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
	30RC	A. BUILDING: _____ B. WING _____	C 08/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER CHASE VILLAGE	5090 GAUTIER VANCLEAVE ROAD GAUTIER, MS 39553

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M 000	Initial Comments The State Agency (SA) conducted a complaint investigation survey, MS #16148, from 8/19/2019 through 8/20/2019. During the survey, it was determined the facility was not in compliance with the Mississippi Regulations for Minimum Standards for Institutions for Aged or Infirm with deficiencies cited at M500. The facility was licensed for 60 beds and had a census of 51 residents.	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 contraindicated (as documented by a physician or nurse practitioner/physician assistant in his	M 500		9/3/19

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M 500	Continued From page 1	M 500		

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 given at least a quarterly accounting of financial transactions made on his behalf should the

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M 500	Continued From page 2	M 500		

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 facility to work for improvements in resident care, and send and receive his personal mail

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M 500	Continued From page 3 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 interviews, record review, facility investigation review, and facility policy review, the facility failed to prevent verbal and/or mental abuse for one (1) of four (4) residents reviewed	M 500	1. Policy and procedure on abuse was followed on 8/12/2019 when Administrator and Director of Nursing were notified of incident that happened on Friday, 8/9/2019. The Mississippi State Department of Health State Agency	

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M 500	Continued From page 4 for abuse, Resident #1. Findings include: Review of the facility policy, "Abuse and Neglect Reporting and Intervention Policy and Procedure", undated, revealed the resident has a right to be free from abuse-verbal, sexual, physical, mental, corporal punishment and/or involuntary seclusion, as well as exploitation. The resident will not be subjected to abuse by anyone. Review of an outside-source complaint, dated 8/13/19, revealed Resident #1 had been harassed by a staff member, Certified Nursing Assistant (CNA) #2, who threatened to have sex with the resident's husband and threatened to beat the resident up. During an interview on 8/19/19 at 9:45 AM, Resident #1 responded "yes", when asked if staff had ever been ugly to her, and had a tear in her right eye. Resident #1 denied any other incidents. Resident #1 did not respond, when asked the staff's name, but stated "no", when asked if the staff was still working with her. Resident #1 did not allege any specific event had occurred. The facility admitted Resident #1 on 8/30/18, with diagnoses of Hemiplegia, Hypertension (High Blood Pressure) and Type II Diabetes. The Quarterly Minimum Data Set (MDS) with the Assessment Reference Date (ARD) of 5/24/19, indicated Resident #1 had a Brief Interview for Mental Status (BIMS) score of 8, which indicated Resident #1 had moderate cognitive impairment. During an interview on 8/19/19 at 9:48 AM, Resident #1's husband stated that he came to visit his wife on 8/9/19, and she reported that	M 500	(MSDH SA) hotline was notified on 8/12/2019 by the Administrator at 8:00am and again at 10:00am. On 8/12/2019 at 9:30am the Local State Ombudsman was notified of incident with Resident #1 by the Administrator. On 8/12/2019 at 10:00am the State Attorney General's office was notified of incident with Resident #1 by the Administrator. Certified Nursing Assistant (CNA) #2 was suspended pending investigation beginning 8/12/2019, with termination notice given on 8/19/2019, related to alleged abuse. Licensed Clinical Social Worker for psychotherapy evaluated Resident #1 regarding abuse on 8/12/2019 with follow-up appointment. Licensed Clinical Social Worker reported elder seemed happy and stated no issues with facility or care of facility. Resident #1 was checked on daily beginning 8/12/2019 by the Administrator and Director of Nursing and continued until 8/26/2019 to ensure resident safety and comfort. 2. All residents at River Chase Village have the potential to be affected by the facility failing to prevent verbal or mental abuse. A Well-Being Audit began on 8/15/2019 with completion on 8/21/2019 by the Administrator and Director of Nursing to identify any residents having the potential to be affected by the facility failing to prevent verbal or mental abuse, this audit was completed by speaking/evaluating cognitive resident privately and	

