STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A414	A. BUILDING _____ B. WING _____	C 01/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METHODIST SPECIALTY CARE CENTER	1 LAYFAIR DRIVE SUITE 500 FLOWOOD, MS 39232

(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) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted a survey for Complaint Investigation (CI), MS #18447 and a Facility Reported Incident (FRI), MS #18448 at the facility from 1/20/2022 to 1/21/2022. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid. The SA did not substantiate MS #18447 for call bells not operative and no pressure sore precautions. The SA did substantiate MS #18448 for failure to ensure adequate privacy and maintaining a resident's dignity during care and cited F550. The facility held a license for 60 beds, with a census of 60.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and	F 550		3/7/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 02/04/2022

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F 550	Continued From page 1 practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, the facility failed to maintain a resident's dignity by ensuring adequate privacy when two (2) nonclinical staff members were allowed to remain in a resident's room during Activities of Daily Living (ADL) care. Resident #1 Record review of the facility's "Resident's Rights" revealed " ...17. To Privacy and Respect - A resident has the right to privacy in ...personal care ... You shall be treated with consideration, respect and full recognition of your dignity ..." On 1/21/22 at 9:48 AM, during an interview with the Administrator, he stated the facility reported an incident that occurred on 1/17/2022 in which two environmental services employees	F 550	This plan of correction is being submitted in accordance with specific regulatory requirements. It should not be construed as an admission of any deficiency cited. 1. One Resident had the potential to be affected by the cited deficient practice. Resident #1 informed the Nurse Manager on 01/18/22 of the incident that occurred on 01/17/22. the Nurse Manger immediately reported the incident to the Director of Nursing, who then informed the Administrator and Assistant Administrator. Resident #1 was interviewed and assessed, initially, by the Nurse Manager on 01/18/22, followed by the Director of Nursing and Assistant	

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F 550	Continued From page 2 (Housekeeper #1 and Housekeeper #2) were talking with Resident #1 and two Certified Nursing Assistants (CNA #1 and CNA #2) in the resident's room. The CNA's used the ceiling lift to assist Resident #1 to the bed and continued to undress the resident while the environmental services employees were in the room. After the resident complained about the event, the facility immediately suspended the employees and began to investigate and make the appropriate notifications to the physician, Mississippi State Department of Health (MSDH), and the Attorney General's Office (AGO). The resident felt embarrassed and humiliated because of the actions of the CNA's and the Environmental Services employees. After the investigation was completed, all four employees were terminated. On 1/21/22 at 12:00 PM, in an interview with RN #1, First Shift Supervisor, she said Resident #1 asked to see her on Tuesday morning (1/18/2022). She has a good rapport with the resident and when the resident told her what had happened, she immediately notified the DON and Administrator. Resident #1 has not been withdrawn since the event and has not expressed that she is afraid of staff or afraid of any reprisal from making the complaint. On 1/21/22 at 12:11 PM, in an interview with Resident #1, she stated the event occurred on Monday around 2:00 p.m. She had been up in her wheelchair, fully dressed in pants and a shirt. CNA #1 and CNA #2 came with her to the room, as well as Housekeeper #1 and Housekeeper #2. Resident #1 did not know what they were doing in her room and they "had no business in my room". Resident #1 said the CNAs were upset because they had to put her back to bed after being up for	F 550	Administrator on 1/18/22. Resident was assured the incident would be thoroughly investigated and appropriate action would be taken. Resident #1 expressed understanding and stated, " I know you will do what is necessary to keep me safe." Investigation by the Administrator, Assistant Administrator, and Director of Nursing shows Resident #1's dignity was not maintained when Housekeeper #1 and Housekeeper #2 were allowed to remain in the room during Activities of Daily Living care by Certified Nursing Assistant #1 and Certified Nursing Assistant #2. Records indicate Certified Nursing Assistant #1, Certified Nursing Assistant #2,Housekeeper #1 and Housekeeper #2 received recent in-service training on Residents Rights and Abuse and Neglect in December of 2021. Certified Nursing Assistant #1, Certified Nursing Assistant #2, Housekeeper #1 and Housekeeper #2 were immediately suspended on 1/18/22. After investigation, Certified Nursing Assistant #1, Certified Nursing Assistant #2, Housekeeper #1, and Housekeeper #2 employment was terminated on 01/19/22 for failure to follow facility policy regarding maintaining Resident Rights and Dignity. All residents on the same floor as Resident #1, who can communicate their needs, were interviewed by the Director of Nursing and Nurse Manager on January 18 through January 19, 2022, with no other complaints received. 2. Although no other residents were	

