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
	34JC	A. BUILDING: _____ B. WING _____	02/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JONES CO REST HOME	683 COUNTY HOME ROAD ELLISVILLE, MS 39437

(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) contract surveyors determined during an annual recertification survey, conducted from 2/25/19 to 2/28/19, the facility was not in compliance with the Mississippi Regulations for Minimum Standards for Institutions for Aged or Infirm with deficiencies cited at M500, M710, M715 and M915. The census at time of survey was 115 and the facility held a license for 122 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	M 500		4/29/19

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M 500	Continued From page 1 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	M 500		

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M 500	Continued From page 2 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	M 500		

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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 facility policy review, observations, record reviews, and interviews the facility failed to ensure two (2) of 29 sampled residents, Resident (R) 42 and R56, were treated with respect and	M 500	M500 Resident Rights 1) Social Worker met with Resident (R) 42 and R56 on April 15, 2019, to assess the residents for psychosocial harm relating to their residents rights. No psychosocial	

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M 500	Continued From page 4 dignity. Specifically, staff failed to knock before entering the room as requested by R42; and R56 was observed with a soiled brief, and staff failed to provide timely continence care. Tthe facility also failed to ensure the resident's personal funds were available on the weekends for three (3) of the 29 sampled residents. Residents (R) 42, R56, and R95 did not have access to their personal funds on the weekends. The facility also failed to ensure residents had the right to be free from any physical restraints for one (1)of 29 sampled residents, Resident (R) 31. Specifically, R31 had a device in place which she could not remove easily, and limited her freedom of movement. There was no documented evidence the facility assessed the resident for an appropriate medical diagnosis to warrant the use of a restraint. Findings include: Record review of the facility's policy dated 07/18/17, titled "South Central Regional Medical Center", revealed "Resident Respect and Dignity"; the purpose of the policy was to promote resident rights and treat each resident with respect and dignity, and care for each resident in a manner that maintained or enhanced the resident's quality of life. The policy further defined dignity as activities that maintained and enhanced the resident's self esteem and self-worth. Record review of the procedure part of the policy revealed the staff would respond to a resident's need for assistance in a timely manner. The procedure further specified the staff would respect the resident's space by knocking on doors and waiting for permission to enter. Resident #42 Observation of R42 on 02/25/19 at 11:00 AM, revealed the resident lying in bed, in her room.	M 500	harm was found to have occurred. 2) All residents have the potential to be affected. 3) Nursing Staff responsible for the care of R42 and R56 were in-serviced by Medical Records Nurse on April 8, 2019, regarding proper procedures for maintaining resident rights for respect and dignity by knocking on doors before entering room for R42, and for providing timely continence care for R56. The Quality Assessment and Assurance (QAA) Committee updated the Resident Respect and Dignity policy on April 8, 2019, to include respecting and maintaining resident dignity by providing care and personal hygiene in a timely manner. All staff are being in-serviced by the Director of Nurses on the policy, specifically knocking on doors and waiting for permission before entering a resident s room. The in-services began on April 12, 2019, and will continue until all staff have received the in-service training. Other in-service dates include April 16-18, 2019, and April 23-25, 2019. Licensed and non-licensed nursing staff are being in-serviced by Director of Nurses, regarding maintaining resident s respect and dignity by providing care and personal hygiene in a timely manner. In-servicing began on April 12, 2019, and will continue until all nursing staff have received the in-service training. Other in-service dates include April 16-18, 2019, and April 23-25, 2019. To ensure timely care is provided, nurses were also educated during this in-service regarding their responsibility to provide for resident	

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M 500	Continued From page 5 The closets in the resident's rooms were by the door, and this resident had small bells dangling from the door handle. R42 stated she put the bells on the door handle to alert her when someone was opening the door. Observation on 02/25/19 at 9:41 AM, by another surveyor, revealed a Certified Nursing Assistant (CNA) entered room 104 to provide the resident with a snack and did not knock before entering. Observation on 02/25/19 at 9:43 AM, by another surveyor, revealed a CNA opened the door to room 109, knocked, and entered the room without waiting for a response. Observation on 02/25/19 at 2:43 PM, during an interview by another surveyor, revealed a CNA entered room 109 to give the resident a snack and did not knock before entering. Observation on 02/27/19 at 12:01 PM, revealed Licensed Practical Nurse (LPN) #4 entered R56's room to do a skin assessment and did not knock on the door before she entered. The roommate, whose bed was by the door was also present in the room. Observation on 02/25/19 at 9:41 AM, by another surveyor, revealed a CNA entered rooms 103 and 107 to provide the residents with a snack and did not knock on the door before entering. Record review of the "Face Sheet" in the electronic record for R42 revealed the facility admitted the resident on 02/02/17, with diagnoses of contractures, Rheumatoid Arthritis, chronic pain, long term opiate use, Anxiety Disorder, Depressive Disorder, and Bipolar Disorder.	M 500	care needs, including continence care, during meal times when the certified nursing assistants are providing meal assistance to residents. 4) Medical Record Nurse and/or Charge Nurse will conduct three random observations of staff weekly over the next three months to ensure staff are promoting and maintaining resident dignity by knocking on doors and providing timely care and hygiene in accordance with facility s policy and regulatory requirements. These observations will begin on April 15, 2019, and the Medical Record Nurse will present these observation reports to the QAA Committee monthly until such time substantial compliance has been achieved as determined by the committee. The QAA Committee will make any recommendations and/or changes if needed to ensure compliance. Resident Funds: 1) Residents (R) 42 and R56 were provided information on the new procedure for obtaining funds after business hours and on weekends and holidays. Information was provided by Administration Assistant Clerical Level #1 on April 15, 2019. R95 is no longer a resident of the facility. 2) All residents with a personal funds account have the potential to be affected. 3) The Quality Assessment and Assurance (QAA) Committee modified the Resident Rights Personal Funds policy and the petty cash fund system on April 8, 2019. The resident petty cash fund will be	

