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
	46FM	A. BUILDING: _____ B. WING _____	C 06/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLUMBIA REHABILITATION AND HEALTHCARE CEI	1506 NORTH MAIN STREET COLUMBIA, MS 39429

(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) conducted a Complaint Investigation (CI), at the facility on 6/16/23, for one (1) complaint, MS #21746. During the survey, the SA determined the facility was not in compliance with the Mississippi Regulations for Minimum Standards for Institutions for the Aged or Infirm. The SA investigated MS #21746 for Quality of Care related to staffing and incontinence care, Resident Abuse and Resident Rights related to dignity, 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 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		8/7/23

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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

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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

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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 observations, interviews, record review, and facility document review, the facility failed to protect the right of each resident to be treated	M 500	Preparation and submission of this plan of correction by The Columbia Rehabilitation and Healthcare Center does not constitute and admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set	

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M 500	Continued From page 4 with respect and dignity for one (1) resident of four (4) sampled residents, Resident #1. Findings include: Record review of the facility document titled "Statement of Resident Rights," (undated) revealed, "You ...the resident, do not give up any rights when you enter a nursing facility. The facility must encourage and assist you to fully exercise your rights ...If anyone ...violates your dignity, you have the right to file a complaint ...You have a right to ...be treated with courtesy, consideration, and respect ..." On 6/16/23 at 11:10 AM, during an interview with the Administrator, he stated that a copy of "Statement of Resident Rights" was included in all admission packets and provided to each resident admitted by the facility. Record review of the facility's investigation dated 6/02/23, revealed an interview with Resident #1 by the Administrator in which Resident #1 stated that CNA #1 had been "disrespectful" during care and "had a tone and attitude that was unnecessary". The facility's investigation concluded that CNA #1 "will not return to facility due to customer service." Record review of the Daily Staffing Sheet for "B Wing" dated 6/02/23, revealed that on the date of the incident, CNA #1 was assigned to seven (7) rooms, including that of Resident #1 for the 7AM-7PM shift. The sheet also documented the removal/replacement of CNA #1 with the "Shower Team" CNA. Record review of the Timeclock Record for CNA #1 for 5/25/23 through 6/07/23, revealed she	M 500	forth on the statement of deficiencies. The plan of correction is prepared and submitted solely pursuant to the requirement under the state and federal laws. 1. On 6/02/2023 at approximately 10 AM Resident #1 voiced a complaint against Certified Nursing Assistant (CNA) #1 alleging that CNA #1 had acted with rudeness and discourtesy. Resident#1 was protected by the immediate removal of CNA #1 from the work area and suspended her pending investigation. Life satisfaction rounds for all other residents with a Brief Interview for Mental Status (BIMS) of 13 or higher in the care of CNA #1 were interviewed for complaints of rudeness and or discourtesy on 6/02/2023. No complaints were voiced. 2. All residents are at risk for the deficient practice. 3. All staff were in-serviced on Resident Right's, Customer Service, and The Vulnerable Adult Act on 6/02/2023 by Risk Manager. Also a mandatory staff meeting was held on 6/21/2023 at 1:30 PM, presented by Administrator. Topics included: The Vulnerable Adult Act, Customer Service, and the Residents Rights. CNA #1 was terminated 6/08/2023. Along with the education piece to prevent reoccurrence, Nexion Neighbor Rounds conducted daily, will be modified to include: Resident's feedback on Customer Service and courtesy beginning 6/07/2023. 4. The facility will monitor the progress of	

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M 500	Continued From page 5 clocked in at 6:40 AM on 6/02/23, and clocked out at 10:36 AM. Record review of the Admission Record for Resident #1 revealed they were admitted by the facility on 5/19/23 and had diagnoses of Malignant Neoplasm of the Breast (Left Breast Cancer), Atrial Fibrillation and End State Renal Disease. Record review of the Admission Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 5/26/23, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated no cognitive impairment. Further MDS review revealed that Resident #1 required limited assistance of one-person physical assistance for surface-to-surface transfers and extensive assistance of one-person physical assistance for toilet use and personal hygiene. On 6/16/23 at 10:11 AM, a telephone interview with the facility Ombudsman revealed that she had been made aware of a grievance voiced by Resident #1 regarding "disrespectful treatment by a CNA." On 6/16/23 at 10:51 AM, during a telephone interview, CNA #1 discussed the care she provided for Resident #1 on 6/02/23 and denied any disrespect or resident rights violations. She confirmed she was asked to report to the front office on 6/02/23, "a little after 10:00 AM". She stated she was notified of a complaint regarding her and she was asked to write a statement regarding the interaction between herself and Resident #1, that took place on 6/02/23. She confirmed that she was asked to leave the premises. She confirmed she was not scheduled	M 500	the monitoring modifications by bringing the results of the Nexion Neighbor Rounds to daily Stand Up Meetings beginning 7/03/23 and ongoing, to discuss any findings. All results will be taken to Quality Assurance/ Quality Assurance and Performance Improvement, (QA/QAPI), for four weeks with the completion date of 8/07/2023. A final QA/QAPI meeting will be held on 8/07/2023 to review progress and conclude our monitoring process. 5. Corrective action will be completed by: 8/07/2023.	

