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
	20GE	A. BUILDING: _____ B. WING _____	05/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GEORGE REGIONAL HEALTH & REHAB CENT	859 WINTER ST LUCEDALE, MS 39452

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M 000	Initial Comments The State Agency (SA) conducted a recertification survey at the facility from 4/30/19 through 5/2/19. During the survey the SA determined the facility was not in compliance with the Minimum Standards for the Institutions for the Aged and Infirm. The SA cited the state statutes at M500, M610, and M635.	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	M 500		6/15/19

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M 500	Continued From page 1 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; 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	M 500		

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M 500	Continued From page 3 record); 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: Level II Based on observation, resident and staff interview, and facility policy review, the facility failed to provide privacy during medication administration for one (1) of six (6) residents observed during medication administration (Resident #7).	M 500	1) Licensed Practical Nurse #3 was in-serviced on June 6, 2019, on policies pertaining to providing privacy, quality of life/dignity, including residents rights by closing the door to residents room by the Administrator and the Director of Nursing. Resident #7 was assessed by the Director of Nursing for changes in behavior, and actions. The resident continues with his	

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M 500	Continued From page 4 Findings include: A review of the facility's policy titled, "Quality of Life - Dignity," dated August 2009, revealed that the policy of the facility was that each resident would be cared for in a manner that promoted and enhanced quality of life, dignity, respect, and individuality. The policy further included that the staff should promote, maintain, and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures. An observation, on 05/01/2019 at 9:25 AM, revealed Licensed Practical Nurse (LPN) #3 administering oral medications and applying a lidocaine patch to each of Resident #7's bilateral below the knee amputations. When administering Resident #7's medications, LPN) #3 failed to close the door to Resident #7's room which made the application of patches and medication administration visible to anyone passing in the hallway. During an interview, on 5/1/2019 at 9:29 AM, with Resident #7, he stated he wanted to have privacy when he received his medications, and wanted the door closed when the nurses put patches on his stumps. During an interview, on 5/1/2019 at 9:32 AM, with LPN #3, she stated she knew Resident #7 was adamant about his privacy. LPN #3 stated, "I didn't close the door, because I wasn't thinking about it." LPN #3 stated "I do know he likes his privacy."	M 500	normal behavior and routine, with no evidence of physccocial harm observed on 5/2/19. 2) All residents have been identified as having potential to be affected by the same deficient practice. 3)All nursing staff will be in serviced on June 12, 2019 on policies pertaining to providing privacy, quality of life/dignity, including residents rights by closing the door to each resident's room by the Administrator and the Director of Nursing. In-service acknowledgement documentation will be obtained. Licensed Practical Nurse #3 will be observed weekly for four weeks during medication administration to ensure resident's privacy is maintained, beginning June 6, 2019, and ending July 4, 2019, by the Administrator and or Director of Nursing. Random nurses will be observed monthly by the Quality Assurance Nurse and or Director of Nursing beginning on June 10, 2019. 4)A log with findings will be maintained. Logs with findings will be presented quarterly to the Medical Director, and Quality Assurance Committee for evaluation and review to determine if further action is necessary to ensure compliance is achieved and sustained.	
M 610	45.21.2 Activities of daily living	M 610		6/15/19

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M 610	Continued From page 5 Activities of daily living. Each resident shall receive assistance as needed with activities of daily living to maintain the highest practicable well being. These shall include, but not be limited to: 1. Bath, dressing and grooming; 2. Transfer and ambulate; 3. Good nutrition, personal and oral hygiene; and 4. Toileting. This Statute is not met as evidenced by: Level II Based on observation, staff interview, family interview, record review, and facility policy review the facility failed to provide nail care to prevent the potential for skin breakdown and/or infection for one (1) of three (3) residents reviewed for Activities of Daily Living (ADL) care. (Resident #15) Findings include: A review of facility's policy titled, "Fingernails/Toenails, Care of", with a revision date of February 2018, revealed: "the purposes of this procedure are to clean the nail bed, to keep nails trimmed and to prevent infections." The procedure included, "Review the residents care plan to assess for any special needs of the resident". "Nail care includes daily cleaning and regular trimming", and "trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin. The procedure included that staff were to notify the supervisor if the resident refused the care.	M 610	1)The fingernails of Resident #15 were trimmed and nail care was provided by the assigned Certified Nursing Assistant. Registered Nurse #2 was counseled on providing proper documentation of nail care by the Director of Nursing on 06/04/19. The care plans for Resident #15 were updated to reflect the preference of the Responsible Party for Resident #15 on 6/4/2019. 2)All residents have been identified as having potential to be affected by the same deficient practice. 3)Registered Nurse Number #2, the facility nursing staff and the Certified Nursing Assistant will be re-educated on the importance of providing routine and as needed nail care to residents on 6/12/2019. Certified Nurse Assistant #1 and the Facility Certified Nursing Staff will be re-educated, by the Director of Nursing and/or Quality Assurance Nurse, on the importance of providing nail care on 6/12/2019. Nails will be monitored on	

