM, with Registered Nurse (RN) #1 revealed CNA #6 was in the shower the day of the incident between Resident #28 and Resident #60. RN #1 stated however CNA #6 had quit and walked out of the building this morning after coming to work. An interview, on 08/01/19 at 4:34 PM, revealed the DON stated, in my opinion based on the evidence presented to me, I feel neither Resident was protected from reoccurrence. An interview, on 08/01/19 at 2:55 PM, with the Administrator revealed, "I don't really know what time they called and told me about the incident. We did separate them for a little while that day, but we did allow them to go back to their room the same day since there was no more incidents. They do still share a bathroom and shower room." The Administrator further revealed the residents are in the same room they were in at the time of the incident. The Administrator stated, "I'm not sure what time I was notified of the incident. I don't have any documentation where I wrote down when I was notified, nor the instructions I gave them. I'd have to review my notes. You've got all my documentation from that day." Resident #24 Review of the facility's Report Information, signed by the Administrator, and no date revealed a reported incident and brief description of an altercation between Resident #24 and another resident. The Brief Description of the event stated another resident lightly hit Resident #24 on the arm and Resident #24 hit another resident in the face, another resident has skin tears on the right	M 500		

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M 500	Continued From page 15 side of the right eye, on his jaw, and on the right side of his neck. Review of the facility's investigation documented on the Information Report revealed, on July 14, 2019 it was reported that Resident #24 had hit another resident. "Upon investigation into this incident, on July 14, 2019 around 3:19 PM, another resident entered the activity room. Another resident took a chair from one table and placed it at another table nearby. Before he could sit, a female resident grabbed the chair returning it to the original table and sat down. Another resident went to retrieve another chair. After getting it, another resident pushed his walker with one hand and pulled the chair with the other. Resident #24 came into the activity room and had his arms over the shoulder of the female resident. Another resident came back toward the table, but the tables were in close proximity and the other resident could not get through. It appears that another resident touched Resident #24 with his walker. Resident #24 pushed another resident's walker causing his drink to spill. Another resident balled up his fist and touched Resident #24 on the arm. Resident #24 got in another resident face and hit him. Resident #24 lost his balance and fell to the floor. The other resident did not fall. Both residents were separated, and both have been referred for evaluation by Psych services. The other resident was evaluated by the nurse, but Resident #24 refused to be evaluated. The physician was called and both RP were notified. No other incidents have occurred. This completes the investigation." Review of the Narrative of Incident revealed, "This nurse was at unit one nurses station doing CNA assignments when loud noises came from activity room where Residents were lining up to	M 500		

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M 500	Continued From page 16 smoke. This nurse ran into room. Noted that Resident was sitting in a chair at the table, in front of the table was spilled drinks and the walker of another resident. When asked what happened Resident stated, "I did not hit him". This nurse asked him who, Resident then pointed at another resident. This nurse asked him to explain what happened, Resident would not. Immediate Post-Incident Action: Other resident taken out with unit 2 staff to smoke without having to come onto same hall as this resident. Residents were immediately separated." On 07/30/19 at 10:10 AM, with Resident # 24 regarding his incident with another resident, revealed Resident #24 stated another resident popped him on his back, so then he attacked the other resident, the other resident is no longer in facility, according to the Resident #24. Review of the Care Plan for the Problem/Need, dated, 09/10/2018, revealed Resident #24 displays physically aggressive behavior at times. The approaches included: Identify causes for behavior and reduce factors that may provoke Resident #24. Discuss Resident #24 options for appropriate channeling of anger. Talk with Resident #24 in calm voice when behavior is disruptive. Remove Resident #24 from public area when behavior is disruptive and unacceptable. On 07/31/19 at 2:36 PM, an interview with Certified Nurse Assistant (CNA) # 2, revealed normally Resident #24 is in bed and if there was an altercation the other resident had to set him off, he normally helps all the residents out. On 08/01/2019 at 12:47 PM, with the DON,	M 500		

