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
	17DH	A. BUILDING: _____ B. WING _____	04/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESOTO HEALTHCARE CENTER	7805 SOUTHCREST PARKWAY SOUTHAVEN, MS 38671

(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 Based on administrative review and communication with CMS, this 2567 was amended. During the recertification survey of 4/01/19 through 4/07/19, conducted by Healthcare Management Solutions, LLC (HMS) on behalf of the Mississippi State Department of Health, the survey determined that the facility was not in compliance with federal requirements at F600, F688, F804, and F808. It is also determined as a result of the survey finding of 4/01/19 through 4/07/19, that the facility was not in compliance with the Minimum Standards of Operation for Institutions for the Aged or Infirm, state licensure requirements at M500, M625, M645, and M865. The census at the time of survey was 106, and the facility held a license for 120 beds.	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	M 500		5/24/19

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M 500	Continued From page 1 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 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,	M 500		

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M 500	Continued From page 2 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; 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;	M 500		

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M 500	Continued From page 3 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 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	M 500		

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M 500	Continued From page 4 choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level III Based on facility policy review, interview and record review, the facility failed to recognize and prevent abuse and neglect, and failed to protect residents after allegations of abuse and neglect were reported to staff, for three (3) of 47 sampled residents, Residents (R) #55, R #157, and R #158. Two (2) allegations of verbal abuse and one (1) allegation of neglect were reported to staff, by cognitively intact residents. Certified Nursing Assistant (CNA) #143 was identified to be involved in one (1) allegation of verbal abuse on 1/30/19, and again in the allegation of neglect on 02/04/19. Resident #55 voiced concerns about repercussions. Resident #55: CNA #143 neglected to take the resident to the bathroom, per request, for four (4) hours on 02/04/19. This was reported to the staff on 02/04/19, by the resident. DON #30 counseled the CNA and signed the section of the grievance form "Corrective Action Complete" on 02/06/19. (This was two (2) days after the event). CNA #143 continued to work. Resident #158: Licensed Practical Nurse (LPN) #142 verbally abused the resident on 09/30/18, and the resident reported the abuse to staff on 10/01/18. Director of Nursing (DON) #30 counseled the LPN and signed the section of the grievance form "Corrective Action Complete" on 10/03/18. (This was three (3) days after the alleged event). LPN #142 continued to work. Resident #157: CNA #143 verbally abused the resident on 01/30/19, which was reported to staff by the roommate on 01/30/19, and confirmed by Resident #157. DON #30 counseled the CNA and signed the section of	M 500	.1)Resident #55 was discharged from the facility on 3/21/19. Director of Care Transition spoke to the resident's daughter on 3/25/19 and 4/24/19 and they had no complaints about care. Certified Nursing Assistant # 143 is no longer employed at the facility. Licensed Practical Nurse #142 is no longer employed at the facility. Resident #158 was discharged from facility on 10/27/18. The Director of Care Transition was unable to reach the resident or responsible party. Licensed Practical Nurse #142 is no longer employed at the facility. Resident #157 was discharged from the facility on 2/1/19. The Director of Care Transition spoke to the resident's responsible party on 2/1/19 had they had no complaints and was appreciative of care. Certified Nursing Assistant # 143 is no longer employed at the facility. Director of Nursing #30 is no longer employed at the facility. Social Worker #90 is no longer the Grievance Officer (2)Residents who report grievances have the potential to be affected by facility's failure to recognize and prevent abuse and neglect. (3)On 04/04/19, all grievances filed from 02/2018 until 04/06/19 were reviewed by Administrator, Risk Manager , Registered	

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M 500	Continued From page 5 the grievance form "Corrective Action Complete" on 02/03/19. (This was four (4) days after the alleged event). CNA #143 continued to work. Findings include: The facility "Abuse Policy," with an implemented date of 1/11/18, reads: Policy: It is the policy of this facility that abuse will be handled as follows: The facility will: -Prevent, identify, investigate and report all allegations of abuse/neglect/exploitation or mistreatment, including injuries of unknown sources and misappropriation of resident property ... -Protect the resident during an abuse investigation ... Guidelines 3. Prevention... The facility will identify, correct and intervene in situations in which abuse, neglect and/or misappropriation of resident property is more likely to occur. 4. Identification: The facility will identify events, occurrences, patterns and trends that may constitute: a. Neglect: Failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. b. Abuse: The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. This also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychological well-being. Any instances of abuse of any residents, irrespective of any mental or physical condition, cause physical harm, pain or mental	M 500	Nurse #12, Regional Nurse Consultant and Quality Assurance Nurse. No further allegations of abuse or neglect were identified. Beginning on 04/04/19 interviews were initiated for eighty-five interviewable residents and assessments were conducted for eighteen non interviewable residents regarding abuse and neglect. Interviews were conducted by four Social Workers and assessments were conducted by Medicare Nurse and Unit Manager and there were no new allegations of abuse and neglect and Medical Director was notified of results. On 04/04/19, In-Services were conducted by Regional Nurse Consultant with the Administrator, Director of Nursing, Assistant Director of Nursing, Risk Manager , Quality Assurance Nurse, Medicare Nurse , two Minimum Data Set Nurses, and Social Worker on the Abuse Policy to include examples of abuse, reporting and investigating abuse. On 04/04/19 In-services were initiated with all staff by the Risk Manager and Staff Development Nurse on the Abuse and Neglect Policy. Examples of abuse and how to identify abuse were reviewed. Reviewed with staff that investigations were to start immediately following allegations. Reporting to the appropriate State Agencies immediately but no later than two hours if the violation involves abuse or results in serious bodily injury or	