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M 500	Continued From page 6 Record review of the yearly "Minimum Data Set (MDS)," dated 01/04/19 revealed R42 had a "Brief Interview of Mental Status (BIMS)," score of 15 out of 15, which indicated the resident was cognitively intact, and able to make decisions about her care. Record review of the "'Care Plan" for R42, with an onset date of 10/15/18, and a goal date of 04/08/19, revealed a problem for choices, and one (1) of the interventions was to allow R42 to make her own decisions. Interview with R42 on 02/25/19 at 11:05 AM, revealed staff did not always knock on the door when they came into the room. While R42 and this surveyor were conversing, the door to her room was opened abruptly, and a staff member brought her roommate, who was in a geri-chair, into the room. Observation revealed the staff member did not knock on the door before entering. R42 stated, "See". R42 revealed she has had her toes hit by the door before because the staff did not knock and just came right on in and she couldn't get out of the way. R42 also stated she has asked the staff to knock on the door before entering, but some staff continued to enter without knocking. Interview with LPN #4 on 02/27/19 at 12:15 PM, revealed staff were supposed to knock on the door before entering because it was the resident's room and staff should be respectful of that. Interview with CNA #1 on 02/28/19 at 12:51 PM, revealed staff should knock on the resident's door before entering because anything could be going on. CNA #1 further revealed resident's families could be visiting and staff could be performing	M 500	managed by the Charge Nurse during non-office hours to ensure residents have access to their personal funds after business hours, on weekends and holidays. All staff will begin being in-serviced by Director of Nurses on April 12, 2019, until all staff is in-serviced regarding the new procedures allowing resident access to his/her funds after business hours. The in-services began on April 12, 2019, and will continue until all staff have received the in-service training. Other in-service dates include April 16-18, 2019, and April 23-25, 2019. All residents and/or resident representatives were provided notice of the new procedures to allow access to available resident funds by letter on April 12, 2019, by Administrator. Information regarding access to available resident funds will be included during new admission process and acknowledged through the Availability of Personal Funds Notice. 4) The Business Office staff will randomly conduct three resident interviews weekly over the next three months to determine if they were able to obtain personal funds after business hours or during the weekend or holidays, or if no funds were desired, was the resident aware of how to access available funds. These observations will begin on April 15, 2019, and the Administrator will present these observation reports to the QAA Committee monthly until such time substantial compliance has been achieved as determined by the committee. The QAA Committee will make any	

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M 500	Continued From page 7 personal care. CNA #1 stated privacy was a big deal and knocking on the door showed respect for the resident. CNA #1 revealed everyone knew R42 and that you needed to knock on the door before your entered. Interview on 02/28/19 at 11:57 AM, with the Director of Nursing (DON), revealed staff should knock on the resident's doors before they entered the room. The DON stated it was just like home, in that you knock on the door before going into someone else's room. The DON revealed there had been concerns voiced from the "Resident Council" in the past about staff not knocking on doors before they entered. The DON revealed they had done in-services related to privacy and knocking on doors. Resident #56 Record review of the "Face Sheet" in the electronic chart revealed the facility admitted R56 on 09/28/07, with diagnoses of Cerebral Palsy, Hypertension, Hemiplegia, and Depression. Record review of the quarterly "MDS", dated 01/01/19, revealed a "BIMS" score of 15 out of 15, which indicated the resident was cognitively intact. The MDS indicated that R56 was totally dependent on staff for hygiene. The MDS indicated in "Section H: Bladder and Bowel" that R56 was always incontinent of bowel and bladder. Record review in the electronic chart revealed a "Care Plan (CP)" for R56 dated 10/18/18. A problem was listed for staff to honor the wishes of R56. A goal was to provide dignity and support to R56 and the family. Review of the interventions revealed staff were to provide emotional support to the resident. Another problem identified on the CP was the resident required total assist with her	M 500	recommendations and/or changes if needed to ensure compliance. Free from Physical Restraints 1) Resident (R) 31 was transferred to a geri-chair on April 12, 2019, by the Director of Nurses to ensure that resident is free from physical restraint. 2) R31 is the only resident with the potential to be affected. 3) The Quality Assessment and Assurance (QAA) Committee reviewed the Resident Rights Restraint Free Environment policy on April 8, 2019, with no revisions at that time. All therapy staff, licensed and non-licensed nursing staff will be in-serviced by Director of Nurses starting on April 12, 2019, regarding the facility policy, and included definitions of a restraint, proper assessment, and possible alternative(s) to restraint usage until all staff are in-serviced. The in-services began on April 12, 2019, and will continue until all these staff members have received the in-service training. Other in-service dates include April 16-18, 2019, and April 23-25, 2019. 4) The Director of Nurses will conduct three random audits weekly over the next three months to ensure devices used by the resident do not act as a restraint, and that the reason(s) for device use are properly identified, evaluated, documented and care planned in accordance with facility policy and regulatory guidance. These audits will begin on April 15, 2019, and the Director of Nurses will present these audits to the QAA Committee monthly until such time substantial	