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F 550	Continued From page 3 two hours. When the CNA's began to undress her, she did not know why they (the housekeeper's) didn't walk out, and she kept thinking they were going to leave. She said, "I just kept thinking why did they do this? This really happened and I don't know why." Resident #1 confirmed she did not feel comfortable telling the CNAs to tell the housekeeping staff to leave because she could tell they were already upset. She chose not to say anything to them to keep down confusion and an argument, but she was embarrassed and humiliated. A Record review of the "Risk Management Accident/Incident Investigation summary" revealed the Administrator, Assistant Administrator, and the Director of Nursing (DON) conducted an investigation. The date of the accident/incident is 1/17/2022. The Description of Accident/Incident "Resident was undressed and left uncovered during ADL care in the presence of non-clinical (Environmental Services) employees... Injury/Adverse Effects "Resident was embarrassed and humiliated... Assessment/Treatment Provided "...Resident expressed that she was embarrassed and humiliated by the experience... Investigation Summary "... Two Environmental Services employees, Housekeeper #1 and Housekeeper #2 (not assigned to Resident #1's room) followed CNA #1 and CNA #2 into Resident #1's room and remained in the room talking with the CNAs during the entire transfer and ADL care. Resident #1's clothing was removed from the waist down and she was left uncovered in plain view of Housekeeper #1 and Housekeeper #2...Resident #1 indicated she felt embarrassed and humiliated from being exposed for a prolonged period of time with the Environmental Services Employees	F 550	affected, the facility has determined that all residents had the potential to be affected by the cited deficiency. 3. The Director of Nursing and Nurse Manger conducted immediate in person in-service training for all staff members on Resident's Rights, from January 19 through February 7, 2022 with emphasis on ensuring resident dignity during Activities of Daily Living care. A complete and comprehensive review of the facilities annual computer based Resident's Rights training program was conducted by the facility Administrator, Assistant Administrator and Director of Nursing on January 19, 2022, which included the efficacy of the annual training program. It was determined additional training on Resident's Rights with emphasis on dignity during Activities of Daily Living care was needed for all staff members. To protect residents in similar situations the Nurse Manager and Certified Nursing Assistant Coordinator will observe Activities of Daily Living care on ten (10) randomly selected residents, each, on a weekly basis (Total of 20 residents). These audits will begin on February 7, 2022 and end on March 4, 2022. All cognitive residents will be interviewed weekly by the Director of Nursing, Assistant Administrator and the Nurse Manager for four (4) weeks to determine compliance of Resident's Rights with emphasis on maintaining resident dignity. This process will begin on February 7, 2022 and be completed on March 7, 2022. In addition, the Director of Nursing,	

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F 550	Continued From page 4 watching all of her ADL Care. CNA #1 and CNA #2 were interview by DON via telephone on 1/19/22 and confirmed they allowed the Environmental Services employees to remain in the room during ADL care. CNA #1 indicated she knew Housekeeper #1 and Housekeeper #2 were not supposed to be in the room but continued with the ADL care and transfer. CNA #2 indicated she was aware Resident #1 is a very modest and private person and the Environmental Services employees were not supposed to be in the room..." A record review of the "Face Sheet" revealed Resident #1 was admitted on 5/30/13 and readmitted on 9/4/2014 with diagnoses of Guillain-Barre syndrome. A record review of the annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/3/2022 revealed Resident #1 has a BIMS of 15 which means she is cognitively intact. A record review of a written statement signed by RN #1 dated 1/18/22 revealed "I was called to (Resident #1's Room) today by resident to issue a complaint about CNAs who cared for her on 1/17/22. Resident asked to be put to bed between 1400-1430 (2:00 PM to 2:30 PM). CNA #1 and CNA #2 went into room to put her back in bed and two houskeepers walked in behind them carrying on and joking. The CNA's put her in the bed and started undressing her. They took her pants and brief off to clean her up. She stated she kept thinking there should be privacy when they undress me. They just kept joking and kidding around with the houskeepers. She kept thinking that they would tell the houskeepers to leave but they never did. She stated she felt very uncomfortable, embarrassed and humiliated.	F 550	Assistant Administrator, Nurse Manager and Social Worker will provide education on resident's rights with emphasis on privacy and respect to all cognitive residents and all responsible parties, to be completed by March 7, 2022. 4. Audit results, from resident observations, will be reported to the ad hoc Quality Assurance committee on march 7, 2022. The Quality assurance committee will make recommendations for any additional monitoring, if needed. Resident's rights in-service training will be conducted quarterly to ensure 100% compliance for all staff. first quarter Resident's Rights training was conducted January 19 through February 7, 2022, and will be reported to the ad hoc Quality Assurance meeting on March 7, 2022 and reviewed during the first quarter Quality Assurance meeting, scheduled for April 20, 2022. Second quarter Resident's Rights training will begin April 4, 2022 and end on June 30, 2022; and reported to second quarter Quality Assurance Meeting tentatively scheduled for July 20, 2022. Third quarter Resident's Rights training will begin on July 1, 2022 and end on September 30, 2022; and reported to the third quarter Quality Assurance Committee tentatively scheduled for October 19, 2022. Fourth quarter Resident's Rights training will begin on October 1, 2022 and end on December 31, 2022; and reported to the fourth quarter Quality Assurance Meeting tentatively scheduled for January 23,2023.	

