STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255332	A. BUILDING _____ B. WING _____	C 03/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLMES COUNTY LONG TERM CARE CENTER - DURANT	15481 BOWLING GREEN ROAD DURANT, MS 39063

(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) COMPLETION DATE
F 000	INITIAL COMMENTS A Complaint Investigation (CI) MS #18608 was conducted by the State Agency (SA) on 3/23/22-3/24/2022. The State Agency (SA) initiated the complaint investigation after a report by the Attorney General that a resident was not permitted to be re-admitted to a facility. CI MS #18608 was substantiated related to inappropriate discharge. The facility was found to not be in compliance with the Centers for Medicare and Medicaid (CMS) regulations and cited F622 and F626. The facility is licensed for 80 beds with a census of 79 at time of survey.	F 000		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party	F 622		4/28/22

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

Electronically Signed | 04/21/2022

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F 622	Continued From page 1	F 622		

payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).
(ii) The documentation required by paragraph (c)

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F 622	Continued From page 2 (2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: The State Agency (SA) initiated a complaint investigation (CI) MS #18608 after a report by the Attorney General that a resident was not permitted to be re-admitted to a facility. Based on record review, facility policy review and staff interview; the facility inappropriately discharged a resident to an acute care hospital for one (1) of four (4) residents reviewed. (Resident #1) Also see F626. Findings include: Review of the facility's Policy and Procedure for "Transfer and Discharge Policy (including AMA)"	F 622	1. On 3/25/22 Social Services began an audit of all residents discharged/transferred out to the hospital for the last 60 days, no other residents were denied re-admission to the facility. The audit was completed by 3/28/2022. 2. All residents transferred/discharged to the hospital have been identified as having the potential to be at risk of being affected by this deficient practice. 3. On 4/21/22 the Director of Nursing and Infection Control/Staffing nurse provided educational in services to nursing staff regarding residents transfer/discharge documentation and residents rights. On	

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F 622	Continued From page 3 dated "2018/7" revealed, "It is the policy of this facility to permit each resident to remain in the facility, and not transfer or discharge the resident from the facility except in limited situations when the health and safety of the individual or other residents are endangered." The policy's definition "Facility-initiated transfer or discharge" is defined as "a transfer or discharge which the resident objects to, did not originate through a resident's verbal or written request, and/or is not in alignment with the resident's stated goals for care and preferences." The policy revealed "orientation for transfer or discharge must be provided and documented to ensure safe and orderly transfer or discharge from the facility" and "notice requirements and procedures for facility-initiated discharges shall be followed. Record review of Resident #1's Admission Record revealed he was admitted to the facility 12/3/2020 with the diagnosis of Paraplegia, Stage 4 pressure ulcer of right hip, Stage 4 pressure ulcer of other site, Vitamin Deficiency and Personality Disorder unspecified. Record review of Resident #1's care plans revealed behaviors were care planned as Resident #1 would "repeatedly removed dressing from my wound after nursing has applied it". On 6/9/21 "I refuse to allow staff to do wound care. I prefer to do my own wound care to areas I can reach." Noncompliance with medication administration care plan was initiated on 3/11/21. Combative behaviors at times Care plan was initiated on 3/22/21. He would curse and yell at staff, call the police on staff, and record staff when they enter his room. A care plan initiated on 4/23/21 was for resisting/refusing care. He resisted the evaluation of his wounds by the	F 622	4/21/2022 the Administrator provided educational in services to social services and business office manager regarding policy related to permitting residents to return to facility after hospitalization and residents rights. 4. Beginning 3/30/2022 Social services and/or Administrator or Director of Nursing will audit residents transferred to the hospital to ensure return to facility when medically cleared for hospital discharge weekly for 3 months. The report will be presented to Quality Assurance Committee on 4/27/2022 for review and recommendations then monthly for 3 months.	