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M 610	Continued From page 6 An observation, on 4/30/19 at 10:24 AM, with Certified Nursing Assistant (CNA) #1, revealed Resident #15 lying in bed with obvious contractures of both hands. There was a hand roll in his right hand, but none in his left hand. Resident #15 had long, jagged, nails and the left hand fingers were contracted with his nails pushing into his left palm. After observing the fingers pushing down into the palm of the left hand, CNA #1 opened the left hand to view the fingers and palm of the hand. Resident #15's ring finger left an approximately .5 inch indented area in the hand with a purple hue. Resident #15's right hand had a wash cloth (handroll) in it, and although the nails were uneven and long, there was no discoloration or indentions. An interview, on 4/30/19 at 10:56 AM, with CNA #1, regarding Resident #15's nails revealed she thought the resident's mother cut his nails. A review or Resident #15's Treatment Record, for April 2019. revealed there was a treatment listed for weekly fingernail audit on body audit day. Staff filled in N for No and Y for Yes. The most recent Treatment Record entry, was dated 4/22/19, performed by Registered Nurse (RN) #2 with N being checked as nails not needing to be trimmed. A review of Resident #15's Minimal Data set (MDS), with an Assessment Reference Date of 2/28/19, revealed Resident #15 required total assistance from staff for personal hygiene needs. An observation and interview, with the Director of Nursing (DON), on 4/30/19 at 2:10 PM, confirmed the resident had long nails with jagged edges on both hands, and a deep indention in the palm of his left hand that was purple in color with no	M 610	random Residents weekly for 4 weeks beginning 6/13/2019 and ending 7/11/2019 and then monthly thereafter by the Charge Nurse, Director of Nursing, or Quality Assurance nurse to ensure proper nail care is provided. A log of findings will be maintained. Any problems identified will be reported promptly to the Administrator and or Director of Nursing for corrective action. 4)Logs with findings will be presented quarterly to the Medical Director, and Quality Assurance Committee for evaluation and review to determine if further action is necessary to ensure compliance is achieved and sustained.	

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M 610	Continued From page 7 broken skin. An interview, on 4/30/19 2:20 PM, with the DON revealed the resident's mother usually cut his nails, and the resident didn't want anyone to do it but her. The DON stated Resident #15's finger nails were long and jagged. The DON stated the facility called the resident's mother today, and his mother said she would cut them on her next visit. The DON stated the mother visited 2-3 times per week depending on the weather. A review of Resident #15's Comprehensive Care Plan regarding skin integrity revealed an intervention written in with no date of "Family request- only mother to trim resident's nails". An interview, on 4/30/19 at 2:38 PM, with Licensed Practical Nurse (LPN) #1/MDS and Care Plan Nurse, revealed she added the intervention on this date to the care Plan for only the mother to trim the resident's nails after the Social Worker spoke to the resident's mom regarding the resident's nails. LPN #1 stated "We usually date the interventions as we put them on the Care Plan, but I didn't date the intervention today". LPN #1 then dated the intervention 4/30/19. An observation, on 5/01/19 at 9:18 AM, revealed Resident #15 lying in bed with hand rolls in both hands, nails long and jagged. An interview, on 5/01/19 at 10:20 AM, with Resident #15's mother, revealed, "I didn't tell them not to cut his nails. His daddy used to cut them but now I try to do it because he can get combative and I'm afraid he'll hit somebody. But no I did not tell them not to cut his nails".	M 610		

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M 610	Continued From page 8 An interview, on 5/02/19 at 7:50 AM, with the DON and Administrator in Training (AIT) revealed the AIT stated it was not the parent's responsibility to cut the resident's nails, and it was the facility's responsibility. The DON stated she thought there was a communication error, and maybe we just assumed she wanted to do it because he does react to her better. Resident #15's mother visited often and the resident reacted to her better, and she was able to calm the resident, so staff had gotten used to her cutting the resident's nails. An interview, on 5/02/19 at 11:03 AM, with the Social Service Director revealed, "I spoke to Resident #15's mother about the nails. She said she was coming to the facility the next day and she would cut them. She did not demand us not to cut the nails, she just stated she was coming to visit and she would do it. She would never command us not to do something, but she just likes to care for him as much as possible. That's just the type of person she is. But it is the facilities responsibility to make sure his nails were trimmed. We get used to family members doing things for their loved ones that we just forget it is our responsibility to check and make sure things are done."	M 610		