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M 500	Continued From page 6 anguish, includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. c. Verbal Abuse means 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 ... 5. Investigation: The facility will investigate all allegations and types of incidents as listed above in accordance to facility procedure for reporting/response/ investigating as described below. 6. Protection: a. The facility will protect residents from harm during an investigation by: i. [sic] Suspending the accused employee until facility has conducted its own investigation and no evidence of abuse was found ... Procedure for Response, Reporting, Investigation Allegations of Abuse/Neglect/Exploitation... When suspicion of abuse/neglect/exploitation or reports of abuse/neglect/exploitation occur, the following procedure will be initiated: Response ... c. Notify the Director of Nursing Services and Administrator ... f. Complete an initial report on Abuse/Neglect/Exploitation form and initiate an investigation. Reporting ... The complaint must be reported immediately to the Administrator, Director of Nursing, and the Nursing Supervisor on duty ... "	M 500	twenty-four hours if alleged violation does not involve abuse and does not result in serious bodily injury. No staff will be allowed to work until in-serviced. (4)Beginning 4/17/19, staff will be asked in morning stand-up meeting daily Monday through Friday, by the Assistant Director of Nursing/Risk Manager, if they are aware of any allegations of Abuse and Neglect. This will be documented on the abuse and neglect audit form and investigated immediately by the Director of Nursing and Assistant Director of Nursing/Risk Manager. Risk Manager will bring all discrepancies to Quality Assurance Committee monthly for further review and any corrective actions needed. The Quality Assurance Committee met on 4/5/2019, and discussed the deficiency and possible corrective actions. Further problems and concerns identified by continued monitoring will be presented to the Quality Assurance Committee as the need arises.	

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M 500	Continued From page 7 Review of the facility's Grievance Log for the last six (6) months revealed 26 grievances that were documented. Review of each of the grievances revealed two (2) allegations of verbal abuse (for Resident #157 and Resident #158) and one (1) allegation of neglect (for Resident #55). The three (3) allegations were reviewed and discussed with the Risk Manager, DON #30, Social Worker (SW) #90 (who was also the Grievance Officer), and the Administrator. During the interviews, it was discovered that DON #30 and SW #90 did not follow the facility policy by failing to identify abuse and neglect for the three (3) residents. DON #30 counseled the employees and allowed them to continue working. The DON did not thoroughly investigate the allegations, nor did she report the abuse and neglect to the Administrator and the State Agency. Resident #55 Review of R #55's Electronic Medical Record (EMR) revealed an undated "Face Sheet." The "Demographics" section indicated an admit date of 01/22/19. The "Diagnoses" section listed: Need for assistance with personal care, Muscle weakness, Chronic obstructive pulmonary disease (COPD), Parkinson's disease, and Mild cognitive impairment. Review of R #55's admission "MDS" with an "ARD" of 02/04/19, specified the resident had a "BIMS" score of 15 out of 15, which indicated no cognitive impairment. R #55 did not exhibit any behavioral symptoms. R #55 required extensive assistance of one (1) staff member with bed mobility, transfers, toileting and personal hygiene. R #55 was frequently incontinent of bladder and occasionally incontinent of bowel. R #55 was discharged home on 03/21/19.	M 500		

