STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255217	A. BUILDING _____ B. WING _____	C 03/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER HEIGHTS HEALTHCARE CENTER	402 ARNOLD AVENUE GREENVILLE, MS 38701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted a complaint investigation (CI) MS# 20798 at the facility on 3/13/23. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid Services. The SA identified non-compliance and cited F604 for CI MS# 20798 for having the right to be free from physical restraints. The census at the time of the survey was 37 with a bed capacity of 60 beds.	F 000		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free	F 604		4/12/23

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

Electronically Signed | 03/27/2023

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F 604	Continued From page 1 from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, record review, and facility policy review, the facility failed to ensure a resident was free from restraints as evidenced by the placement of a hand mitt without proper assessment and a physician's order for one (1) of four (4) residents reviewed for restraints. Resident #1. Findings include: Review of the facility policy titled "Use of Restraints," with a revised date of December 2007, revealed, "Policy Statement: Restraints shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully. Restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience. ... 1. 'Physical Restraints' are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body. ... 3. Examples of devices that are/may be considered physical restraints include ... hand mitts ... 6. Prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to	F 604	1. The Director of Nursing, completed a Pre-restraining assessment and review for resident #1 on 2/20/2023, the assessment revealed the need for a restraint to prevent self-harm by resident #1. The Director of Nursing received a physician's order for the hand mitten with instructions on 2/21/2023. The facility obtained a consent to use the hand mitten by Resident #1s responsible party on 2/20/2023. The Director of Nursing services assessed resident #1 for injuries on 2/15/2023 resident #1 suffered no adverse effects from this deficient practice. 2. All resident have the potential to be effected by this deficient practice. 3. The Director of Nursing completed a 100% audit of residents on 2/16/2023, to see if any other resident had on a hand mitten to ensure all necessary restraint assessments, orders, and consents were in place. The audit/observation revealed that no other resident had on a hand mitten. The Director of Clinical services provided additional education to nursing staff on the facility policy and procedure	

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F 604	Continued From page 2 determine the need for restraints. The assessment shall be used to determine possible underlying causes of the problematic medical symptom and to determine if the are less restrictive interventions (programs, devices, referrals, etc.) that may improve the symptoms. ... 9. Restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and /or representative. ... Documentation: The following information should be recorded in the resident's medical record: 1. The date and time the restraint was applied; 2. The name and title of the individual(s) who applied the restraint; 3. The type of physical restraint applied; 4. The specific reason the restraint was applied..." Review of the facility policy titled "Physical Restraint Application," with a revision date of October 2010, revealed, "Purpose: The purpose of this procedure is to provide safety or postural support of a resident to prevent injury to the resident or others when the resident has medical symptoms that warrant the use of restraints. ... Preparation 1. Verify physician's order for the use of restraints..." An observation during the initial facility tour on 3/13/23 at 09:30 AM, revealed Resident #1 to have a mitten on her right hand as a restraint. Resident #1 was observed to not be using her left hand and it appeared to be contracted. An interview on 3/13/23 at 09:00 AM, with the Administrator he confirmed a hand mitten was placed on Resident #1 as a restraint, without an order. He also revealed that the nursing facility staff should not have placed the hand mitten on Resident #1 without a proper assessment for	F 604	for the use of restraints on 2/16/2023. 4. Beginning on 2/16/2023 the Director of Nursing Services began monitoring facility residents for a period of 14 days to ensure no resident had hand mittens applied without an assessment and written physicians order. Beginning on 3/20/2023 the Director of Nursing will begin observing all residents 3 times per week for 4 weeks and then 1 time a week for 3 weeks to ensure that no resident has hand mittens applied without an assessment and physician's order. Any adverse events in regards to restraints will be presented to the Quality Assurance Committee on 4/11/2023 for review and revisions as needed and then there after for a period of 3 months or until issue is revised or resolved.	

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documentation to show the medical or safety need for the restraint, that there was a possibility that the nursing staff placed the hand mitten on Resident #1 for convenience, and that Resident #1 had the right to be free from restraint.

Record review of the nurse notes revealed there was no documentation regarding the mitten/restraint being placed on Resident #1 by any of the nursing staff on or before 2/15/23.

Record review of the physician's orders in the medical record for Resident #1 revealed there was not an order for any form of restraint before 2/16/23.

An interview on 3/13/23 at 02:56 PM, with Certified Nurse Assistant (CNA) #1, revealed she was not aware of who put the mitten on Resident #1 as a restraint and did not know how long she had been wearing it. She revealed Resident #1 was wearing the hand mitten on 2/15/23.

