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
	36GR	A. BUILDING: _____ B. WING _____	C 01/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD HEALTH & REHAB CENTER	1301 BELK BOULEVARD OXFORD, MS 38655

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M 000	Initial Comments The State Agency (SA) conducted a complaint investigation (CI) for MS#19765 and MS#19950 at the facility from 01/09/23 to 01/10/23. During the survey, the SA determined that the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm for CI MS#19765 for resident abuse and cited M500. Based on the facility's implementation of corrective actions completed on 11/08/22, this was determined to be Past Non-Compliance. The SA found no deficient practice for CI MS#19950 related to assessment and notification. The facility had a census of 114 at the time of the survey, and held a license for 120 beds.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or	M 500		1/19/23

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M 500	Continued From page 1 nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 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;	M 500		

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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	M 500		

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M 500	Continued From page 3 with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and 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 Past Non-Compliance	M 500	No POC required due to past noncompliance.	

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Based on observation, interview, record review and facility policy review the facility failed to ensure that one (1) of five (5) residents were protected from physical abuse. Resident #2. Based on the facility's implementation of corrective actions taken on 11/08/22, this was determined to be Past Non-Compliance.

Findings Include:

Review of the facility's policy titled, "Abuse, Neglect, And Exploitation," revised date 10/10/2022, revealed, "This facility's policy is to protect each resident's health, welfare, and rights by developing and implementing written policies and procedures that prohibit abuse, neglect, exploitation, and misappropriation of resident property."

Record review revealed an investigation of alleged physical abuse conducted by the facility on 11/08/22 involving Certified Nursing Assistant (CNA) #1 and Resident #2. At approximately 9:30 AM on 11/08/22, CNA #1 and CNA #2 were in Resident #2's room changing her brief when Licensed Practical Nurse (LPN) #1, who was just inside the door to Room #B95, overheard what sounded like two pops. Immediately after hearing that, Resident #2 stated, "Ouch, don't hit me" and CNA #1 stated, "I didn't hit you, you hit me first." CNA #2 witnessed CNA #1 slap Resident #2 two times on her hand. LPN #1 checked on Resident #2, made sure that she was okay and then reported the incident to LPN #2. The incident was then reported immediately to the Administrator (ADM), the Director of Nursing (DON), Assistant Director of Nursing (ADON), and B-Unit Manager. CNA #1 was immediately pulled off the floor and interviewed. The B-Unit Manager completed a full body audit on Resident

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#2 and multiple x-rays were completed with no injuries found. The facility immediately began an investigation, reported the incident to the Local Police Department, the State Department of Health, and to the Attorney General's Office. CNA #1 was terminated. The Police Department arrived about five minutes after the alleged abuse was reported. CNA #1 admitted that she slapped Resident #2's hand while changing her. CNA #2 was interviewed and stated, "We were changing her, and we had her legs up and she slapped at (Resident's proper name). Resident slapped her hand and said, don't be hitting me." Resident #2 was interviewed, and she confirmed that CNA #1 had slapped her hand. CNA #1 was immediately terminated, and charges were filed against her for abuse and neglect of a vulnerable adult. Resident #2's son was notified. An immediate in-service was started with all staff on abuse and neglect and reporting of abuse and neglect. Resident's Care Plan was updated. An emergency Quality Assurance (QA) Meeting was held, and interviews were started immediately with residents and staff.

On 01/09/23 at 12:45 PM, an observation/interview with Resident #2 revealed that she could talk very little due to the recent use of an oxygen face mask on at 10 liters/minute continuously.

On 01/09/23 at 5:00 PM, an interview with the DON, revealed that Resident #2 has had a recent decline in her health and was now on hospice. She also revealed that Resident #2 was able to talk and answer questions some days and not able to on other days. The Administrator revealed that on 11/08/22, two CNAs were in Resident #2's room to change her brief and had the privacy curtain pulled. ADM revealed that LPN #1 was

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just inside the resident's room and heard the commotion. LPN #1 had reported that she had overheard the resident state, "Don't hit me again." This LPN also overheard CNA #1 reply with, "Well, you hit me first." CNA #2 was assisting with the care of the resident. The ADM revealed that LPN #1 reported this to LPN #2 and the incident was immediately reported to administrator, the police were called, the AG office was contacted and so was SA office. The Administrator revealed that the local police arrived about five minutes after they were called and interviewed CNA #1. CNA #1 confessed to them that she had slapped the resident's hand and CNA #1 was given a court date. CNA #1 was terminated at this time. The DON stated that they called the Resident's son and reported all of this to him. She also stated, "The resident could get a little feisty at times, but this did not justify her (CNA #1) actions."

On 01/09/23 at 5:30 PM, an interview with DON, revealed that she accompanied the local police department into the resident's room and that initially, resident denied any abuse. As the interview continued, Resident #2 stated that the aid with glasses and dark, wavy hair slapped her hand. Resident could not remember her name but stated that this aid was here all the time.

