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
	71PM	A. BUILDING: _____ B. WING _____	C 09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TISHOMINGO MANOR	230 KHAKI STREET IUKA, MS 38852

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M 000	Initial Comments The State Agency (SA) conducted a complaint investigation CI MS# 19328 and CI MS# 19435 at the facility from 9/7/22 to 9/8/22. The SA substantiated CI MS# 19328 for resident abuse. The SA did not substantiate CI MS# 19345 related to quality of care and treatment. During the investigation , the SA determined that the facility was not in compliance with the Mississippi Regulations for Minimum Standards for Institutions for Aged or Infirm with deficiencies cited at M 500. The facility had a license for 105 beds and a census of 94 at the time of the survey.	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	M 500		10/11/22

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M 500	Continued From page 1	M 500		

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;

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;

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M 500	Continued From page 2 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 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	M 500		

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M 500	Continued From page 3 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 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 and staff interviews, record reviews, and policy review, the facility failed to prevent sexual abuse of Resident	M 500	Certified Nursing Assistant #1 was suspended on May 31, 2022, pending investigation of alleged sexual abuse	

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M 500	Continued From page 4 #1 for one (1) of five (5) residents reviewed for abuse. Findings include: Review of the facility policy titled, "Incident Investigation & Reporting" with a revision date of 05/18 revealed, "Each resident residing in this facility has the right to be free from any type of abuse including verbal, sexual, mental, physical abuse, neglect, misappropriation of resident property and exploitation." "Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse." On 09/7/22, the State Agency (SA) entered the facility complete an investigation related to MS00019328 regarding a Certified Nurse Aide (CNA) #1 that was witnessed on 05/26/22 touching Resident #1 inappropriately in his private area while performing perineal care. Interview and observation on 09/8/22 at 9:30 AM with Resident #1 revealed he was alert and knew his name and where he was. He was soft-spoken, with clear speech. The interview revealed the resident answered questions with one and two word responses. When asked if he remembered a staff member by the name of CNA #1 he responded "Yes." When asked if a staff member had ever mistreated him or touched him inappropriately while they were cleaning his private area. The resident stated, "Yes," and revealed CNA #'s last name. This interview and observation was witnessed by two State Agency employees. An interview on 09/7/22 at 11:40 AM with CNA #3	M 500	against Resident #1. Certified Nursing Assistant #1 was terminated on June 2, 2022, after the facility substantiated the allegation of sexual abuse against Resident #1. Resident #1 had a weekly body audit on May 30, 2022, by the Medication Nurse on the 7-3 shift with no issues noted. Resident #1 had a complete body audit on May 31, 2022, by the Director of Nursing and Staff Development Nurse with no issues noted. All residents have the potential to be affected by this deficient practice. No other residents have been identified as being affected by this deficient practice. Facility Staff was in-serviced on Resident Abuse/Neglect and Resident Dignity/Respect on May 31, 2022, by the Administrator. All cognitive residents were interviewed on June 1, 2022, by the Regional Supervisor and Social Services regarding any abuse or neglect with no further concerns noted. Facility Staff was in-serviced on September 13, 2022, on Resident Abuse, Elder Justice Act, Incident Investigation and Reporting and Residents Rights by the Director of Nursing and Administrator. A Quality Assurance Meeting was held on September 9, 2022, to discuss findings from survey exit and systematic changes needed to ensure deficient practice will not reoccur to include staff education on Resident Abuse/Neglect and reporting monthly for three months. Beginning September 19, 2022, the Administrator or Director of Nursing will	

