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
	06CH	A. BUILDING: _____ B. WING _____	06/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND NURSING AND REHABILITATION	4036 HIGHWAY 8 EAST CLEVELAND, MS 38732

(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) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) determined during an annual recertification survey, conducted from 6/4/19 to 6/6/19, the facility was not in compliance with the Mississippi Regulations for Minimum Standards for Institutions for Aged or Infirm with deficiencies cited at M810. The SA also conducted a complaint investigation (CI MS #15960) and determined the complaint was substantiated for resident to resident abuse, and cited M500. The census was 119 and the facility held a license for 120 residents.	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	M 500		7/1/19

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M 500	Continued From page 1 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 changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal;	M 500		

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M 500	Continued From page 2 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 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	M 500		

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M 500	Continued From page 3 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 the fullest exercise of these rights. This Statute is not met as evidenced by: Level II Based on staff interview, resident interview,	M 500	Please consider this Plan of Correction as Cleveland Nursing and Rehabilitation Center, LLC credible allegation and	

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M 500	Continued From page 4 record review, and facility policy review, the facility failed to ensure residents were free from abuse for one (1) of five (5) residents reviewed for resident to resident incidents, Residents #60. Findings include: Review of facility policy, Abuse Prevention, with an effective date July 1, 2003, revealed: The facility is committed to protecting the residents from abuse by anyone including, but not limited to: facility staff, other residents, consultants, volunteers, staff from other agencies providing services to our residents, family members, legal guardians, surrogates, sponsors, friends, visitors, or any other individual. Review of a Resident to Resident incident that occurred on 2/19/19 at 3:00 PM, revealed Resident #60 entered Resident #99's room at 3:00 PM, and a physical altercation occurred between the two (2) residents. This resident was last seen on 2/19/19 at 2:45 PM, and was not exhibiting any behaviors at that time. The facility staff were not able to determine who the aggressor was, but did witness Resident #99 make contact with Resident #60's face. Resident #60 had an abrasion under his left eye and to the left side of his forehead. Resident #99 was placed on one on one (1:1) observation and transferred to the Behavior Health Unit and Resident #60's medications were adjusted. Review of an incident that occurred on 5/25/19, revealed Resident #99 and Resident #60 were involved in a physical altercation when Resident #60 entered Resident #99's room and Resident #99 asked him to leave and he wouldn't. Resident #99 hit Resident #60. Further review of Resident #60's record revealed he was transferred to the	M 500	compliance. This plan constitutes a written allegation of substantial compliance under the Federal Medicare and Medicaid requirements. Submission of this plan of correction is not an admission that a deficiency exist or that the facility agrees they were cited correctly. This plan of correction reflects a desire to continuously enhance the quality of care and services provided to our Residents and are submitted solely as a requirement of provisions of Federal and State Law. 1. Resident #60 care plan was reviewed and revised on 5/28/2019 by Activities Director with new interventions for activities to decrease wandering behaviors and entering other Resident's room. Resident #99 was placed on one-on-one (1:1) monitoring 5/25/2019 until he was transferred to the Behavior Unit on 5/27/2019. Resident #99 returned to facility on 6/4/2019. An additional stop sign was placed on Resident #99's door. A door alarm was placed on Resident #99's door to alert staff to door opening. 2. All Residents have a potential to be affected. 3. Nursing staff was in-serviced on the facility's Abuse Prevention Policy on 6/5/2019 by Risk Manager. 4. The Director of Nurses will audit incident reports three x week for four weeks starting 6/10/2019 to ensure appropriate supervision and interventions. Any concerns will be immediately corrected. The Director of Nurses will forward the results of the audits to the monthly Quality Assurance Committee.	

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M 500	Continued From page 5 local hospital where X-rays were obtained and revealed a nasal fracture. Review of the Physician documentation at the Emergency Room revealed the resident did not experience any loss of consciousness. The severity of the symptoms: At their worst the symptoms were mild and were unchanged in the Emergency Room. Review of the CT of Brain revealed Acute bilateral nasal bone fractures with minimal displacement. On 6/4/19 at 5:00 PM, an interview with the Risk Manager stated when resident #60 was first admitted he was very lethargic and once the lethargy wore off resident became more aggressive and started to wander. The Risk Manager revealed Resident #60 is hard to redirect and will not sit any longer than it takes to eat, or a short activity. She stated when you try to redirect the resident he will become agitated and aggressive. The Risk Manager stated after the incident in February with Resident #99, Resident #60's medications were changed. She stated that Resident #60 was restarted on his Depakote 250 milligrams(mg) per feeding tube two (2) times a day and Zyprexa 5 mg per feeding tube daily. The Risk Manager stated that staff started involving the resident in more small group activities and this helped the resident's behaviors and wandering for a while. The Risk Manager revealed Resident #60 was wandering the day of the incident on 5/25/19, and had been redirected by staff. She stated he was last seen at 1:15 PM by staff, at the Memory Care Unit door, and was redirected to his room. The Risk Manager revealed that at 1:34 PM, Resident #99 hollered for staff to assist Resident #60. Resident #99 stated the resident came in his room and was messing with his stuff, and he asked him to get out and he wouldn't. When staff responded to the room they found Resident #60 laying on the floor	M 500	The monthly Quality Assurance Committee will determine the frequency and continuation of audits based upon the results achieved and make recommendations as needed.	