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M 500	Continued From page 8 daily care needs. Observation of R56 on 02/27/19 at 11:39 AM, revealed the resident was lying in bed with the head of the bed in up position and staff were assisting with her meal. The Resident consented to an observation of her skin assessment by staff. Observation on 02/27/19 at 12:01 PM, of the skin assessment with LPN #4 and another nurse, revealed the resident did not have any pressure areas. However, R56 had a wet brief on and LPN #4 verified it was urine. Continued observation revealed LPN #4 reapplied the urine-soaked brief to R56 and told the resident she would get someone in there to clean the resident up. Observation revealed both nurses walked out of the room leaving a wet brief on R56. Continued observation on 02/27/19 at 12:18 PM, revealed a CNA delivered a tray to R56's room-mate and did not assist R56. At 12:33 PM, a CNA brought a water pitcher into the room and did not assist R56. Observations of LPN #4, after leaving R56's room, revealed the LPN had returned to her medication cart multiple times without following up to see if R56 had been changed. The medication cart was right outside R56's room. Observation on 02/27/19 at 12:38 PM, revealed a CNA removed the tray from the other resident in the room and did not assist R56. Interview with LPN #4 on 02/27/19 at 12:45 PM, revealed 45 minutes would be too long for a resident to wait to have their soiled brief changed. LPN #4 stated skin breakdown can occur when a resident laid in urine. LPN #4 asked CNA #2 to	M 500	compliance has been achieved as determined by the committee. The QAA Committee will make any recommendations and/or changes if needed to ensure compliance.	

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M 500	Continued From page 9 help R56. Interview with CNA #2 on 02/27/19 at 12:45 PM, revealed the other nurse in the room with LPN #4 had asked her to change R56, but she had forgotten. The interview further revealed when the food trays were being passed, they (CNAs) were to keep passing trays and not provide hands on care to the residents. CNA #2 revealed the trays had to be passed immediately, so no one received cold food. Interview on 02/27/19 at 12:50 PM, with Registered Nurse (RN) #2, who was the charge nurse that day, revealed she would have changed R56 herself unless there was something more pressing had occurred. RN #2 stated if a nurse was just passing medications, they should go ahead and change the resident themselves. RN #2 stated 45 minutes was not an acceptable time range for a resident to have to wait to be changed. RN #2 further revealed when the CNA's were passing trays the nurses on the unit answered the call lights and helped with the resident's care. CNA's were not supposed to answer call lights or do rounds while they passed trays. Interview with the DON on 02/27/19 at 2:52 PM, revealed a resident should be changed when soiled, and at a maximum within 15 minutes. The DON revealed 45 minutes was not acceptable. The DON stated, "I would not want to sit in a soiled brief for that long and the nurses who were aware of the soiled brief should have changed it right then, unless they had something else going on and, in that case, they should have made sure someone assisted R56." The DON confirmed it was a dignity issue for R56, and it also increased the resident's risk for skin breakdown and a	M 500		

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M 500	Continued From page 10 urinary tract infection. The DON stated the CNA's were to check on the residents before passing trays and the nurses were to answer the call lights and provide care while the CNA's passed trays. Interview on 02/28/19 at 4:51 PM, with the Administrator, revealed she would expect a resident to be changed when soiled, and within 15 minutes of staff being aware of it. The Administrator stated she would have expected the nurses to change R56 when they saw she was soiled. . Resident Funds: Review of the facility's policy dated 08/30/18, titled, "South Central Regional Medical Center," under the "Resident Rights - Personal Funds," section, revealed the purpose of the policy was to ensure the residents had the right to manage their own funds. Review of the policy revealed there was no indication that the facility had to provide availability for personal funds on the weekends. Resident #42 Record review of the "Face Sheet" in the electronic chart revealed R42 was admitted by the facility on 02/02/17, with diagnoses of Rheumatoid Arthritis, Chronic Pain, Anxiety Disorder, Depressive Disorder, Bipolar Disorder and Deep Vein Thrombosis. Record review of the yearly "Minimum Data Set (MDS)," dated 01/14/19, revealed a Brief Interview of Mental Status (BIMS) (a cognitive evaluation) score of 15 out of 15, which indicated R42 was cognitively intact, and could be	M 500		

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M 500	Continued From page 11 interviewed about her care. Observation and interview with R42 on 02/26/19 at 9:08 AM, revealed she was in her room and agreeable to an individual resident interview. R42 revealed she had personal funds held by the facility for her, however she was not able to access it on the weekends. She stated there was no one in the office to dispense money to her on the weekends. R42 stated there had been occasions when she wanted some money on the weekend but was unable to access it. R42 revealed she could get money on Fridays, but she may not always know in advance that she wants/needs money for the weekend. Resident #56 Record review of the "Face Sheet" in the electronic chart revealed R56 was admitted by the facility on 09/28/07, with diagnoses of Cerebral Palsy, Hypertension, Scoliosis, Hemiplegia, Dysphagia, Anxiety, and Depression. Record review of the quarterly "MDS" dated 01/01/19, revealed in "Section C: Cognitive Patterns" R56 had a "BIMS" score of 15 out of 15, which indicated R56 was cognitively intact. Record review of the MDS in "Section G: Functional Status" revealed R56 needed extensive assistance with mobility and two-person support. Observation of R56 on 02/26/19 at 12:36 PM, revealed she was in her room in bed. Interview with R56, at the time of the observation, revealed she had a personal fund account in the office. However, the office was closed on the weekends and she could not access her funds. R56 revealed if she needed something on the weekends she would call home.	M 500		