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M 500	Continued From page 8 Review of a "Grievance Investigation", dated 02/04/19 at 8:00 AM, Speech Language Pathologist (SLP) #3 documented, on either 02/03/19 and 02/04/19 at 3:00 AM, R #55 called for CNA #143 because she needed to go to the bathroom. CNA #143 came by and told the resident she was making rounds and she would get her when it was her turn. CNA #143 came back at 5:28 AM, (the buzzer went off at the desk) and asked her what she needed. R #55 told her she needed help going to the bathroom. CNA #143 came in to the resident's room and told her to roll over. The resident asked why. CNA #143 said she was going to change her pad. The resident asked why she was going to change her pad. R #55 said no, she needed help going to the bathroom. The CNA told her that the patients could not get up to go to the bathroom during the night. The resident said, "Then I will take myself." CNA #143 went out of the room mad and mouthing off complaints to the nurse, or whomever, and said the resident was refusing to cooperate. LPN #144 then came in and asked if she said she was going to walk to the bathroom herself. The resident said "No, I wouldn't do that." The resident sat on the edge of the bed, still LPN #144 nor CNA #143 helped her to the bathroom or helped her get her leg back in bed. The resident was finally able to pull her leg back into the bed to stretch out. No one helped her to the bathroom until the 7:00 AM shift came on. The resident was concerned for repercussions. When the day shift came, she told the CNA, "My diaper will probably drag the floor, it was so full." The resident also said CNA #143 said they couldn't take her to the bathroom at night until therapy said they could. The resident said this had happened every night since she came, and they come in and expect her to use the pad. Resident	M 500		

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M 500	Continued From page 9 #55 voiced concerns with fear of repercussions. The section titled "Details of Investigation", revealed, "Spoke w/aide regarding this incident. Educated aide that residents should get up to the restroom anytime they need to go ..." This was signed by the DON. The DON signed the grievance form indicating the corrective actions were completed on 2/6/19, which was two (2) days after the alleged event. The CNA continued to work. On 04/03/19 at 1:15 PM, DON #30 was given the "Grievance Investigation" for R #55 and was asked to classify the allegation. She stated, "I don't have a good answer." She looked at the policy again and stated, "According to the "definition", could be neglect." Resident #158 Review of R #158's electronic medical record (EMR) revealed an undated "Face Sheet." The "Demographics" section identified an admit date of 09/20/18. The "Diagnoses" section listed, Mild cognitive impairment, Type 2 diabetes, and Pain. Resident #158's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/03/18, specified the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated no cognitive impairment. R #158 did not exhibit any behavioral symptoms. R #158 required extensive assistance of one (1) staff member with activities of daily living (ADLs) for bed mobility, transfers, dressing, and toileting. The MDS specified R #158 had an ostomy bag. R #158 was discharged home on 10/27/18. A "Grievance Investigation" documented by SW	M 500		

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M 500	Continued From page 10 #90, dated 10/01/18 at 9:20 AM, revealed, on 09/30/18 at 3:00 PM, R #158 stated she turned on the call light. She needed a nurse to look at her bag [colostomy] because she thought it was leaking. At the same time R #158 felt her blood sugar dropped. At 3:30 PM, LPN #142 came in and checked her blood sugar. It was 95. LPN #142 told the resident to eat a couple more M&Ms, but did not check the colostomy bag. LPN #142 told the resident she would return later. The resident was concerned about her bag. A friend of R #158 called the facility and said that R #158 needed help. At 6:58 PM, LPN #142 returned to the room and yelled, "I told you I was coming back. Don't you ever call and tell someone I am not doing my job." The resident stated that the DON must have texted her. The section titled "Details of Investigation" revealed, "Spoke with employee regarding this and counseled with her on appropriate customer service. She will take someone with her from now on." This was signed by DON #30. The DON signed the corrective actions were completed on 10/3/18, this was three (3) days after the alleged event. On 10/10/18, no time indicated, SW #90 documented on the "Additional Comments," of the Grievance form, "BSW [Bachelor of Social Work] spoke w/[with] resident on 10/10/18, regarding nurse. Resident stated that at first she was a little disappointed to see the nurse back in her room ..." During an interview with DON #30 on 04/03/19 at 1:00 PM, she was asked if she could define abuse. She said she would need to look at the policy for the definition. DON #30 was given the "Grievance Investigation" and was asked to how	M 500		

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M 500	Continued From page 11 should would classify R #158's allegation. She stated, it could have been "disparaging for the resident and it is verbal abuse." She was asked if the "Details of Investigation" she had documented addressed verbal abuse and if she had spoken with the resident regarding the allegation. She replied, the counseling provided to LPN did not include the situation was verbal abuse, because she had not recognized it as such. She confirmed she had not spoken to the resident about the incident to verify the information. She failed to provide protection to other residents. Resident #157 Review of R #157's EMR revealed an undated "Face Sheet" under the "Demographics" section with an admit date of 10/06/17, and a re-admit date of 11/01/18. The "Diagnoses" section listed: Acute upper respiratory infection, Muscle weakness, Alzheimer's disease, Unspecified dementia without behavioral disturbance, and Anxiety disorder. R #157's admission "MDS" with an "ARD" of 11/14/18, specified the resident had a "BIMS" score of 15 out of 15, which indicated no cognitive impairment. R #157 did not exhibit any behavioral symptoms. R #157 required extensive assistance of two (2) staff members for transfers, dressing and toileting R #157 was frequently incontinent of bowel and bladder. R #157 was discharged home on 02/01/19. Review of a "Grievance Investigation", documented by SW #83 on 01/30/19 at 8:45 AM, revealed, on 01/30/19 at 4:00 AM, R #260 stated CNA #143 was very rude to his roommate (R #157) that morning. R #157 went to the bathroom and was going back to bed when CNA #143 came into the room. CNA #143 went to R #157's closet and got a pair of pants out and threw them on the bed. R #260 stated CNA #143 told R #157,	M 500		