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F 622	Continued From page 4	F 622		

wound care doctor. He refused the Nurse Practitioner wound care evaluation. He refused to be transported to the hospital for evaluation of his great toe of the left foot on 4/22/21 and 4/23/21.

Record review of Resident #1's lab results drawn on 12/22/21 for a Complete Blood Count (CBC) with Differential on Resident #1 revealed that the facility was notified on 12/23/21 that there was a critical lab for Hemoglobin at 4.0 grams/deciliter (g/dL). The reference range for Hemoglobin is 13.5-17.5 g/dL.

Record review of the Physician's Order dated 12/23/21 for Resident #1 revealed "Transfer/Discharge to (Proper Name local hospital) ".

Record review of the facility's "Transfer Form" dated 12/23/21, for Resident #1 revealed the "Reason for Transfer" was "Altered Mental Status" and "Critical Hemoglobin 4.0".

Interview on 3/23/22 with the Local Ombudsman at 9:10 AM, revealed that she did recall Resident #1 when he was in the facility. She stated he was "aggressive", refused treatments and medications, called the police 2-3 times a day. She recalled Resident #1 was discharged to a hospital for "medical reasons". They didn't send him for behavior reasons. The nursing home didn't take him back.

Interview on 3/23/22 with the Administrator at 11:40 AM, revealed the reasons for the discharge letters sent to Resident #1 were "he refused treatments, he refused medications, he refused to let our MD's see him. He was self-mutilating. He would pick his skin and throw it at staff." She

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F 622	Continued From page 5	F 622		

confirmed that the facility sent Resident #1 to the local hospital, and he was transferred to a hospital in Jackson, MS.

Interview on 3/23/22 with the Director of Nurses (DON) at 3:20 PM, revealed that Resident #1 was sent to the local hospital and the DON was called "2 days later" by the hospital saying they were prepared to discharge him back to the facility. She said treatment at the hospital was a blood transfusion. Resident #1 was then transferred to a hospital in Jackson, MS.

Interview on 3/23/22 with the Administrator at 3:30 PM, revealed she called Resident #1's conservator on 12/29/21 to inform him of the discharge of Resident #1 from the facility.

Interview on 3/24/22 with the Administrator at 1:50 PM, revealed "(Name of Hospital) in Jackson, MS only called and asked if I planned on taking him back. I told the case manager, not at this time. She asked if he was on bed hold, I said no. No one ever called and said he was ready for discharge. The Case manager called on 12/27/21. We discharged him on 12/23/21, the day he went to (name of local hospital) for the critical lab."

Record review revealed on 10/8/21, a 30-day discharge letter was sent to the Conservator, Resident #1, State Long Term Care Ombudsman, and local Ombudsman. The facility began to send referrals to other Long-Term Care (LTC) facilities for admission into their facility. The 2nd 30-day discharge letter was sent 11/15/21 and the 3rd was sent 12/14/21. The facility continued to send referrals to other LTC facilities looking for placement for Resident #1. The letters state that

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F 622	Continued From page 6	F 622		

the reason for the discharge was "due to threatening and harassing behavior towards staff. This pattern of dangerous behavior has progressed and has become increasingly problematic." Each letter also states the behavior is a contrast to the facility's "promise to maintain an environment that is free from harassment and hostility."
There was no evidence in the medical record to indicate that a discharge notice to include the resident's right to appeal the decision was sent to Resident #1, the Conservator, or the Ombudsman after the facility transferred Resident #1 to the acute care hospital and determined he would be discharged and not allowed to return to the facility.