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M 500	Continued From page 12 Resident #95 Record review of the "Face Sheet" for R95, revealed he was admitted by the facility on 01/04/19, with diagnoses of Weakness, Atrial Fibrillation, Congestive Heart Failure, and Hypertension. Record review of the admission "MDS", dated 01/31/19, revealed under "Section C: Cognitive Patterns" a "BIMS" score of 15 out of 15, which indicated R95 was cognitively intact, and a reliable interview about his care. Observation and interview with R95 on 02/25/19 at 3:38 PM, revealed he was sitting on the side of his bed and his wife was visiting at bedside. R95 stated he had money in the office, but the office was not open on weekends. R95 stated when the office wasn't opened, he would have to call his wife if he needed any money. Interview on 02/27/19 at 11:47 AM, with Certified Nursing Assistant (CNA) #1, revealed she would have to talk to the charge nurse and see what to do if a resident asked for money on the weekends because the office was closed, and that was where the residents kept their money. CNA #1 revealed there weren't many residents that have asked for their money on weekends, but that may be because they knew the office was closed. Interview with Registered Nurse (RN) #2, who was the Charge Nurse, on 02/27/19 at 12:15 PM, revealed she was not sure how the residents could get their money on the weekends because the office was closed, and the personal funds were locked in the office. RN #2 further revealed there were staff on call on weekends and the nurses could maybe call them.	M 500		

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M 500	Continued From page 13 Interview with Licensed Practical Nurse (LPN) #3 on 02/27/19 at 12:58 PM, revealed the nurses do not have access to the funds and she did not know who did have access on the weekends. LPN #3 revealed she would have to ask the Charge Nurse what to do. Interview with the Administration Assistant Clerical Level (CL) #1 on 02/27/19 at 1:02 PM, revealed many of the residents do have a personal fund set up, and they usually will come to the office on Friday to get any money for the weekend. CL #1 revealed the office was not opened on weekends and the weekend nursing staff do not have access to the funds. CL #1 stated if a resident needed money on the weekend they would have to ask the staff to call her, and if she wasn't available, they would have to call another "on call" staff member until they got someone that could come in and dispense the money. In an interview with the Administrator on 02/27/19 at 01:05 PM, she stated she was also on call and could come in if a resident needed access to their funds. Free from physical restraints: Review the facility's policy titled, "Resident Rights-Restraint Free Environment," revised on 12/27/16, revealed the purpose of the facility's policy was to ensure the resident's right to be free from any physical or chemical restraints imposed for the purposes of discipline or convenience, and not required to treat the resident's medical symptoms. The facility's policy defined a physical restraint as: any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that	M 500		

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M 500	Continued From page 14 the individual cannot remove easily which restricts freedom of movement or normal access to ones' body; and any device in conjunction with a chair (such as bars or belts) that the resident could not remove easily, that prevent a resident from rising. The facility's policy also revealed the facility could not use restraints solely based on a legal surrogate or representatives request, and a physician's order alone was not enough to warrant the use of a restraint. Continued review of the facility's policy revealed restraints would not be used at the facility and when the resident required the use of an orthotic body device such as specialty chairs, an assessment would be conducted to ensure the use of the device did not restrain or restrict freedom of movement or normal access to the resident's own body. The facility's policy indicated residents who are restrained may face a loss of autonomy, dignity, and self-respect, and may show symptoms of withdrawal, depression, or reduced social contact. Review of R31's "face sheet" revealed the facility admitted the resident on 06/13/18, with diagnoses which included Nontraumatic Intracerebral Hemorrhage, Weakness, and Hemiplegia following Intracerebral Hemorrhage affecting left nondominated side. Observation, on 02/25/19 at 9:12 AM, in the lounge area on the east wing, revealed R31 sitting in her wheelchair in front of the television. Continued observations revealed the resident had a seat belt on while in her wheel chair. Review of R31's "Physician Orders," dated February 2019, revealed no documented evidence of a current order for the restraint, and no documentation that a restraint was medically	M 500		

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M 500	Continued From page 15 necessary. Review of the resident's "Minimum Data Set (MDS)," dated 12/18/18, revealed a cognitive evaluation could not be completed because the resident was rarely/never understood however; the facility assessed the resident's cognitive skills for daily decision making was severely impaired. Continued review of the MDS under "Section G: Functional Status," the facility assessed the resident to have "Functional Limitation in Range of Motion" to only one (1) side of her upper and lower extremity. Further review of the MDS under "Section P: Restraints," the facility assessed the resident as not using any physical restraints including equipment attached or adjacent to the resident's body that the individual could not remove easily which restricts freedom of movement or normal access to one's body. Review of R31's "Care Plan," reviewed and updated 12/19/18, revealed the problem of the resident's wheelchair has a lap and leg strap related to poor trunk control. The intervention was "personal wheelchair with lap and leg strap for security due to poor trunk control." Continued review of the resident's care plan revealed the goal: the resident would not have further loss of mobility or contracture development. Interview on 02/27/19 at 8:30 AM, with the Therapy Coordinator revealed he was aware the resident's wheelchair had the seat belt and the leg straps; however, the therapy department did not recommend them. Continued interview revealed the facility had a no restraints policy, and the wheelchair straps were restraints. The Therapy Coordinator stated there was no assessment or a physician's order. The Therapy Coordinator further stated the facility did not	M 500		