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to return and that she had been notified by the Director of Nurses (DON) that her employment at the facility had been terminated.

On 6/16/23 at 11:20 AM, during an interview with Resident #1, she stated that she recalled the morning of 6/02/23 when CNA #1 was assigned to her care. She stated that CNA #1 "was really rude." Resident #1 stated that she had an episode of diarrhea on the morning of 6/02/23 and engaged her call light for assistance. She stated that CNA #1 was rude when she offered the option of wearing an incontinence brief and stated, "I did not have a problem wearing a diaper (incontinent brief), but the CNA was bossy and rude and told me that she did not intend to keep coming in here to change me." She confirmed that after CNA #1 cleaned her and her wheelchair, she cleaned the bedside commode, and when trying to replace the bucket beneath the seat the CNA "shoved the potty against the wall and tossed the bucket on the floor." Resident #1 stated she had then gone to therapy, where she reported the "rude behavior" to the therapists. She stated that CNA #1 "needs compassion." She reported, "She wasn't abusive toward me." She stated that CNA #1's attitude had caused her concern and stated, "I thought I should report it because I didn't want her taking care of me again. I didn't want her in my room again. I was concerned about how she might be if she got worse."

On 6/16/23 at 12:20 PM, an interview with the Rehabilitation Technician, she revealed that she recalled that she had gone to assist Resident #1 to the therapy department on the morning of 6/02/23 and that Resident #1 had reported to her that CNA #1 had been "rude" during care the same morning. She stated that she had

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immediately taken Resident #1 to the Rehabilitation Director and asked Resident #1 to repeat her concern.

On 6/16/23 at 12:30 PM, an interview with the Rehabilitation Director revealed that she recalled that on the morning of 6/02/23, the Rehabilitation Technician had brought Resident #1 to her, and that Resident #1 had reported an incident during care provided by CNA #1. She stated, "I immediately called the Registered Nurse (RN) Supervisor, and she came to therapy and she (Resident #1) reported what had happened to the RN Supervisor." She stated that she recalled Resident #1 saying that CNA #1 "had been rude and had slammed the potty chair against the wall". She stated that Resident #1 required one-person physical assistance to stand, for surface-to-surface transfers and for other activities of daily living (ADLs), but that she was also able to participate in ADLs.

On 6/16/23 at 12:45 PM, an interview with the RN Supervisor revealed that she recalled that she had supervised "B Hall" on 6/02/23. She stated she became aware of the report by Resident #1 "between 9:30 AM and 10:00 AM," when the Rehabilitation Director summoned her to the Therapy Department. She stated that Resident #1 described the behavior of CNA #1 as "rude" and had "forcefully pushed the bedside potty against the wall" and that she (RN Supervisor) had immediately notified the Risk Manager, Social Worker, and the Staff Development Nurse, because the Administrator and the Director of Nurses (DON) were unavailable at the time.