Post Survey Interviews

In a interview on 4/8/22 at 9:04 AM, with the Medical Director stated he does remember Resident #1. "He was resistant to about any treatment that was ordered. He would ask for physical therapy, the facility would evaluate him, get the orders then Resident#1 would refuse to participate. He would not comply. He would pull his wound bandages off. He wouldn't take his medications consistently. He was non-compliant and resistant to any care. He had to be the only resident in a semi-private room because he wouldn't allow another resident stay in the room with him. He refused to be evaluated by the local hospital. I don't know of any other resident this has happened to. It was a tough situation. Residents have the right to refuse care but where there is imminent danger, like his was, it makes it very difficult. He had to be medicated just to get him to a higher level of care." "He was a danger to himself and others. When he would refuse his

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F 622	Continued From page 7	F 622		

medications and treatments, he was a danger to himself and others." The Medical Director was aware there are regulations regarding discharging a resident from a nursing home. He said the resident was discharged to a hospital, a medical facility. He said that Resident #1 required the higher level of care due to his lab levels.

During an interview on 4/8/22 at 9:57 AM, with the Director and Manager of Case Management at the local hospital, revealed the SA asked about the phone call between a part time Case Manager and the Nursing Home Administrator. They stated that the first call to the Administrator was the initial discharge planning that has to take place in the first 24 hours after a patient has been admitted to the hospital. There were several case managers that spoke with the Administrator after his admission to the hospital. Resident #1 was admitted to the local hospital on 12/25/21. The Manager of Case Management said that the Nursing Home Administrator did say Resident #1 had been given an eviction notice prior to being admitted by the hospital. She stated she specifically remembers that because she thought the word eviction was strange to use. The Nursing Home Administrator did say they would not be taking Resident #1 back into the facility. The Nursing Home Administrator did say he was refusing treatment at the nursing home. She stated that she had called the Nursing Home Administrators about Resident #1's vaccination status and asked again if the facility would be accepting him back. The Nursing Home Administrator said he had behaviors and had been issued a 30-day discharge notice. We sent out 184 referrals electronically and no one would admit him. There were more referrals done by phone, but I know there are 184 electronically.

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F 622	Continued From page 8 The SA asked how Resident #1 was as a patient in the local hospital and was told "He was a very difficult patient while here." This was confirmed by both the Director and Manager of Case Management. The SA asked this twice and that was the response both times. "He would on occasion allow treatments". The Director of Case Management stated, "He came to us on 12/25/21 and was here until a court ordered departure on 3/30/22 to the State Mental Hospital for evaluation." Record review of the medical record revealed there is no evidence in the chart that the facility assisted the hospital in finding appropriate placement for the resident.	F 622		
F 626 SS=D	Permitting Residents to Return to Facility CFR(s): 483.15(e)(1)(2) §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. (ii) If the facility that determines that a resident who was transferred with an expectation of	F 626		4/28/22

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F 626	Continued From page 9 returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. This REQUIREMENT is not met as evidenced by: The State Agency (SA) initiated a complaint investigation (CI) MS #18608 after a report by the Attorney General that a resident was not permitted to be re-admitted to a facility. Based on record review, facility policy review and staff interview, the facility failed to allow a resident to return to the facility following transfer to an acute care hospital for one (1) of four (4) residents reviewed. Resident #1. Also see F622. Findings include: Review of the facility's Policy and Procedure for "Transfer and Discharge Policy (including AMA)" dated "2018/7" revealed, "It is the policy of this facility to permit each resident to remain in the facility, and not transfer or discharge the resident from the facility except in limited situations when the health and safety of the individual or other residents are endangered." The policy's definition "Facility-initiated transfer or discharge" is defined	F 626	1. On 3/25/22 Social Services began an audit of all residents discharged/transferred out to the hospital for the last 60 days, no other residents were denied re-admission to the facility. The audit was completed by 3/28/2022. 2. All residents transferred/discharged to the hospital have been identified as having the potential to be at risk of being affected by this deficient practice. 3. On 4/21/22 the Director of Nursing and Infection Control/Staffing nurse provided educational in services to nursing staff regarding residents transfer/discharge documentation and residents rights. On 4/21/2022 the Administrator provided educational in services to social services and business office manager regarding policy related to permitting residents to return to facility after hospitalization and residents rights. 4. Beginning 3/30/2022 Social services	