On 01/10/22 at 9:40 AM, a phone interview with CNA #2 revealed that on 11/08/22, she and CNA #1 were in Resident #2's room changing her brief. While CNA #1 was changing her brief, the resident slapped CNA #1 because she was being a little rough and was rushing to get through. CNA #2 witnessed CNA #1, pop Resident #2 on her hand twice and heard the resident say, "Ouch, that hurt, don't hit me again!" CNA #2 revealed that Resident #2 had no marks or red places on

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her hand where she was slapped. CNA #2 revealed that the resident was back to herself acting like nothing ever happened. CNA #2 revealed that this was reported immediately, investigated and that in-services on abuse, neglect was completed with all staff.

On 01/09/23 at 10:00 AM, the State Agency (SA) attempted to call CNA #1 with no answer and SA was unable to leave a voicemail. CNA #1 did not return any calls.

On 01/10/23 at 11:55 AM, a phone interview with LPN #1 revealed that she was standing just inside Resident #2's room when she heard some loud talking. She heard CNA #1 say, "Quit, be still, quit yelling, we gotta change you!" She then heard the resident say, "You're being too rough, you're hurting me." She also revealed that she heard what sounded like two slaps but did not see it. This LPN also revealed that Resident #2 was in her right mind at this time and that if someone would rush her or get rough with her, she would sometimes be loud. LPN #1 revealed that she stayed in the room until the CNAs had finished changing the resident and then she immediately reported this. She also revealed that CNA #1 was immediately pulled off the floor and was terminated later that same day.

On 01/10/23 at 1:30 PM, an interview with the Staff Educator revealed that she had been here for 22 years and that oversaw staff education. She revealed that the staff members receive training on Abuse/Neglect/Reporting Abuse upon hire, quarterly and anytime an incident in the facility occurred. She also revealed that upon hire and yearly, staff were required to watch videos on how to deal with residents in different scenarios and stated that it is one on one

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in-services and each staff member was required to sign that he/she attended.

Record review of "Investigation/Statement Form" dated 11/08/22 revealed the following statement written by accused CNA #1: "I know I don't post to hit a resident, but it was a reflex went she hit me and I am very sorry. I know I will get trouble for that." This statement was signed by CNA #1.

Record review of the acknowledgement of the "Abuse Policy" signed by CNA #1 on 3/2/20, revealed the following: "It is the policy of this nursing facility to prohibit abuse of any kind and all residents. Any employee who is guilty of any type of abuse: mental, verbal, physical, sexual, or any other, resulting from a full investigation will be discharged without notice and could face criminal and civil penalties for failure to exercise reasonable care."

Record review of the "Investigation/Statement Form" dated 11/08/22 revealed the following written statement completed by CNA #2 which stated, "I seen (CNA #1) hit (proper name) on her hand after (proper name) hit her. Form was signed by CNA #2.

Record review of CNA #1's Personnel Record revealed that a Criminal History Background Check had been completed prior to her employment and no violations found that would prevent her from working and she was hired on 03/02/22. Annual Employee Evaluation Forms had been completed on 03/19/21 and 03/09/22. This SA also observed in the personnel record no other write-ups or disciplinary actions were noted. The CNA License was observed with an expiration date of 07/31/23 and the CNA was terminated on 11/08/22 for Substantiated Abuse

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of a resident.

Record review of "Employee Final Exit Job Performance Record" Form on employee with date employment ended date of 11/08/2022 revealed reason as "Substantiated Abuse."

Record review of Resident #2's Face Sheet revealed that she was admitted to the facility on 06/06/2014 with the following diagnoses to include: Encounter for Attention to Colostomy, Dementia, Edema, Cellulitis, Cognitive Communication Deficit, Chronic Pain, Muscle Weakness, Lack of Coordination, Shortness of Breath, Major Depressive Disorder, and Generalized Anxiety. Record review of Resident #2's most recent Minimum Data Set (MDS) with an Assessment Reference date (ARD) of 12/27/22 revealed a Brief Interview for Mental Status (BIMS) Score of 11 indicating a moderately impaired cognitive status.

Record review revealed that on 11/08/22, the ADON conducted an interview with all residents on B-Hall who had been under the care of CNA #1 and no further issues were noted. CNA #1 was immediately terminated, and charges were filed against her for abuse and neglect of a vulnerable adult. The facility notified the Responsible party, the local police, the Attorney General, the State Agency and immediately began in-services regarding abuse and neglect until 100% of the staff had completed their in-services. Resident #2 was immediately assessed, and a body audit was completed. The Social Worker (SW) followed up with the resident for the next several weeks to ensure that she did not suffer any negative outcome, and none was evidenced by the SW visits with the resident one on one. An immediate in-service was started with

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M 500	Continued From page 10 all staff on abuse and neglect and reporting of abuse and neglect. Resident's Care Plan was updated. An emergency Quality Assurance (QA) Meeting was held, and interviews were started immediately with residents and staff. The SA feels that the facility completed all the requirements and cited abuse at past noncompliance.	M 500		