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
	62SC	A. BUILDING: _____ B. WING _____	C 04/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MS CARE CENTER OF MORTON	96 OLD HIGHWAY 80 EAST MORTON, MS 39117

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M 000	Initial Comments The State Agency (SA) conducted the Complaint Investigations, CI #17749, from 04/19/21 through 04/21/21. The SA determined the facility was not in compliance with the Minimum Standards of Operation for Institutions for the Aged or Infirm, State Licensure requirements and cited 0500 45.17.2.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a	M 500		6/11/21

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M 500	Continued From page 1 pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law;	M 500		

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M 500	Continued From page 2 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical	M 500		

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M 500	Continued From page 3 record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level II Based on staff and resident interview, record review and facility policy review, the facility failed to ensure two (2) residents were free from physical abuse for two (2) of four (4) residents reviewed for abuse. Resident #1 and Resident #2.	M 500	1 Resident #1 was transferred to the Emergency Department (ED) after incident with no abnormal findings and no new orders. Resident #1 has been safely kept away from Resident #4 until discharged from facility on 3/31/2021 to another LTC facility. Resident #2 has been safely away from Resident #3 until planned discharge on 06/01/2021 to a	

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M 500	Continued From page 4 Findings include: The facility's policy titled "Free from Abuse and Neglect", revised November 2016, revealed all residents of this facility will be free from abuse, neglect, misappropriation of resident property, and exploitation. Physical abuse includes hitting, slapping, pinching, and kicking. Resident #1 A review of Occurrence Report on 3/17/21 at 5:10 PM revealed, nurse heard female Resident #1 yelling, "Help, Help." Upon entry to the room Resident #4 was observed holding Resident #1 right arm and twisting it. Resident #1 complained of pain to right upper extremities and face. Resident #1 was transferred to Emergency Department (ED) Resident #4 was moved to private room in less populated area of facility. On 4/19/21 at 4:12 PM, the State Agency (SA) interviewed Resident #1. Resident #1 stated she was in bed resting when Resident #4 entered her room. She stated she thought Resident #4 was going to shake her hand but instead he started hitting her right arm/hand and her head. Resident #1 stated Resident #4 has never hit her before and stated he was always gentle. On 4/19/21 at 4:45 PM, in an interview with the Administrator revealed Resident #4 did come into Resident #1's room and hit her and the occurrence report was completed on 3/17/21. An investigation was completed, and the SA was notified, as well as the Attorney General (AG), Physician, and Responsible Party (RP) on 3/18/21. On 4/20/21 at 10:51 AM, an interview with the	M 500	memory care unit. 2 All residents who are in an area with a resident who may exhibit abuse has the potential to be affected. 3 a Facility's Freedom from Abuse, Neglect, and Exploitation Policy was reviewed on 04/22/2021 by the Quality Assurance Committee including the Administrator and no revisions were necessary. b All employees were inserviced on Facility's Freedom from Abuse, Neglect, and Exploitation Policy and Resident Rights Policy on April 22, 2021 and again on May 19, 2021 by the Staff Development Nurse to include protection from and reporting of abuse. c Directed In-Service is scheduled for all staff on the Facility's Freedom from Abuse, Neglect, and Exploitation Policy with an emphasis on identifying abuse to be performed by the ADON at MSCC of Raleigh, on June 3, 2021. d Each morning in the Stand Up Meeting, department supervisors will review all incident reports to determine if any incidents constitute alleged abuse and if found to be alleged abuse, will be reported to the State Agency as required. All incident reports will be initialed as checked by the DON or designee. Abuse, Crime Reporting Checklist is to be completed and reviewed if incidents are found to be alleged abuse. This was put into place on June 1, 2021.	

