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
	53TC	A. BUILDING: _____ B. WING _____	C 05/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON, LLC D/B/A THE CARRINGTON	307 REED RD STARKVILLE, MS 39759

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M 000	Initial Comments Level II The State Agency (SA) conducted a complaint survey from 5-10-21 to 5-12-21. During the survey, the SA determined that the facility was not in compliance with the Minimum Standards of Operation for Institutions for the Aged or Infirm state licensure reguirements.. The SA substantiated the complaint MS#17791 for Verbal Abuse and cited M500, and substantiated MS#16671 for Admission, Transfer and Discharge Rights. The following complaints were not substantiated, MS#17494 for residents left wet and callbells not answered, MS# 17731for physician and resident representative not notified of change in resident condition, and MS#17732 for resident representative not notified of change in resident condition. The facility's census was 55 at the time of the survey.	M 000		
M 500 SS=D	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	M 500		6/21/21

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M 500	Continued From page 1 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 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	M 500		

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M 500	Continued From page 2	M 500		

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;

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

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M 500	Continued From page 3 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); 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	M 500		

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M 500	Continued From page 4 the fullest exercise of these rights. This Statute is not met as evidenced by: Based on resident interview, staff interview, record review and facility policy review, the facility failed to prevent the verbal abuse of one (1) of twenty-three (23) residents reviewed for abuse, Resident #1. Findings Include: Review of the facility's policy titled, "Abuse Program", dated 05-23-2017, revealed, "It is the policy of this facility to take all steps necessary to maintain an environment free of abuse and neglect. Each resident has the right to be free of verbal, sexual, physical and mental abuse, neglect, exploitation, misappropriate of resident property, and involuntary seclusion... Definitions: ... Verbal Abuse is defined as the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents, or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to, threats of harm, saying things to frighten a resident..." Review of Resident #1's Face Sheet revealed he was admitted to the facility on 10-22-2019 with diagnoses of Metabolic Encephalopathy, Pneumonia, Chronic Kidney Disease, Diabetes, History of Alcohol Abuse, Hyperlipidemia, and Hypertension. Review of Resident#1's most recent Minimum Data Set (MDS) dated 03-18-2021, revealed his Brief Interview of Mental Status (BIMS) score to be 15, which makes him cognitively intact and able to answer questions appropriately. He	M 500	1. Resident #1 was assessed on May 2, 2021 by the Registered Nurse Supervisor (RN) #1. Assessment revealed Resident #1 stated that he (Resident #1) had not been scared or felt threatened during the incident&just that he was mad that she (C.N.A. #1) had come in there like she did. Resident #1 continued his normal, daily routine without interruption. No sign or symptoms of any mental, emotional, or physical abuse noted. No adverse outcomes were identified to Resident #1 related to the alleged deficient practice of failure to prevent abuse. An investigation was conducted by the Nursing Home Administrator (NHA) and the Director of Nursing (DON) regarding the allegation of verbal abuse that allegedly occurred between Resident #1 and the Certified Nursing Assistant (C.N.A.) #1 on May 2, 2021 at approximately 8:00 am. The RN #1 intervened and C.N.A. #1 was removed from the resident□s room and off the floor at the time of the incident. After interviewing Resident #1 regarding the incident, RN #1 interviewed C.N.A. #1. After C.N.A. #1□s interview, RN #1 escorted C.N.A. #1 to the time clock and out of the facility: C.N.A. #1□s time card shows she clocked out on May 2, 2021 at 8:30 am. As a result of the investigative findings by the NHA and DON, C.N.A. #1 was terminated on May 5, 2021. 2. The facility has determined that any resident has the potential to be affected by	

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M 500	Continued From page 5 requires extensive assistance of one staff member for his Activities of Daily Living (ADL's), Review of the facility's "Reportable Incident Form" dated 05-05-2021 revealed, on 05-02-2021 at approximately 8:00 AM, Certified Nurse Aide (CNA)#2, and CNA#3 were in Resident #1's room assisting he and his roommate with their breakfast trays, when CNA#1 stepped into the room and stated the room "smelled like sh**". CNA#1 went to hand Resident #1 a cup of coffee, and he hit it out of her hand causing it to spill on the floor, and stated, "I don't want sh** from you". A verbal exchange of words occurred between Resident #1 and CNA#1, and she stepped out into the hallway and yelled for the supervisor and said, "Y'all better come and get this MF before I beat his MF a**. Ima be on his a** like white on rice." Registered Nurse (RN) #1 arrived in the room, escorted CNA#1 out and down the hallway, and came back to interview Resident #1. CNA#1 was suspended and walked out to the time clock and out the door. CNA#1 was terminated following the complete investigation and not allowed back on the property. On 05-11-2021 at 11:15 AM, during an interview with the Administrator, concerning this incident, she stated CNA #2, and CNA#3 were passing out breakfast trays. CNA#1 came into the room with a cup of coffee and on her way in the door, told Resident #1 his room "smelled like sh**". He got upset and offended at what she said, and hit the cup of coffee out of her hands and onto the floor. He told her he "didn't want sh** from her." There was a verbal exchange between the two of them, and CNA#1 stepped outside the doorway into the hallway and starting yelling for the RN Supervisor stating, "Y'all better come and get this MF before I beat his MF a**. Ima be on his a** like white on	M 500	the identified practice. 3. Facility staff were in-serviced on May 2, 2021 by the Nursing Home Administrator (NHA) regarding Abuse and Neglect including a pre and post test. Local Ombudsman to provide a directive in-service re: Free from Abuse and Neglect to facility staff to by June 11, 2021. 4. The Director of Nursing Services or Social Service Director will conduct weekly audits consisting of one (1)resident who resides on the 100 Hall, of two (2) residents who resides on the 200 Hall, and of two (2) residents who resides on the 300 Hall for four (4) consecutive weeks beginning the week of June 7, 2021. These residents will be assessed and interviewed to ensure that any alleged violations are identified, properly investigated and reported according to facility policy and procedures. Findings of this audit and this plan of correction will be monitored at the monthly Quality Assurance meeting starting June, 2021 then x3 months thereafter or until such time Quality Assurance Committee determines consistent substantial compliance is met . 5. Corrective action completion date: June 21, 2021.	