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M 500	Continued From page 16 utilize restraints because residents' had the right to be restraint free. Interview, on 02/27/19 at 9:00 AM, with the facility's Medical Director revealed it was his expectation the facility would have followed their policy related to the known restraints. The Medical Director stated to the best of his knowledge, there was no physician's order for the use of the seat belt, and no matter who brought the chair in, it did not make it ok for the seat belt to be used. Interview, on 02/27/19 at 9:35 AM, with Certified Nursing Assistant (CNA) #3, who was providing care for R31, revealed she was familiar with the resident. Continued interview revealed the resident did not have much movement in her left arm, but she could move her right arm well. CNA #3 stated she did put the seat belt on the resident when the resident was in her wheel chair. The CNA stated the purpose of the seat belt was for the resident's safety, so the resident did not fall out of her wheelchair. Interview, on 02/28/19 at 12:18 PM, with Registered Nurse (RN) #4, revealed R31's wheelchair was brought into the facility by the resident's spouse. Continued interview revealed the use of the seat belt was technically a restraint, so it was care planned. Interview, on 02/28/19 at 1:20 PM, with the MDS Coordinator revealed R31 was not assessed on the MDS to have a restraint, because she did not consider the seat belt a restraint. Continued interview revealed if the seat belt prevented the resident from getting up from her wheelchair, then she should consider the seat belt a restraint.	M 500		

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M 500	Continued From page 17 Interview, on 02/28/19 at 3:16 PM, with CNA #4, who was assigned to R31's care, revealed CNA #4 was not buckling the resident's seat belt when the resident's spouse first brought the wheelchair to the facility; however, the spouse requested she start buckling it. When asked if she could ask the resident to unbuckle the seat belt, the CNA stated she knew the resident could not, and did not want to ask her to do something she could not do. Interview, on 02/28/29 at 3:30 PM, with the Director of Nursing (DON), revealed she was aware the seat belt was being used on R31; however, she did not view the seat belt as a restraint. The DON confirmed there was not an assessment to indicate whether it was or was not a restraint, and there was no physician's order for the seatbelt. Interview on 02/28/19 at 4:06 PM, with the Administrator, revealed even though she was not aware the resident was being buckled in the chair, she did not consider the seat belt a restraint.	M 500		
M 710	45.24.3 Consultation Consultation. Each facility shall obtain the services of a licensed pharmacist who will be responsible for: 1. Establishing a system of records of receipt and disposition of all controlled drugs and to determine that drug records are in order and that an account of all controlled drugs are maintained and reconciled; 2. Provide drugs regimen review in the facility on each resident every thirty (30) days by a licensed pharmacist;	M 710		4/29/19

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M 710	Continued From page 18 3. Report any irregularities to the attending physician or nurse practitioner/physician assistant and the director or nursing; and 4. Records must reflect that the consultation pharmacist monthly report is acted upon. This Statute is not met as evidenced by: Level II Based on review of the facility's policy, interviews, and record reviews, the facility failed to ensure the Consultant Pharmacist identified and acted upon an irregularity related to an antipsychotic medication that was in use without adequate clinical indication. This failure effected one (1) of 29 sampled residents, Resident (R) 68. Findings include: Review of the facility's policy titled, "Medication Regimen Review and Psychotropic Medication Use," dated 01/08/18, revealed the purpose of the policy was each resident's medication regimen will be monitored and managed to promote highest resident function and well-being and is free from unnecessary drugs. The facility's policy revealed unnecessary drugs were defined by CMS (Center for Medicare/Medicaid Services) as any drug in any of the following ways: in excessive dose, for excessive duration, without adequate monitoring, without adequate indications for use and in the presence of adverse consequences. Further review of the policy revealed a psychotropic medication was defined by CMS as any drug that affects brain activities associated with mental processes and behavior including antipsychotics. The policy also specified the medication regimen of each resident would be reviewed by a licensed pharmacist, at least once a month; and the "Medication Regimen Review"	M 710	M710 1) On April 11, 2019, the Geodon for Resident (R) 68 was decreased by the attending physician and the resident will be monitored and documented for any changes. 2) All residents receiving an antipsychotic medication have the potential to be affected. The Consultant Pharmacist reviewed the drug regimen of each resident receiving an antipsychotic medication on March 29, 2019, and all irregularities were reported to the Director of Nurses on March 30, 2019, and to the Medical Director on March 30, 2019. The Medical Director acted upon all irregularities identified on March 30, 2019. No other residents were affected. 3) The Quality Assessment and Assurance (QAA) Committee reviewed the Medication Regimen Review and Psychotropic Medication Use policy on April 8, 2019, and approved the policy with no revisions. This policy includes the following guidance: Residents who use psychotropic medications will receive gradual dose reductions, unless clinically contraindicated, in an effort to discontinue use of these drugs: a. Within the first year in which a resident is admitted on a psychotropic drug or after the prescribing practitioner	

