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
	30PL	A. BUILDING: _____ B. WING _____	C 01/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

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M 000	Initial Comments This is an amended 2567 for the complaint survey, CI MS #16463, on 1/7/2020. After an administrative review, it was determined the 2567 required additional information from the State Agency (SA) regarding the facility's failure to provide the resident's Representative Person (RP) a written Notice of Discharge. The State Agency (SA) conducted a complaint survey for CI MS #16463 at the facility on 1/7/2020. The SA determined the facility was not in compliance with the Minimum Standards for The Institutions For The Aged And Infirm. The SA cited the state statute M500 due to the facility's failure to notify the Responsible Party (RP) in writing 2 weeks prior to discharge. The census at the time of entrance was 88, and the facility was certified 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,	M 500		2/7/20

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M 500	Continued From page 1 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 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	M 500		

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M 500	Continued From page 2	M 500		

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 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;

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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	M 500		

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M 500	Continued From page 4 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 resident record review, discharge notification review, and staff interviews, the facility failed to provide a written notice of discharge to a resident's Representative Person (RP) for one (1) of three (3) residents reviewed for discharge notification as evidenced by the facility failed to provide written notice to the RP of the discharge and right to appeal the discharge when Resident #1 required an acute level of treatment due to escalating behaviors which were a threat to self and other residents. Findings include: The facility admitted Resident #1 on 4/18/2019 with diagnoses including Intracranial Injury, Frontal Lobe Deficit, Dementia with Behaviors, Anxiety, and Insomnia. Medications included Zyprexa 15 milligrams (mg) twice a day, Valporic Acid 750 mg three times a day, Ativan 1 mg daily and Trazodone 50 mg at bedtime which could be repeated if not effective. A hospital history and physical dated 4/14/19 (four days prior to admission to the facility) revealed R#1 had been admitted for behavioral disturbances, was noted to have poor intake and required treatment for cellulitis of his toe. The physician talked with his responsible party who stated Resident #1 has been sedated which is why he is not eating and became dehydrated. Record review revealed Resident #1's behaviors	M 500	1. The facility mailed a 30 day discharge notice to Resident #1 representative on 1/10/2020 notifying them of the discharge plan to send the residents to Oceans Behavior Unit and then to Ruleville Nursing and Rehabilitation due to the safety risk to residents and staff. 2. The facility recognizes that all residents have the potential to be affected by this supposed cited deficient. 3. The Business Office Manager was in-serviced 1/8/2020 on the procedures to issue a notice of transfer letter to the residents representative whenever a resident is sent out to the hospital. An audit was conducted of all discharge notices on 1/8/2020 for all discharge notices from 10/1/2019 through 12/31/2019 with no errors noted. Weekly audits X 4 audits will be conducted by the Business Office Manager starting 1/8/2020 using an audit tool. 4. The results of the audits will be brought to the Quality Assurance Committee and corrective action will be monitored and evaluated by the committee quarterly and more often as necessary. If any revisions of the plan of correction are needed, the revisions will be developed and approved by the QA Committee to ensure the plan of correction is achieved and sustained.	

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noted at time of admission continued to escalate. The facility was unable to identify any specific triggers causing Resident #1's behavioral aggression and outburst. Record review of the resident's care plan and nurses' notes revealed the facility attempted to manage the resident's behaviors. The facility notified the resident's physician as needed regarding the behaviors, new orders would be given to make medication changes, and anti-anxiety medications would be administered as ordered. The facility staff would re-direct Resident #1, separate him from overly stimulating events, and offer him snacks and fluids frequently to de-escalate the behaviors. The facility moved Resident #1's room to a quieter area of the building to help manage the behaviors. The facility discharged the resident on 11/12/2019 after being unable to manage his behavior.

On 1/7/2020 at 9:00 AM, interview with the Administrator revealed that Resident #1 was a threat to self and others, that staff and residents were afraid of him. She submitted copies of a 30-day discharge notice, but this notice was not mailed, due to the urgency of sending Resident #1 to a psychiatric unit due to escalating behaviors with threats to himself and others. She admitted that she never sent discharge notice. She stated she initially thought the resident would be sent to another facility, but when the family refused that transfer because it was too far away, she failed to pursue the notification process.