A telephone interview on 3/13/23 at 03:19 PM, with the Director of Clinical Services, revealed she made rounds in the nursing facility on 2/15/23 and observed Resident #1 was wearing a mitten and did not see an order for that restraint. She noted Social Services rounded with her and observed the mitten on Resident #1's hand. She noted she immediately went to get the Director of Nursing (DON) to inform her of the improper use of restraints by the nursing staff.

An interview on 3/13/23 at 03:37 PM, with CNA #2, revealed she was the one who removed mitten from Resident #1's hand on 2/15/23, but did not know who put it on her or how long she had been wearing it.

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A telephone interview on 3/13/23 at 03:44 PM, with Licensed Practical Nurse (LPN) #1, revealed she was not aware of who put the mitten on Resident #1, was aware she was wearing a hand mitten, did not know how long it had be placed on Resident #1, and she did not check to see if there was an order for the restraint.

An interview on 3/13/23 at 04:05 PM, with Social Services revealed she rounded with the Director of Clinical Services and observed Resident #1 had a mitten on her right hand on 2/15/23. She revealed she was not sure who ordered it or placed it on Resident #1 to stop her from scratching herself and digging in her feces.

An interview on 3/13/23 at 05:05 PM, with the DON, confirmed Resident #1 did have a mitten on her right hand as a restraint to stop her from scratching herself, playing in her feces, and there was not a physician's order in the medical record. She revealed the use of the hand mitten was brought to her attention, by the Director of Clinical Services on 2/15/23. She noted there was no nursing documentation regarding who placed the mitten on Resident #1's right hand and why it was placed, nor was there a physician's order in the medical record for any form of restraint for Resident #1. She revealed that a physician's order was obtained on 2/16/23 for the mitten to be placed on Resident #1's right hand. She revealed she was not aware of the mitten that had been placed on Resident #1 as a restraint until 2/15/23 and did not know who had placed it on her. The DON revealed there had not been a pre-restraining assessment review done to determine the need for restraints and that no other alternative measure had been tried to assist

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to deter Resident #1 from scratching and mutilating herself, to deter her from pulling at the Percutaneous Endoscopic Gastrostomy (PEG) tube, or to deter her from digging in her feces. She confirmed that the hand mitten that was placed on Resident #1 was improper use of a restraint, and there should have been a physician's order for the mitten with instructions for care. She confirmed the nursing facility staff should not have placed the hand mitten on Resident #1 without a proper pre-restraining assessment for documentation to show the medical or safety need for a restraint, that the hand mitten should not have been placed on Resident #1 before alternative measures had been attempted to deter the behaviors, that there was a possibility that the nursing staff placed the hand mitten on Resident #1 for convenience, and that Resident #1 had the right to be free from restraint.

Record review of the "Departmental Notes," for Resident #1, revealed " ... 2/17/2023 6:22 PM ... On 2/15/2023 Director of Clinical Services came and got DON and we both went to resident's room ... No noted injury. This nurse found CNA and explained to her that this was considered a form of restraint ... to remove ... mitten. This nurse instructed charge nurse to call the Family Nurse Practitioner (FNP) and get an order for ... mitten..."

Record review of the "Physician Order List," for Resident #1 revealed " ... ORDER DATE: 2/16/2023; START DATE: 2/16/2023 ... STRESS RELIEVE ALL BOTH HANDS DX (diagnosis) DEMENTIA WITH MOOD BEHAVIOR DISTURBANCE ... ORDER DATE: 2/16/2023; START DATE: 2/16/2023; Discontinued

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F 604	Continued From page 6 2/16/2023 ... HAND MITTENS TO PREVENT DISLODGEMENT OF PEG TUBE R/T TO ENCOUNTER FOR GASTROSTOMY." Record review of the "Statement of Witness-Confidential," completed by the DON, dated 2/16/23 revealed " ... I ... went and found CNA & told her that resident could not have ... & take mitten off because that was considered a restraint. ... I spoke with (CNA #2) about removing mitten and she did." Record review of the Face Sheet for Resident #1 revealed an admission date of 10/15/21, with diagnoses of Acute Cerebrovascular Insufficiency, Non-suicidal self-harm, Other Lack of Coordination, Alzheimer's Disease with Early Onset, Altered Mental Status, Unspecified, Encounter for Attention to Gastrostomy, and Schizophrenia, Unspecified, and Dysphagia, Oropharyngeal Phase. Record review of Section C of the Quarterly Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 1/9/2023, for Resident #1, revealed a Brief Interview for Mental Status (BIMS) of 00, indicating Resident #1 is severely cognitively impaired.	F 604		