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M 710	Continued From page 19 (MRR) would include a review of the medical record to prevent, identify, report, and resolve medication-related problems, medication errors, or other irregularities. The policy revealed the pharmacist did not need to document a continuing irregularity in the report each month if the physician had documented a valid clinical rationale for rejecting the pharmacist's recommendation with the MRR communication form being provided to the physician and the Director of Nursing (DON) within 10 working days of the pharmacy review. The facility's policy indicated the physician would document the irregularity, or recommendation was reviewed and what action would be taken to address it; if there was no change to the medication, or the physician declined the recommendation, it would require a documented clinical rationale describing the reason a GDR was clinically contraindicated. Review of R68's "Face Sheet," revealed the facility admitted the resident on 02/17/17, with diagnoses which included other recurrent Depressive Disorders, other Cerebral Infarction, Hemiplegia affection left non-dominate side, Essential Tremor, Hyperlipidemia, Insomnia, Gastro-Esophageal Reflux Disease, and Dysphagia. Review of R68's "Physician Orders," dated February 2019, revealed the resident was ordered one (1) Geodon (an antipsychotic used to treat Schizophrenia and Bipolar disorder) 40 Milligram (MG) capsule to be administered PO (by mouth) at HS (hour of sleep) for agitation. The date of the original order was upon admission on 02/17/17. Review of R68's "Electronic Medication Administration Records (EMAR's)," dated	M 710	has initiated a psychotropic drug, the facility will attempt a gradual dose reduction (GDR) in two separate quarters (with at least one month between attempts). b. After the first year, a GDR will be attempted annually. All nurses and the Consultant Pharmacist will begin being in-serviced by Director of Nurses on April 12, 2019, until all nurses and the Consultant Pharmacist is in-serviced regarding the facility Medication Regimen Review and Psychotropic Medication Use policy. The in-services began on April 12, 2019, and will continue until all these staff members have received the in-service training. Other in-service dates include April 16-18, 2019, and April 23-25, 2019. 4) The Director of Nursing will conduct three random audits weekly over the next three months for residents receiving an antipsychotic medication to ensure the Consultant Pharmacist conducted a medication regimen review to identify any irregularity related to antipsychotic medication use per facility policy. These audits will begin on April 15, 2019, and the Director of Nurses will present these audits to the QAA Committee monthly until such time substantial compliance has been achieved as determined by the committee. The QAA Committee will make any recommendations and/or changes if needed to ensure compliance.	

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M 710	Continued From page 20 January 2019 and February 2019, revealed the resident received the medication Geodon 40 MG every day. Review of the "Medication Review Nurse-Physician Communication Form," dated 09/14/17, revealed the Consultant Pharmacist requested R68's Geodon 40 MG be reduced or D/C (discontinued) with the rational being no Gradual Dose Reductions (GDR's) had been attempted with the antipsychotic medication since admission. The communication form revealed the Psychiatric Physician initially responded to the GDR by reducing the dose to 20 MG; however, the medical director, who is the resident's attending physician increased the dose back to 40 MG the same day, documenting the clinical rationale as: "The resident's family insists no medication changes and no visits from the psychiatric physician." Review of the "Physician's Order Sheet," dated 09/14/17, revealed a verbal order from the Psychiatric Physician to decrease R68's Geodon 40 MG PO at HS to Geodon 20 MG po at HS. Continued review of the "Physician's Order Sheet," dated 09/14/17, revealed a verbal order from the Medical Director, who is R68's attending physician, to D/C (discontinue) the above change for R68's Geodon. The physician also documented the resident's family requested no psychiatrist visits and no medications be changed r/t (related to) past psychotic episodes. Review of R68's medical record revealed the resident's medication regimen was being reviewed monthly by a licensed Pharmacist; however, there was no documented evidence a licensed Pharmacist had identified the irregularity of the use of Geodon without adequate indication	M 710		

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M 710	Continued From page 21 since 09/14/17, and had not communicated the irregularity to the physician and the Director of Nursing (DON) after the 2017 GDR was declined. In an interview, on 02/28/19 at 9:15 AM, the Medical Director, who is R68's attending physician, stated he thought all anti-psychotics should be eliminated in nursing homes. Continued interview revealed the reason the R68 was ordered Geodon was because of behavioral issues. In an interview, on 02/28/29 at 12:25 PM, the facility's Consulting Pharmacist stated he was the pharmacist who requested the GDR on 09/14/17, of R68's Geodon. The Pharmacist made the GDR recommendation related to regulatory requirements. The Pharmacist stated he normally recommends a GDR of an antipsychotic every 90 days. The pharmacist further stated he had not recommended another GDR because of the physician's response that the resident's family did not want the resident's medication of Geodon changed. Interview, on 02/18/19 at 3:35 PM, with the DON, revealed she was aware no GDR had been completed and she was aware no further recommendations had been made by the Pharmacist since 09/14/17. The DON confirmed the reason that no further recommendations had been made was because R68's family did not want any of the resident's medications changed. During a subsequent interview on 02/28/19 at 3:55 PM, the Medical Director stated the dose of Geodon was increased back to the original dose in 2017, because an attempted GDR was met with great resistance from R68's family, due to recurrent behaviors in the past. The Medical	M 710		

