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 05/31/2018 |

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

| (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 |
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| M 000 | Initial Comments<br><br>The State Agency (SA) conducted complaint surveys MS 15221 and MS 15227 from 5/30/18 through 5/31/18. During the survey, the SA substantiated MS 15227 and cited a related deficiency M500, related to dignity. MS 15221 was not substantiated related to Activity of Daily Living (ADL) care, hydration, or abuse/neglect. No deficiencies cited for MS 15221. The facility was not in compliance with State Licensure Regulations for the Aged or Infirm.<br><br>The census at the time of survey was 133, and the facility was certified for 150 beds. | M 000 | Bullet 1<br><br>On 5/17/18, CNA #1 was suspended pending the outcome of facility investigation. This allegation was reported to MSDH, VA and the State Attorney Generals Office by ADON on 5/18/18. Resident #1 was assessed by ADON on 5/17/18 with no injuries noted.<br>A complete investigation was initiated on 5/18/18, which was conducted by facility Administrator and ADON. CNA #1 was terminiated on 5/24/18 for violating resident #1 Residents Rights. | |
| M 500 | 45.17.2 Residents' Rights<br><br>Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility:<br><br>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;<br><br>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;<br><br>3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his | M 500 | Bullet 2<br><br>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. | 6/30/18<br><br>6/30/18 |

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| M 500 | Continued From page 1<br><br>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;<br><br>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;<br><br>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 | Bullet 3<br><br>On 6/12/18, an in-service was conducted by in-service coordinator for all staff on Residents Rights. All staff voiced understanding of the material that was presented to them. Additionally, all new staff will be trained on Residents' Rights upon hire by the in-service coordinator before they engage in direct care of the residents.<br><br>Bullet 4<br><br>A QA monitor on Residents Rights was put in place on 5/3/18 and will be extended from 3 months to 6 months to ensure compliance with facility Residents Rights Policy. The facility LSW's will interview 15 residents that are deemed interviewable to monitor staff compliance with Residents Rights Policy to include Verbal and Physical Abuse and neglect. Another QA monitor was 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 understanding and compliance with reporting any Residents Rights violations to thier supervisors immediately. | 6/30/18<br><br>6/30/18 |

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| M 500 | Continued From page 2<br>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;<br><br>7. is free from mental and physical abuse;<br>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;<br>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;<br><br>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;<br><br>11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care;<br><br>12. may associate and communicate privately with persons of his choice, may join with other | M 500 | | |

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| M 500 | Continued From page 3<br>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);<br><br>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);<br><br>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);<br><br>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<br><br>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.<br><br>This Statute is not met as evidenced by:<br>Based on staff interview, facility policy review and record review the facility failed to ensure residents were cared for in a dignified manner for | M 500 | | |

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| M 500 | Continued From page 4<br>one (1) of eight (8) residents reviewed, Resident #8<br><br>Findings Include:<br><br>Review of the facility's policy, Quality of Life, not dated, revealed: A. Dignity The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his/her individuality.<br><br>Review of the Face Sheet revealed the facility admitted Resident #8 on 4/9/18, with diagnoses which included Diabetes Mellitus and Essential Hypertension.<br><br>Review of Resident #8's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/15/18, revealed Resident #8 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated Resident #8 had moderate cognitive impairment.<br><br>Review of the facility's written report and investigation, dated 5/17/18, revealed a visitor of Resident #8 reported to the Administrator that Certified Nursing Assistant (CNA) #1 had refused to help Resident #8 with brushing his teeth and gave him a cold bath cloth to wash his face. The visitor also stated that Resident #8 had asked CNA #1 to assist him to the bathroom and she did not help him. Review of the visitor's written statement during the investigation, revealed CNA #1 told Resident #8 to use his brief for toileting and she would come back later and clean him up.<br><br>Interview with visitor of Resident #8 on 5/31/18 at 9:20 AM, revealed that Resident #8 reported to her that the CNA with the long red hair gave him a | M 500 | | |

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| M 500 | Continued From page 5<br>cold bath cloth to wash his face and wouldn't allow him to brush his teeth when he requested. The visitor stated after breakfast Resident #8 requested to go to the bathroom. The visitor stated she took him to his room and turned the call light on. CNA #1 came to the room and turned the light off and asked what was needed. The visitor informed CNA #1 that the resident needed to use the restroom and the CNA stated, "I don't have time for that right now, I have someone in the shower and a bunch of beds to make." The visitor stated CNA #1 told Resident #8 that he would have to use his brief and she would come back and clean him up.<br><br>Interview with Assistant Director of Nursing (ADON) on 5/31/18 at 9:50 AM, revealed CNA #1 told her that she did tell the resident that she didn't have time to take him to the bathroom that she had other residents to take care of and that she would come back later.<br><br>Interview and observation of Resident #8 on 5/31/18 at 10:50 AM, revealed that he was alert but has episodes of confusion. Resident #8 was not able to recall the events of 5/17/18.<br><br>Interview with CNA #1 on 5/31/18 at 12:45 PM, revealed she denied being asked to take Resident #8 to the restroom. CNA #1 stated if she had been asked she would have carried him because that's her job.<br><br>Interview with the Administrator on 5/31/18 at 2:00 PM, revealed CNA #1 failed to provide care to Resident #8 in a dignified manner. The Administrator stated CNA #1 should have asked for assistance from another staff member if she was too busy to take the resident to the bathroom. | M 500 | | |

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