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M 500	Continued From page 6	M 500		

rice." RN#1 arrived in the room, and removed CNA#1, and took her down the hallway. She came back and asked Resident #1 what had happened. Once she heard the whole story, she escorted CNA#1 to get her things, and then took her to the time clock and escorted her out of the building. The Administrator stated CNA#1 had worked for her before and she never acted out like that. She never had any complaints about her care or attitude.

On 05-12-2021 at 10:30 AM, during an interview with CNA#2, she stated, she and CNA#3 were passing out breakfast trays in room 305. They were helping pass out the trays, however, that room was not on their assignment sheets, it was CNA#1's room. While they were setting up the trays, CNA#1 walked into the room with a cup of coffee and said the room "smelled like sh**." Resident #1 and CNA #1 were going back and forth at each other, and CNA#3 told them to stop. CNA#1 had coffee and Resident #1 hit it out of her hand. CNA#1 went to the doorway and hollered down the hall to the supervisor, "Y'all better come and get this MF before I whoop his a**." RN#1 came and got CNA#1 and took her out of the room. CNA#2 stayed with the resident until she came back to talk to him and see what happened.

On 05-12-2021 at 1:00 PM, during an interview with CNA#3, she stated, they were passing out breakfast trays in room 305 for CNA#1, because they were not their residents to take care of that day. They were helping her out. I was fixing a tray and heard bickering back and forth and heard something hit the wall. It was the cup of coffee. I told CNA#1 to leave the room and calm down. She went out into the hall and called the supervisor and said, "Y'all better come and get

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this fat MF, looking like Uncle Phil, before I whoop his MF a**." The supervisor came to the room and took CNA#1 out and down the hallway, and we didn't see her again after that.

On 05-12-2021 at 2:30 PM, during an interview with Resident #1, he stated another CNA was helping him set up his breakfast tray when CNA #1 walked into the room and told him his room "smelled like pee and sh**." He states he told her, "it didn't smell that way till she came in and if she didn't like it, she could leave." Resident #1 stated, she tried to hand him a cup of coffee after that and he hit it to the floor and told her he "didn't want sh** from her now", and to "get her ugly a** out of here." He stated the supervisor had come in because of all the yelling and cussing, and got CNA#1 out of his room. He didn't see her again after that. When asked by the SA if he heard what CNA#1 was yelling about while she was in the hallway, he stated, "yeah, she said somebody better come get me cause she was gonna whip my MF a**." He stated he was not afraid of her, and didn't feel threatened during the exchange of words. He was just not going to allow her to do him like that and it made him mad that she came in running her mouth.

The SA attempted several times and left voicemail for CNA#1 to return a call for interview. She had not responded and the SA did not recieve a call back from her.

The SA attempted to reach RN #1 for interview, as she was not scheduled to work until the weekend. She had a written statement for the investigation that revealed, "I was at the nurses station at approximately 8:00 am and heard someone yell from B hall, "Somebody better come get this man." I went down the hall and

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M 500	Continued From page 8 CNA #1, was standing in resident's room yelling, "he slapped that coffee out of my hand!" I told her to step out of the room and explained to her that's not how to handle the situation appropriately and if there's a problem she needs to come to me." I then asked the resident, (Formal name) Resident #1 what happened. He stated, "she came in here and said it smelled like shit. It didn't smell like that until she got in here. Yeah, I slapped that coffee out of her hand. I'm not mad about it. I'm not scared of that girl." While in the resident's room, I turned my back and messaged the DON to inform her of (formal name) CNA#1's attitude. I was told to fire her. (Formal name) CNA #1 began to yell while standing outside the resident's room, "I'll beat that MF's a**. If he does it again Ima be on his like white on rice!" While standing between the resident and (formal name) CNA #1, I told her she cannot speak to a resident that way and to stay out of that room. She was pushing meal trays at this time back to the dining room. I spoke with the resident and roommate to ensure they weren't upset about the situation. They both stated they weren't bothered about it. I closed the room door. (Formal Name) Licensed Practical Nurse (LPN) #1 and I met CNA #1 coming out of the dining room and told her to come with us to the front office. I explained to her that her attitude and threatening a resident cannot be tolerated and she is fired. (formal name) LPN #1 and I accompanied her down to the nurse's station to gather her belonging. We then walked her to the time clock to clock out and to the front door to exit the facility. She did not make any inappropriate comments at this time. At 8:35 AM the administrator was notified of the situation." A review of CNA#1's employee file revealed a "Personnel Termination Notice" dated 05-02-2021 which stated, "dc' d (discharged) due to staff to	M 500		

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M 500	Continued From page 9 res. (resident) verbal abuse, cursing a resident - verbiage "s--t", "M-F", and threatened to whip his black "a-s"." This form was signed by the administrator on 05-05-2021.	M 500		