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M 710	Continued From page 22 Director further stated it would have been reasonable for the Pharmacist to have flagged it for him to evaluate it again. Interview, on 02/28/19 at 4:06 PM, with the Administrator, revealed it was her expectation the facility would have assessed the resident and her medication regimen. The Administrator stated per the regulation, the Pharmacist should have reviewed the medication regimen and requested a GDR, even though the Medical Director had previously declined the dose reduction.	M 710		
M 715	45.24.4 Labeling of drugs Labeling of drugs. Each facility shall follow the Mississippi State Board of Pharmacy labeling requirements. This Statute is not met as evidenced by: Level II Based on observation, interview, and record review, the facility failed to remove expired medications from two (2) of the four (4) medication carts audited during the survey. Findings include: Review of the facility's policy dated 07/04/2018, titled, "South Central Regional Medical Center Disposal of Non-Controlled Medication," revealed the purpose of the policy was to provide guidelines for the disposal of non-controlled medications. The procedure was: medications would be properly disposed of when discontinued by the physician, and/or when the resident was discharged or deceased. The policy review	M 715	M715 1) On February 27, 2019, the expired medications were removed from the medication/treatment cart by the Treatment Nurse. 2) All residents have the potential to be affected. The Treatment Nurse conducted a 100% medication audit of all treatments in the treatment cart on February 27, 2019, to ensure no expired medications were present. 3) The Quality Assessment and Assurance (QAA) Committee reviewed the Administration and Charting of Medications policy on April 8, 2019, and revised to indicate the nurses responsibility for proper removal and disposal of expired medications.	4/29/19

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M 715	Continued From page 23 revealed expired medications were not addressed in the policy provided. Observation on 02/27/19 at 10:01 AM, with Licensed Practical Nurse (LPN) #1 present, at the East Unit treatment cart, revealed 23 prescription Baza Cream Sensicare, with expired dates, were available for use by the residents. The expiration dates were written on the top of the containers and ranged from 06/18/18 to 01/19/19 (all expired at the time of the survey). Continued observation revealed a Nutraderm patch that expired on 01/13/19. Observation on 02/27/19 at 10:35 AM, with LPN #1 present, at the West Unit treatment cart, revealed 12 expired Baza Cream Sensicare containers with expiration dates that ranged from 01/21/18 to 02/21/19. Interview with LPN #1 on 02/27/19 at 10:05 AM, revealed one (1) container of the Baza Cream Sensicare was in the East Unit treatment cart and belonged to a resident that passed away. LPN #1 revealed a container of Ammonia Nitrate was no longer being utilized, but remained on the cart. Continued interview with LPN #1, revealed she was not sure what the dates on top of the Baza Cream Sensicare indicated, but after she talked to the Pharmacist, she realized the dates were indeed the expiration dates of the medication. LPN #1 confirmed the Baza Cream Sensicare that was expired should be removed from the cart. LPN #1 stated that, ultimately, it was her responsibility to make sure medications that were expired or no longer in use were removed from the treatment carts. Interview with LPN #2 on 02/27/19 at 10:54 AM, revealed she was not aware that Baza Cream	M 715	The nursing staff will begin being in-serviced by Director of Nurses on April 12, 2019, until all nursing staff is in-serviced regarding the Administration and Charting of Medications policy, specifically proper removal and destruction of expired medications. The in-services began on April 12, 2019, and will continue until all these staff members have received the in-service training. Other in-service dates include April 16-18, 2019, and April 23-25, 2019. 4) The Treatment Nurse will conduct three random audits weekly over the next three months of the medication/treatment cart to monitor for expired medications. These audits will begin on April 15, 2019, and the Treatment Nurse will present these audits to the QAA Committee monthly until such time substantial compliance has been achieved as determined by the committee. The QAA Committee will make any recommendations and/or changes if needed to ensure compliance.	

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	34JC	A. BUILDING: _____ B. WING _____	02/28/2019

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M 715	Continued From page 24 Sensicare expired in 30 days after being made as a compound mixture. She revealed it was new for the Pharmacy to write the expiration date on top of the Baza Cream Sensicare containers. LPN #2 stated she did the audits on the medication rooms and medication carts, and LPN #1 did the audits on the treatment carts. Interview with the Director of Nursing (DON) on 02/27/19 at 10:44 AM, revealed if medications were expired they should be removed from the treatment carts. The DON revealed it was the responsibility of LPN #1 to ensure expired and discontinued medications were removed from the carts.	M 715		
M 915	45.31.9 Equipment and Utensil Construction Equipment and Utensil Construction. Equipment and utensils shall be constructed so as to be easily cleaned and shall be kept in good repair. This Statute is not met as evidenced by: Level II Based on review of the facility's policy, observations, and interviews, the facility failed to ensure proper cleaning of the ice machine in accordance with professional standards for service safety and prevention of infection. The deficient practice effected all of the residents on the east wing, who were served ice and water that was being dispensed from an unsanitary machine. Findings include: Review of the manufacturer's recommendations titled, "Maintenance and Cleaning	M 915	M915 1) The ice machine was taken out of service on February 25, 2019. A new ice machine was installed and put into service on April 8, 2019. 2) All residents have the potential to be affected. 3) The Quality Assessment and Assurance (QAA) Committee revised the policy for Ice Making and Dispensing on April 8, 2019. The Maintenance staff was in-serviced on April 15, 2019, by the Administrator regarding the policy, specifically maintaining proper infection control practices by following manufacturer s recommendations to	4/29/19