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M 500	Continued From page 17 revealed Resident #24 may have a temper at intervals, and he has been transferred to Geri-Psych Hospital. On 08/01/2019 at 1:00 PM, an interview with the DON, revealed the other resident involved in the facility reported investigation was also admitted to Geri-Psych Hospital. On 08/01/2019 at 1:10 PM, the surveyor attempted to contact both of the Resident's Representatives regarding the facility's reported incidents, however did not receive any return calls. On 08/01/19 at 4:33 PM, an interview with the Director of Nursing, revealed Resident #24 would become very agitated with his room-mates. Review of the Face Sheet revealed the facility admitted Resident #24, on 09/10/18, with included diagnoses Acute Upper Respiratory Infection and Pain. Review of Resident #24's Quarterly MDS, with an ARD date of 03//13/19, revealed a BIMS score of 15, which indicated no cognitive impairment, and no behavior concerns were identified. Resident #27: Review of the facility's Report Information signed by the Administrator, no date, revealed, on 06/27/19, the facility's Receptionist stepped into the office and reported to the Administrator in the presence of the Dietary Manager she had observed a resident swinging at Resident #27, and she wanted to report it. The Receptionist stated she had pushed the resident up the hill, and there was no contact made. On July 1, 2019,	M 500		

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M 500	Continued From page 18	M 500		

it was discovered that no incident report had been made. Further investigation found that (Name of Receptionist) had not reported the incident to the nurse. Therefore, the incident was immediately reported to the Mississippi State Department of Health and the Mississippi Attorney General's Office. Statements were gathered from staff from that day. The Receptionist stated she was coming through the side doorway toward Unit #1 to clock in from lunch. According to the Witness Statement, the Receptionist stated she saw the resident hit Resident #27 in the face three times. Witness statement was not written until 07/01/19. The Receptionist reported to the Administrator and the Dietary Manager no contact was made. Camera footage was not available for this incident. On June 27,2019, immediately after this event, Resident #27 went to smoke. (Name of Staff Member) gave Resident #27 her cigarette and saw no injury. Following smoking, Resident #27 went to activities, and the Activities Director said she did not see any injury. This completes the investigation.

Review of the Brief Description of the event, documented on the Report Information, revealed Resident on Resident altercation - Employee Receptionist reported seeing another resident was swinging at Resident #27. The following investigation from June 27, 2019 where no injuries were noted.

Record review of the Departmental Notes-Nursing, dated 07/01/2019 at 4:14 PM, revealed a Resident on resident incident, which occurred on 6/25/2019. Reported by employee to administration at the time of incident. Resident was observed being punched in the face x three (3) by another resident. Staff member stated that both residents were propelling their wheelchairs

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M 500	Continued From page 19 in the hallway. On the hill, on unit one. Resident was rolling down the hill. When she punched resident in the face x three (3). The nurse's note on 07/01/2019, revealed no apparent injuries to the face area. On 07/31/19 at 5:00 PM, an interview with Resident # 27, about being punched in the face, revealed she gave a thumb's up, for no injuries. On 07/31/19 at 5:05 PM, an interview with the Administrator revealed the resident was slapped in the face by another resident and she had no injuries. The Administrator stated she reported the injury to the Department of Health. On 08/01/2019 at 12:47 PM, an interview with the DON, revealed Resident #27 very mild mannered. On 08/01/2019 at 3:10 PM the surveyor contacted Responsible Party and they revealed they were informed of the incident. Resident #24 Misappropriation of Resident Property Review of the facility's Complaint-Incident reported to the Mississippi State Department of Health, on 04/24/2019 at 1:19 PM, by the Administrator, revealed it was reported this AM, Resident #24 had given money (Name of Dietary Staff #2), an ex-dietary worker. The Administrator interviewed Resident #24, and he said that (Dietary Staff #2) had asked him for money, but he could not remember the time or day that this took place. Resident #24 said he was trying to help Dietary Staff #2. Dietary Staff #2 said Resident #24 gave her the money, she did not	M 500		

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M 500	Continued From page 20	M 500		

ask the resident for the money. Dietary Staff #2 said she tried to find a nurse to give the money to, but she was not able to find one, and put the money in her car. Dietary Staff #2 said she had forgotten about it, until I spoke with her this morning. Dietary Staff #2 is out of state, so she sent the money via a money cable service for me to pick up.