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F 626	Continued From page 10 as "a transfer or discharge which the resident objects to, did not originate through a resident's verbal or written request, and/or is not in alignment with the resident's stated goals for care and preferences." The policy revealed "orientation for transfer or discharge must be provided and documented to ensure safe and orderly transfer or discharge from the facility" and "notice requirements and procedures for facility-initiated discharges shall be followed." Record review of Resident #1's Admission Record revealed he was admitted to the facility 12/3/2020 with the diagnosis of Paraplegia, Stage 4 pressure ulcer of right hip, Stage 4 pressure ulcer of other site, Vitamin Deficiency and Personality Disorder unspecified. Record review of Resident #1's care plans revealed behaviors were care planned as Resident #1 would "repeatedly removed dressing from my wound after nursing has applied it". On 6/9/21 "I refuse to allow staff to do wound care. I prefer to do my own wound care to areas I can reach." Noncompliance with medication administration care plan was initiated on 3/11/21. Combative behaviors at times Care plan was initiated on 3/22/21. He would curse and yell at staff, call the police on staff, and record staff when they enter his room. A care plan initiated on 4/23/21 was for resisting/refusing care. He resisted the evaluation of his wounds by the wound care doctor. He refused the Nurse Practitioner wound care evaluation. He refused to be transported to the hospital for evaluation of his great toe of the left foot on 4/22/21 and 4/23/21. Record review of Resident #1's lab results drawn on 12/22/21 for a Complete Blood Count (CBC)	F 626	and/or Administrator or Director of Nursing will audit residents transferred to the hospital to ensure return to facility when medically cleared for hospital discharge weekly for 3 months. The report will be presented to Quality Assurance Committee on 4/27/2022 for review and recommendations then monthly for 3 months.	

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F 626	Continued From page 11	F 626		

with Differential on Resident #1 revealed that the facility was notified on 12/23/21 that there was a critical lab for Hemoglobin at 4.0 grams/deciliter (g/dL). The reference range for Hemoglobin is 13.5-17.5 g/dL.

Record review of the Physician's Order dated 12/23/21 for Resident #1 revealed "Transfer/Discharge to (Proper Name local hospital) ".

Record review of the facility's "Transfer Form" dated 12/23/21, for Resident #1 revealed the "Reason for Transfer" was "Altered Mental Status" and "Critical Hemoglobin 4.0".

Interview on 3/23/22 with the Local Ombudsman at 9:10 AM, revealed that she did recall Resident #1 when he was in the facility. She stated he was "aggressive", refused treatments and medications, called the police 2-3 times a day. She recalled Resident #1 was discharged to a hospital for "medical reasons". They didn't send him for behavior reasons. The nursing home didn't take him back.

Interview on 3/23/22 with the Administrator at 11:40 AM, revealed the reasons for the discharge letters sent to Resident #1 were "he refused treatments, he refused medications, he refused to let our MD's see him. He was self-mutilating. He would pick his skin and throw it at staff." She confirmed that the facility sent Resident #1 to the local hospital, and he was transferred to a hospital in Jackson, MS.

Interview on 3/23/22 with the Director of Nurses (DON) at 3:20 PM, revealed that Resident #1 was sent to the local hospital and the DON was called

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	255332	A. BUILDING _____ B. WING _____	C 03/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLMES COUNTY LONG TERM CARE CENTER - DURANT	15481 BOWLING GREEN ROAD DURANT, MS 39063

(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) COMPLETION DATE
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"2 days later" by the hospital saying they were prepared to discharge him back to the facility. She said treatment at the hospital was a blood transfusion. Resident #1 was then transferred to a hospital in Jackson, MS.

Interview on 3/23/22 with the Administrator at 3:30 PM, revealed she called Resident #1's conservator on 12/29/21 to inform him of the discharge of Resident #1 from the facility.