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M 500	Continued From page 6 with a bloody nose. The Risk Manager stated the Physician and the Responsible Party were notified and Resident #60 was transferred to the hospital and diagnosed with a nasal fracture. The Risk Manager stated the resident's day to day activities have not been altered. She revealed that Resident #60 has not complained of any pain and continues with his normal activities. On 06/04/19 at 4:00 PM, an observation of Resident #60 revealed he was in his room laying in his bed. Resident #60 appeared calm and resting. On 06/05/19 at 10:00 AM, an observation of Resident #60 revealed he was outside with Activity staff. Resident #60 was noted with a broom in his hand, sweeping around patio area. Resident #60 was walking around outside. There were other residents in attendance along with staff and volunteers. On 6/5/19 at 2:15 PM, an observation of Resident #60 revealed he was outside engaging in activities, Ball toss, sweeping, music being played, and swaying to the music at times. Resident #60 appeared calm. On 6/5/19 at 3:00 PM, an interview with the Activity Director (AD) revealed Resident #60 likes to be outside; he enjoys sweeping, and cleaning up surroundings. The AD stated they (activity staff and volunteers) take him out at least twice a day. The AD stated the resident does not participate in group activities, only one to one activities. During an interview on 06/06/19 at 11:24 AM, Resident #99 stated that man (Resident #60) had come into his room a couple of times and fooled with his stuff. Resident #99 stated, "I asked him	M 500		

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M 500	Continued From page 7 nicely to get out and he wouldn't". Resident #99 stated the resident said, "Make me." Resident stated, "That's just what I did." Resident #99 stated, "I don't think I will have any more problems with him coming up in my cell". Resident #99 kept referring to his cell and people coming in that didn't have any business being in there. Resident #99 stated he couldn't call for help if someone comes in his room, because then he would be labeled a "punk." On 06/06/19 at 11:42 AM, an interview with Licensed Practical Nurse (LPN) #1 revealed she witnessed Resident #99 hit Resident #60 on 2/19/19. She stated she was at the Nurse's Station and heard a commotion coming from the direction of the resident's room and went to the room. LPN #1 stated as she was entering the room, she saw Resident #99 hit Resident #60. LPN #1 revealed Resident #60 had an abrasion under his left eye. She stated the residents were immediately separated and placed on one on one (1:1) until Resident #99 was transferred to the Behavior Unit. LPN #1 stated outside the room Resident #99 gets along well with all staff and residents. she stated he does not want anyone in his room, which he refers to as a cell. During an interview on 06/06/19 at 1:30 PM, Certified Nursing Assistant (CNA) #1 revealed Resident #99 does for himself; she provides assistance with showers. She stated the resident is outgoing and friendly until someone goes in his room and then he gets upset and angry. CNA #1 stated she was working 5/25/19, the day he hit Resident #60, but she did not witness the altercation. CNA #1 stated she heard a commotion and went to the room and saw the resident on the floor. CNA #1 revealed she and other staff assisted him up and took him to the	M 500		

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M 500	Continued From page 8 Nurse's station. On 06/06/19 at 1:42 PM, an interview with LPN #2 revealed Resident #60 required frequent redirection and will wander into other residents room. She stated the resident will get aggressive toward staff, but has never seen him be aggressive toward other residents. LPN #2 stated other residents will say "this is not your room and you need to get out", and he will or they will call for help and staff will go in the room and assist the resident out. LPN #2 stated she has never witnessed the resident being aggressive toward any residents; only staff. On 06/06/19 at 2:06 PM, an interview with CNA #2 revealed Resident #60 required frequent redirection and will try to fight staff if he's in a bad mood. She stated he spends a lot of time outside now and he really enjoys that. The CNA stated the activity staff take him outside with them. On 06/06/19 at 2:15 PM, an interview with LPN #5 revealed she heard Resident #99 holler for someone to get this man out of his room. LPN #5 stated when she and other CNAs went in the room, Resident #60 was on the floor. She stated the residents were immediately separated. LPN #5 stated Resident #60 wanders and has to be redirected throughout the day. She stated Activity staff work hard to keep him engaged in activities but his attention span is so short that he can't remember. On 06/06/19 at 4:00 PM, an interview with the Director of Nursing (DON) stated after the incident in February 2019, the Physician changed Resident #60's medications and staff implemented small group activities rather than encouraging large group activity participation,	M 500		

