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
	17SH	A. BUILDING: _____ B. WING _____	C 03/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF SOUTHAVEN	1730 DORCHESTER DR 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 The State Agency (SA) conducted a complaint survey, investigating MS #16639 and MS #16676, from 03/03/2020 to 03/05/2020. 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. The SA substantiated MS #16676 for resident abuse and cited the state statute at M500. The SA did not substantiate MS #16639 for Quality of Care and no deficiencies were cited. At the time of the complaint survey, the facility had a census of 128, and held a license for 140 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	M 500		4/20/20

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M 500	Continued From page 1 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, 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	M 500		

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M 500	Continued From page 3 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 choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level II	M 500	-Resident #1 was evaluated on 2/22/2020 by Licensed Practical Nurse #1 (LPN #1)	

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M 500	Continued From page 4 Based on observation, staff interview, resident interview, and facility policy review, the facility failed to ensure that one (1) of seven (7) residents reviewed were protected from physical abuse; Resident #1. Review of the facility's "Abuse, Neglect and Misappropriation, Exploitation Policy," dated January 2019, revealed: "To prohibit and prevent abuse and to ensure reporting and investigation of alleged violations in accordance with Federal and State Laws." Record review revealed an investigation of alleged abuse was conducted by the facility on 02/22/2020 involving Certified Nursing Assistant (CNA) #1 and Resident #1. On 02/22/2020, Resident #1 was asked by Dietary Worker #1 to remove himself from the kitchen where he was getting himself several cartons of milk from the cooler. Resident #1 began to cuss Dietary Worker #1 and used racial slurs towards her. CNA #2 was attempting to calm Resident #1, when CNA #1 overheard the incident that was occurring and approached Resident #1 . Resident #1 began to use racial slurs towards CNA #1. CNA #1 used both hands to push Resident #1 backwards into a chair that was in the hallway. This incident occurred in the hallway in front of other witnesses. Licensed Practical Nurse (LPN) #1 asked CNA #1 to leave the building and she notified the Administrator and Director of Nursing (DON) of the incident. The facility immediately began an investigation, suspended CNA #1 and reported the incident to the State Agency (SA) and notified the local police department, who arrived at the facility at 3:30 PM. On 03/03/2020 at 2:50 PM, an interview with	M 500	immediately after the event with no negative physical findings. Social Services conducted a psychosocial evaluation of resident on 2/24/2020 with no negative lasting effects related to the incident. -All facility residents could have the potential to be affected by the same deficient practice. -Director of Clinical Services (DCE) started staff education for Abuse, Neglect and Misappropriation of Resident Property on 2/23/2020. Regional Director of Human Resources conducted Anger Management training with all staff beginning 3/6/2020. Center DCE will educate on Abuse, Neglect and Misappropriation of Resident Property during team member orientation, quarterly and annually to ensure staff are knowledgeable and competent related to the requirement. -Center Director of Nursing Services and Director of Clinical Education will audit staff knowledge weekly related to Abuse, Neglect and Misappropriation of Resident Property on all shifts beginning 4/20/2020 for eight weeks, then on random shifts for four weeks to ensure staff knowledge and competence related to the requirement. DNS and Social Services Director will interview four residents per week for eight weeks and two residents per week for four weeks to ensure there are no resident concerns with team members. Results of audits will be taken to the center Quality Assurance Performance Improvement	

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M 500	Continued From page 5 Resident #1 revealed, he recalled the events of 02/22/2020. Resident #1 stated, "I had went to the dietary department to get some milk and a woman (Dietary Worker #1) startled me and said that I wasn't supposed to be back there and it made me mad the tone she used, so I called her the N-word." Resident #1 stated, "I feel bad about it now and I shouldn't have but I did. I won't ever say it again because I've realized it will get you killed around here." Resident #1 revealed he got the milk though and was walking up the hall. He stated that he had a chair in the hall that he usually sat down in because he gets out of breath, and he was trying to get to that chair. Resident #1 stated when CNA #1 came around the corner, he was saying "you ' re not going to talk to her that way." Resident #1 revealed that he told CNA #1 to mind his business that he was a CNA and this didn't have anything to do with him. Resident #1 stated CNA #1 told him that he was messing with the wrong guy, and that he had better "knock this shit off right now." Resident #1 stated CNA #1 and came at him, shoved him right in the chest, and he fell back into the chair and hit head on the magazine rack, on the wall, on his way down. Resident #1 revealed, when CNA #1 hit him, the nurse (LPN #1) and the CNA (CNA #2) grabbed him and they all made him leave. Resident #1 stated he called the police on CNA #1 and he went to court. Resident #1 revealed CNA #1 was being charged with simple assault. Resident #1 stated, "I've lived here eight years and I've never had anything like that ever happen before. He (CNA #1) was in the Army and he's got a temper. They checked me out, I mean I'm okay now, but I was shocked that he did what he did." On 03/03/2020 at 12:45 PM, during an interview with Licensed Practical Nurse (LPN) #1, she stated that she was in her office and overheard	M 500	committee meeting for four months to ensure compliance. Any deficient practices identified will be discussed with plans for correction documented and implemented.	