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M 915	Continued From page 25 Instruction-GEMD270A," undated, revealed the ice machine should have maintenance completed at least two (2) times per year which included taking the ice spout off the machine, washing and sanitizing it. Continued review revealed the water system should be thoroughly cleaned during the regular maintenance by running a manufacture recommended cleaning solution through the water system. Further review of the recommendations revealed the times and the procedures for maintenance and cleaning were given as guidelines but were not to be construed as absolute or invariable. Review of the facility's policy titled, "Infection Control Policy for Food Services Department," dated 06/14/18, revealed all iced used would be free from visible trash and sediment. The policy further specified the ice storage bin would be cleaned on a regular basis following the manufacturer's recommendation. Observation on the east wing, near the nurses' station, on 02/25/19 at 11:40 AM, revealed an ice and water dispenser used by the facility staff to deliver ice and water to the residents of the 100, 200, and 300 halls. Continued observation revealed a white and gray, crusty substance on and around the dispensing mechanism (where the ice and water come out of). Observation and interview, on 02/25/19 at 2:02 PM, with the facility's Registered Dietitian, confirmed there was white and gray, crusty sediment on and around the dispensing mechanism. The dietitian stated the ice machine was dirty, and the area where the water and ice were actually dispensed "was gray, white, and slimy."	M 915	remove the ice spout from the machine and to wash and sanitize it at least two (2) times per year. 4) The Infection Preventionist will inspect the ice machines monthly to ensure the machine is clean and free of obvious buildup of substances. These inspections will begin on April 15, 2019, and the Infection Preventionist will present these audits to the QAA Committee monthly until such time substantial compliance has been achieved as determined by the committee. The QAA Committee will make any recommendations and/or changes if needed to ensure compliance.	

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M 915	Continued From page 26 Observation and interview, on 02/25/19 at 2:12 PM, with the facility's Maintenance Employee revealed he was responsible for cleaning the ice and water machine. Continued observation revealed the Maintenance Employee took a white wash cloth and wiped the inside of the dispensing mechanism where the ice and water come out; when he removed the wash cloth, there was a black substance on the wash cloth. The maintenance employee stated he had never cleaned that part of the machine and did not realize it was dirty. Observation and interview on 02/25/19 at 2:22 PM, with the Infection Control Nurse, revealed the nurse stated the ice machine needed to be cleaned. She stated it was important the ice/water machine was cleaned due to infection control concerns such as mold. She further stated maintenance was to schedule cleaning and maintenance of the ice machine. Interview, on 02/28/19 at 4:25 PM, with the Administrator revealed it was her expectation maintenance would have cleaned the ice machine per manufacturers recommendations. The Administrator confirmed the importance of cleaning the ice machine to reduce infection control and food borne illness concerns.	M 915		

MSDH - Health Facilities Licensure and Certification

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	34JC	A. BUILDING: **01 - MAIN BUILDING 01** B. WING _____	**02/28/2019**

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M1245	45.41.1 Date of Construction & Life Safety... Date of Construction and Life Safety Code Compliance. 1. Buildings constructed after the effective date of these regulations shall comply with the edition of the Life Safety Code (NFPA 101) effective on the date of construction. 2. Buildings constructed prior to the effective date of these regulations shall comply with Chapter 13 of the Life Safety Code (NFPA 101), 1985 edition. This Statute is not met as evidenced by: Based on observation, the facility failed to properly maintain patient sleeping room doors as directed by NFPA 101 section 19.2.2.2.5. This deficiency affected 59 of the 119 residents in the facility on the day of survey. Findings include: On February 28, 2019 at 11:25 AM, observations revealed locked, blocked, and obstructed exit doors on the 400, 500 and 600 Halls of the facility. These three (3) exit doors did not release upon activation of the fire alarm system and created a dead end corridor on the 400, 500 and 600 Halls of the facility. Staff members were immediately placed and trained the door code on the three (3) exit doors of the facility.	M1245	M-1245 1) Once identified on February 28, 2019 at 11:25 a.m., a staff member was immediately placed at each set of exit doors on the 400, 500 and 600 halls of the facility. The staff members were trained regarding the door code and when to release the doors. These staff members also kept monitoring logs until exit doors were completely repaired at 2:04 p.m. that same day by third party contractors. 2) All residents have the potential to be affected by locked exit doors. 3) The Fire Drill Form was updated by the Administrator on March 6, 2019 with QAA approval on April 8, 2019, to include Did all exit doors work properly. The Fire Alarm or Sprinkler Systems Out of Service policy and procedure was also reviewed and updated on March 6, 2019, by the Administrator with QAA approval on April 8, 2019, to include guidance when any component of the fire alarm or sprinkler systems are out of service. All staff were in-serviced regarding fire drills and the addition of verifying that all exit doors work	4/29/19

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M1245	Continued From page 1	M1245	properly. The in-service will begin on April 12, 2019, and will continue until all staff have received the in-service training. All current staff will be in-serviced by April 29, 2019, and all new employees during the initial orientation process. 4) This corrective action will be monitored by the Maintenance Director or Maintenance Assistant, in the absence of the Director, who will provide fire drills quarterly on each shift per Life Safety Code K-712. Any issues identified will be immediately addressed by the Maintenance Director or Maintenance Assistant, in the absence of the Director, and the Fire Alarm or Sprinkler Systems Out of Service policy will be initiated. The deficiency and the corrective action was presented to the QAA Committee on April 8, 2019. The plan was reviewed and accepted by the QAA Committee.	