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M 500	Continued From page 9 which the resident would not participate in. The DON stated after the incident in May 2019, staff implemented 1:1 activities throughout the day. She stated that Resident #60 continued to require redirection. She stated the CNAs care guide was also updated to include diversional activities when behaviors occur. The DON stated after the incident in February 2019, Resident #99 was sent to the Behavioral Health Unit and a stop sign was placed on the resident's door to discourage wanderers from entering his room. The DON stated the only time Resident #99 exhibits behaviors is if someone enters his room uninvited. She revealed Resident #99 refers to his room as his cell and protects his belongings. The DON stated after the incident in May 2019, Resident #99 was placed 1:1 until transferred out of the facility to the Behavioral Health Unit. The DON stated since the resident's return to the facility on 6/4/19, staff have added a second stop sign to the resident's door. The DON stated one (1) is located at ambulatory height and the other is located at wheelchair height. She stated staff have also added a door alarm to the resident's door that alarms when the door is opened; this was done in an effort to keep wanderers from entering the resident's room. Review of Resident #99's Face Sheet revealed the facility admitted him on 4/9/13, with diagnoses which included, Schizophrenia, and Hypertension. Review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/2/19, revealed Resident #99 had a Brief Interview for Mental Status score of 15, which indicated Resident #99 was cognitively intact. Review of Resident #60's Face Sheet revealed	M 500		

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M 500	Continued From page 10 the facility admitted him on 1/4/19, with diagnoses which included, Alzheimer's Disease, and Anxiety. Review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/8/19, revealed Resident #60 had a Brief Interview for Mental Status score of 3, which indicated Resident #60 was severely cognitively impaired.	M 500		
M 810	45.28.1 Direction and Supervision Direction and Supervision. Food service is one of the basic services provided by the facility to its residents. Careful attention to adequate nutrition and prescribed modified diets contribute appreciably to the health and comfort to the resident and stimulate his desire to achieve and maintain a higher level of self-care. The facility shall provide residents with well-planned, attractive, and satisfying meals which will meet their nutritional, social, emotional, and therapeutic needs. The dietary department of a facility shall be directed by a Registered Dietitian, a certified dietary manager, or a qualified dietary manager. If a qualified dietary manager is the director, he/she must receive frequent, regularly scheduled consultation from a licensed dietitian, or a registered dietitian exempted from licensure by statute. This Statute is not met as evidenced by: Level II Based on observation, resident interview, staff interview, record review, and facility policy review, the facility failed to honor resident food preferences at mealtime and serve salad as	M 810	Please consider this Plan of Correction as Cleveland Nursing and Rehabilitation Center, LLC credible allegation and compliance. This plan constitutes a written allegation of substantial compliance under the Federal Medicare	7/1/19

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M 810	Continued From page 11 requested, for one (1) of 14 residents interviewed during initial tour, Resident #33. Findings include: Review of the facility's "Food Preferences" policy, dated 2016, revealed the guideline for food and nutrition services department will gather information upon admission to the facility regarding resident food preferences. Following admission to the facility, and periodically as necessary, the Director of Food and Nutrition Services and/or Registered Dietitian will interview the resident to determine foods preferred and inform resident about meal services at community. A form such as a Food Preferences Form may be used to document this information and filed in the Food and Nutrition Services department or the medical record according to facility practice. The resident food preferences are kept on file in the Food and Nutrition Services Department and used to ensure each resident's needs and desires are met. On 06/04/19 at 4:00 PM, an interview with Resident #33 revealed "they" will not give me salads anymore and they only give me chopped up meat. He stated he doesn't like the chopped up meat and really want his salads back. Resident #33 revealed he was not sure why they changed his diet, because he did not get choked, he just has coughing spells. Resident #33 revealed he told several people he wanted his salads back. On 06/04/19 at 5:20 PM, interview and observation of Resident #33 sitting at a table in the dining room revealed the resident being served his supper meal, which included chicken and dumplings, cornbread and fruit. Resident	M 810	and Medicaid requirements. Submission of this plan of correction is not an admission that a deficiency exist or that the facility agrees they were cited correctly. This plan of correction reflects a desire to continuously enhance the quality of care and services provided to our Residents and are submitted solely as a requirement of provisions of Federal and State Law. 1. Resident #33 was offered his salad for supper 6/4/2019 after Risk Manager was notified of issue. Resident #33 refused his salad 6/5/2019. Resident #33 was screened by Speech Therapist on 6/5/2019 to ensure resident was able to tolerate a salad. Registered Nurse #1 was in-serviced on 6/5/2019 by the Director of Nurses on the facility's Resident Food Preference policy. 2. All Residents that receive meals from Dietary have the potential to be affected. 3. An in-service was initiated on 6/5/2019 by the Director of Nurses on ensuring that documentation accurately affects Resident's Food Preference. A 100% audit was completed by Dietary Manager on 6/6/2019 on the facility's Food Preference Policy. Nursing staff was in-serviced on 6/5/2019 by Risk Manger on Resident's Rights and review of the facility's Food Preference Policy. No other concerns identified. 4. The Director of Nurses and/or Unit Manager will monitor meal services three x week for four weeks to ensure accuracy of documentation to reflect Resident's Food Preference starting 6/10/2019. Any concerns will be immediately corrected.	