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M 500	Continued From page 12 "You will put these dam [sic] pants on." She then walked out of the room. SW #83 asked R #157 if his roommate's statement was true. R #,157 said it was true, and he did not understand why he had to change his pants. The section titled "Details of Investigation" revealed, "Counseled w/[with] aide regarding incident, that this language is not acceptable at all. Verbalized understanding and stated it will not happen again ...signed by DON #30. The DON signed the corrective actions were completed on 2/3/19, which was four (4) days after the alleged event. During interview on 04/03/19 at 1:08 PM, with DON #30, she was shown the "Grievance Investigation" for R #157 and was asked how she would classify the allegation. She stated, "It is verbal abuse." She stated she did not counsel the aide on verbal abuse because she had not considered it to be abuse, until she read the policy and definition of abuse. The DON stated the CNA was pulled from Resident #157's room and told not to go back to that room. She confirmed she had not talked with R #157 or R #260 about the allegation to verify the situation, and she had not provided protection to residents at the time of the allegation, because she did not investigate the allegation. Review of R #260's admission "MDS" with an "ARD" of 01/23/19, specified the resident's hearing was adequate and vision was adequate but wore corrective lenses. R #260 had a "BIMS" score of 13 out of 15, which indicated no cognitive impairment. R #260 did not exhibit any behavioral symptoms. R #260 was a resident at the time of the survey.	M 500		

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M 500	Continued From page 13 During group interview on 04/03/19 at 10:00 AM, R #260 recalled the event with his old roommate, R #157. He stated, "The staff member was mean to him." During an interview on 04/03/19 at 2:11 PM, SW #90 stated she was also the Grievance Officer. SW #90 was asked what that entailed, and she stated that she would take the grievance by talking with the resident and then take the grievance to the department in which the grievance was with. SW #90 added, she would follow up in a few days with the resident to see if everything had been worked out to their satisfaction. SW #90 was asked what she would do if she received any allegations of abuse or neglect. She stated she would take them to the Administrator and DON. She reviewed the three (3) allegations (for R #55, R #157, and R #158) and was asked what category she thought them to fall in. SW #90 stated, "Re-reading them now, "they are abuse and neglect." When asked why they appear that way now, SW #90 stated that she had received the others from DON #30, and was told they were worked through. SW #90 stated that she was aware they (grievances) had not been taken to the Administrator. She stated there was a discussion of grievance and allegations usually at the morning meeting. SW #90 stated she just did not catch it, that those had not been discussed. During an interview on 04/03/19 at 3:00 PM, the Administrator was shown the three (3) "Grievance Investigations" and asked how they appeared to him. The Administrator stated he thought they were abuse and neglect. He was asked if had seen them before. He stated, "No. I should have." He stated that DON #30 never showed those to	M 500		

MSDH - Health Facilities Licensure and Certification

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M 500	Continued From page 14 him He stated the residents were no longer here.	M 500		
M 625	45.21.5 Range of motion Range of motion. Residents with limited range of motion shall receive treatment and services to increase range of motion or prevent further decline in range of motion. This Statute is not met as evidenced by: Level II Based on observation, interview, clinical record review, and facility policy review, the facility failed to ensure Resident (R) #14, one (1) of 26 sampled residents, reviewed for limited range of motion (ROM), received the appropriate services and equipment to maintain or improve ROM, including: 1. Failure to follow therapy recommendations for the use of hand splints to reduce the risk of developing bilateral hand contractures. 2. Failure to follow therapy recommendations to place R #14 on a restorative program to reduce the risk of developing contractures. The failed practices resulted in actual harm to R #14, who developed bilateral upper and lower extremity impairment in ROM, and bilateral upper and lower extremity contractures. Findings Include: A review of the facility's policy titled, "Range of Motion Policy" undated, indicated the facility provided ROM services, " ...to move the resident's joints through a full ROM as possible, to improve or maintain joint mobility, and to prevent contractures."	M 625	(1) Resident # 14 was evaluated by the Restorative Nurse on 4/19/19 for a treatment plan to include Passive Range of Motion and application of bilateral hand splints. Treatment plan was initiated on 4/24/19. (2) All residents of the have the potential to be affected by the facility's failure to follow Therapy recommendations for the use of hand splints and place residents on a restorative program to reduce the risk of developing contractures. (3) Beginning on 4/18/19 the Minimum Data Set (MDS) Nurses initiated Range of Motion assessments on all residents in the facility. Any residents found to have limited range of motion will be referred to therapy services for screening and recommendations. Residents will receive services from restorative aides or therapists as needed. On 4/24/19, Minimum Data Set Nurses, Restorative Nurse, and Therapy Department were in serviced by the Quality Assurance Nurse to include that Licensed Nurses will assess residents	5/24/19