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M 500	Continued From page 5 revealed she worked with CNA #1 and that she had a harsh tone when she talked to the residents. An interview on 09/7/22 at 1:50 PM with CNA #4 revealed that she worked with CNA #1 in the past and considered CNA#1 to have sort of a smart mouth with a bad attitude, and the residents have dementia and deserved to be treated well and not talked to badly. An interview on 09/7/22 at 1:50 PM with Registered Nurse (RN) #1 revealed that in her opinion, CNA #1 was a "bad egg" and had been the whole time she had been here and revealed that her demeanor was rough and stated, she just wasn't a kind person. An interview on 09/7/22 at 2:40 PM with Social Services (SS) #1 revealed that Resident #1 answers in one to two word statements, but if you know him you can understand him, but he usually answers in very few words. She confirmed she was asked by the administrator to go interview the resident and was told to ask him if any staff had touched him inappropriately or had made him feel uncomfortable. She revealed that she was unaware of the situation or what had been alleged, so she just went to the resident's room and asked him if a staff member had ever made him feel uncomfortable or if anyone had ever touched him inappropriately. SS#1 stated CNA #1 and CNA #3 entered the room during her interview with Resident #1 and CNA #1 stood at the foot of the bed and CNA #3 asked if he needed assistance to cut his meat on his lunch tray and he yelled "No." SS#1 stated once the CNAs left the resident's room she asked the resident if anyone made him feel uncomfortable or touched him inappropriately and he gestured to	M 500	report any concerns regarding F Tag 600 in the Department Head Meeting weekly for four weeks then monthly for three months. Beginning September 19, 2022, the Administrator, Director of Nursing or Social Services will interview five cognitive resident weekly for four weeks then monthly for three months to ensure residents are free of any abuse/neglect. Beginning September 23, 2022, the Administrator or Director of Nursing will report any concerns to the Quality Assurance Committee. Beginning October 10, 2022, the Administrator or Director of Nursing will report any concerns to the Quality Assurance Committee and then monthly for three months until substantial compliance is achieved with F Tag 600. The Quality Assurance Committee will revise the corrective action plan as needed until substantial compliance is achieved with F Tag 600.ied as being affected by this deficient practice.	

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where CNA #1 had been standing. SS#1 stated she confirmed with the resident to make sure he meant that CNA #1 had done something to him or touched him inappropriately and he nodded his head yes. SS#1 stated, "I believe he gave me the best answer he could without being verbal."

An interview on 09/7/22 at 3:15 PM with Nurse Aide in Training (NAT) #2 revealed on the day of the incident 05/26/22 that it was just her second day at the facility. She revealed she was just observing and was standing at the foot of the bed, while CNA #5 and CNA #1 were giving Resident #1 a sponge bath. She revealed that CNA #1 started wiping the resident's penis roughly and told the resident "Do you not like it?" She revealed the resident did not say anything but had his hand over his face. NAT#2 revealed that CNA#5 did not say anything to CNA#1, and left the room as soon as the sponge bath was over because she was so uncomfortable. She stated CNA#1 and CNA#5 were friends, so she didn't feel comfortable reporting it, but finally did on 5/31/22 to the Staff Development Nurse.

An interview on 09/8/22 at 9:30 AM with the Staff Development nurse revealed, that NAT#2 came to her office on 05/31/22 and requested to be taken off C Wing duty. She revealed when she inquired about why she wanted to be removed from C Wing duty, the NAT#2 reported that an incident had occurred, and she did not feel comfortable working over there. NAT#2 reported she observed CNA #1 and CNA #5 giving Resident #1 perineal care and CNA #1 slapped around the resident's penis and asked him if he liked it. NAT#2 stated this made her so uncomfortable that she left the room before they were finished with the resident's care. The Staff Development Nurse revealed that Resident #1's

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speech is sometimes difficult to understand due to his cerebrovascular accident (CVA) but he knows what's going on and at times has trouble getting his words out.

An interview on 09/8/22 at 10:50 AM with the Director of Nurses (DON) revealed that CNA #1 was just not a happy bubbly person. She confirmed there had been some complaints about CNA #1 in the past about her attitude. The DON stated she was made aware by the Staff Development Nurse of the incident involving CNA#1 immediately after NAT#2 reported the incident to the Staff Development Nurse. The DON stated NAT #2 retold the story to both her and the Staff Development Nurse and made a hand motion to show how CNA #1 was flinging the resident's penis back and forth.

