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
	300S	A. BUILDING: _____ B. WING _____	C 04/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OCEAN SPRINGS HEALTH & REHABILITATION CENTI	1199 OCEAN SPRINGS ROAD OCEAN SPRINGS, MS 39564

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M 000	Initial Comments The State Agency (SA) conducted Compliant Investigations (CI) at the facility for three (3) complaints, CI MS #20710, CI MS #20797, and CI MS #21326 from 4/17/23 through 4/19/23. During the survey the SA investigated MS #20710 for verbal abuse and MS #21326 for water not being offered, resident assessment, and medications given per physician orders. There were no deficiencies cited related to these complaints. The SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirement related to CI MS #20797 for verbal abuse and cited M500.	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		5/13/23

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M 500	Continued From page 1	M 500		

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;

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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	M 500	* On 2/18/23, a skin observation was completed by Director of Nursing on	

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M 500	Continued From page 4 Based on interviews, record review, and facility policy review the facility failed to ensure residents were free from abuse for one (1) of four (4) sampled residents. Resident #1 Findings include: A review of the facility's policy, "Abuse, Neglect, Exploitation & Misappropriation", revised 11/16/22, revealed " ...Policy: It is inherent in the nature and dignity of each resident at the center that he/she be afforded basic human rights, including the right to be free from abuse, neglect, mistreatment ...Employees of the center are charged with a continuing obligation to treat residents so they are free from abuse, neglect, mistreatment ...No employee may at any time commit an act of physical, psychological, or emotional abuse ..." A record review of the facility's "Verification of Investigation" revealed, " ...On 2/18/23 at approximately 4:45 pm, (Proper Name of Resident #1) was upset, wanting a cup of coffee. He approached (Proper Name of Registered Nurse [RN] #1) yelling and asking why he couldn't get a cup of coffee ...(Proper Name of Certified Nurse Aide [CNA] #1) was walking by and approached them and began to talk with them ... (Proper Name of RN #1) while in the dining room heard yelling, went to the lobby area to see (Proper Name of Resident #1) and (Proper Name of CNA #1) exchanging words with each other ...Before (Proper Name of RN #1) could reach them, (Proper Name of CNA #1) and (Proper Name of Resident #1) both had a hold of his cane, neither wanting to let go of it ...(Proper Name of CNA #1) stated ..., "he tried to hit me, he tried to hit me and lost it" ...He tried to hit me with his cane and I tried to take it from him ..."	M 500	Resident #1 with no adverse findings noted. On 2/19/23, Resident #1 was evaluated by Psychiatric Nurse Practitioner for any potential psychosocial needs. The Director of Nursing suspended Proper Name of CNA #1 immediately, pending investigation on 2/18/23 and subsequently discharged Proper Name of CNA #1 from employment on 2/24/23. On 2/18/23, Registered Nurse Supervisor completed interviews of residents with a Brief Interview for Mental Status of 12 or greater with no negative findings noted. The Director of Nursing reported allegation of abuse for Resident #1 to State Agency on 2/18/23 at 9:58pm. *All residents have the potential to be affected by stated deficient practice. Registered Nurse Supervisor to complete three resident interviews to determine if any abuse and/or neglect has occurred weekly for three weeks, then monthly x three months starting on 4/24/23. *Initial in-service on Prevention of Abuse and Neglect was initiated on 2/18/23 by the Director of Nursing and completed on 2/24/23. Additional all staff in-service on Prevention of Abuse and Neglect and Strategies for Dealing with Challenging Behaviors began on 4/21/23 by Registered Nurse Educator and was completed on 5/1/23. * Registered Nurse Supervisor to complete three resident interviews to determine if any abuse and/or neglect has occurred weekly for three weeks, then monthly x three months starting on	

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M 500	Continued From page 5 A record review of the handwritten statement signed by RN #1, dated 2/18/23, revealed, " ...I then heard arguing when I got to the lobby the resident and (Proper Name of CNA #1) were arguing ...Next thing I knew, before I could get to them they both had their hands on his cane neither wanting to let go. (Proper Name of CNA #1) lifted him (Resident #1) off the bench with the cane and pulled him across the hallway to doorway of bathroom. I called the police immediately ..." Record review of a handwritten statement dated 2/18/23 from Resident #1 and taken by the Director of Nursing (DON) revealed, " ...Before dinner time, I went to the kitchen and asked for a cup of coffee. The kitchen staff told me they couldn't give any and that they weren't allowed to unless there was staff in the dining room. I got upset and did yell at them. There were 5 people in the dining room with coffee cups in front of them so I don't know why I couldn't have any coffee ...I spoke to a nurse and a CNA that said they would get me some. Then this lady approached me in the lobby, she was a CNA. She told me my mother was a whore. We did have words back and forth. I raised my cane in front of my face and she grabbed it. I wasn't letting go of it. Its my cane. We tussled with the cane across to the other side of the hall. She let go and I got it back. I did tell her "don't' disrespect me, I'm 62 years old" ...She went outside, then the policeman came and talked to me. She didn't hurt me or anything. She just disrespected me ..." On 4/17/23 at 7:49 AM, an interview with RN #1 revealed that on 2/18/23 at 5:06 PM, Resident #1 was upset initially because the kitchen staff would	M 500	4/24/23. Findings will be brought to the Quality Assurance Performance Improvement meeting by Administrator on 5/12/23 and and will be continued monthly for three months to determine effectiveness and make necessary changes as indicated.	

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not provide him with coffee. RN #1 stated she immediately went and got him a cup of coffee and he seemed to calm down. She said she then heard CNA #1 tell Resident #1, "The kitchen does not work for you" and they started arguing with each other. CNA #1 grabbed the resident's cane, and they began struggling over it. RN #1 explained that she brought Resident #1 into the dining room to calm him down. She said she then called 911 because she was scared and it bothered her, and she also notified the DON.

On 4/17/23 at 8:15 AM, an interview with the Director of Nursing (DON) revealed she was aware of the event that occurred on 2/18/23 regarding Resident #1 and CNA #1. She explained that CNA #1 was immediately suspended, pending the investigation. Following the investigation, the CNA was subsequently terminated from employment on 2/24/23 for violation of the facility policy regarding unprofessional conduct. The DON stated that she expected the staff in the facility to not get in any type of verbal altercation with a resident.

On 4/17/23 at 10:08 AM, an interview with RN #2 confirmed that on 2/18/23, she heard CNA #1 and Resident #1 yelling at each other. She explained that Resident #1 was using racial slurs, and CNA #1 yelled at him. She said the incident lasted almost 15 minutes. When the police arrived at the facility, then the resident and CNA #1 calmed down and CNA #1 clocked out.

On 4/18/23 at 12:00 PM, an interview with the Administrator revealed that it was her expectation for staff at the facility not to get into any type of verbal altercation with any resident. She stated it is the facility policy to treat all residents with respect and dignity and that Resident #1 may

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M 500	Continued From page 7 have insulted CNA #1, but staff should not engage in any type of verbal altercation with residents. The Administrator advised that she was notified following the incident, and CNA #1 was immediately suspended pending investigation and was terminated. Record review of the "Admission Record" revealed Resident #1 was admitted by the facility on 1/31/22 and had diagnoses including Type 2 Diabetes Mellitus without Complications and Bipolar Disorder. Record review of the facility's " ...BIMS (Brief Interview for Mental Status) " document, dated 4/6/23, revealed Resident #1 was cognitively intact.	M 500		