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
	30PL	A. BUILDING: _____ B. WING _____	C 02/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

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M 000	Initial Comments The State Agency (SA) determined during an annual recertification survey, conducted from 2/23/21 to 2/26/21, the facility was not in compliance with the Minimum Standards of Operation for Institutions for the Aged or Infirm, state licensure requirements at M500 and M645.	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 pharmacy or pharmacist provider in accordance	M 500		3/26/21

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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		

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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		

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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 observation, interviews, record review and facility policy review, the facility failed to interact with a resident during meal observation one (1) of ten (10) meal observations of residents fed by staff, Resident #19. Record review of the facility's, "Residents Rights", revised November 28, 2016, revealed the resident has a right to dignified existence, self-determination, and communication with and	M 500	This plan of correction constitutes a written allegation of compliance for the deficiencies cited. Submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements established by the State and Federal law. 1. Resident #19 was fed her meal by	

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M 500	Continued From page 4 access to persons and services inside and outside the facility. The facility must treat each resident with respect, dignity and care for each resident in a manner and in 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 residents. Record review of the facility policy titled " Respect and Dignity", no date, revealed the facility promotes independence and dignity in dining by avoidance of staff standing over residents while assisting them to eat and staff interacting or conversing only with each other rather than the resident. Record review of the facility's, "Serving Food Policy", dated August 18, 2011, revealed residents who are unable to feed themselves shall be fed with attention to safety, comfort, and dignity. Resident #19 On 2/23/21, at 12:00 PM, State Agency (SA) observed lunch meal in the North Hall dining room. Certified Nurse Assistants (CNA) #5 spoonfed Resident #19 while talking with CNA #6. They talked to each other throughout the meal. CNA #5 and CNA #6 did not address or talk to the residents during the meal. CNA #5 stood beside the resident being fed. On 2/23/21 SA attempt to interview Resident #19 was less than successful due to resident's inability to communicate verbally. On 2/23/21, at 11:00 AM, interview with CNA #5 revealed training in procedures for feeding	M 500	Certified Nursing Assistant (CAN) # 5. Resident # 19 showed no signs of discomfort or distress from the encounter. 2. All residents in the facility who are unable to feed themselves have the potential to be affected by this practice. 3. The Director of Nursing (DON) completed an education with Certified Nursing Assistants (CNA)s on Resident Rights/Exercise of Rights in correspondence with feeding residents with attention to safety, comfort, and dignity as well as correct feeding techniques on February 26, 2021. The Administrator completed a one-on-one in-service with Certified Nursing Assistant (CNA) # 5 on March 24, 2021 on Resident Rights/Exercise of Rights in correspondence with feeding residents with attention to safety, comfort, and dignity as well as correct feeding techniques. Certified Nursing Assistant (CNA) # 6 is no longer an employee at Plaza Community Living Center as of March 2, 2021. Her last day worked was February 25, 2021. 4. The Director of Nursing (DON), Assistant Director of Nursing (ADON), or Unit Manager(s) will complete an audit weekly to ensure residents are receiving proper care regarding feeding etiquette and Resident Rights by making rounds during any of the 3 main mealtimes, to begin on March 15, 2021. Any concerns related to Resident Rights, Dignity, or inadequate feeding techniques will be addressed immediately.	

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M 500	Continued From page 5 dependent residents were taught in the CNA program in which CNA #5 graduated from. When asked correct procedure for feeding dependent residents, CNA #5 stated she remembered being taught to sit next to or close to resident and giving the resident attention during meals. CNA #5 stated she was aware and remembered that she had not positioned herself appropriately nor had she been engaged with the resident during meal. CNA #5 stated "I really can't even believe I did that because even though she don't talk back I talk to her all the time." On 2/23/21, at 12:45 PM, interview with Director of Nursing (DON) revealed the facility provided in-service on "Supervision of Resident Nutrition" to all CNA's. The DON stated she had not observed any CNA feeding residents while standing or failing to interact with residents during meals while spoon feeding. The DON also stated she had received no complaints from residents or families regarding CNA's spoon feeding residents. On 2/26/21 the SA attempted to contact CNA # 6 for a telephone interview because she had not been on the schedule for work on 2/25/21 or 2/26/21. The SA was unable to contact CNA #6.	M 500	The Director of Nursing (DON), Assistant Director of Nursing (ADON), or Unit Manager(s) will complete an audit to begin on March 15, 2021 weekly during any of the 3 main mealtimes to include 3 residents, 2 times a week for 30 days; then 3 residents monthly for 6 months to ensure residents are engaged during mealtimes with proper feeding techniques and Resident Rights are honored regarding being treated with dignity and respect. Any concerns related to Resident Rights, Dignity, or inadequate feeding techniques will be addressed immediately to begin with one-on-one in-service education and will move to disciplinary actions. The results of such audits will be reviewed at the facility's Quality Assurance Performance Improvement meeting monthly to monitor compliance for a period of 6 months to end on September 15, 2021. 5. The results of the audits will be reviewed at the facility's Quality Assurance Performance Improvement meeting monthly to monitor compliance for a period of 6 months to end on September 15, 2021. The first Quality Assurance Performance Improvement meeting to review such audits will be held on March 30, 2021. If the Quality Assurance team identifies non-compliance, the interdisciplinary team will review policies and procedures and submit solutions and/or changes to make as needed and complete further in-service education. Completion date as of March 26, 2021.	

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M 500	Continued From page 6 Based observation, interviews, record review and facility policy review, the facility failed to interact with a resident during meal observation one (1) of ten (10) meal observations of residents fed by staff, Resident #19. Record review of the facility's, "Residents Rights", revised November 28, 2016, revealed the resident has a right to dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. The facility must treat each resident with respect, dignity and care for each resident in a manner and in 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 residents. Record review of the facility policy titled " Respect and Dignity", no date, revealed the facility promotes independence and dignity in dining by avoidance of staff standing over residents while assisting them to eat and staff interacting or conversing only with each other rather than the resident. Record review of the facility's, "Serving Food Policy", dated August 18, 2011, revealed residents who are unable to feed themselves shall be fed with attention to safety, comfort, and dignity.	M 500		

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M 500	Continued From page 7 Resident #19 On 2/23/21, at 12:00 PM, State Agency (SA) observed lunch meal in the North Hall dining room. Certified Nurse Assistants (CNA) #5 spoonfed Resident #19 while talking with CNA #6. They talked to each other throughout the meal. CNA #5 and CNA #6 did not address or talk to the residents during the meal. CNA #5 stood beside the resident being fed. On 2/23/21 SA attempt to interview Resident #19 was less than successful due to resident's inability to communicate verbally. On 2/23/21, at 11:00 AM, interview with CNA #5 revealed training in procedures for feeding dependent residents were taught in the CNA program in which CNA #5 graduated from. When asked correct procedure for feeding dependent residents, CNA #5 stated she remembered being taught to sit next to or close to resident and giving the resident attention during meals. CNA #5 stated she was aware and remembered that she had not positioned herself appropriately nor had she been engaged with the resident during meal. CNA #5 stated "I really can't even believe I did that because even though she don't talk back I talk to her all the time." On 2/23/21, at 12:45 PM, interview with Director of Nursing (DON) revealed the facility provided in-service on "Supervision of Resident Nutrition" to all CNA's. The DON stated she had not observed any CNA feeding residents while standing or failing to interact with residents during meals while spoon feeding. The DON also stated she had received no complaints from residents or families regarding CNA's spoon feeding residents.	M 500		

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