Interview on 09/8/22 at 11:45 AM, the facility Administrator recalled the incident that occurred with CNA #1 on 05/26/2022 and stated that she suspended CNA #1 pending investigation on 5/31/22 the day she was made aware of it. The Administrator stated she believed CNA #1 did what was reportedly witnessed.. The Administrator stated there had not ever been any allegations of inappropriate touching regarding CNA#1, but there had been complaints of her being disrespectful to some residents.

Record review of Resident # 1's face sheet revealed that the resident was admitted to the facility on 03/12/10 with medical diagnoses that included: Hemiplegia following cerebral vascular disease affecting the right dominant side, and dysphagia following unspecified cerebrovascular disease, aphasia following unspecified cerebrovascular disease, contracture of muscle, right hand, unspecified dementia with behavioral

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M 500	Continued From page 8 disturbance. Record review of Resident # 1's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/19/22 revealed a Brief Interview for Mental Status (BIMS) of 09, which indicates the resident is moderately cognitively impaired. The facility had substantiated the sexual abuse of Resident #1 by CNA #1 and terminated CNA #1 while she was out on suspension. CNA#1 was suspended from the facility on 5/31/2022 and was terminated on 6/2/2022. Based on observation, resident and staff interviews, record reviews, and policy review, the facility failed to prevent sexual abuse of Resident #1 for one (1) of five (5) residents reviewed for abuse. Findings include: Review of the facility policy titled, "Incident Investigation & Reporting" with a revision date of 05/18 revealed, "Each resident residing in this facility has the right to be free from any type of abuse including verbal, sexual, mental, physical abuse, neglect, misappropriation of resident property and exploitation." "Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse." On 09/7/22, the State Agency (SA) entered the	M 500		

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facility complete an investigation related to MS00019328 regarding a Certified Nurse Aide (CNA) #1 that was witnessed on 05/26/22 touching Resident #1 inappropriately in his private area while performing perineal care.

Interview and observation on 09/8/22 at 9:30 AM with Resident #1 revealed he was alert and knew his name and where he was. He was soft-spoken, with clear speech. The interview revealed the resident answered questions with one and two word responses. When asked if he remembered a staff member by the name of CNA #1 he responded "Yes." When asked if a staff member had ever mistreated him or touched him inappropriately while they were cleaning his private area. The resident stated, "Yes," and revealed CNA #'s last name. This interview and observation was witnessed by two State Agency employees.

An interview on 09/7/22 at 11:40 AM with CNA #3 revealed she worked with CNA #1 and that she was kind of stern when she talked to the residents.

An interview on 09/7/22 at 1:50 PM with CNA #4 revealed that she worked with CNA #1 in the past and that she was sort of a smart mouth and had a bad attitude, and these residents have dementia, the residents deserve to be treated right and not talked to badly.

An interview on 09/7/22 at 1:50 PM with Registered Nurse (RN) #1 revealed that in her opinion, CNA #1 was a "bad egg" and had been the whole time she had been here and revealed that her demeanor was rough and stated, she just wasn't a kind person.

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M 500	Continued From page 10 An interview on 09/7/22 at 2:40 PM with Social Services (SS) #1 revealed that Resident #1 answers in one to two word statements, but if you know him you can understand him, but he usually answers in very few words. She confirmed she was asked by the administrator to go interview the resident and was told to ask him if any staff had touched him inappropriately or had made him feel uncomfortable. She revealed that she was unaware of the situation or what had been alleged, so she just went to the resident's room and asked him if a staff member had ever made him feel uncomfortable or if anyone had ever touched him inappropriately. She revealed that CNA #1 and CNA #3 came into the room during her interview with Resident #1 and CNA #1 stood at the foot of the bed and CNA #3 ask to cut his meat on his lunch tray and he yelled "No." Social Services revealed that when the CNAs left the room, she told the resident that she wanted to pick up that conversation they were having before they had came in the room, so she asked the resident, "Has anyone made you feel uncomfortable or touched you inappropriately," and the resident raised his arm in the direction of where CNA #1 was standing. She revealed she confirmed with the resident to make sure he meant that CNA #1 had done something to him or touched him inappropriately and he nodded his head yes. She stated, "I believe he gave me the best answer he could without being verbal." An interview on 09/7/22 at 3:15 PM with Nurse Aide in Training (NAT) #2 revealed on the day of the incident 05/26/22 that it was just her second day at the facility. She revealed she was just observing and was standing at the foot of the bed, while CNA #5 and CNA #1 were giving Resident #1 a sponge bath. She revealed that CNA #1 started wiping the resident's penis	M 500		