Review of the typed note, dated Wed, Apr 24, 2019 (Wednesday, April 24, 2019), and signed by the Dietary Manager revealed, "Today and employee approached me and explained that I might want to "look into a dietary employee borrowing money from a resident, (Name of Resident #24)." I spoke with (Name of Resident #24 on this matter and he said (Name of Dietary Staff #2) did indeed borrow $25-$35 cash ...He couldn't remember the exact amount. I explained to him that any employee should not ask for help from a resident. I explained that I understood him wanting to help but if any employee needed help they could come to me (Name of Dietary Manager) or the Administrator, (Name of Administrator). Furthermore, (Name of Dietary Staff #2 no longer works for this facility.

Review of training provided to Dietary Staff #2, dated 02/14/19, revealed a copy of the facility's policy, Abuse and Neglect-Reporting-Resident, which also included Misappropriation of Resident Property, and identified the Seven Types of Abuse. Further review of the training revealed Dietary Staff #2 signed a document, on 02/04/19 stating, I have completed viewing the Hand N Hand series.

Review of the facility's Grievance/Complaint Form, dated 04/24/19, revealed Resident #24 filed a grievance stating an employee came to

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M 500	Continued From page 21 him and stated she need to talk to him later. She came back later and asked him to borrow $25.00. Resident #24 said he wanted his money back. Review of the facility's Grievance/Complaint Investigation Report Form, dated 04/24/19, revealed Resident #24 said the incident occurred in March 2019. Resident #24 said the employee came to him and said she needed to talk to him later, and she returned later and asked to borrow $25.00. Resident #24 said he gave it to her. The findings for the incident revealed the facility was unable to validate the incident, and did recommend returning the resident's money. Resident #24 signed the document on 04/24/19, and checked yes for was the grievance/complaint resolved to satisfaction of all concerns. During an interview, on 08/01/19 at 2:54 PM, the DM confirmed Dietary Staff #2 did borrow $35.00 from Resident #24. The DM said Resident #24 asked him, where is Dietary Staff #2. He told Resident #24 Dietary Staff #2 moved to (Name of State). Resident #24 said he loaned her money and wanted it back. Resident #24 said he was trying to help her. The DM said he notified the Administrator. During an interview, on 08/01/19 at 3:01 PM, the Administrator confirmed Dietary Staff #2 borrowed money from Resident #24. The Administrator said she called Dietary Staff #2 and asked her about the money. The Administrator stated Dietary Staff #2 said she did not borrow the money, and that Resident #24 gave her the money. Dietary Staff #2 said she attempted to give the money to a nurse, but could not find one in the building. Dietary Staff #2 said she put it in her glove box. The Administrator told her to return Resident #24's money. Dietary Staff #2 said that	M 500		

