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
	04AC	A. BUILDING: _____ B. WING _____	C 09/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATTALA COUNTY NURSING CENTER	326 HIGHWAY 12 WEST KOSCIUSKO, MS 39090

(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 complaint survey MS #15431 from 9/25/18 through 9/26/18. During the survey, the SA determined the facility was not in compliance with State Licensure Regulations for the Aged or Infirm, and cited State Statute at M500. The census at the time of entrance 98, and the facility held a license 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, 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	M 500		10/26/18

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M 500	Continued From page 1 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 facility accept his written delegation of this	M 500		

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M 500	Continued From page 2	M 500		

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 unopened, unless medically contraindicated (as

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M 500	Continued From page 3 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: Based on observation, resident interview, staff interviews, record review, facility policy review, and facility investigation documents, the facility failed to prevent abuse for one (1) of four (4) residents reviewed; Resident #1 as evidenced by Resident #1 was observed by another staff member being physically abused by Certified	M 500	*CNA #2 was suspended pending investigation on 09-07-18 after it was reported that she hit a resident. Resident #1 was assigned to another CNA for the remainder of the shift. A body audit was performed and neuro checks were initiated by the Licensed Practical Nurse	

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M 500	Continued From page 4 Nursing Assistant (CNA) #2. Findings include: Review of the facility's policy titled, "Resident Abuse," dated 10/2009, revealed: Conduct detrimental to resident care that results in neglect or abuse of any resident is strictly prohibited and is considered a critical offense. Any employee suspected of abuse will be suspended immediately with future employment based on the outcome of the investigation. Any charge of resident abuse will be investigated by the Administrator. In cases of abuse involving a resident, where required by law, the facility Administrator will notify the proper authorities. A review of the "Resident Incident Report" for Resident #1, dated 9/7/18 at 11:15 PM, revealed Resident #1 reported physical abuse from a CNA. Resident stated CNA was rough with her, throwing her around in the bed and hit her in the face a few times. Complete audit performed, scattered healing bruises noted to bilateral upper and lower extremities, no apparent new bruises or skin issues noted at this time. Immediate actions taken: Assessed for new injuries, V/S (vital signs) obtained, Administrator and Director of Nursing (DON) contacted immediately, the on-call Medical Doctor (MD), and Resident Representative contacted and aware. The incident was reported by CNA #1 and report completed by LPN #1. A review of the "Incident Witness Statement" dated 9/7/18, completed by CNA #1, revealed, "Walked passed Resident Room, noticed door was cracked. I peeked in, noticed that the aide was handling her rough. I walked in, I told the	M 500	on 09-07-18. The Physician and Responsible Representative were notified of the allegation on 09-07-18 by the Nurse Supervisor. When the investigation was completed on 09-10-18, Administrator notified Pro-Nurse Contract Agency Supervisor that CNA#2 is no longer allowed the work at the facility. *24 of 98 residents were identified by the Administrator to have the potential to be affected by this deficient practice. 7 of the 24 residents with a BIM score of 13 or greater were interviewed by the Nurse Supervisor for any complaints of abuse or neglect, with 2 of the 6 residents stating that CNA #2, "wasn't nice," "kind of hateful," "not really nice," and "rough during care," with no other complaints voiced during interviews. *An in-service was initiated on 09-07-18 by the Nurse Supervisor and continued by the Staff Development Nurse and/or Director of Nursing on the policies/procedures on "Abuse/Crime Reporting" revised 07/11, "Resident Abuse" revised 10/09, "Abuse/Neglect-Recognizing and Dealing with Signs of Burnout, Frustration and Stress that May Lead to Abuse" revised 08/17, and "Residents' Rights and Dignity" revised 02/12, to include compliance with abuse and neglect reporting and resident rights with staff. In-servicing will continue with other staff until all staff are in-serviced by 10-26-18. The Quality Assurance Committee reviewed the policy on "Abuse/Crime Reporting" with revision date of 07/11, "Resident Abuse" revised 10/09, "Abuse/Neglect-Recognizing and Dealing	

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M 500	Continued From page 5 aide I would take over from here. She kept trying to take care of resident. I told her again to leave the room I would finish taking care of the residents. Resident stated, that lady is evil! She said the woman physically assaulted her and the woman kept saying I got to get out of here." On 9/26/18 at 2:00 PM, an interview with Resident #1 revealed, no one had hurt or mistreated her since the girl left. Resident #1 identified the girl as "the one with the blue hair." On 9/26/18 at 4:00 PM, an interview and observation with CNA #1 and the DON, revealed what occurred on 9/7/18 with Resident #1. CNA #1 revealed at approximately 11:15 PM on 9/7/18, she passed by Resident #1's door which was ajar. She stopped and pushed the door open further and observed CNA #2, a temporary agency CNA, handling the resident roughly. CNA #1 recalled telling CNA #2 to pick-up her things, as she (CNA #1) would complete the care of the resident. The interview room had a full-length couch in which CNA #1 asked the DON to lie on for demonstration of how CNA #2 handled Resident #1. CNA #1 demonstrated her observation of Resident #1 being rolled one side to the other, tossed and grasped roughly, while her brief was being changed. CNA #1 recalled that Resident #1 told her that CNA #2 kept tossing her roughly, hitting her face against the bedrails and repeatedly saying, "I've got to get out of here." Resident #1 further stated to her that CNA #2 was "evil". Resident #1 requested a nurse to come because CNA #2 had slapped her and was really rough with her. CNA #1 revealed she was present when Licensed Practical Nurse (LPN) #1 interviewed and evaluated the Resident #1. CNA #1 revealed Resident #1 demonstrated for LPN #1, with her fist clenched, how CNA #2	M 500	with Signs of Burnout, Frustration and Stress that May Lead to Abuse" revised 08/17, and "Residents Rights and Dignity" revised 02/12 on 10-16-18 and did not recommend any changes to the policies. *All incidents with injury and/or allegation of abuse or neglect will be audited by the Director of Nursing or Administrator to ensure compliance with facility policies/procedures related to abuse and neglect weekly for four weeks and monthly for two months. Findings will be recorded on the Department Head Meeting minutes form and maintained by the Administrator. The Quality Assurance Committee will evaluate the observations completed by the Director of Nursing or Administrator monthly for three months and make recommendations as needed.	

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M 500	Continued From page 6 had been hitting her. Review of the (Name of Agency) sign-in time sheet for the facility, revealed CNA #2 signed in on 9/7/18 at 4:10 PM to work the second (2nd) shift and signed out at 11:20 PM. On 9/26/18 at 4:25 PM, an interview with LPN #1, revealed on the date of the incident, CNA #1 called for her to come to Resident #1's room. CNA #1 told her that she saw CNA #2 handling Resident #1 very roughly. LPN #1 revealed she called for LPN #2 as a witness. LPN #1 recalled Resident #1 described the person (CNA #2) handling her roughly and hitting her, wearing jeans with blue hair. LPN #1 stated, CNA #2 was nowhere to be found in the facility. LPN #1 revealed she contacted the Physician on-call, the resident's son, the Administrator and the DON to report incident. Review of the Face Sheet revealed, Resident #1 was admitted by the facility on 4/24/17, with diagnoses which included Muscle Weakness, Dysphagia, and Parkinson's Disease. Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/5/18, revealed Resident #1 had a Brief Interview of Mental Status (BIMS) score of 14, which indicated the resident was cognitively intact.	M 500		