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roughly and told the resident "Do you not like it?" She revealed the resident did not say anything but had his hand over his face. (NAT) #2 revealed that CNA #5 did not say anything to CNA #1, nor the resident. She revealed she left the room as soon as the sponge bath was over because she was so uncomfortable. She confirmed that CNA #1 and CNA #5 were friends, so she didn't feel comfortable reporting it, but finally did on 5/31/22 to the Staff Development Nurse.

An interview on 09/8/22 at 9:30 AM with the Staff Development nurse revealed, that NAT #2 came to her office on 05/31/22 and requested to be taken off C Wing duty. She revealed when she inquired about why she wanted to be removed from C Wing duty, the NAT #2 reported that an incident had occurred, and she did not feel comfortable working over there. She revealed that one day the week before she had observed CNA #1 and CNA #5 giving Resident #1 perineal care and CNA #1 slapped around the resident's penis and asked him if he liked it. She revealed that the NAT #2 revealed to her that this made her so uncomfortable that she left the room before they were finished with the resident's care. The Staff Development Nurse revealed that Resident #1's speech is sometimes difficult to understand due to his cerebrovascular accident (CVA) but he knows what's going on and at times has trouble getting his words out. She revealed that she had several complaints from residents on CNA #1 regarding her attitude and rough demeanor in the past.

An interview on 09/8/22 at 10:50 AM with the Director of Nurses (DON) revealed that CNA #1 was just not a happy bubbly person. She confirmed they had some complaints about CNA #1 in the past about her attitude. She revealed

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that she was made aware of the incident when the Staff Development Nurse came and got her after the NAT #2 told her about the incident. She stated at that time that the NAT #2 retold the story to both her and the Staff Development Nurse and made a hand motion to show how CNA #1 was flinging the resident's penis back and forth. She revealed that this made her so uncomfortable that she left the room.

Interview on 09/8/22 at 11:45 AM, the facility Administrator recalled the incident that occurred with CNA #1 on 05/26/2022 and stated that she suspended CNA #1 pending investigation on 5/31/22 the day she was made aware of it. The Administrator revealed she thinks that CNA #1 did what was witnessed, her personality and demeanor I could see her doing this. The Administrator revealed we have never had any sexual allegations regarding CNA #1, but we have had complaints of her mouth and being disrespectful at times to residents.

Record review of Resident # 1's face sheet revealed that the resident was admitted to the facility on 03/12/10 with medical diagnoses that included: Hemiplegia following cerebral vascular disease affecting the right dominant side, and dysphagia following unspecified cerebrovascular disease, aphasia following unspecified cerebrovascular disease, contracture of muscle, right hand, unspecified dementia with behavioral disturbance.

Record review of Resident #1 care plan dated 06/24/13 "Resident requires extensive/total assistance with most Activities of Daily Living (ADL) decline in function related to the history of CVA with right side hemiplegia and aphasia with a goal of resident will maintain the ability to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	71PM	A. BUILDING: _____ B. WING _____	C 09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TISHOMINGO MANOR	230 KHAKI STREET IUKA, MS 38852

(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 500	Continued From page 13 participate in ADL care as tolerated by next review 10/22/22 and interventions that include providing assist with ADL's, as needed (CNA), prefers bed baths, requires 2 persons assist with bed mobility, toileting/peri care, dressing and bathing." Record review of Resident # 1's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/19/22 revealed a Brief Interview for Mental Status (BIMS) of 09, which indicates the resident is moderately cognitively impaired. The facility had substantiated the sexual abuse of Resident #1 by CNA #1 and terminated CNA #1 while she was out on suspension. CNA#1 was suspended from the facility on 5/31/2022 and was terminated on 6/2/2022.	M 500		