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
	29CY	A. BUILDING: _____ B. WING _____	C 06/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

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M 000	Initial Comments The State Agency (SA) conducted a complaint survey investigating MS CI #17402 from 6/7/2021 through 6/9/2021. 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 requirements. The SA substantiated the complaint and deficiencies were cited M500 related to competent nursing staff. The facility's census was 49 at the time of the survey.	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	M 500		7/2/21

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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;

6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the

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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 residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail

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M 500	Continued From page 3 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 resident and family interviews, staff interviews, record review, and facility policy review, the facility failed to establish a consistent method of weighing a resident and accurately	M 500	1. The facility will ensure there are sufficient nursing staff with the appropriate competencies and skills sets regarding weight loss, accurately weighing and monitoring resident's weights. This will be accomplished by establishing a consistent	

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M 500	Continued From page 4 monitoring the resident's weight for one (1) of five (5) residents. Resident #1 Findings include: Review of facility policy titled, "Weight Loss Prevention", dated 12/27/2017, revealed it is the policy of this facility to prevent weight loss if avoidable and if unplanned. A Malnutrition Risk Assessment will be completed for each resident upon admission, readmission, with significant change in condition, and at least quarterly." Review of facility policy titled, "Evaluating Weight", dated 9/27/2013, revealed, "Each resident's weight will be evaluated monthly, as indicated by the resident's condition, or as ordered by the physician. Unintentional weight loss is any loss other than planned weight loss." Review of facility policy titled, "Weights: Obtaining and Documenting", dated 9/27/2013, revealed, "Each resident will be weighed monthly or as indicated by their condition unless contraindicated. Residents at the end of life may be excluded from routine weights. The DON or designee, the Dietary Manager, and the RD will review the weights for the current month and compare the current weight to the 30 and 180 day weights to determine significant weight loss." An interview by phone with Resident #1's Resident Representative (RR), on 6/7/2021 at 3:10 PM, revealed her concerns of her father's care in the facility. She stated Resident #1 was admitted to the hospital from the facility and she was alarmed when she saw how thin her Dad appeared. She stated that the Resident's weight on admission to the hospital was 128 pounds, and his normal weight was between 170 - 180 pounds. She stated he had tested positive for	M 500	method of weighing residents, inservices and competency completion by staff and following weight loss policy established by the facility. All residents in facility were weighed on 6/9/21 to establish a baseline weight and documented in electronic medical record. 2.All residents have the potential to be affected by the alleged deficient practice. All residents in facility were weighed on 6/9/21 to establish a baseline weight and documented in electronic medical record. 3.The Director of Nursing will oversee weight process beginning 6/25/21. Resident weights will be obtained as ordered by clinical staff and given to Director of Nursing or Assistant Director of Nursing to input. Weights will be put in electronic health record by Director of Nursing or Assistant Director of Nursing only. Director of Nursing or Assistant Director of Nursing will monitor weights while inputting for any weight loss or changes. The Director of Nursing will inservice and complete a competency with clinical staff beginning 6/25/21 on weight loss policy, how to weigh a resident accurately and consistently, and process for obtaining and reporting weights. Maintenance calibrated wheelchair scale on 7/1/21 and will complete calibration weekly x 4 weeks, then monthly x 3 and then every 6 months. 4.Director of Nursing or Assistant Director of Nursing will input all weights into electronic medical record beginning 6/25/21 and will monitor for any weight	

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M 500	Continued From page 5 COVID-19 upon admission to the hospital. She notified the facility and told them, "My father has been neglected by your facility." She stated she informed the DON (Director of Nursing) that her father had a massive weight loss and she wanted the facility to investigate and determine what happened to him and why had no one noticed his decline. She stated that before COVID-19, the Resident's wife and other family members would go to see him daily. She stated they would assist him with meals and other care. Once COVID-19 started, the family could no longer go into the facility to check on him but they could window visit and FaceTime, but they could not get close to him or see how his weight was decreasing. The family was relying on the staff to care for him.She confirmed he was in the hospital from 7/23/2020 - 7/28/2020 and when he was discharged, he had to return to the same facility due to his positive COVID-19 status.He passed away on November 10, 2020. Interview with the Director of Nursing (DON) on 6/8/2021 at 10:25 AM, the DON stated Resident #1 was a Resident in the facility He stated his family would visit daily, but when the facility was placed on lockdown due to COVID-19, the family visits were stopped, and Resident #1 began declining. The family did window visits and FaceTtime with the Resident, but that was not the same. He stated he was not at the facility when the incident occurred or when the daughter initially called and spoke to previous administration concerning her father's lack of care and alleged neglect. He stated the RR informed the previous administration of the weight the hospital obtained on her father (Resident #1) which indicated there was a massive weight difference (approximately 50 pounds). He stated when he found out about it, an investigation was	M 500	changes. Director of Nursing or Assistant Director of Nursing will report any weight changes to Interdisciplinary Team in weekly weight meeting for review beginning next scheduled meeting on 6/30/21. Residents with weight loss will be reported to Registered Dietician for review and recommendations. Director of Nursing will report findings to the Quality Assurance and Performance Improvement Committee monthly beginning 6/25/21 and will continue to be monitored monthly indefinitely when there is any resident weight loss.	