At 9:45 AM, on 1/7/2020, the Ombudsman related that the Administrator told her she would not accept the resident back due to the safety risk to her staff and residents. The Ombudsman confirmed she had not received a copy of a discharge notice.

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M 500	Continued From page 6 The resident's physician was interviewed on 1/7/2020 at 10:05 AM. He related that Resident #1's level of violent behavior was too acute for long term care. He said the facility tried medications, but regulations limited the amount he could order, and he did not want to sedate the resident. The doctor related that Resident #1 abused two nurses, and residents complained of fear of Resident #1. He stated that they attempted to get a local hospital with a psychiatric unit to admit him, but they refused, so they had to send Resident #1 to a unit out of state. On 1/7/2020 10:15 AM, the SA interviewed Resident #1's Responsible party (RP). The RP stated that while at the acute psychiatric unit Resident #1's behaviors led to his refusal to eat or drink, then he got a bad urinary infection and was sent to a nearby hospital for IV therapy. She stated Resident #1 remains in the hospital and they still need to find a place to take him, but his behavior is no better and no facility will take him. On 1/7/2020 at 10:45 AM, the Assistant Director of Nursing (ADON) was interviewed. She stated that she has nursed for 10 years and never had a resident with behavior like that, she stated they were all afraid of him; that he is about 6 feet tall, loud and threatening. She stated that it took six (6) men to hold him down so they could give him medication to calm him down. Resident #2 was interviewed on 1/7/2020 at 10:40 AM. He stated that on one occasion he saw Resident #1 come out of his room "buck naked" and grabbed a nurse. Resident #2 also stated that once the police had to come out. Resident #3 was interviewed on 1/7/2020 11:05	M 500		

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AM. He related that Resident #1 was "real bad", adding that he yelled, and threatened people. He hit staff; did not belong here. "Don't let him come back".

At 11:45 AM on 1/7/2020, interview with Registered Nurse (RN) #2 staff related that his behavior was very difficult for staff. He yelled, threatened and threw chairs, his walker and anything handy. He was difficult to give care due to his sexual behavior of grabbing private parts of nurses and displaying and requesting sexual acts.

On 1/7/2020 12:40 PM, Certified Nurse's Aide (CNA) #1 stated she has worked in the facility for 8 years, but never worked with a resident like Resident #1. He yelled, cursed, hit out and threatened. "He'd grab my butt". I finally had to get other staff with me just to pick up his food tray. He was really scary. She stated that if he was readmitted, she would have to find another place to work, "I can't handle that kind of stress and others feel that way too".

Review of an incident report dated 11/11/2019, revealed Resident #1 had self-inflicted damage to his toes with blood on the floor and 4 toenails were missing from his bloody feet. When she went to the nurses' station, Resident #1 followed, kicking the door, grabbing the nurse' hand and twisting it. He attempted to attack a nearby female resident. 911 was called and Resident #1 had to be held down by police so an Ativan injection could be administered.

Review of Resident #1's care plans revealed 1) I use anti-anxiety medications, agitation at times, I disrobe at times, 2) I use psychotropic medications related to anxiety, insomnia and

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M 500	Continued From page 8 behavior management, 3) I have a history of being physically and verbally aggressive, I like to scoot around on the floor and into hallways and yell out. I throw feces around and stimulate genitals while staff attempt to provide care. I have hit my head against the wall, am easily angered. 4) I become physically aggressive with staff and other residents, hitting and kicking staff, throwing objects. Minutes of a care conference dated 11/7/2019 reflected attendance by Resident #1's RP. The RP was informed verbally that Resident #1's behavior required a level of treatment that their facility could not provide and that he required psychiatric treatment. The report had a goal to admit him to a secure unit and added that referrals have been sent and family is aware. At 1:30 PM on 1/7/2020, the Administrator stated she did not want to risk the safety of the staff and residents. She stated that the CNAs said they will leave if the facility accepts him back. She stated that one of Resident #1's sisters had her arm in a sling due to being injured by Resident #1 and that she was informed by family that Resident #1 had suffered a head injury by a male family member in self-defense.	M 500		