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
	76WC	A. BUILDING: _____ B. WING _____	12/22/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CARE CENTER	1920 LISA DRIVE EXTENDED GREENVILLE, MS 38703

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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 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;	M 500		2/25/21

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M 500	Continued From page 1 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 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	M 500		

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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 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

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M 500	Continued From page 3 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 interview, record review and facility policy review, the facility failed to ensure the privacy for residents as related to a video and a picture that was posted on a personal social media for two (2) of 43 residents (Residents #1 and #2). Findings include: Record review of the facility policy titled "Cell Phone/Electronic Communication Devices Policy (Facility Personnel)", dated 7/19, revealed under the section titled "Prohibited Actions" revealed any use of Cell Phones to record or take still or video pictures of the facility, employees, residents, or property is strictly prohibited, and such activity may subject an employee to	M 500	M500 1. Administrator was notified of video circulating on social media of Resident #1 by Resident #1 family member on 10/20/2020. Administrator was notified of photo circulating on social media of Resident #2 on 10/21/2020. Staff Development Nurse and Assessment Nurse assessed Resident #1 on 10/20/2020 and noted no adverse side effects related to video on social media. Staff Development Nurse and Assessment Nurse assessed Resident #2 on 10/21/2020 and noted no adverse side effects related to photo on social media. Administrator initiated incident report procedures and notified resident physician and resident representative.	

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M 500	Continued From page 4 disciplinary action up to and including termination. Uploading resident PHI (personal/protected health information), videos, photos, or other private information to social media including but not limited to Facebook, Snapchat, Instagram, Twitter, etc. shall subject employee to disciplinary action up to and including termination. Noted signature of Certified Nursing Assistant (CNA) #1 at the bottom of the policy with the date of 3/12/20, also signed by the facility representative signature. On 12/22/20 at 8:30 AM an interview with the Administrator revealed the facility was called by Resident #1's niece on 10/20/20 and made aware of the video that was posted on a personal Facebook account of her uncle. The Administrator revealed CNA #1 was hired in March 2020 and terminated in May 2020, the video was not known of until 10/20/20 so the facility has no idea when the video was taken. The Administrator was also made aware on 10/21/20 a "selfie" picture taken by CNA #1 of Resident #2. The Administrator revealed it is against facility policy to take pictures or videos of any residents and new hires are educated on this policy. The Administrator revealed CNA #1 was terminated on 5/14/20 for an unrelated incident of leaving during a shift and not returning. On 12/22/20 at 9:30 AM an interview with Resident #2 revealed he could not recall ever having his picture taken. On 12/22/20 at 11:15 AM an interview with the Director of Nursing (DON) revealed she did not know about the video or picture that was posted on Facebook by CNA #1's boyfriend until Resident #1's family called to report to the	M 500	2. Forty-five (45)of(45) residents were identified by the Director of Nursing and the Administrator to have potential to be affected by this deficient practice on 10/20/2020 and 10/21/2020. 3. An in-service was conducted on 10/20/2020 by the Director of Nursing and Staff Development Nurse on policy/procedure titled Cell Phone/Electronic Communication Devices Policy revised 7/19 with staff and was continued until all staff had been in-serviced. Quality Assurance meeting was held on 10/21/2020 with Medical Director, Administrator, Director of Nursing, Staff Development Nurse, Assessment Nurse, Medical Records Clerk, Social Services Director and Activities Director in attendance and reviewed policy/procedure titled Cell Phone/Electronic Communication Devices Policy revised 7/19 with no changes recommended. 4. Beginning 01/18/2021 rounds will be conducted by the Director of Nursing and Nurse Case Manager to ensure compliance related to the company□s cell phone use policy weekly for four (4) weeks and monthly for two (2) months by Director of Nursing and Nurse Case Manager. Findings will be recorded on the rounds flow record and maintained by the Director of Nursing. The Quality Assurance committee will address concerns identified from rounds and evaluate the monitoring completed by the Director of Nursing and	

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M 500	Continued From page 5 Administrator. The DON questioned staff, and no one knew of the video or picture taken of Resident #1 or Resident #2. As soon as she was aware of the posting to Facebook, she in-serviced all staff on privacy policies and cell phone use. CNA #1 was terminated in May (2020) and they have no idea when the video was taken. All new hires are educated on the policy of privacy and cell phone use. The facility tried to reach CNA #1 but without success. On 12/22/20 at 1:49 PM an phone interview with Resident #1's responsible party (RP) revealed she was notified by friends and family that a video of her uncle was on Facebook. She called her sister that was working near the nursing home and told her to go to the nursing home and make sure he was okay. The Administrator brought her uncle to the front lobby so her sister could see that he was fine. The RP revealed she was told CNA #1 and her boyfriend had a confrontation, and he was the one that posted the video CNA #1 made. The RP revealed she and her family did not know CNA #1 or her boyfriend. On 12/22/20 at 2:08 PM an interview with the Attorney General agent revealed he had been unable to contact CNA #1 and had been told she was working as a travel CNA and was last in Texas. The Attorney General agent revealed he had a copy of a short clip of the video and stated he saw and heard Resident #1 being asked why he was on the floor by CNA #1. Review of the Cell Phone/Electronic Communication Devices Policy, under the heading of Prohibited Actions, revealed any use of Cell Phones to record or take still or video pictures of the facility, employees, residents, or	M 500	Nurse Case Manager, monthly for three (3) months and make any recommendations or changes needed.	

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property is strictly prohibited, and such activity may subject an employee to disciplinary action up to and including termination. Uploading resident PHI, videos, photos, or other private information to social media including but not limited to Facebook, Snapchat, Instagram, Twitter, etc. shall subject employee to disciplinary action up to and including termination. CNA #1's signature is on the bottom of the page with the date of 3/11/20. The DON's signature is on the bottom of the page as the Facility Representative Signature.

Review of the Search Results Mississippi Nurse Aides revealed CNA #1 has been certified since 2/26/20.

Record review of the Employee Warning Report revealed CNA #1 was terminated on 5/14/20. CNA #1 worked on 5/13/20 and left the facility between 5:30 PM and 6:00 PM and was never seen again. On 5/14/20 a phone call to CNA #1 revealed she was not coming back to work.

Review of the Termination Report for CNA #1, dated 5/14/20, noted it was because the employee walked out of building and stated that she was not coming back.

Review of the signed statement related to "The Mississippi Vulnerable Adults Act" revealed CNA #1 was given the information on the Vulnerable Adults Act and in-serviced on this information. CNA #1 noted she understood the steps to be taken if she suspects or witnesses an incidence of resident rights violation. The signature of CNA #1, with the date of 3/12/20, was noted.

Review of a statement presented by the DON revealed she watched the video on Facebook on

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M 500	Continued From page 7 10/20/20 of Resident #1 and a picture of Resident #2. The DON identified CNA #1 as the person taking the picture and talking in the video. Review of the Greenville Police incident report (#20064196) revealed a report was made by the Administrator on 10/20/20 a post on Facebook about Resident #1 was sent to a boyfriend of one of the ex-employees. The Administrator stated CNA #1 was fired months ago. Review of the Employee Acknowledgements and Authorizations revealed CNA #1's signature and initials confirming she had read, received, understood and agreed to abide by the stipulations included in the following policies, procedures, and forms. Included in the list of policies are resident rights and cell phone/electronic communication devices.	M 500		