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M 625	Continued From page 15 A review of R #14's "Face Sheet" in the clinical record, indicated R #14 was admitted to the facility on 06/14/16, with diagnoses of, but not limited to, Alzheimer's disease, Dementia in Other Disease Without Behaviors, Urinary Tract Infection (UTI), Major Depressive Disorder, Pain, Hospice, and Primary Hypertension (HTN). Review of the admission "Minimum Data Set (MDS)" with an "Assessment Reference Date (ARD)"of 06/21/16, specified R #14's cognition was severely impaired-never or rarely made decisions. Resident #14's "Brief Interview for Mental Status (BIMS)" score was unable to be completed, due the resident's cognitive status. The resident required extensive assistance of one (1) to two (2) staff members for bed mobility, transfers, and activities of daily living (ADLs). The "MDS" specified R #14 had no ROM impairment to her upper and lower extremities. The "MDS" indicated no ROM services were provided and R #14 used no mobility devices. Review of the admission "Interim Care Plan", undated, revealed, no contractures were indicated, and transfer and bed mobility were an assist of one (1) staff. Review of R #14's "Therapy Services Screening" notes, dated from 06/16/16 through 03/18/19, indicated the following: 06/16/16 - "Multidisciplinary Screen" notes indicated, "Pt [sic] (patient) is on hospice and skilled services are not appropriate at this time." 06/20/16 - "Physical Therapy Screen" notes indicated, "Recommend restorative screen..." There was no therapy screening or recommendation documentation provided from 06/20/16 through 01/23/18.	M 625	range of motion (such as current extent of movement of his/her joints and the identification of limitations) on admission/readmission, quarterly, and upon a significant change. Residents who exhibit limitations in range of motion, initially and thereafter, will be referred to the Therapy Department for a focused assessment of range of motion. Residents will receive services from Restorative Aides or Therapists as needed. (4)This corrective action will be monitored by the Director of Nursing beginning 4/25/19, by reviewing all therapy recommendations for a Restorative program for range of motion and splinting daily Monday through Friday except holidays for three months. The Director of Nursing will bring all discrepancies to Quality Assurance Committee monthly for further review and any corrective actions needed. The Quality Assurance Committee met on 4/5/2019, and discussed the deficiency and possible corrective actions. Further problems and concerns identified by continued monitoring will be presented to the Quality Assurance Committee as the need arises.	

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M 625	Continued From page 16 01/23/18 - "Physical Therapy Quarterly Screen" notes indicated, "Patient at baseline. Eval [sic] (evaluation) not warranted." 04/03/18 - "Multidisciplinary Screen" notes indicated, "No change in function. PT [sic] (patient) not warranted at this time." Review of the annual "MDS" with an "ARD" of 05/12/18, specified ROM impairment bilaterally to the upper and lower extremities and indicated no ROM or therapy services. There was no change in R #14's cognition of severely impaired-never or rarely made decisions. R #14's "BIMS" was 99, which indicated the mental status interview could not be completed. The "MDS" specified the resident was dependent on staff for all ADLs and indicated transfer activity had not occurred during the assessment period. Review of the "Care Plan Sign - In Sheet" dated, 05/17/18, indicated the interdisciplinary team (Registered Nurse (RN), MDS Coordinator, Social Services (SS), Activities, Dietary, and a CNA) and family were present for the care plan meeting. There were no therapy services representatives listed. On 07/16/18 - "Physical Therapy Screen" notes indicated, "Pt [sic] (patient) has not had any changes in functional status to warrant PT (Physical Therapy) eval [sic] (evaluation)." On 10/03/18 - "Occupational Therapy Quarterly Screen" notes indicated, "Pt [sic] (patient) at baseline. Eval [sic] (evaluation) is not recommended." On 12/19/18 - "Occupational Therapy Quarterly Screen" notes indicated, "Pt. [sic] (patient) would benefit from hand splint to decrease risk of skin	M 625		