On 6/16/23 at 1:00 PM, an interview with the Risk Manager revealed she had been made aware of the incident on 6/02/23 at approximately 9:30 AM,

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M 500	Continued From page 8 by verbal report from the RN Supervisor. She said she immediately assessed and interviewed Resident #1 and was told that CNA #1 had been "rude" and had "tossed the bedside commode pot on the floor out of frustration." She stated she spoke with the Staff Development Nurse shortly after speaking with Resident #1 and made sure that CNA #1 had been removed from the facility to ensure the safety of the residents. She confirmed she had conducted "Life Satisfaction Rounds with residents on B Hall with BIMS of 12 or higher," with no complaints noted. She stated she had conducted "Peer Review" interviews with staff who had worked with CNA #1 and there were no concerns reported. She confirmed that she had reviewed the personnel file for CNA #1 and there were no disciplinary reports in CNA #1's personnel file. On 6/16/23 at 1:20 PM, an interview with the Social Worker revealed she had been made aware of the incident on 6/02/23 "around 9:30 AM" by verbal report from the RN Supervisor and had conducted an interview with Resident #1 who reported that CNA #1 had been "gruff with her" during care that morning. The Social Worker stated that the resident preferred that CNA #1 not provide care for her anymore and said that CNA #1 made her feel "uncomfortable." On 6/16/23 at 1:50 PM, an interview with the Staff Development Nurse revealed she had been made aware of the incident on 6/02/23 at approximately 9:30 AM by verbal report from the RN Supervisor and had immediately summoned CNA #1 to her office and at 10:18 AM on 5/02/23, conducted an interview with CNA #1, obtained a written statement, and notified the CNA that she was suspended pending investigation and needed to leave the premises.	M 500		

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M 500	Continued From page 9 On 6/16/23 at 2:10 PM, an interview with Licensed Practical Nurse (LPN) #1 revealed he stated he recalled being assigned as the primary care nurse for residents "on the 200 Hall", which included Resident #1, on 6/02/23. He stated that he was made aware of the incident on at approximately 10:30 AM on 6/02/23, by the facility Risk Manager. He confirmed that the facility provided mandatory in-service training on Resident Rights on 6/02/23. On 6/16/23 at 4:00 PM, an interview with the Director of Nurses (DON) revealed she was made aware of the incident on 6/02/23 "shortly after 9:30 AM." She stated that she was familiar with Resident #1 and her care. She stated that Resident #1 had not displayed any behavior of making false accusations. She stated that she considered Resident #1 a reliable witness. She stated that following completion of the Facility Investigation, CNA #1 was issued a notice of termination due to "Unsatisfactory Performance." She stated that Resident #1 had alleged that CNA #1 was "rude" and "made her uncomfortable" and that was not in line with facility standards or Resident Rights. She stated that the facility conducted a mandatory in-service for all staff, including contract staff, on Resident Rights on 6/02/23 and that no staff were allowed to provide care without completion of the in-service. On 6/16/23 at 4:15 PM an interview with CNA #2 revealed that she confirmed that the facility provided mandatory In-Service training on Resident Rights on 6/02/23. She stated that the facility provided In-Service training on Resident Rights monthly and as needed. Regarding Resident Rights, she stated that she had received training from the facility that residents were to be	M 500		

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M 500	Continued From page 10 "treated with courteously and respect" at all times. On 6/16/23 at 4:25 PM, an interview with CNA #3 revealed that she confirmed that the facility provided mandatory In-Service training on Resident Rights on 6/02/23. She stated that the facility provided In-Service training on Resident Rights monthly and as needed. Regarding Resident Rights, she stated that she had received training from the facility that residents were to be "treated with courteously and respect" at all times. She confirmed that the facility provided mandatory In-Service training on Resident Rights on 6/02/23. On 6/16/23 at 4:50 PM, an interview with the Administrator revealed he had been made aware of the incident on 6/02/23, between 9:30 AM and 10:00 AM. He stated that he was the Abuse Prevention Officer at the facility and had interviewed Resident #1 on 6/02/23, and that the resident denied abuse but reported that CNA #1 was "rude," and he confirmed that the resident said CNA #1 had made her uncomfortable. He stated that Resident #1 stated she felt safe at the facility but did not want CNA #1 to provide care for her anymore. He confirmed that CNA #1 had been suspended on 6/02/23 and terminated on 6/03/23 and had not worked at the facility following the report of Resident #1. He confirmed the complaint was reported to State Agency (SA) and other appropriate agencies on 6/02/23, with conclusion of the Facility Investigation reported on 6/04/23, in accordance with reporting requirements. He stated that the facility conducted a mandatory In-Service for all staff, including contract staff, on Resident Rights on 6/02/23, and that no staff were allowed to provide care without completion of the in-service. He confirmed that the facility Quality Assurance and	M 500		

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M 500	Continued From page 11 Performance Improvement (QAPI) Committee had not met since the incident, but that the incident had been placed on the agenda for the next QAPI Committee meeting.	M 500		