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
	36OX	A. BUILDING: _____ B. WING _____	C 04/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MS STATE VETERANS HOME-OXFORD	120 VETERANS DRIVE OXFORD, MS 38655

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M 000	Initial Comments The State Agency (SA) conducted a complaint survey, MS 15123, at the facility 4/9/18 through 4/10/18. During the survey, the SA determined the facility was not in compliance with State Licensure Regulations for the Aged or Infirm, and cited State Statute M500.	M 000		
M 500 SS=D	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance	M 500	Bullet 1 On 3/30/18, LPN #1 was suspended pending the outcome of facility investigation and allegation was reported to MSDH, VA and the State Attorney General's Office by DON on 3/30/18. A complete investigation was initiated on 3/30/18 and conducted by facility Administrator and DON. A complete body audit assessment was completed on 3/30/18 for Resident #1 by DON and ADON with no noted injuries. LPN #1 was terminated on 4/3/18 for violating Resident #1's residents rights. The MSDH, VA, Local Ornsbudsman , Resident #1 RP, MVAB, Resident #1 physcian and the State Attorney General office were notified by the DON on 4/3/18 that LPN#1 was terminated.	6/3/18

POC Accepted for Desk Review 6/7/18 KW

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE Administrator (X6) DATE 5/3/18

Revised 6/6/18 KSM

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M 500	Continued From page 1 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	Bullet #2 For any and all residents residing in the home we recognize that all residents have the potential to be negatively affected by any violation of thier Residents Rights by any person.	6/3/18

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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 record);	M 500	Bullet # 3 On 4/10/18 an inservice was conducted by facility In-service Coordinator for all staff on Residents Rights, dignity and Respect and the types of Abuse. Additionally, on 4/18/18 another inservice was conducted by In-service Coordinator and Physical Therapists from Summit REhab on Dementia Resident care to include ways to decrease behaviors. Crime stoppers in-service was also conducted by in-service coordinator on 4/11/18 for all staff on the importance of reporting any abuse and neglect and that it can be done anonymously, if needed. All staff attending the inservices voiced understanding of the material that was presented to them. Additionally, new staff will be trained on Resident's Rights and Abuse and neglect reporting upon hire before they engage in direct care by the in-service coordinator.	6/3/18

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M 500	Continued From page 3 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: Based on record review, staff interview and facility policy review, the facility failed to ensure one (1) of five (5) residents was not verbally abused and failed to report the incident of verbal abuse at the time of occurrence, Resident #1. Findings include: Review of the facility's policy, Abuse Policy and Procedure, dated 10/16/12, revealed: All	M 500	Bullet 4 A QA monitor will be put in place on 5/318 and will be in place for 3 months, to ensure that all residents rights are observed and respected at all times. The LSW 's will interview 15 interviewable resident's weekly to monitor staff compliance of Resident's Rights to include Verbal/Physical abuse and neglect. Additionally, a QA monitor was will be put in place on 5/3/18 for the Administrative staff and RN supervisors to interview 5 -10 employees, chosen at random, each week to ensure staff compliance with reporting any Residents rights violations to thier supervisor immediately. Any and all negative findings will be reported to ADON, DON and/or Administrator immediately. Failure to obtain/maintain subtaintial compliance shall result in the issue being brought to the monthly QA committee meeting for review, revision and/or change in the current plan of correction to obtain substantial compliance.	6/3/18

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M 500	Continued From page 4	M 500		

residents have the right to be free from abuse, neglect, or exploitation. The facility will strive to maintain an environment that is free from threat of and /or occurrence of harassment, abuse (verbal, physical, mental, psychological, or sexual), neglect, corporal punishment, involuntary seclusion, and misappropriation of property.

Review of the facility's written report, dated 4/4/18, revealed Licensed Practical Nurse (LPN) #1 verbally abused Resident #1 and this incident was witnessed by a visitor and several staff members. LPN #1 was suspended pending investigation after Administration was notified of the incident on 3/30/18, by the visitor of the facility. LPN #1 was terminated after completion of facility investigation.

