STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255306	A. BUILDING _____ B. WING _____	C 09/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLOY DYER MANOR NH	1000 EAST MADISON HOUSTON, MS 38851

(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 Complaint Investigation at the facility on 09/28/21 through 09/29/21 for CI MS #17526 related to dignity and respect. During the survey, the SA determined that the facility was not in compliance with Medicare and Medicaid regulations of participation and cited F550 for resident rights. Census at time of the survey was 49 with a license for 66 beds.	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 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	F 550		10/28/21

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

Electronically Signed | 10/20/2021

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F 550	Continued From page 1 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 record review, interviews, and facility policy review, the facility failed to ensure resident rights were maintained for (1) one of five (5) residents reviewed. Resident #1 An Interview with the Ombudsman at 10:30AM on 09/28/21 stated that she was involved in an investigation that the State Office of Ombudsman had recieved from a Responsible Party (RP) of Resident #1 that her office recieved on 01/10/21 regarding how a staff member had interacted with his mother. The Ombudsman stated that the facility investigated the incident and assured the son that the staff member that he had concerns about would not be in a manner to interact with his mother again and that the Social Worker (SW) was working on a transfer to another facility that had a secured dementia unit. Record review of the closed chart for Resident #1 revealed an admission date of 12/22/20 and a discharge date of 01/19/21 with an admitting diagnosis of Dementia with behavioral	F 550	Statements contained herein are intended for the purpose of compliance with Federal and state laws regarding responses to Statements of Deficiencies. The language herein is not intended to be used as admission against the facility nor is it intended to be used by any third party. It is solely for the purpose of compliance with participation requirements of Medicare and Medicaid. Incident took place under the management of previous administration. Current Administrator started position on 3/1/2021 and was not aware of the issue until 9/28/21. Corrective Action: 1. How corrective actions will be taken for residents affected by deficient practice. Director of Nursing interviewed nursing staff on 1/11/21 to determine if redirection was given to resident other than	

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F 550	Continued From page 2 disturbance, wandering and heart disease. Resident #1 was initially admitted to a geriatric-psych unit prior to her admission to the long term care facility. Records revealed that while she was at the geriatric-psych facility that Resident #1 had a fall with injury and continued to be a fall risk at the long term care facility. A Pre-Admission Screening and Resident Review (PASRR) Level 1 was completed on 12/28/20 and indicated that Resident #1 was appropriate for long term care. Resident #1 had a physicians order for behavior monitoring every shift for agitation and wandering and notify Medical Director (MD) if behavior disturbances are present. Resident recieved Physical Therapy (PT), Occupational Therapy (OT) and Speech Therapy (ST) services for four weeks and discharged on 01/19/21 to another facility with a Certified Alzheimer's Unit. Record review of the a complaint/grievance log dated 01/11/21 stated, "Son was concerned with certain staff handling his mother and how she is not being redirected properly. Son does not want (proper name) Licensed Practical Nurse (LPN) #1 caring for his mother and stated he witnessed her yelling at her and not proper redirection." Documented investigation revealed, "Interviews with staff done, no reports of any need to redirect other than during exit seeking behavior especially during visitation. Social Worker will work with family to get resident to a dementia unit." An interview on 9/28/21 at 10:20AM with the Social Worker (SW) revealed to the State Agency (SA) that she had a grievance from the RP of Resident #1 regarding the care she received here and a staff member not talking nice to his mother when he came to visit. The SW revealed that	F 550	exit-seeking behaviors. In those situations, staff instruct Residents to move away from the door and take a seat. 2. How facility will identify other residents having potential to be affected by the deficient practice. Any residents on Hall A can be affected by the alleged deficiency. 3. What measures or changes will be made to ensure non-recurrence? Social worker began working with the family on 1/11/2021 to find a facility that offers more one on one care. As a result, Patient #1 was discharged on 1/19/2021. Administrator began working with Assistant Director of Nursing and Social Worker 9/29/21 on the complaint process to ensure a more thorough documentation of statements and interviews. Per policy #0042, any persons suspected of abuse, neglect, or exploitation shall be placed on suspension with pay until the investigation is completed. Employees will remain on suspension until a complete investigation is conducted and evidence has proven that the employee is not guilty. Employee shall not be allowed in the same area where the incident took place if the employee returned to work. All staff was in-serviced on 10/13 for Abuse & Neglect by the Administrator. On 9/28/21, an investigation took place by current Administrator and Assistant Director of Nursing regarding the treatment of Resident #1 from Licensed	

