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
	16CO	A. BUILDING: _____ B. WING _____	C 02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MS STATE VETERANS HOME-COLLINS	3281 HIGHWAY 49 SOUTH COLLINS, MS 39428

(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 a complaint survey MS #15588, from 2/18/19 through 2/19/19. During the survey, the complaint was substantiated for violation of resident rights. The SA determined the facility was not in compliance with State Licensure Regulations for the Aged or Infirm, and cited State Statutes at M500.	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	• **The contract employee *that failed to* protect the rights of Resident #1 was placed on leave 01/02/2019 until the investigation was completed. The owner of the agency was contacted on 01/02/2019 and informed of the allegation and told not to send contract employee back to facility. On 01/04/2019 after completion of the investigation on, the employee was terminated and placed on the "Staff who are Restricted from the facility" list placed in the RN Supervisors office and all information reported to the appropriate agencies for further investigation. The owner of the contract *agency was contacted on* 01/04/2019 and informed the allegation was substantiated and remove her permanently from returning to MSVH-Collins. Resident #1 was not an interviewable resident due to his sever cognitive deficit.** • ***All* Residents have the *potential* to be affected by the deficient practice.** • **In-services were initiated on 01/02/2019 on Resident Rights and Abuse and neglect by In-service coordinator and NHA. A new Protocol prohibiting individual from taking, transmitting, or displaying of any electronic images of any resident in the facility where the caregiver's action constitute a willful act or statement to shame, degrade, humiliate or otherwise harm the personal dignity of the vulnerable adult on 01/04/2019 by In-service coordinator and NHA. New Employees will receive this training by the in-service coordinator during orientation prior to working in the facility. Agency Staff will be required to complete this training prior to working in the facility.**	3/19/2019

Revised POC 4/3/19 accepted JW

Mississippi State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 03/14/2019

Revised 3/29/19

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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	• **Beginning 03/14/2019, The Administrative Staff and RN Supervisors will make rounds 6 times per day covering all three shifts to ensure that staff are being monitored for non-use of cell phones or any device that can take electronic image of any residents in the facility in resident care areas. This will be monitored 6 x per day X 30 days ensure that staff are being monitored for non-use of cell phones or any device that can take electronic image of any residents in the facility. The Nursing Home Administrator will report findings to the Quality Assurance Committee monthly for further corrective action if necessary.**	

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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 record review, policy review, and interviews, a facilities contract/agency Certified Nursing Assistant (CNA), failed to protect the rights of Resident #1 and violated his privacy, by taking unauthorized photos of him and forwarding them to a non-employee of the facility (an ex-boyfriend) in December 2018. This affected	M 500		

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M 500	Continued From page 4 one (1) of two (2) sampled residents, Resident #1. Findings include: Review of the "Phone Policy", dated 7/2/10, revealed: Cell phones should not be used.. Personnel calls in resident care area are prohibited except in case of actual emergencies. Review of the "Abuse policy and procedure", dated 10/16/12, documents: Exploitation is defined as the illegal or improper use of a vulnerable adults or his resources for another's profit or advantage with our without the consent of the vulnerable adult. The policy documented zero tolerance for abuse issues. Review of the "Confidentiality and Privacy" policy dated 7/17/12, revealed residents must be allowed privacy when receiving care. Resident #1 was admitted to the facility on 12/18/12, with diagnoses including Dementia with behaviors, Anxiety, and Restlessness. He was dependant on staff for assistance with activities of daily living and close supervision due to history of falls. He expired 2/11/19. Review of the facility investigation reported on 01/02/18, revealed the following: On 12/31/18 (time unknown) a gentleman, later identified as the boyfriend of CNA #1, called to inform the facility that CNA #1 sent him photos of a resident of the facility about a week before he called to report the incident. A Registered Nurse (RN) #1 took the report. The written statement, documented by CNA #1, revealed the CNA denied taking and sending photos of Resident #1. Review of the photos, documented in the	M 500		

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M 500	Continued From page 5 investigation, revealed a left sided face shot of Resident #1 (identified by facility staff) sitting in a chair with a shirt on and his pants around his ankles, with his bare legs exposed. The genital area could not be visualized. A caption under the photo revealed: Two (2) Emojis faces and the statement, "he taking it off for me now baby". Interview with the gentleman who reported the incident, on 02/18/19 at 5:59 PM, revealed he called the facility to report receiving photos from his girlfriend (CNA#1). He didn't know the name of the resident (later identified by the Administrator as Resident #1), he felt this was not right and needed to be reported. When asked her why she sent the pictures, he stated, "having fun". The facility Administrator was interviewed on 02/18/19 at 3:00 PM. She revealed that CNA#1 exploited Resident #1 by taking photos and distributing them, violated his privacy, and violated the Cell Phone policy. She stated the gentleman who received the photos provided the photos to the facility. The Administrator confirmed the photos were of Resident#1, a resident. The Director of Nursing (DON) was interviewed on 02/18/19 at 3:30 PM, and revealed she became aware of the allegation after finding the note from the nurse on 01/02/19, after returning to work from the holiday. No one called to inform her of the allegation of Abuse/Exploration and/or violation of privacy. Upon investigation, she found that the photos, provided by the gentleman who called to report receiving the photos, provided photos via email to the facility and they confirmed that the photos were of Resident #1. The DON stated Resident #1 would have been unable to provide consent for the photos to be taken due to Dementia. She stated CNA #1 was an Agency	M 500		

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M 500	Continued From page 6 CNA, who was suspended immediately, and she contacted the agency and terminated her service. On 02/19/19, RN#1 was interviewed at 9:50 AM, and revealed she thought the call was a prank. She slipped a note under the DON's door on 12/31/18, of the report she had received about photos of a resident. She further revealed she should have notified the DON immediately after receiving the call/allegation. Attempts were made on 02/18/19, to contact CNA#1; the phone was disconnected and she was unreachable for interview. Review of CNA#1's personnel file revealed she signed a confidentiality agreement with the agency. The agreement documents the following: "... Confidential and information is valuable, sensitive and protected by law and the facility policies As a Health care Professional, you are required to conduct yourself in strict conformance to applicable laws and facility policies and to abide by duties described below governing confidential information...you will use confidential information only as needed to perform legitimate duties at facilities. You will not in any divulge, copy, release, sell ... You will not misuse or fail to safeguard confidential information..."	M 500		