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started. During the investigation, he determined Licensed Practical Nurse (LPN) #1 was not weighing Resident #1 accurately.He stated LPN #1 was not subtracting the wheelchair weight from the scale weight and Certified Nursing Assistant (CNA) #1 once documented a weight she was told from another staff member. He stated he interviewed all the staff that had worked with Resident #1 and each employee denied they had not weighed the resident and just documented a weight close to the previous weight. Stated he determined one employee admitted he was weighing incorrectly, and therefore an inaccurate weight was obtained. New baseline weights were obtained on each resident and none of the other residents had a significant weight difference.The DON stated some had a smaller difference, but it was hard to determine if it was due to inaccurate weighing or from being on lockdown from COVID-19 and the residents feeling more isolated or a combination of both.

Interview on 6/9/2020 at 10:00 AM, with the Registered Dietician, when asked about the 54.8 pound weight loss in less than a month for Resident #1 (from 174.8 pounds on 7/16/2020 to a weight of 128 pounds on 7/23/2020-date of hospital admission to weight of 120 pounds on the date RD evaluated on 8/10/2020), and a 46.8 pound decrease in one week (from 174.8 pounds on 7/16/2020 until 7/23/2020's weight of 128 pounds at hospital) the RD stated she would not think that was possible. Stated it could be that the scales were not calibrated accurately.

A phone interview with Certified Nursing Assistant (CNA) #1 on 6/9/2020 at 11:20 AM, revealed she had worked with Resident #1 at this facility and at the previous facility she had worked in, so she

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knew him well. She stated Resident #1 had a good appetite and would usually "clean his plate and eats snacks too" and did not require much assistance, but as he got weaker, he required the staff to feed him. She stated there were times she weighed Resident #1 and did not remove the footrests or did not subtract the chair weight from the total weight. Stated she did not realize that the footrests and chair itself could make such a big difference. She stated she was in-serviced on weighing residents before this incident and was in-serviced again after incident. She stated she had also documented a weight another staff member had obtained, so that weight may have been inaccurate as well.

Attempts were made to contact LPN #1 on6/8/21 at 5:10 PM, 6/9/21 at 1:15 PM. and 6/11/21 at 9:20 AM. LPN#1 did not return the call to the State Agency. The facility staff also tried to reach out to him, but no return call.

Review of facility's weight log revealed Resident #1 with a weight of 174.8 pounds in the facility on 7/16/2020. Review of hospital record revealed one week later, on 7/23/2020, the resident's hospital admission weight was 128 pounds. Hospital records revealed Resident #1 was discharged from the hospital on 7/28/2020 and returned to the facility. Review of the facility's weight log revealed on 7/30/2020, Resident #1's weight was 127.6 pounds.

Record review of the facility's investigation revealed:
- Written statements dated 8/18/2020, by LPN #1 revealed, "I have thought about this weights. I believe I was getting an inaccurate weight because I was not counting the weight of the w/c (wheelchair) accurately. I was not remembering

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to take the foot pedals off, also it is difficult to set weight because he moves around in the w/c. (Proper Name) (Resident #1) is not compliant with care often trying to climb out of the w/c and leaning during weights." Signed (Proper Name) LPN #1
- Another written statement by LPN #1, undated, revealed, "Sorry. I saw this as I was going out. I have mostly been getting them myself. He was confused several times fighting with the staff so I would just try to catch him and do it when I could. I was trying to get them in the w/c mostly so it was me." Signed (Proper Name) LPN #1
- Written statement by CNA #1, dated 8/7/2020, revealed "On 4/16 I was informed that (Proper Name) Resident #1 weighed 182.6 so that's what I documented. I can't remember who the person was but I do know I just documented what I was told. On 3/12 I weighed (Proper Name)(Resident #1) using the lift and sling in his bed and got 182.5" Signed (Proper Name) CNA #1 08/07/20
- Disciplinary Form for LPN #1 dated 8/14/2020 listed dates of incident as: "multiple dates from September, 2019 - August 2020.Comments of Department Head, (describing the occurrence(s), indicating the timing between occurrences, and summarizing the action taken or recommended and its justification) stated, "Obtaining and documenting correct weights and processes not being followed. This nurse was obtaining weights himself and states that he forgot to subtract the wheelchair weights with leg extensions from the total weight obtained to acquire the correct baseline weight." Signed by employee (Proper Name) LPN #1 and supervisor (Proper Name) DON.

An interview with Administrator on 6/9/2021 at 2:30 PM, confirmed the facility failed to have a consistent method of weighing a resident.

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M 500	Continued From page 9 Interview with the Director of Nursing (DON) on 6/9/2021 at 2:32 PM, the DON confirmed the facility failed to have a consistent method of weighing residents accurately and did not adequately weigh Resident #1 to reveal that he could have possibly had a weight loss. Record review of the Admission Record revealed Resident #1 was admitted to the facility on 4/4/2019 with diagnoses which included Dementia, Chronic Obstructive Pulmonary Disease, Hypertension, Anxiety Disorder, Vitamin Deficiency, Anemia, Anorexia, Dysphagia Following Unspecified Cerebrovascular Disease; Transient Cerebral Ischemic Attack. Record review of Minimum Data Set (MDS), Section C - Cognitive Patterns, dated 10/26/2020 revealed Resident#1 had a Brief Interview for Mental Status (BIMS) score of "0" indicating severe cognitive deficits. Record review of an In-service dated 2/10/20 titled "Weight Monitoring", revealed LPN #1 and CNA #1's signatures were listed on the sign in sheet as attending the inservice.	M 500		