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two male voices yelling and loud tones. LPN #1 revealed she stepped out of her office and observed an altercation that was occurring at the doorway of her office. LPN #1 confirmed that she saw CNA #1 and Resident #1 both standing facing each other and CNA #1 took both hands with his palms opened and shoved Resident #1 backwards into the chair that was in the hallway. LPN #1 confirmed CNA #2 was grabbing at CNA #1 trying to remove him from the situation. LPN #1 stated she looked at CNA #1 and told him he had to leave. LPN #1 stated CNA #1 was yelling, "Ya'll let him call people the N word." LPN #1 revealed she remembered telling CNA #1 that he couldn't put his hands on a resident. LPN #1 confirmed she assessed Resident #1 for injuries and did not see any, and that she told the witnesses to write a statement of what they saw. LPN #1 stated she called the Administrator and the DON. LPN #1 revealed she heard Resident #1 talking to the police on his cell phone.

During an interview, on 03/03/2020 at 2:15 PM, CNA #3 stated she was in the hallway and heard CNA #1 and Resident #1 getting loud. CNA #3 stated when she began to walk towards them, she observed CNA #1 shove Resident #1 into the chair. CNA #3 stated she could not hear everything that was said, but she did hear CNA #1 tell Resident #1, "Come at me now," after he had shoved Resident #1 into the chair.

On 03/04/2020 at 11:15 AM, during an interview with Dietary Worker #1, she confirmed that she had returned to the dietary department and observed Resident #1 in the milk cooler, with his foot propping the door open. Dietary Worker #1 stated she told Resident #1, he was not supposed to be in there. Dietary Worker #1 stated before she could say anything else,

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M 500	Continued From page 7 Resident #1 started cussing her and called me a "nigger." Dietary Worker #1 stated, she guessed that she was shocked, that she stood there a second, and Resident #1 came on by her and walked up the hallway. Dietary Worker #1 stated CNA #1 and CNA #2 were at the time clock, and CNA #2 was trying to get him to calm down. Dietary Worker #1 revealed she heard CNA #1 say, "You're not going to talk to her like that. You messing with the wrong one now." Dietary Worker #1 stated she was walking up the hallway looking for someone to report the incident to, when she saw CNA #1 shove Resident #1 backwards into a chair. Dietary Worker #1 revealed CNA #2 was behind CNA #1 and grabbed him by the arm and pulled him back. Dietary Worker #1 stated she heard one of the nurses tell CNA #1 that he had to leave. Dietary Worker #1 stated she heard CNA #1 say, "Ya'll just let him talk anyway he wants, and he called me a nigger." During an interview, on 03/04/2020 at 12:15 PM, CNA #2 stated she was in the hallway by the time clock when she saw Resident #1 getting the milk, and Dietary Worker #1 told him that he wasn't supposed to be in there. CNA #2 stated Resident #1 started cussing Dietary Worker #1 and called her a nigger. CNA #2 confirmed that she was trying to calm Resident #1 when CNA #1 overheard the conversation and came back down the hallway towards Resident #1. CNA #2 stated CNA #1 and told Resident #1, "Don't talk to her like that," and Resident #1 called CNA #1 a nigger. CNA #2 stated that CNA #1 put his arm up and Resident #1 fell back into the chair. On 03/04/2020 at 12:30 PM, CNA #1 was interviewed by phone. CNA #1 stated that he was by the front desk and was leaving when he	M 500		

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overheard Resident #1 yelling and cussing. CNA #1 stated he went to try to calm Resident #1 down. CNA #1 stated, "It happened in just an instant, he stood up, and I put my arm up and he stumbled back into the chair. The nurse told me to leave so I did." CNA #1 stated he never cussed or threatened Resident #1. CNA #1 stated he only put his arm up to stop Resident #1 from coming at him, and Resident #1 fell back in the chair.

On 03/04/2020 at 1:30 PM, during an interview with the DON, she confirmed that she had just put a psychosocial evaluation in for Resident #1 on 02/21/2020, the day before the incident occurred. The DON stated, "We could see his behaviors escalating and if he doesn't get what he wants, then he acts out." The DON confirmed the doctor visited and made medication changes. The DON stated CNA #1 was a great CNA, he was always at work, and never had any issues with him. The DON stated that she just hated it so bad that this happened between CNA #1 and Resident #1.

Record review revealed CNA #1 was immediately suspended, and was terminated on 03/03/2020 after the abuse allegation was substantiated by the facility.

A review of CNA #1's personnel records, revealed, CNA #1 was hired by the facility on 04/24/2017 as a CNA. CNA #1 received an in-service, "Survey Readiness," on 01/23/2020, which included training on Abuse Reporting. CNA #1 was in attendance on 10/07/2019, which covered the topic of Abuse.

Resident #1 was admitted to the facility on 01/22/2013 with diagnoses which included,

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M 500	Continued From page 9 Schizophrenia, Major Depressive Disorder, and General Anxiety Disorder. The most recent Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 01/29/2020, revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated Resident #1 was cognitively intact.	M 500		