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M 500	Continued From page 5 CNA #2 was mean to her. He stated he reported this to the nurse, who told the RN Supervisor. He stated his wife stated that CNA #2 was "real mean". Resident #1's husband stated that CNA #2 had told his wife that she would get in her (wife's) bed with him (Resident #1's husband) that night. Resident #1's husband stated that he came to visit on 8/10/19, and stated that he confronted CNA #2, and told her not to pick on his sick wife and was banned from the facility until after the investigation. Review of the facility investigation, dated 8/9/19, revealed the Housekeeping Supervisor overheard a conversation in the dining room between CNA #2 and Resident #1. The CNA was overheard questioning Resident #1 about sex when she goes home with Resident #1's husband. Resident #1 was observed to push her chair back from the table in the dining room and CNA #2 pulled her back to the table and kept questioning Resident #1, when the Housekeeping Supervisor intervened and asked the CNA to leave the resident alone. The investigation revealed a statement received by Resident #1, which revealed, "She would go after my husband", referring to CNA #2, and that CNA #2 was mean to her. The investigation documented that the CNA was suspended during the investigation. Resident #1 was assessed with no injury and no concerns with day to day activity. No other incidents were reported by any resident. In an interview on 8/19/19 at 12:45 PM, Resident #4 confirmed she overheard CNA #2 being ugly to Resident #1 in the dining room. She stated the CNA said she was going to sleep with Resident #1's husband and it made Resident #1 cry. Resident #4 stated that she didn't tell anyone about the incident. Resident #4's most recent	M 500	confidentially and nursing evaluations for cognitively impaired residents. Upon Well-Being Audit review, no other residents were identified for being affected by verbal or mental abuse. 3. All staff at River Chase Village were in-serviced by the Administrator and Director of Nursing on 8/15/2019 regarding abuse and neglect policy and procedure and unusual incidents. All staff at River Chase Village were in-serviced by the Administrator and Director of Nursing on 8/15/2019 regarding Grievance Process and Resident Rights. All staff at River Chase Village were in-serviced by the Attorney General's Office on 9/3/2019 regarding reporting and identifying abuse. All staff at River Chase Village were in-serviced by the Administrator and Director of Nursing on 9/3/2019 regarding updated abuse and neglect policy and procedure and unusual incidents completed on 9/2/2019 by the River Chase Village Nursing consultant for reporting immediately but not later than 2 hours after an allegation is made due to previous policy stating only immediately and within 24 hours. Certified Nursing Assistant(CNA) #2 was suspended pending investigation beginning 8/12/2019, with termination notice given on 8/19/2019, related to alleged abuse. A Well-Being Audit began on 8/15/2019 with completion on 8/21/2019 by the Administrator and Director of Nursing to ensure all residents were free from verbal	

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M 500	Continued From page 6 MDS, with an ARD of 7/15/19, revealed a BIMS score of 15, which indicated no cognitive impairment. Resident #4 denied any other incidents. In an interview on 8/19/19 at 1:15 PM, the Housekeeping Supervisor stated she overheard CNA #2 tell Resident #1 that she would have sex with her husband when she went home. The Housekeeping Supervisor stated this occurred in the dining room toward the end of the 7:00 AM-3:00 PM shift. She stated that she observed Resident #1 push her chair away from the table, but couldn't see if she was upset, because she was behind the resident. She stated that she did not see the resident have any further behavior related to the incident. In an interview on 8/19/2019, the Administrator stated she was made aware of the altercation between CNA #2 and Resident #1's husband, on Saturday 8/10/19, and she told Registered Nurse Supervisor #1 to not let the CNA work with Resident #1 until the investigation was completed. The Administrator stated she found out on Monday, 8/12/19, about the incident that happened in the dining room on Friday, 8/9/2019, when CNA #2 allegedly told the resident she was going to have sex with her husband. She stated CNA #2 was suspended pending the investigation. Review of CNA #2's personnel file revealed she was suspended beginning on 8/11/19, with termination notice given on 8/19/19, related to alleged abuse. In a post-survey interview, on 8/23/19 at 11:42 AM, CNA #2 denied making comments of sleeping with Resident #1's husband.	M 500	or mental abuse with no findings noted. A Well-Being Audit will be completed every 60 days by the Administrator and/or Director of Nursing on all current residents. Any findings will be immediately reported to appropriate agencies. All staff will continue to be trained upon hire and quarterly thereafter regarding abuse and neglect policy and procedure, unusual incidents, grievance procedure and resident rights. 4. The interdisciplinary team to meet weekly and review past Well-Being Audits to ensure all residents concerns and/or issues with care are being identified and resolved. After the initial Well-Being Audit, the Administrator and/or Director of Nursing will continue the audit with all current residents every 60 days to ensure all residents concerns and/or issues with care are being identified and resolved. The findings of the Well-Being Audits are to be reviewed and presented by the Administrator and/or Director of Nursing to the Quality Assessment and Assurance(QAA) team quarterly.	