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
	59AL	A. BUILDING: _____ B. WING _____	C 02/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LONGWOOD COMM LIVING CENTER	200 LONG STREET/P. O. BOX 326 BOONEVILLE, MS 38829

(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) conducted a complaint survey investigating CI MS #16486 at the facility on 02/19/20. During the survey, the SA determined that the facility was not in compliance with the requirements for Institutions for the Aged or Infirmed. The SA substantiated the complaint for improper use of a restraint for Resident #1.The SA cited the state statute M500 related to the complaint. The facility had a census of 41 at the time of the complaint survey, with a license for 60 bed capacity.	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		4/1/20

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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: Based on interview, record review and facility policy review, the facility failed to prevent the violation of the resident;s right to be free from the	M 500	1.Resident #1 was assessed by the Registered Nurse Supervisor on 12/16/2019 for any emotional needs	

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M 500	Continued From page 4 use of physicial restraints for one (1) of three (3) residents reviewed for restraints. Resident #1 Findings include: Review of the facility policy entitled, "Restraints," dated 08/23/2017, stated, "It is the policy of this facility that residents have the right to be free of physical restraints. Physical restraints are not to be used for the convenience of a staff or as a punishment of the resident." Review of the facility's investigation, signed and dated by the Executive Director on 12/18/2019, stated, "Restraint inappropriately applied to resident on 12/15/2019 at 3:30 PM by (Proper Name)/Licensed Practical Nurse (LPN) #1 applied a gait belt around (Proper Name)/Resident #1's waist while resident was in her wheelchair for approximately twenty minutes. Resident was restrained without a physician's order, without responsible party notification and with an improper restraint. Another witness to the incident above, (Proper Name of a CNA) reported this alleged incident to the Director of Nurses (DON), on 12/16/2019, while she was off campus doing errands for the facility along with (Proper Name) Business Office Manager. An interview with Certified Nursing Assistant (CNA) #1 at 2:30 PM on 02/19/2020, revealed she stated she had returned from a break and CNA #2 approached her and told her she was clocking out and leaving because this was a "no restraint" building and LPN #1 had just strapped Resident #1 to a chair with a gait belt. CNA #1 attempted to calm CNA #2 and told her to allow her time to go to that hall and check on the resident. CNA #1 stated she approached	M 500	related to the application of restraint and need for care plan updates. No needs or updates were required. Resident #1 skin was assessed for impairment from the application of an improper restraint by the Registered Nurse Supervisor on 12/16/2019, 12/17/2019 and 12/18/2019 with no negative findings. 2.Any residents who have restraints have the potential to be affected. An audit was performed by the Director of Nursing on 02/20/2020 with no residents noted to have restraints. Abuse and Neglect Education and when to report suspected Abuse or Neglect was completed on 02/20/2020 by the Director of Nursing. 3.The Licensed Practical Nurse (LPN) #1 was terminated on 12/16/2020. Education was completed by the Director of Nursing on 12/16/2020 for all staff on right to be free from physical restraints, application of restraints, physician orders, notification of responsible party and assessments required with the application of restraints. The Director of Nurses re-educated all staff on 02/20/2020 on the right to be free from physical restraints, the application of restraints, physician orders, notification of the responsible party and assessments required with the application of restraints. 4.An audit was performed by the Director of Nursing on 02/21/2020 on all residents for the use of restraints with none found to be in use. The Director of Nursing or Registered Nurse Supervisor will monitor residents five x week x four weeks for the application of improper restraints starting	

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M 500	Continued From page 5 Resident #1 sitting in a high back wheelchair and at first you couldn't see that she had a gait belt around her waist because it was hidden under her clothes, but you could see it buckled on the back of the wheelchair and it was not where the resident could remove it, she couldn't reach her hands back that far to remove the gait belt. CNA #1 approached LPN #1 and talked to her and told her it was a restraint and she stated LPN #1 just ignored her and then she heard LPN #1 state, "I'll do it again." CNA #1 stated you could tell LPN #1 was mad, so she went and took the belt off the resident and laid her down in her bed and she checked on her constantly the rest of the night and Resident #1 never tried to get up again. CNA #1 stated she worked until 11 PM that night and so did LPN #1, but Resident #1 never tried to get up again that night. CNA #1 confirmed the gait belt was on the resident for about 15-20 minutes by the time CNA #2 had reported it to her, and she had tried to talk to LPN #1 and then went and removed the belt and placed Resident #1 in bed. An interview with CNA #2, on 02/19/2020 at 4:05 PM confirmed she saw LPN #1 put the gait belt around Resident #1's waist while she was sitting in her wheelchair. CNA #2 stated LPN #1 was very annoyed and mad that night because they had to watch Resident #1 and LPN #1 was intimidating and mean, so when she tied her (Resident #1) to the chair, she went to look for CNA #1 because she knew she had worked there a long time and she trusted her and she told her she was upset, so she (CNA #1) came to the resident and saw what she was talking about. An interview with LPN #1, on 02/19/2020 at 3:45 PM, by telephone, revealed LPN #1 denied she used a gait belt to tie Resident #1 to her wheelchair. LPN #1 stated she had put the gait	M 500	on 02/24/2020. The Director of Nursing will report the findings to the Quality Assurance and Performance Improvement Committee monthly and as needed for review, revision and\or resolution of the plan.	

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M 500	Continued From page 6	M 500		

belt around Resident #1's waist and walked her back to her wheelchair and then she untied it because she realized it was a restraint.

Review of Resident #1's Comprehensive Care Plan revealed no Approaches, Goals, or Interventions for the use of restraints. The Care Plan did address the resident's behaviors of yelling and screaming, and refusing care at times, but did not address the need or use of restraints.

An interview with the Director of Nursing (DON), on 02/19/2020 at 5:30 PM, confirmed she notified LPN #1 the next morning, on 12/16/2019, and had her come to the facility to write a statement and when the investigation was completed the facility substantiated the allegation and terminated LPN #1's employment later the same day, on 12/16/2019, due to resident abuse.

Review of the facility's Personnel Action Notice (PAN) revealed LPN #1's hire date was 05/16/2018.

Review of the facility's Personnel Action Notice (PAN), dated 12/16/2019, revealed LPN #1 was terminated for resident abuse.

Review of the facility's In-Service sign in sheet revealed LPN #1 attended an in-service in June 2019 titled, "Abuse/Neglect," which included restraints.

Resident #1 was admitted to the facility, on 03/26/2019 with diagnoses which included, Cirrhosis of the Liver, Hepatic Failure and Mental and Behavioral Disorders.

Review of Resident #1's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date

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M 500	Continued From page 7 (ARD) of 12/03/2019, revealed a Brief Interview for Mental Status (BIMS) score of 13, which indicated no cognitive impairment. Further review of the MDS revealed the Specialized Treatments/Programs was not checked for the use of restraints or devices.	M 500		