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M 500	Continued From page 22 she was in (Name of State). Dietary Staff #2 sent $35.00 via (Name of Store) to the Administrator. The Administrator said she reported this to the Attorney General's office. A review of the Face Sheet revealed the facility admitted Resident #24, on 09/10/2018, with diagnoses which included Asymptomatic Human Immunodeficiency Virus Infection, Cerebrovascular Accident and Pain. A review of Resident #24's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD), of 03/19/2019, revealed Resident #24 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact.	M 500		
M 700	45.24.1 General General. The facility shall provide routine drugs, emergency drugs and biologicals to its residents or obtain them by agreement. This Statute is not met as evidenced by: Level IV Based on observations, staff interview, record review, and facility policy review, the facility failed to ensure Resident #28's pain medications were available for one of three (1 of 3) residents reviewed for pain medication administration. Findings include: A review of a document provided by the Director of Nursing (DON)/Interim Infection Control Nurse, 07/31/19 revealed, "We do not have a specific policy for ordering medications related to cycle	M 700	1. On 07/30/2019, Resident # 28 received Lyrica 75 milligrams (mg) by mouth (po) per Medical Doctor (MD) order. An immediate in-service for nurses began on 07/30/2019 regarding medication ordering and receiving medications per Director of Nursing (DON). 2. All residents receiving medications have the potential to be affected by this deficient practice. On 8/29/2019, the Quality Assurance (QA) Committee, consisting of, Administrator, Medical Director, Director Of Nursing/Infection	9/3/19

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M 700	Continued From page 23 refills". An interview, on 07/30/19 at 9:36 AM, revealed LPN #1 stated, "the resident is out of Norco and Lyrica. I'm not sure how long he has been out of the medication. I don't have the Lyrica to give him this morning. I never saw where Lyrica was in the Pixis (after hour medication dispenser)". An observation, on 07/30/19 at 10:09 AM, revealed Licensed Practical Nurse (LPN) #1 entered Resident #26's room to administer his medications. Upon entering the room Resident #26 stated he had not had his Lyrica since 07/29/19. Resident #26 said they got his pain pill out of the Pixis last night, but he had not received it regularly for a few days. Resident #26 stated his pain level was a 10, and he was hurting and sweating. The resident's colostomy bag was also full, and he was agitated and exhibited facial grimacing. LPN #1 stated, "I worked last Friday and we sent the request to the Nurse Practitioner (NP) for a hard script on his Norco and Lyrica but we don't have it today. I called the pharmacy today and they told me they didn't have the script. I told my nurse supervisor (Registered Nurse #1) and she called them to. They told her they didn't have a hard prescription either. I don't have Lyrica in the after hour medication dispenser (Pixis) to give him this morning". An interview, on 07/30/19 10:50 AM, with RN #1 revealed, she called the pharmacy this morning and they said they were waiting on the physician's signature for the Norco and Lyrica. Pharmacy said they got the request yesterday but could not fill it because they didn't have a signed prescription for it. They were waiting on the physician's signature. The Norco or the Lyrica is not at the facility today that I know of.	M 700	Control Preventionist (DON), Social Services Director, Wound Care/Licensed Practical Nurse (LPN), Minimum Date Set (MDS)/Admissions Coordinator, Environmental Supervisor, Unit One Manager/Registered Nurse (RN), Unit Two Manager/Registered Nurse (RN), Dietary Manager, Minimum Data Set (MDS) Coordinator, Environmental Supervisor, Medical Records Clerk/Licensed Practical Nurse (LPN), Therapy Supervisor, reviewed the policy and procedure for Accepting Delivery of Medications and Medication Orders and Receipt Record with no recommended changes to the policy at this time. 3. All nurses in-serviced on 7/30/2019 regarding ordering and receiving medication per Director of Nursing (DON) and completed on 8/29/2019. No nurse will be allowed to work until in-service is completed. Medication order binders have been placed at each nursing station and Unit Managers will audit these binders every day Monday through Friday to ensure medications are ordered timely. Each Unit Manager will document audits on the medication order log at each station binder for three (3) months. 4. Any concern will be addressed immediately and the Director of Nursing (DON) will be notified. Findings will be brought to Quality Assurance (QA) Committee meeting quarterly for compliance and recommendations.	