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M 625	Continued From page 17 breakdown." On 12/20/18 - "Multidisciplinary Screen" notes indicated, "Pt [sic] (patient) has not experienced a functional change in area of PT and ST (Speech Therapy). Recommendation OT (Occupational Therapy) to eval [sic] (evaluation) to address new contractures to B [sic] (bilateral) hands." On 03/15/19 - "Occupational Quarterly Screen" notes indicated, "Pt [sic] (patient) has history of refusing therapy and she does not get out of bed ..." Review of R #14's clinical record, indicated no documentation that R #14 had refused therapy or had a history of refusing therapy. On 03/18/19 - "Physical Therapy Quarterly Screening" notes indicated, "Patient presents at baseline and will not benefit from physical therapy." There were no documented therapy screenings or recommendations between the dates of 12/20/18 through 03/15/19. A review of R #14's "Care Plan" problem, dated with a goal and target date of 06/28/19, indicated, the Problem; " ...Requires total dependence with activities of daily living (ADLs), transfers and mobility. ...See Care guide ADL for individual needs." There were no interventions for restorative services to offer ROM for upper and lower extremities. A review of R #14's Hospice collaborative plan of care "Hospice Notes", dated from 01/03/18 through 04/01/19, indicated no restorative ROM program or services.	M 625		

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M 625	Continued From page 18 A clinical record review of the "Physician Orders" (PO), dated for April 2019, indicated R #14 had no orders for restorative or therapy services for ROM and the care plan had been reviewed and agreed upon. Observation during the initial tour on 04/01/19 at 6:30 AM, revealed R #14 was in her room in bed. Her bilateral arms were contracted inwards toward her chest and bilateral hands were fully contracted with hand rolls in place. Observations on 04/01/19 at 8:00 AM, 12:11 PM, 12:45 PM, and 2:00 PM, revealed, R #14 was in bed, with the head of the bed slightly elevated, and she was lying on her backside with her legs crossed, contracted, and feet and lower legs angled upward, not touching the bed. Her bilateral arms and hands were contracted inward toward her chest with hand rolls in place. Observation and interview on 04/02/19 at 9:08 AM, revealed R #14 was in bed with the head of the bed upright. CNA #14 stated R #14 was unable to grab or hold anything with her hands due to the contractures. R #14's position, while in bed lying on her backside, revealed an upward inverted angle of her body, not allowing her to lay flat on the bed. This body position was due to her upper and lower extremity contractures. Interview with CNA #14 on 04/02/19 at 10:30 AM, revealed R #14 was considered extensive assistance of two (2) staff members and required a lift for transfer. She stated R #14 did not get out of the bed every day. In an interview with R #14's "Power of Attorney" (POA) [daughter] on 04/03/19 at 9:30 AM, she	M 625		

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M 625	Continued From page 19 stated R #14 was not admitted with contractures to bilateral upper and lower extremities. She stated R #14, to her knowledge, had never received therapy or restorative services, nor had it been discussed with the family. She stated the family would like the resident to receive any type of ROM services to help with comfort. In an interview with the "Restorative Program" Licensed Practical Nurse (LPN) #38 on 04/03/19 at 10:00 AM, she stated she was new to the position and did not have knowledge of what the prior Restorative Nurse had done. She stated the process for a resident to be placed on the restorative program was when therapy made weekly rounds they would refer residents to the program. She stated nursing could also refer residents who may have had a decline in ADLs. She confirmed R #14 had bilateral upper and lower extremity contractures and should have been recommended, and placed on restorative services for ROM, prior to her developing them. She stated nursing administration would be the ones to refer residents. In an interview with Director of Nursing (DON) #30, on 04/03/19 at 10:45 AM, she stated, regarding not following therapy recommendations from 06/20/16 and 12/20/18, she could not speak to that and wasn't sure what happened, but confirmed nursing had not followed up on the recommendations. She stated it was not normal for Hospice residents to be on therapy or restorative caseload, but couldn't see a reason why they could not be. She confirmed R #14 had upper and lower contractures and that "they" (meaning the facility) missed the opportunity to place R #14 on a restorative program for ROM, to reduce the risk of developing contractures and a decline in her ROM. The DON could not confirm	M 625		

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M 625	Continued From page 20 the date R #14's contractures developed. In an interview with the Director of Therapy (DOT), Occupational Therapist (OT) #1, on 04/04/19 at 9:50 AM, she stated she was familiar with R #14 and confirmed R #14 had developed upper and lower extremity contractures. She stated the therapy department had screened R #14 for being at risk for contractures, and had concluded she would benefit from hand splints and a restorative ROM and positioning program, to reduce the development of contractures; however, they had not followed through to see if it was completed. The DOT could not confirm the date R #14's contractures developed. In an interview with the MDS Coordinator, Licensed Practical Nurse (LPN) #105, on 04/04/19 at 12:27 PM, she stated to her knowledge, the completed MDS assessments for R #14 were accurate. She stated she was not completely familiar with R #14. She stated Hospice services attend the care plan meetings and collaborate with the facility care plans. She stated residents who are referred to nursing restorative services were discussed in the "Transmission" meeting along with Interdisciplinary Team (IDT) meetings. She stated she was not sure how the facility missed R #14 for restorative services, but confirmed R #14 should have been placed on a ROM program.	M 625		
M 645	45.21.9 Nutrition Nutrition. Residents shall maintain acceptable parameters of nutritional status, such as body weight and protein levels, unless residents ' clinical condition indicates that this is unavoidable. All residents shall receive diets as	M 645		5/24/19

