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
	76ME	A. BUILDING: _____ B. WING _____	C 03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MS CARE CENTER OF GREENVILLE	1221 EAST UNION STREET GREENVILLE, MS 38703

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M 000	Initial Comments The State Agency (SA) conducted complaint investigations (CI) MS #20747 and CI MS #20894 at the facility from 3/28/23 through 3/30/23. The SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements at M for MS #20747 for Resident Rights and cited M500. No deficiencies were cited for CI MS #20894. The facility is licensed for 90 of beds and at the time of the survey the census was 74.	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	M 500		5/12/23

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M 500	Continued From page 1	M 500		

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;

6. may manage his personal financial affairs, or is

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M 500	Continued From page 2	M 500		

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 residents or individuals within or outside of the

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M 500	Continued From page 3 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 . Based on facility policy review, resident interview, staff interviews, and record reviews, the facility	M 500	1.RN Supervisor apologized to Resident #1 and was inserviced on 4/13/23 on Resident Rights and Dignity by Staff Development.	

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M 500	Continued From page 4 failed to respect a resident's rights, as evidenced by a staff member calling a resident "boy" for one (1) of six (6) residents reviewed. Resident #1 Findings include: Review of facility policy titled, "Resident Rights Policy/F550 Resident Rights/Exercise of Rights," with a revised date of 9/2022, revealed "Facility will ensure the resident has the right to a dignified existence... Facility will treat each resident with respect and dignity... The facility will protect and promote the rights of each resident..." An interview with the Ombudsman on 3/28/23 at 08:30 AM, revealed she had been involved with Resident #1 regarding his complaint of being called a "boy" by the Registered Nurse (RN) Supervisor on 2/10/23 and she noted that Resident #1 was very upset by the incident. An observation and interview on 3/28/23 at 06:50 PM, with Resident #1 revealed he was called a "boy" by the RN Supervisor on 2/10/23. Residents #1 revealed he was getting off the second (2nd) floor elevator when the RN Supervisor asked him "Where you going boy?" Resident #1 noted he heard the RN Supervisor but did not respond. Resident #1 then revealed the RN Supervisor expressed "You're on the wrong floor aren't you boy?" Resident #1 stated that he responded after being called a boy the second time and cursed the RN Supervisor. He informed the RN Supervisor that he was a grown man and should be called Mr. or Sir. Resident #1 revealed he was very upset from being called a boy and did not feel as he was being respected by the RN Supervisor.	M 500	2.All residents who want to be addressed with a title of their choice have the potential to be affected. 3 a Resident Rights policy was reviewed by Administrator with Social Services Designee on 3/31/23 and no revisions were necessary. b The care plans have been updated by careplan nurse on 4/14/23 to reflect how the facility staff will address each resident by name with dignity and respect to protect and promote their rights. c Inservice on Residents Rights was done for all employees by Staff Development beginning on 4/10/23. d. Employees who are witnessed to fail to use Resident's choice names will receive discipline and be reinserviced immediately as appropriate by the Supervisor and Administrator. 4.Beginning on 4/13/23, the Respect and Dignity Name Audit will be done by interviewing ten (10) residents weekly for eight (8) weeks, then quarterly by the DON and/or designee to ensure Resident choice is being honored. Audit findings of employees using resident choice names will be reported by the Director of Nursing to the Quality Assurance Committee monthly on 5/11/23 for three months then quarterly to ensure continued compliance.	

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M 500	Continued From page 5 An interview on 3/28/23 at 07:45 PM, with Social Services revealed she spoke with Resident #1 on 2/10/23 regarding the incident where the RN Supervisor called him a boy. She noted Resident #1 was noticeably upset and cursed often in his description of the incident. Social Services revealed Resident #1 was still upset about the incident on 2/12/23, as he continually expressed his feelings about it, and how it bothered him. An interview on 3/28/23 at 07:52 PM, with the RN Supervisor, confirmed he did call Resident #1 a "boy" on 2/10/23. He noted he patted Resident #1 on the shoulder and he said, "You are on the wrong floor boy." He confirmed that Resident #1 became furious with him but could not remember everything Resident #1 said. He stated he did remember him expressing that he was a grown man and should not be called a boy. He also revealed that when Resident #1 became as mad as he did, he realized what he had done by calling Resident #1 a "boy". He expressed that he had addressed Resident #1 incorrectly and should have called him Mr. An interview on 3/29/23 at 05:40 PM, with the Director of Nursing (DON) revealed that the RN Supervisor did report that he called Resident #1 a "boy" on 2/10/23 and confirmed that the RN Supervisor should have treated Resident #1 with dignity and respect by addressing him as Mr. or Sir. An interview on 3/29/23 at 06:35 PM, with the Former Administrator in Training (AIT) ,that was working at the facility during the time of the incident revealed that she did not feel that Resident #1's Resident Rights were violated because the RN Supervisor did not mean anything by calling Resident #1 a boy. She	M 500		

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M 500	Continued From page 6 revealed it was done in a playful manner and was not intended to violate Resident #1. A telephone interview on 3/30/23 at 11:41 AM, with the Former Interim Administrator, that was working at the facility during the time of the incident confirmed that Resident #1's Resident Rights were violated by the RN Supervisor by calling Resident #1 a "boy" and not Mr. or Sir on 2/10/23. Record review of the Face Sheet for Resident #1 revealed an admission date of 12/1/21 and diagnoses that included Acquired Absence of Limb, Unspecified, and Unspecified Sequelae of Cerebral Infarction. Record review of Section C of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/8/2023, for Resident #1 revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating Resident #1 is cognitively intact.	M 500		