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M 700	Continued From page 24 An interview, on 7/30/19 at 10:55 AM, with LPN #1 revealed, she did not have any Lyrica to give him this morning, and she did not see any Norco. LPN #1 said she called the pharmacy this morning and they told her they didn't have an order for the Norco or the Lyrica, and that they needed a prescription signed before they could send the medication. Record review of the July 2019 Electronic Medication Administration Record (EMAR) for Resident #26, revealed Lyrica was signed as not being administered on 07/29/19 at 5 PM and 07/30/19 at 9 AM. Further review revealed the Norco was administered last on 07/29/19 at 8:36 PM Record review of the July 2019 Physician's Orders, revealed an order, dated 05/23/19, for Lyrica 75 milligrams (mg), one (1) capsule by mouth twice a day. Further review revealed an order, dated 05/23/19 for Norco 10-325 tablet, give one by mouth every 12 hours as needed for breakthrough pain. Further review also revealed an order dated, 05/28/19, for Fentanyl 12 microgram per hour (mcg/hr) related to breakthrough pain. (The July 2019 EMAR documented the last Fentanyl Patch was administered on 07/27/19.) There was also an order, dated 05/23/19, for Tylenol Extra Strength 500 milligram (mg) caplet by mouth every six hours as needed for pain, for pain scale of one to five (1-5). Record review of the Narcotic Sign-Out Sheet for Resident #26's Lyrica revealed the last dose of medication was signed out on 07/29/19 at 9 AM. An observation, on 07/30/19 at 11:40 AM,	M 700		

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	25CR	A. BUILDING: _____ B. WING _____	08/01/2019

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M 700	Continued From page 25 revealed while the surveyor was sitting at the nurse's station a CNA came and told RN #1 that Resident #26 was in his room acting out and throwing things. On entrance to the room, Resident #26 was lying in bed. The Director of Nursing (DON) was at Resident #26's bedside. Resident #26 stated that his pain was a 10, and he was lying here hurting and trying to eat and can't get his pain medication. Resident #26 stated he had not received his Lyrica since yesterday morning, that he had not received his Lyrica in two days. Resident #26 said he had not received his Norco today. Resident #26 stated they are telling me my Norco is not here, and the Pixis is out of Norco. An interview, on 07/30/19 at 2:55 PM, with LPN #1, revealed she should have called the Nurse Practitioner (NP) or the physician to go ahead and send the hard prescription (Rx) for Resident #26 to the pharmacy when she saw he was out of medication. LPN #1 said she did not give the Norco when Registered Nurse (RN) #1/Supervisor told her about the order at 12:07 PM today. LPN #1 stated Resident #26 acts out like he did today usually when he is hurting. An interview, on 07/30/19 at 3:20 PM, revealed RN #1 stated Resident #26 told her he was hurting when she went down to assist the resident to his wheelchair. RN #1 said he ranged his pain level six to seven (6-7). RN #1 said this was right after she took the order and wrote it, so it was probably around 12:15 PM. RN #1 said she informed LPN #1 she had a new order for the Norco, and to please give it to the resident. An interview, on 07/30/19 at 3:34 PM, with Resident #26, revealed he had not received anything for pain yet. Resident #26 said his pain	M 700		

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M 700	Continued From page 26 level was six to seven (6-7). Resident #26 said they had offered him a Norco, but he couldn't take it this late because he would not be able to receive one at bedtime because it would be to soon, and he would hurt and could not sleep. Resident #26 said he would rather tough it out for a little while longer and be able to get his night time dose. Resident #26 said they never offered him any Tylenol. Resident #26 stated he had his pain patch on, but it doesn't help the pain totally. An interview, on 07/30/19 at 4:05 PM, revealed Registered Nurse (RN) #1 said Resident #26 told her about 3:25 PM, that he was hurting at a six to seven (6-7) level, but he couldn't take his Norco this late because then he couldn't take his bedtime dose, and he would not be able to sleep. RN #1 said she spoke with Licensed Practical Nurse (LPN) #1 at approximately 3:25 PM, and asked her if she had given Resident #26 his Norco when she told her (LPN #1) about the order and she told RN #1 that she had not given him anything. Record review of the Delivery Manifest revealed Resident #26's Lyrica was delivered to the facility on 07/30/19, and checked in on the 3-11 shift. Review of the Delivery Manifest, dated 07/30/19, revealed the Norco 10-325 tablets x 60 was delivered to the facility. The date and time line was blank. The form was signed by Registered Nurse (RN) #1. An interview, on 07/30/19 at 11:23 AM, with RN #1 revealed the facility had a back-up pharmacy She wanted to say it is (Name of Pharmacy), but she was not sure why they were not used. RN #1 said she still didn't know if the resident's Lyrica was at the facility at this time.	M 700		