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F 550	Continued From page 3 their was an investigation into the matter and that the former Administrator had talked to LPN #1 regarding her tone. The investigation concluded and the family agreed to let her stay until they could get Resident #1 to a facility that had a dementia care unit, but that they did not want LPN #1 caring for his mother while she was there. An interview with the Administrator on 9/28/21 at 3:00PM revealed to the SA that he was familiar with LPN #1 and stated, "Oh, no she's a good nurse. I don't know of any problems or concerns with her." The Administrator confirmed that he started to work at the nursing home in March of 2021 and records revealed that the complaint allegation occured on 01/09/21. The Administrator reviewed the personel file of LPN #1 with the SA and found that LPN #1 did not have any disqualifying factors or past history of occurences on her employee file and that LPN #1 had been inserviced regarding Residents Right and Abuse and Neglect annually. An interview on 9/28/21 at 3:10PM with Registered Nurse (RN) Charge Nurse revealed to the SA that she normally works with LPN #1 and she confirmed that she had residents complain sometimes of rude staff and that she had seen 'burn-out" with some of the nurses during the COVID outbreak, but that everyone seems to be working well together and everything seems good now. An interview on 9/28/21 at 3:37PM with the Speech Therapist (ST) revealed to the SA that some of the families do not get along with LPN #1 because of her tone and she sounds aggravated when she talks to families. The ST stated, "I don't think she even knows she does it. The residents	F 550	Practical Nurse (LPN) #1. Interviews were conducted throughout the facility from 9/28/21 to 9/29/21 to determine if there was potential for other residents to be affected by the behavior of LPN #1. Residents were interviewed on the halls that LPN #1 works on 9/28/21. Interviews were also conducted on all staff on the shift from 9/28-29/21. All interviewees were asked if they felt threatened by a LPN or if they had any issues with a LPN, and all replied “no.” On 9/29/21 the Administrator and Assistant Director of Nursing spoke with coworkers regarding the behavior of LPN #1. Administrator checked LPN #1’s file to make sure that this was the only time of occurrence. Administrator did not see any patterns of rude behavior for LPN #1. However, A disciplinary notice was performed on the LPN to ensure that LPN #1 understood the level of severity of the situation. On, 10/13/21 an In-Service was conducted on Customer Service/ Burnout by the Administrator for all staff. The Ombudsman also conducted a directed in-service at the on Residents Rights on 10/13/21. This in-service included all LPNs from 7-3, 3-11, and 11-7 shifts. 4. How corrective actions to be monitored to ensure non-recurrence. On October 4, the Assistant Director of Nursing started monitoring LPN#1 every day during the week and on every other weekend by the Charge Nurse. One on one counseling started with LPN #1 weekly by the Assistant Director of Nursing on 10/4/2021 for 1 month to	

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F 550	Continued From page 4 that know her just know that is how she is." An interview on 9/28/21 at 3:54PM with the SW revealed to the SA that she had talked with LPN #1 regarding the grievance reported to her on 01/11/21 and stated, "She is dry and can come across as rude but that she has known her for a long time and she doesn't mean anything bad by it, that is just her demeanor." An interview on 9/28/21 at 4:35pm with LPN #1 revealed, that she has worked at the facility for 23 years and stated, "I've never been rude to anyone, I've had family members being rude to me." She recalls the incident with Resident #1's son and that he made a statement that he did not want me taking care of his mother anymore, so I told my charge nurse and they took care of her. She stated that she did not remember exactly what was said but that she wasn't rude to them. LPN #1 stated, "I've had family call and get mad because we didn't answer the phone and I told them we were all taking care of the patients." Record review revealed that the LPN had attended an annual in-service on 07/06/21 for "Dignity, Abuse, and Neglect" and an annual in-service for "Resident Rights" on 06/16/21. Facility policy titled, "Resident's Rights," with no date, stated, "The right to be treated with dignity and respect." An interview on 09/29/21 at 1:15PM RP of Resident #1 stated that his mother was doing well now and was in an alzheimers unit and he was very pleased with her care there. He stated that he had come to visit his mother on 01/09/21 and had brought his mother's small dog with him. He stated that his mother had saw him approaching	F 550	discuss daily routine and look for potential signs of burn-out. Assistant Director of Nursing will coach LPN #1 on customer service skills during this Performance Improvement Plan. Assistant Director of Nursing will report to Administrator weekly and to the Quality team at the November Quality team meeting on November 24, 2021. Incidents of non-compliance will perform a Performance Improvement Plan as part of the Quality Assurance and Performance Improvement program. The inability for a staff member to adhere to the performance Improvement Plan will result in suspension or immediate termination. The October Quality meeting was on October 27, 2021 at 11:30 AM and are held monthly. During the meeting, the staff discussed the Plan of Correction: The Administrator and Assistant Director of Nursing will continue to provide Continuing education every month to the staff. Management will add Residents Rights to the scheduled monthly in-service regimen as well as new hires. Also, the Social Worker will conduct daily interviews with Residents while performing rounds to document any grievances. This should be sufficient for monitoring any performance issues with any staff member. If any grievances, the Social worker will report those during “stand-up” everyday. From there, the Assistant Director of Nursing will conduct investigations as usual. The Assistant Director of Nursing reported good performance from LPN# 1 from 10/4/21-10/27/21.	

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F 550	Continued From page 5	F 550		

the door and had excitedly gotten up from her wheelchair and was attempting to greet him at the door and that LPN #1 looked visibly annoyed and frustrated and began scolding my mother in a demeaning manner and commanding her to sit down in the wheelchair. She had let us in the door by this time and I told her that was a trigger for my mother and you do not talk to my mother that way and the nurse (LPN #1) stormed away and told me that she was not going to listen to this. My overall impression of LPN #1 was that she was frustrated and was having difficulty redirecting my mother. My mother was a fall risk and had fallen at the Geri-Psych unit. I had spoken with the Social Worker about my concerns and that we wanted to seek a facility that specialized in caring for people with dementia.

Record review revealed that the Resident #1 was admitted to the facility on 12/22/20 with diagnosis of Dementia with behavioral disturbance and Wandering. The Brief Interview for Mental Status (BIMS) for completed on 12/29/20 and revealed a BIMS score of 03 indicating severely impaired mental status.