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M 500	Continued From page 5 Director of Nurses (DON) revealed she began working on 4/13/21 as DON and she was unaware of any injuries prior to 4/13/21. On 4/21/21 at 10:40 AM, in an interview with the Licensed Master Social Worker (LMSW), she stated there was an incident on 3/17/21 when Resident #4 struck Resident #1. She also stated Resident #4 has never acted out to another resident and this was his first episode. On 4/21/21 at 11:22 AM, an interview with Licensed Practical Nurse (LPN) #1, revealed she witnessed Resident #4 placing his hands on Resident #1's right arm area. LPN #1 stated with the assistance of Certified Nurse Assistant (CNA) #1, they removed Resident #4's hands off Resident # 1. She stated then she calmed Resident #1 down and CNA #1 assisted Resident #4 to his room. LPN #1 stated she then notified Registered Nurse (RN) #1, the Administrator, the Physician, and Resident #1's Responsible Representative (RR). On 4/21/21 at 1:00 PM, an interview with CNA #1 revealed, Resident #1 was hollering out loud when she entered her room and Resident #4 was standing to the right of her, hitting her on her arm. She stated she separated Resident #4 from Resident #1 and brought Resident #4 to his room and calmed him down. A record review of the Face Sheet for Resident #1 revealed the facility admitted Resident #1 on 2/13/19 with diagnoses of Hypertension, Peripheral Vascular Disease, and Depressive Disorder. Review of Resident #1's Annual Comprehensive Minimum Data Set (MDS) with the Assessment Reference Date (ARD) of 3/22/21 revealed Resident #1 had a Brief	M 500	4 All alleged abuse incident reports will be reviewed monthly during the Quality Assurance Meeting by the Administrator and QA Committee to ensure continued compliance. This was put into place on June 3, 2021.	

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M 500	Continued From page 6	M 500		

Interview for Mental Status (BIMS) of 15 indicating the resident was cognitively intact.

Review of a Nurses' Note dated 3/17/21 revealed Resident #4 was in Resident #1's room and was twisting her right arm. This nurses' note stated both Resident #1 and Resident #4 were separated. Resident #1 was transferred to the Emergency Department (ED) for evaluation.

Record review of Nurses' Notes on 3/18/21 revealed Resident #1 returned from the ED with no new orders.

Record review of Resident #1's Computed Tomography (CT) of head without contrast, on 3/17/21, noted the impression was no evidence of an acute intracranial injury and no acute facial fractures.

Resident #2

Record review of an internal investigation performed by Administrator revealed on 3/12/21 Resident #2 was in day room when Resident #3 hit Resident #2 on the arm three (3) times and both residents were separated. Resident #3 was sent to Geri-psych for evaluation and treatment. Resident #2 was assessed by nursing staff, no acute distress, no emotional reaction, no redness to arm, and no complaint of pain when arm moved. Due to evidence from the investigation from the facility it was deemed no reporting was necessary.

On 4/20/21 at 1:05 PM in an interview with the Social Services Assistant (SS-A), revealed she had been standing close to the B-Wing Day Room, when Resident #2 was sitting in a

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M 500	Continued From page 7	M 500		

wheelchair, talking out loud and with rambling speech. Resident #3 walked past Resident #2, became agitated and grabbed Resident #2's arm and slapped her three (3) times fast on her right wrist/arm. The SS-A stated after the incident she separated both residents and re-directed them. The SS-A stated she then reported the incident to the DON, the Administrator, and the RR.

On 4/21/21 at 10:40 AM, in an interview with the LMSW revealed she was aware of the incident on 3/12/21 with Resident #2 and Resident #3. She stated Resident #3 slapped Resident #2 on her arm three (3) times.

On 4/21/21 at 11:54 AM, in an interview with LPN #2, she stated she heard Resident #3 yelling in the B-Wing Day Room and went to investigate. She observed the SS-A separating Resident #3 from Resident #2. LPN #2 stated she observed Resident #3 slapping Resident #2 on her arm. LPN #2 performed a body audit and observed no bruising on Resident #2 and notified the RR.

On 4/21/21 at 1:30 PM in an interview with Resident #2's RR, stated the facility informed her of Resident #3 hitting my mother (Resident #2), and stated Resident #3 and Resident #2 were cousins, and they had a history of hitting each other in the past when they were younger.

The facility admitted Resident #2 on 1/29/15 with diagnoses of Chronic Obstructive Pulmonary Disease (COPD), Hypertension, and Dementia per the Face Sheet. In a review of Resident #2's Quarterly MDS with an ARD of 3/24/21 revealed Resident #2 had a Brief Interview for Mental Status (BIMS) of 4 indicating Resident #2 was severely, cognitively impaired.

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M 500	Continued From page 8 Review of Resident #2's Nurses' Notes for 3/12/21 noted Resident #2 was in the day room and Resident #3 hit her on the arm. Resident #2 and Resident #3 were separated immediately and checked. No bruising or skin tears were noted and the SW and RR were called. The facility admitted Resident #3 on 6/2/17 with the diagnosis of Cognitive Deficit, Hypertension, and Dementia per the Face Sheet. In a review of Resident #3 Quarterly MDS with the ARD of 3/11/21 revealed Resident #3 BIMS of six (6).	M 500		