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M 645	Continued From page 21 orders by their physician or nurse practitioner/physician assistant. Residents identified with significant nutritional problems shall receive appropriate medical nutrition therapy based on current professional standards. This Statute is not met as evidenced by: Level II Based on policy review, observation, interview, and record review, the facility failed to ensure therapeutic diet orders were followed for one (1) of 47 sampled residents, Resident (R) #75, as evidenced by R #75, who had a physician's order to receive nectar thickened liquids, was served and consumed thin liquids. Findings include: Review of the facility's policy titled, "Thickened Liquids Policy," undated, revealed, ". . . thickened liquids will be utilized with specific physician's order to indicate the desired consistency, thickener to be added by dietary with meals and by nursing staff with other liquids, and pre-thickened liquids may be used when available." Observation on 04/01/19 at 12:13 PM, during the lunch meal in the main dining room, revealed R #75 was served liquids by Licensed Practical Nurse (LPN) #105. R #75 took a drink of the liquids and immediately started coughing. LPN #105 removed the liquids from the resident. Interview with LPN #105, on 04/01/19 at 12:14 PM, revealed she mistakenly served R #75 thin fluids. During interview with LPN #105 on 04/01/19 at 1:26 PM, she stated she was going too fast during the lunch meal service and poured	M 645	1) Resident # 75 was assessed on 4/1/19 by Registered Nurse and Respiratory Therapist and found to have no negative consequences from receiving thin liquids. The Nurse Practitioner was notified of resident receiving thin liquids and no new orders were received. Practical Nurse (Licensed Practical Nurse) #105 was given a one on one in-service by the Risk Manager the to include ensure tray card is checked thoroughly for special diet needs or liquids prior to giving them. (2) All residents on thickened liquids have the potential to be affected by the facility's failure to ensure therapeutic diet orders are followed. (3) Staff Development Coordinator began in-servicing nursing, dietary and therapy staff on 4/15/19 to include that tray cards are to be checked prior to serving liquids. On 04/18/19, all residents with thickened liquids were monitored by the Quality Assurance Nurse and Assistant Director of Nursing to ensure all residents with thickened liquids order received thickened liquids, no deficiencies were identified. (4)On 4/18/19, the Quality Assurance Nurse began auditing meal services to ensure that resident's received the appropriate diet and fluids. The audit will	

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M 645	Continued From page 22 thin liquids for R #75. She stated before she could catch her mistake, R #75 drank the thin liquid (iced tea). LPN #105 confirmed the resident started coughing immediately, as soon as she took a drink. She stated it was important the resident received nectar thickened, and not thin liquids, to prevent her from aspirating and getting pneumonia. The LPN notified the RN, who came and assessed the resident along with the in-house Respiratory Therapist. Based on observations and interviews, the facility failed to implement their policy and ensure thickened liquids were utilized to conform with specific physician's orders for the correct consistency. Review of R #75's "Face Sheet," revealed the resident was admitted to the facility on 06/27/17, with diagnoses which included: Dementia without behavioral disturbances, Major Depressive Disorder, Mild Cognitive Impairment, Functional Dyspepsia, and Other Speech Disturbances. Review of "Physician Orders," dated April 2019, revealed R #75 had a physician's order, dated 06/29/17, for a mechanical soft diet with nectar thick liquids. Review of R #75's "Meal Card," dated 04/01/19, revealed the resident was to have nectar thick liquids. Review of R #75's "Care Plan," revealed, a problem onset date of 06/27/17, which indicated the resident was at risk for weight loss due to dx (diagnosis) of Dementia and Depression. The resident had a "Goal" to consume 50%-75% of meals thru [sic] (through) next review, with a goal date of 06/01/19. The "Care Plan" revealed	M 645	be completed on ten residents daily Monday through Friday by the Quality Assurance Nurse and on the weekend by the Treatment Nurse for one month, then weekly. All audits will be presented to the Assistant Director of Nursing for corrective actions needed. The Assistant Director of Nursing will bring all discrepancies to Quality Assurance Committee monthly for further review and any corrective actions needed. The Quality Assurance Committee met on 4/5/2019, and discussed the deficiency and possible corrective actions. Further problems and concerns identified by continued monitoring will be presented to the Quality Assurance Committee as the need arises.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17DH	A. BUILDING: _____ B. WING _____	04/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESOTO HEALTHCARE CENTER	7805 SOUTHCREST PARKWAY SOUTHAVEN, MS 38671