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M 700	Continued From page 27 An interview, on 07/30/19 at 11:24 AM, with LPN #1 revealed, "I worked last Friday, and I realized he was out of the Lyrica, so I faxed a request to the pharmacy for the medication". An interview, on 07/30/19 at 11:42 AM, with the Director of Nursing (DON) revealed, Resident #26 missed last night's Lyrica. The DON stated they have a back-up pharmacy, it is (Name of Pharmacy. If the nurses don't have the medication then they should call the physician to get a hold order on the medication, or to get a replacement medication. Evidentially they didn't call the doctor or the Nurse Practitioner (NP). They should have called one or the other when they first saw that Resident #26 was running out of his Lyrica. If they don't have the medication they should call the physician or the NP, and ask for a prescription or at least for something to replace the medication until the medication can be ordered and come from the pharmacy. They should get an order to hold the medication if it's not here. The DON said she did not know that Resident #26's medication was not here until about 15 minutes ago when RN #1 told me. An interview, on 07/30/19 at 11:53 AM, revealed the facility's Pharmacist stated, "the facility doesn't have Lyrica in the Pixis for them to get out. We did not receive an order over the weekend for Resident #26's Norco and Lyrica. We have not filled the Lyrica since 06/26/19. They could send a request all day, but without a signed hard script from the physician, we would not have sent it. If the medication was not a schedule II the physician could have called it in to (Name of Pharmacy), and someone would have had to go pick it up from them. Lyrica is not a schedule II so that should have been called to (Name of	M 700		

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M 700	Continued From page 28 Pharmacy). We have nothing on file for the Lyrica to be refilled. I don't understand. They have a card with the medication on it, and they can see before they are running out of a narcotic. But they still let it run out. They are not ordering medications accordingly, or they would not run out of the medication. This issue has been a problem for the facility as well as other facilities". An interview, on 07/30/19 at 12:15 PM, with RN #1 revealed, she just took an order from the Nurse Practitioner (NP) and wrote the order at 12:07 PM to hold the Lyrica until it could get here. We have obtained a new script for Resident #26's Lyrica, and the NP sent them to the pharmacy, and I've resent them to the pharmacy also. An interview, on 07/31/19 at 1:35 PM with the Nurse Practitioner revealed, it is not recommended to stop Lyrica abruptly because you can have withdrawal symptoms. The NP stated she did not think Resident #26 would have withdrawal symptoms just missing a couple doses, but it was hard to say. The NP stated her understanding was that apparently Resident #26 ran out of medications this weekend. The NP stated she gave a hold order until the medication could arrive, and she sent a new script over to the pharmacy yesterday. An interview, on 08/01/19 at 8:10 AM, with the DON revealed, "we do have a problem with the nurses not ordering medications in a timely manner. The nurses just need some education on ordering narcotics. The nurses may just fax a request over to the pharmacy for a narcotic and not realize they need an order from the physician, and the physician needs to physically sign the order. The nurses need to follow up when ordering medications to make sure they arrive to	M 700		

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M 700	Continued From page 29 the facility. It is every nurse's responsibility to order medication". An interview, on 08/01/19 at 5:31 PM, revealed the Administrator stated, "The nurses should have immediately called the Medical Director and got instructions as what to do when the medication is out. Whatever the MD says to do is what we need to do. Doing nothing is not the right thing to do. We have to be diligent in keeping enough medications at the facility for the residents".	M 700		