Interview on 3/24/22 with the Administrator at 1:50 PM, revealed "(Name of Hospital) in Jackson, MS only called and asked if I planned on taking him back. I told the case manager, not at this time. She asked if he was on bed hold, I said no. No one ever called and said he was ready for discharge. The Case manager called on 12/27/21. We discharged him on 12/23/21, the day he went to (name of local hospital) for the critical lab."

Record review revealed on 10/8/21, a 30-day discharge letter was sent to the Conservator, Resident #1, State Long Term Care Ombudsman, and local Ombudsman. The facility began to send referrals to other Long-Term Care (LTC) facilities for admission into their facility. The 2nd 30-day discharge letter was sent 11/15/21 and the 3rd was sent 12/14/21. The facility continued to send referrals to other LTC facilities looking for placement for Resident #1. The letters state that the reason for the discharge was "due to threatening and harassing behavior towards staff. This pattern of dangerous behavior has progressed and has become increasingly problematic." Each letter also states the behavior is a contrast to the facility's "promise to maintain an environment that is free from harassment and

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hostility."
There was no evidence in the medical record to indicate that a discharge notice to include the resident's right to appeal the decision was sent to Resident #1, the Conservator, or the Ombudsman after the facility transferred Resident #1 to the acute care hospital and determined he would be discharged and not allowed to return to the facility.

Post Survey Interviews

In a interview on 4/8/22 at 9:04 AM, with the Medical Director stated he does remember Resident #1. "He was resistant to about any treatment that was ordered. He would ask for physical therapy, the facility would evaluate him, get the orders then Resident#1 would refuse to participate. He would not comply. He would pull his wound bandages off. He wouldn ' t take his medications consistently. He was non-compliant and resistant to any care. He had to be the only resident in a semi-private room because he wouldn ' t allow another resident stay in the room with him. He refused to be evaluated by the local hospital. I don't know of any other resident this has happened to. It was a tough situation. Residents have the right to refuse care but where there is imminent danger, like his was, it makes it very difficult. He had to be medicated just to get him to a higher level of care." "He was a danger to himself and others. When he would refuse his medications and treatments, he was a danger to himself and others." The Medical Director was aware there are regulations regarding discharging a resident from a nursing home. He said the resident was discharged to a hospital, a medical facility. He said that Resident #1 required the higher level of care due to his lab levels.

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During an interview on 4/8/22 at 9:57 AM, with the Director and Manager of Case Management at the local hospital, revealed the SA asked about the phone call between a part time Case Manager and the Nursing Home Administrator. They stated that the first call to the Administrator was the initial discharge planning that has to take place in the first 24 hours after a patient has been admitted to the hospital. There were several case managers that spoke with the Administrator after his admission to the hospital. Resident #1 was admitted to the local hospital on 12/25/21. The Manager of Case Management said that the Nursing Home Administrator did say Resident #1 had been given an eviction notice prior to being admitted by the hospital. She stated she specifically remembers that because she thought the word eviction was strange to use. The Nursing Home Administrator did say they would not be taking Resident #1 back into the facility. The Nursing Home Administrator did say he was refusing treatment at the nursing home. She stated that she had called the Nursing Home Administrators about Resident #1's vaccination status and asked again if the facility would be accepting him back. The Nursing Home Administrator said he had behaviors and had been issued a 30-day discharge notice. We sent out 184 referrals electronically and no one would admit him. There were more referrals done by phone, but I know there are 184 electronically. The AS asked how Resident #1 was as a patient in the local hospital and was told "He was a very difficult patient while here." This was confirmed by both the Director and Manager of Case Management. The SA asked this twice and that was the response both times. "He would on occasion allow treatments". The Director of Case

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F 626	Continued From page 15 Management stated, "He came to us on 12/25/21 and was here until a court ordered departure on 3/30/22 to the State Mental Hospital for evaluation." Record review of the medical record revealed there is no evidence in the chart that the facility assisted the hospital in finding appropriate placement for the resident.	F 626		