Interview with Direct Care Worker (DCW) #1 on 4/9/18 at 4:10 PM, revealed Resident #1 was trying to get out the secured door of the Dementia Unit as other personnel were trying to come in. DCW #1 stated she was trying to get the resident back in the door and redirect him when LPN #1 came over and intervened. DCW #1 stated LPN #1 said to Resident #1, "Come on, let's go." Resident #1 said, "No" and became combative. DCW #1 stated at that point LPN #1 became loud and said, "Go to your room" very loud and was screaming at Resident #1. LPN #1 then said to Resident #1, "Either go to your room now, or you will go to the crazy house." DCW #1 stated LPN#1 then said to the resident, "You don't touch my hair." DCW #1 stated she did not see Resident #1 touch LPN#1's hair, and provided no assistance in removing Resident #1's hands from LPN #1's hair. DCW #1 stated LPN #1 continued to scream at Resident #1 saying, "Go to your room now." DCW #1 stated at that point a visitor approached LPN #1 and said that's not the way

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M 500	Continued From page 5	M 500		

you talk to a Resident with Alzheimer's. DCW #1 stated at that point, she took the resident away from the area and got him a Diet Coke. DCW #1 stated she did not report the verbal abuse. DCW#1 stated it was a busy night and she just didn't. DCW #1 stated she should have reported the incident to the Supervisor when it happened.

Interview with the Visitor, on 4/9/18 at 5:00 PM, revealed LPN #1 was angrily saying to Resident #1, "Go to your room now, go to your room now. Oh, you want to go out there, go ahead and we will send you to the crazy house." The visitor stated LPN #1 was screaming at the resident. The visitor stated several staff members were present and no one said anything to her. He stated that's when he got up and said to her, "Is that how you talk to a resident with Alzheimer's and Dementia." The visitor stated she looked at him angrily, and was shaking, but walked off without saying anything. The visitor stated he reported the incident to the Administrator and Director of Nursing (DON) on 3/30/18.

Interview with a Housekeeping Staff member, on 4/10/18 at 8:30 AM, revealed he was trying to help DCW #1 get Resident #1 back into the secured unit when LPN #1 came over. The Housekeeper stated that Resident #1 said to the nurse, "Your hair sure is pretty." LPN #1 said to the resident, "Don't you touch my damn hair", and continued to say, "Take your ass to your room". The Housekeeper stated the visitor then came over and spoke with the nurse. The Housekeeper stated he did not report the incident to the Supervisor on duty. He stated that he should have, but the Supervisor wasn't in her office, and he needed to get his dining room cleaned.

Interview with LPN #1 on 4/10/18 at 8:45 AM,

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M 500	Continued From page 6	M 500		

revealed Resident #1 was trying to get out the secured unit and she was assisting DCW #1 in getting him back in. LPN #1 stated Resident #1 grabbed a handful of her hair and DCW #1 helped to break the residents grip. LPN #1 stated she told Resident #1 that he couldn't do that, and that he couldn't go out the door. LPN #1 stated she told Resident #1 that if he wanted to act like that he could go to his room. LPN #1 stated at that point she walked away to continue her medication pass. LPN #1 stated a visitor approached her at that time and asked her if that's how you talk to someone with Dementia. LPN #1 stated she did not respond to him. LPN #1 denied verbally abusing the Resident.

Interview with the Registered Nurse (RN) #1, on 4/10/18 at 10:45 AM, revealed that she was the Supervisor on duty on 3/29/18, the night of the incident. RN #1 stated no one reported an incident of verbal abuse to her, but should have. RN #1 stated she found out about the incident the next day when the Director of Nursing (DON) called her. RN #1 stated staff should have reported the incident to her, she would have notified the DON and Administrator, and followed their direction.

Interview with the DON, on 4/10/18 at 11:15 AM, revealed she was informed of the incident on 3/30/18, when the visitor who witnessed the incident reported it to her. The DON stated upon notification, the facility began an investigation and suspended the nurse. The DON stated LPN #1 was terminated due to verbal abuse. The DON stated that staff should have reported the incident to the Supervisor at the time of occurrence.

Interview with the Administrator on 4/10/18 at 12:00 PM, revealed staff should have reported

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M 500	Continued From page 7 the incident of verbal abuse immediately to the Nursing Supervisor, and that the employee should have been sent home. Review of the Face Sheet revealed the facility admitted Resident #1 on 9/27/17, with diagnoses which included Unspecified Psychosis and Hypertension. Review of Resident #1's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/21/18, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated Resident #1 was cognitively impaired.	M 500		