STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255207	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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F 000	INITIAL COMMENTS This is an amended 2567 for the complaint survey, for CI MS #16463. After an administrative review, it was determined the 2567 required additional information 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 (CI MS #16463) at the facility on 1/7/2020 regarding a complaint of improper discharge of a resident. Upon investigation, the SA determined the discharge was necessary due to Resident #1's behavior placing the resident, other residents, and staff at risk for harm. Other facility residents and staff strongly verbalized fears and concerns for their safety if the resident was to return to the facility. The SA did not substantiate the complaint of improper discharge, however, the SA did identify the facility was not in compliance with the Requirements of Participation for Medicare and Medicaid due to the facility's failure to provide the family notice in writing of the discharge and of the right to appeal the discharge. The SA cited F625. The census at the time of the survey was 88, and the facility was certified for 120 beds.	F 000		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to	F 625		2/7/20

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

Electronically Signed | 02/04/2020

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F 625	Continued From page 1 the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: 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	F 625	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	

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F 625	Continued From page 2 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 4/14/2019 (four days prior to admission to the facility) revealed Resident #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 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.	F 625	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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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 dated 11/11/2019, 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.

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

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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 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

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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 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

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F 625	Continued From page 6 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.	F 625		