STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255264	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) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted a complaint survey at the facility, on 02/19/2020, for CI MS #16486 . The complaint investigation was for the resident's right regarding the application of a physical restraint without a physician's order, assessment, and consent for use. During the survey the SA substantiated the complaint and determined the facility was not in compliance with the requirements of participation for Medicare and Medicaid. The SA cited regulatory deficiencies F604 and F609 related to the complaint. The facility had a census of 41 at the time of the complaint survey, with a license for a 60 bed capacity.	F 000		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.	F 604		4/1/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 03/30/2020

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F 604	Continued From page 1 §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on interview, record review and facility policy review, the facility failed to ensure that residents were free from the use of physical 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	F 604	1.Resident #1 was assessed by the Registered Nurse Supervisor on 12/16/2019 for any emotional needs 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	

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F 604	Continued From page 2 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 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.	F 604	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 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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F 604	Continued From page 3	F 604		

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 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

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F 604	Continued From page 4 (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 (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.	F 604		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events	F 609		4/1/20

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F 609	Continued From page 5 that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, record review and facility policy review, the facility failed to report to the proper authorities an allegation of abuse/neglect for the use of a physical restraint without a physician's order, assessment and consent for one (1) of three (3) residents reviewed for restraints. Resident #1. Findings include: Review of the facility policy entitled, "Freedom from Abuse, Neglect, and Prevention Plan Education," dated 08/23/2017, stated, "Any employee who witnesses or has cause to suspect abuse/neglect, must report it immediately to the Administrator/Director of Nursing of the facility and within two hours if the allegation involves abuse."	F 609	1.Resident #1 was assessed by the Registered Nurse Supervisor on 12/16/2019 for any emotional needs related to improper use of restraint and failure to report to the Administrator or Director of Nurses (DON) within two hours. No needs or adjustment to the plan of care were required. The Licensed Practical Nurse (LPN) #1 was terminated from facility on 12/16/2019. 2.All residents in the facility have the potential to be affected. An audit of all residents was performed by the Director of Nursing on 02/21/2020 to assess for safe and homelike environment and abuse/neglect/misappropriation with no negative findings. Re-Education and counseling were completed with Certified	

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F 609	Continued From page 6 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 CNA #1 confirmed she failed to notify the DON or Administrator of the incident and further stated, "I should have told somebody right away, but I just wasn't thinking. CNA #1 said 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 she just saw LPN #1 strap Resident #1 to a chair with a gait belt. CNA #1 attempted to calm CNA #2 and told her to let her have enough time to go to that hall and check on the resident. CNA #1 stated she arrived to see Resident #1 sitting in a high back wheelchair and at first you couldn't see she had a gait belt around her waist because it was hidden under her clothes, but you could see it was buckled on the back of the wheelchair where the resident could not remove it, she couldn't reach her hands back that far to remove the gait belt. CNA #1 said she approached LPN #1 to talk to her and told her it was a restraint and	F 609	Nursing Assistant (C.N.A) #1 and C.N.A #2 on 12/16/2019 by the Director of Nursing. 3.Education was completed by the Director of Nursing on 12/16/2019 and again on 02/20/2020 for all staff on abuse, neglect, exploitation or mistreatment of a resident property and reporting of alleged violations. 4. The Director of Nursing or Registered Nurse Supervisor will monitor all residents with restraints, five times a week for four weeks for application of improper restraint and/or failure to report starting on 02/23/2020.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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F 609	Continued From page 7	F 609		

she stated LPN #1 just ignored her and then she heard LPN #1 state, "I'll do it again." CNA #1 stated she could tell LPN #1 was mad, so she went and took the belt off the resident and laid her down in her bed and continued to check 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, until she removed the belt and placed Resident #1 in the bed.

An interview with CNA #2, on 02/19/2020 at 4:05 PM, CNA #2 confirmed she failed to tell anyone (except CNA #1) and failed to report the incident to anyone. CNA #2 said 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. CNA #2 said LPN #1 was intimidating and mean and when she saw LPN #1 tie 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. CNA #2 said she told CNA #1 she was upset, so CNA #1 went to check on Resident #1 and saw what she was talking about.

A phone interview with LPN #1, on 02/19/2020 at 3:45 PM, revealed she denied she used a gait belt to tie Resident #1 to her wheelchair. LPN #1 said she put the gait belt around Resident #1's waist and walked her back to her wheelchair. LPN #1 said she untied the gait belt at that time because she realized it was a restraint.

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F 609	Continued From page 8	F 609		

An interview with the Director of Nursing (DON), on 02/19/2020 at 5:30 PM, revealed she was not notified of the allegation until the next morning on 12/16/2019 and she counseled both CNA #1 and CNA #2 and reported the allegation to the State Agency and began an investigation on 12/16/2019. The DON notified LPN #1 the next morning on 12/16/2019 and had her come to the facility to write a statement. The DON stated 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.

Record review revealed CNA #1 and CNA #2 was in-serviced and counseled on 12/16/2019 because they failed to report the allegation of abuse to the DON or the Administrator. Review of the facility's Personnel Action Notice (PAN) dated 12/16/2019, revealed LPN #1 was terminated for resident abuse. LPN #1's date of hire was 05/16/2018, and she had received an in-service titled, Abuse/Neglect which included reporting any witnessed incidents of abuse/neglect immediately to the Administrator.

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 (ARD), of 12/03/2019, revealed a Brief Interview for Mental Status (BIMS) score of 13, which indicated no cognitive impairment.