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M 645	Continued From page 23 approaches which directed: "RD (Registered Dietitian) consult when needed, encourage fluids with meals, supplement as needed and nectar thick liquids per md [medical doctor] order." Interview, on 04/05/19 at 7:00 PM, with the Administrator, revealed it was his expectation staff would have checked the resident's tray ticket prior to serving the liquids for Resident #75. The Administrator stated it was important the resident would receive the correct fluid consistency, to prevent negative outcomes, such as aspiration.	M 645		
M 865	45.30.9 Serving of Meals Serving of Meals. 1. Table should be of a type to seat not more than four (4) or six (6) residents. Residents who are not able to go to the dining room shall be provided sturdy tables (not TV trays) of proper heights. For those who are bedfast or infirm tray service shall be provided in their rooms with the tray resting on a firm support. 2. Personnel eating meals or snacks on the premises shall be provided facilities separate from and outside of food preparation, tray service, and dishwashing areas. 3. Foods shall be attractively and neatly served. All foods shall be served at proper temperature. Effective equipment shall be provided and procedures established to maintain food at proper temperature during serving. 4. All trays, tables, utensils and supplies such as china, glassware, flatware, linens and paper placemats, or tray covers used for meal service	M 865		5/24/19

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M 865	Continued From page 24 shall be appropriate, sufficient in quantity and in compliance with the applicable sanitation standard. 5. Food Service personnel. A competent person shall be designated by the administrator to be responsible for the total food service of the home. Sufficient staff shall be employed to meet the established standards of food service. Provisions should be made for adequate supervision and training of the employees. This Statute is not met as evidenced by: Level II Based on policy review, observation, interview and record review, the facility failed to ensure that one (1) of three (3) residents who received dialysis outside the facility, Resident (R) #29, received a meal that was appetizing and at the appropriate temperature when he returned from dialysis on Monday, Wednesday and Friday evenings. Specifically, staff would deliver R #29's dinner tray to his room, during the evening meal service, and leave it at the bedside until the resident returned at 9:00 PM, from dialysis; then he would eat the meal. Findings include: The facility documented on letter head, dated 04/07/19, there was no policy to address the concern of leaving meals in the resident's room, however; the noted expectations were for staff to assist residents with meals as needed. Observation on 04/01/19, revealed R #29 left the facility at 4:30 PM, for his dialysis treatment. During interview with R #29 on 04/02/19 at 9:45	M 865	(1) Resident # 29 had requested that his dinner tray be left in his room on dialysis days. On 4/15/19, The Director of Nursing offered Resident #29 an early tray with a snack upon return from dialysis on dialysis days, and resident was agreeable with this. (2) The facility has determined that all residents on dialysis have the potential to be affected by facility's failure to receive a meal that was appetizing and at the appropriate temperature. All residents on dialysis were interviewed on 4/24/19 by the Assistant Director of Nursing/Risk Manager regarding meals on dialysis days one resident will receive an early dinner tray and the other resident will take a sack lunch with her to dialysis. (3)On 4/24/19, Nursing, Social Services and Dietary staff was in serviced by the Quality Assurance Nurse to include that if a resident is out of the facility for an appointment during meal time arrangements are to be made for the	

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M 865	Continued From page 25 AM, he stated when he returns from dialysis on Monday, Wednesday and Friday evenings at 9:00 PM, his meal tray will be waiting for him. He stated the staff re-heated his meal. He stated the food "sucks and tastes terrible." During this same interview, R #29's roommate verified staff brought R #29's tray into the room during the evening meal service and they just left it there. During an observation on 04/03/19 at 5:58 PM, R #29's evening meal tray was setting on the bedside table while the resident was at dialysis. During an interview on 04/05/19 at 1:30 PM, Director of Nursing (DON) #12 was asked if it was appropriate for R #29's meal tray to be delivered to his room and left at the bedside when he was at dialysis. DON #12 stated it was very inappropriate to leave the tray at the bedside. The DON stated the resident should receive a fresh tray upon his return.	M 865	resident to receive an early or late tray for that meal. (4) On 4/15/19, The Director of Nursing began monitoring tray delivery to ensure that the resident received an early tray on dialysis days and that tray is not left in room Monday through Friday; and will continue to monitor for four weeks.The monitoring sheet will be turned in to the Quality Assurance Department weekly for further review. The Quality Assurance Nurse will bring all discrepancies to the Quality Assurance Committee monthly for further review and any corrective actions needed. The Quality Assurance Committee met on 4/5/2019, and discussed the deficiency and possible corrective actions. Further problems and concerns identified by continued monitoring will be presented to the Quality Assurance Committee as the need arises.	