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(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) COMPLETE DATE
M 810	Continued From page 12 #33's meal ticket had chicken and dumplings, tossed salad, and fruit circled. No salad was served to the resident. Resident #33 revealed he was asked by a nurse what he wanted for supper and he told them salad. On 06/04/19 at 5:35 PM, an interview with Registered Nurse (RN) #1, while in the dining room, revealed Resident #33 did not have a salad served to him for supper and salad was listed as a choice and was circled as his request for supper on his meal ticket. On 06/06/19 at 11:30 AM, an interview with the Speech Therapist (ST) revealed she was not aware of Resident #33 not being served salads, and there had been no recommendation from Speech services that he not be served salads. On 06/06/19 at 12:15 PM, an interview with the ST, while in the dining room observing Resident # 33 eating a salad, revealed she saw no issues with his eating the salad; no choking or difficulty swallowing. The ST stated she saw no problems with Resident #33 eating salads. On 06/06/19 at 1:30 PM, an interview with the Dietary Manager (DM) revealed she was told by Licensed Practical Nurse (LPN) #3 that Resident #33 could not be served salads because he would get choked. The DM revealed she understood that if a resident was on a mechanical soft diet they could not have salads, but she found out yesterday that was not right. The DM revealed a Registered Nurse (RN) #1 was in the dining room on 6/4/19, and asked Resident #33 what he wanted for supper, the RN then circled the items he requested and gave the meal ticket to the Medical Records staff. The Medical Records staff then should have read the	M 810	The Director of Nurses will forward the results of the audit to the Executive Director. The Executive Director will forward the results of the audits to the monthly Quality Assurance Committee. The monthly Quality Assurance Committee will determine the frequency and continuation of audits based on the results achieved and make recommendations as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	06CH	A. BUILDING: _____ B. WING _____	06/06/2019

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M 810	Continued From page 13 resident's request to the dietary department. The DM stated the salad was not read off to dietary on 6/4/19. The DM revealed she did not witness Resident #33 have a choking episode. The DM revealed she stopped giving Resident #33 salads a few weeks ago. The DM stated that before she was instructed not to give Resident #33 salads, he was asking for them and she would send them to him, but after she was told he could not have them, she quit sending them to him. On 06/06/19 at 1:40 PM, an interview with LPN #3 revealed he understood that when a resident is on as Mechanical soft diet they should not get salads, and he thought Resident #33 had choked on a salad. LPN #3 revealed Resident #33 was upset with him and blamed him for having his salads stopped. On 06/6/19 at 1:50 PM, an interview with RN #1 revealed she did question Resident #33 on what he wanted for supper on 6/4/19, and he told her a salad, chicken and dumplings, corn bread, and the dessert of the day, so she marked that on his meal ticket and handed the ticket to the Medical Records staff. On 06/06/19 at 2:00 PM, an interview with Medical Records staff revealed she did get Resident #33's ticket for requested lunch items and when she read it off to the dietary department, she told them he should not get the salad, because she understood he could not have a salad. She did not remember who told her that. On 06/06/19 at 1:045 PM, an interview with the Director of Nursing (DON) revealed she did not know why some of the staff thought that Resident #33 could not get a salad. The DON stated she is not sure Resident #33 ever really got choked,	M 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	06CH	A. BUILDING: _____ B. WING _____	06/06/2019

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M 810	Continued From page 14 or if he just had a coughing spell, due to his Chronic Obstructive Pulmonary Disease. The DON revealed the residents should have their food preferences honored if there is not an doctor's order contradicting their preference. The DON revealed Resident #33 should have been given the salad. Record review of Resident #33's meal ticket, for 6/4/19 supper, revealed chicken and dumplings, with tossed salad, and fruit circled to be served. The resident was not served the salad.	M 810		