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
	50CH	A. BUILDING: _____ B. WING _____	C 03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHOCTAW RESIDENTIAL CENTER	135 RESIDENTIAL CENTER RD CHOCTAW, MS 39350

(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, MS #16722 at the facility on 03/12/2020. 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 #16722 for resident abuse and cited the state statute at M500. At the time of the complaint survey, the facility had a census of 109, with a license for 120 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 medical conditions unless medically	M 500		5/1/20

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M 500	Continued From page 1 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; 6. may manage his personal financial affairs, or is	M 500		

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M 500	Continued From page 2	M 500		

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 residents or individuals within or outside of the

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M 500	Continued From page 3 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 Based on observation, interview, record review and facility policy review, the facility failed to	M 500	The following corrective action was taken by the facility for the resident that was affected by this practice.	

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M 500	Continued From page 4 ensure Resident #8 was protected from physical abuse, for one (1) of seven (7) residents reviewed for Abuse. Findings include: Review of the facility's "Abuse Policy", undated, revealed, all residents will be free from physical, mental and/or verbal abuse. Preventing resident abuse is a primary concern for this facility. It is our goal to achieve and maintain an abuse free environment. Record review of an incident submitted to the State Agency (SA) revealed, on 03/04/2020 an allegation of abuse occurred involving Certified Nursing Assistant (CNA) #1 and Resident #8. Resident #8 reported to staff that CNA #1 was mean to her, rough with her when she gave her a bath, and made statements to her such as "You can do it yourself." On 03/12/2020 at 9:25 AM, an interview with Resident #8, revealed, she remembered the morning she reported the incident to her nurse. Resident #8 stated, "CNA #1 (proper name) has always been rougher than the other ones, but that day she was horrible mean. I have neuropathy real bad in my hands and she knows it. She was unusually rough and pulling on my hands a lot. I was crying in pain and she kept saying, "You ain't hurtin', it's all a show and you don't hurt that bad. Then she just kept grabbing them and pulling on them." Review of the facility ' s "Face Sheet" for Resident #8, revealed, she was admitted by the facility on 07/05/2012 with diagnoses which included, Heart Failure, Hypertension, Anxiety, Depression, Dementia, and Emphysema. The	M 500	A. Certified Nursing Assistant #1 that the allegation was made against on 3/4/2020 was immediately removed from the building and suspended until the investigation was completed. After completion of the investigation Certified Nursing Assistant was terminated as of 3/9/2020. Resident # 8 was assessed on 3/5 for any psychosocial harm by Staff Development Director. She suffered no harm from the event. B.If any resident makes any allegations of abuse or neglect the staff member will be immediately suspended until completion of investigation.Between 3/4/2020 and 3/5/2020 Director of Nurses and Staff Development Director interviewed other residents that had been under the care of Certified Nurses Assistant #1 and found no other residents with complaints. C. The Staff Development Director held an in service on March 4, 2020. They were educated on types of abuse and how to promptly report abuse. The Staff Development Director will in service all staff upon hire and at least quarterly on abuse and neglect. The Director Nurses or the Staff Development Director will meet with the residents council at least quarterly to in service on how to report abuse and neglect. The Social Service/Caseworker will incorporate into her interview question on MDS interview if they have experienced any mistreatment or abuse and will again in in service on how to report. D. Beginning on 3/15 all allegations will be placed on a flow sheet to be managed by	

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M 500	Continued From page 5 most recent Brief Interview for Mental Status (BIMS), revealed a BIMS score of 14, which indicated Resident #8 had full cognitive ability. On 03/12/2020 at 9:35 AM, during an interview with Resident #9, Resident #8's roommate, she stated, "She has been rough with my roommate, but not me. I have my curtain pulled, but I can hear my roommate asking her to stop pulling on her and she was screaming and crying out. I know she told a nurse that day she was rough. I ain't seen that aide since then." A review of the facility ' s "Face Sheet" for Resident #9, revealed, she was admitted by the facility on 02/24/2012 with diagnoses which included Osteoarthritis, Kidney Failure, and Hypothyroidism. Review of Resident #9 ' s most recent BIMS revealed, she had a score of 15, which indicated cognitively intact. During an interview, on 03/12/2020 at 12:05 PM, LPN #1 stated, she went in the room to give Resident #8 her medicine and she was crying. LPN #1 stated, she asked Resident #8 what was wrong, and she said, "Don't let CNA #1 (proper name) come back in here. She's mean and rough with me. Don't tell her because I don't want her to come back in here." LPN #1 stated she then went to RN #1, and she and the Director of Nursing (DON) went to get CNA #1 to send her home. On 03/12/2020 at 12:50 PM, during an interview with RN #1, she stated, Resident #8 asked to speak to her after CNA #1 was walked out and we started the investigation. RN #1 stated, when she went to Resident #8 ' s room, she started to cry again and told her CNA #1 was mean to her and hurt her, when she gave her a bath. RN #1	M 500	the Director on Nurses. The Director of Nurses will receive a weekly report given to them by the Caseworker/Social Service on the interview with residents at Minimum Data Set time. She will immediately report any claims of abuse and neglect to the Director of Nurses. The flow sheet and reports will be brought to the quarterly Quality Assurance/Performance meeting. Any needed changes to policies or reporting methods will be discussed at this time.	

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revealed, Resident #8 stated her hands hurt her a lot and CNA #1 would make statements like "You can do this yourself." RN #1 stated Resident #8 ' s roommate was interviewed separately and told her the same things.

During an interview with the Administrator, on 03/12/2020 at 11:05 AM, she revealed the conclusion of the investigation for CNA #1 was that she had been rough with Resident #8. The Administrator stated, they attempted to call CNA #1 in to tell her of the findings, and she refused to come back in. The Administrator stated, CNA #1 told them "she was through here."

On 03/12/2020 at 12:25 PM, during an interview with the DON, she stated they concluded the abuse had occurred, and called CNA #1 for her to come in, to let her go. The DON stated CNA #1 wouldn't come and told them she was "through with this place." During a second interview, on 03/12/2020 at 12:45 PM, the DON stated, Resident #8 was crying that morning, and she didn ' t know what had set her off. The DON revealed CNA #1 wasn't on that hallway that day, and Resident #8 couldn't tell her the exact date it occurred, that it was just before this morning. The DON stated CNA #1 smart-mouthed staff, but not the residents. The DON stated Resident #8 never complained about anyone, so they knew it was true. The DON stated Resident #8 ' s roommate was interviewed separately and verified the complaint almost word for word.

On 03/12/2020 at 12:55 PM, attempts were made to reach CNA #1 for an interview without success. No return calls were received from CNA #1.

A review of CNA #1 ' s timecard, revealed, on 03/04/2020, she clocked in at 6:40 AM and

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M 500	Continued From page 7 clocked out at 8:32 AM, after the allegation of physical and verbal abuse was made. The time card revealed, on 03/03/2020, CNA #1 clocked in at 6:36 AM, and clocked out at 2:53 PM. A review of the facility ' s CNA group assignments, revealed, CNA #1 was assigned to Resident #8 on 03/03/2020, but was not assigned to Resident #8 on the morning of the allegation (03/04/2020). Record review revealed CNA #1 was immediately suspended on 03/04/2020, and terminated on 03/09/2020, after the abuse allegation was substantiated by the facility. A review of the facility ' s personnel record for CNA #1 revealed, she was hired on 02/11/2019 and received an Abuse in-service upon hire. CNA #1 received additional in-services on Abuse on 10/03/2019, 11/14/2019, 01/09/2020, and 02/06/2020.	M 500		