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F 550	Continued From page 5 She voiced that she is a very private person and it was not right. She stated she was told when she came here that everybody has to knock on my door and they cannot come in when personal care is being provided. She stated that the two housekeepers just stood there and watched while they undressed her. A record review of a written statement signed by the DON and the Assistant Administrator, dated 1/18/2022 revealed "RN #1, Shift Manager received a complaint from Resident #1, regarding CNA #1 and CNA #2. Assistant Administrator and I went to resident's room to discuss the incident. Resident #1 stated that she asked CNA #1 to put her back in bed around 2:00 PM yesterday. CNA #2 was with CNA #1. She said they were "fussy" about putting her back in bed. Resident #1 said the two housekeepers, Housekeeper #1 and Housekeeper #2, followed them into her room. The housekeepers were standing around looking at her pictures on the wall and Resident #1 said she kept thinking they were going to leave. She said that they were not even housekeepers that usually cleaned her room. CNA #1 and CNA #2 proceeded to lift her out of her wheelchair with the ceiling lift, and put her onto the bed...After getting Resident #1 into the bed, CNA #2 and CNA #1 removed her pants and brief, leaving her exposed from the waist down. She said all she had on was a shirt. The two housekeepers were still in the room and both of them were staring at her. Resident #1 said when she knew the housekeepers were still in her room looking at her, she felt humiliated and ashamed..." Record review of a written statement signed by the DON revealed, "1/18/22 at 16:30 (4:30 PM). Statement from CNA #1 via telephone... I	F 550	Staff compliance on quarterly Resident's Rights in-service training will be monitored by the facility Administrator and reported to the Quality Assurance committed during the next four quarters, tentatively scheduled for April 20, 2022, July 20, 2022, October 19, 2022 and January 23, 2023.	

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F 550	Continued From page 6	F 550		

informed CNA #1 that the complaint was regarding getting a resident back into bed (Resident #1) and removing her pants and brief with another CNA assisting her with two housekeepers were present in the room...CNA #1 said she knew they weren't supposed to be in the room, but since Resident #1 was talking to them they went ahead and put her in the bed and removed her pants and brief... CNA #1 said, we weren't talking to Resident #1 when we were putting her in bed..."

Record review of a written statement signed by the DON revealed, "1/18/22 at 16:45 (4:45 PM). Statement from CNA #2 via telephone...I informed CNA #2 that the complaint was regarding assisting another CNA getting a Resident #1 back into bed, removing her pants and brief while two housekeepers were present in the room. CNA #2 said she told them they needed to leave the room. She said she knows Resident #1 won't even get undressed in front of her husband. The houseepers were standing in the entry way of the room and Resident #1 told they didn't need to leave since they were by the door and couldn't see anything..."
Record review of "Course Completion History" dated 1/18/2022 revealed Housekeeper #1 and Housekeeper #2 completed a course titled "Understanding Abuse and Neglect Self-Paced" on 12/14/212021.

Record review of "Course Completion History" dated 1/21/2022 revealed CNA #1 completed "eCOURSE: Protecting Resident Rights in Nursing Facilities" on 12/26/202 which indicated CNA #1 received training on Resident Rights.

Record review of "Transcript for CNA #2"

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F 550	Continued From page 7 revealed Course name "e-COURSE: Protecting Resident Rights in Nursing Facilities" was completed on 12/14/202 which indicated CNA #2 was received training on Resident Rights.	F 550		