

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 78EH	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/17/2023
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF EUPORA		STREET ADDRESS, CITY, STATE, ZIP CODE 156 E WALNUT AVE EUPORA, MS 39744		
(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), MS #22273 from 08/16/23 to 08/17/23. The SA determined the facility was not in compliance with the Minimum Standards of Operation for Institutions for the Aged or Infirm, state licensure requirements and cited M500. Based on the facility's implementation of corrective actions taken on 08/01/23, prior to the SA entrance on 08/16/23, this was determined to be Past Non-Compliance. The facility was determined to be in compliance as of 08/03/23. The facility had a census of 105 at the time of the survey and held a license for 119 beds.	M 000		
M 500 SS=D	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		8/28/23

Mississippi State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

08/28/23

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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 PNC Based on observation, interview, record review	M 500	No POC required	

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M 500	Continued From page 4 and facility policy review the facility failed to ensure that one (1) of three (3) residents reviewed were protected from physical abuse. Resident #1. Based on the facility's implementation of corrective actions taken on 08/01/23, this was determined to be Past Non-Compliance. Review of the facility's policy titled "Abuse, Neglect, Misappropriation, Exploitation Policy" dated January 2019, documented under "Purpose: To prohibit and prevent abuse, neglect, exploitation, misappropriation of resident property and to ensure reporting and investigation of alleged violationsin accordance with Federal and State Laws." Documentation under "Definitions:Physical Abuse: Includes, but not limited to, hitting, slapping, punching, biting, and kicking" Record review revealed an investigation dated 08/01/23 of an alleged physical abuse conducted by the facility involving Certified Nursing Assistant (CNA) #1 and Resident #1. At approximately 2:45 PM on 08/01/23, CNA #1 was assisting CNA #2 and CNA #3 with patient care on a combative resident (Resident #1) in resident's room. CNA #2 witnessed CNA #1 swat back at the resident and slapped the back of his (Resident #1) hand. CNA #3 reported that she heard a noise that sounded like a slap; but did not visually see the incident. CNA #1 reported that she was assisting CNA #2 and CNA #3 care for Resident #1 and that she (CNA #1) swatted resident's hand back while he (Resident #1) was being combative. CNA #2 and CNA #3 did not leave Resident #1's room until CNA #1 left the room. The incident was then immediately reported to the Administrator and Director of Nursing (DON). Resident #1 was assessed and found to have no injuries and no	M 500		

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M 500	Continued From page 5 emotional distress. CNA #1 was immediately pulled off the floor, interviewed, and suspended pending investigation. The facility immediately began an investigation, reported the incident to the State Department of Health and to the Attorney General's Office. Resident #1's wife and Nurse Practitioner (NP) were notified and an immediate in-service on abuse and neglect was initiated with all staff on 08/01/23. Resident's Care Plan was updated and an immediate Quality Assurance (QA) Meeting was held, and interviews were started with residents and staff on 08/01/23. On 08/16/23 at 9:45 AM, an interview with the Administrator (ADM), revealed that she had reported an allegation of abuse which happened between a CNA and Resident #1 on 08/01/23. She revealed that there were three staff members in the resident's room assisting him back to bed and changing his brief when it happened. She revealed that CNA #2 and CNA #3 came to her immediately and reported what happened after they made sure the resident was safe. ADM revealed that it was reported to her that Resident #1 was confused and combative when CNA #1 slapped him on the back of his hand. ADM revealed that when the incident was reported, Director of Nursing (DON) took CNA #1 immediately off the floor and suspended her pending investigation. ADM also revealed that she reported this immediately to State Department of Health and to the Attorney General's Office and completed a thorough investigation. ADM revealed that other residents were interviewed and there were no other allegations of verbal or physical abuse identified. On 08/16/23 at 9:50 AM, an interview with DON, revealed that the incident between the CNA #1	M 500		

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M 500	Continued From page 6 and Resident #1 happened around 2:45 PM on 08/01/23, in Resident #1's room. She revealed that there were two CNAs who witnessed this occurrence and DON stated, "One visualized it and the other heard it." DON revealed that CNA #2 and CNA #3 came immediately into the Administrator's office where she (DON), also was present. DON revealed that they reported that CNA #1, CNA #2, and CNA #3 were assisting Resident #1 into the bed and changing his brief, when he became combative. DON revealed that it was reported to them that CNA #1 slapped Resident #1 on the back of the hand. She also revealed that CNA #1 did not enter another resident's room after this occurred. DON revealed that she went immediately and pulled CNA #1 off the floor, and she was suspended pending investigation. DON revealed that this was considered abuse and was immediately reported to State Department of Health and to Attorney General's Office. DON revealed that they assessed Resident #1 and there was no redness noted to his hand and he was in no emotional distress. She also revealed that ADM interviewed other residents and there were no other allegations of abuse reported. DON confirmed that they in-service and train all staff on abuse and neglect and that this was an example of physical abuse. On 08/16/23 at 10:20 AM, an observation and interview with Resident #1 revealed him sitting up in his wheelchair behind nursing desk with staff members present and he had an activity board in front of him with different gadgets he was fidgeting with. Resident #1 was alert, confused, able to answer only simple yes or no questions and was talking using random speech. On 08/16/23 at 1:00 PM, a phone interview with	M 500		

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M 500	Continued From page 7 CNA #1, revealed that on 08/01/23, she went into Resident #1's room to help CNA #2 and CNA #3 get Resident #1 back to bed and get him changed. She revealed that resident was combative and pushing them back. CNA #1 revealed that she had let his bed down because she was afraid that he was going to fall the way he was fighting. CNA #1 revealed that Resident #1 grabbed her shirt and had a tight grip on it and wouldn't let go. CNA #1 stated, "I aggressively took his hand and snatched my shirt out of his grip." CNA #1 revealed that she never physically touched his hands, just took her shirt out of his grasp. CNA #1 revealed that CNA #2 and CNA #3 reported this to the administrator and CNA #1 stated, "It was told to me that their story checked out." CNA #1 confirmed that she understood that she could lose her certification if the allegation of abuse was investigated, and she was found to be guilty. She stated, "I value my license." CNA #1 confirmed that she had been trained and in-serviced on abuse and neglect. On 08/16/23 at 2:20 PM, an interview with CNA #2, revealed that she had witnessed CNA #1 slap Resident #1's hand. CNA #2 revealed that Resident #1 was not in his right mind, he was confused, often combative, physically, and verbally. CNA #2 revealed that she and CNA #3 entered Resident #1's room to help get him back in the bed and changed when CNA #1 came in to help. She revealed that this happened around 3:00 PM on 08/01/23. CNA #2 revealed that CNA #1 was on one side of the bed holding his hands for comfort while she (CNA #2) was cleaning him up. CNA #2 revealed that Resident #1 snatched his hands away from CNA #1 and that's when she (CNA #1) grabbed Resident #1's wrist with one hand, turned it over and slapped the top of his hand like he was a child	M 500		

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M 500	Continued From page 8 misbehaving. CNA #2 stated, "I physically saw her slap his hand." CNA #2 revealed that CNA #3 was still in the room and heard the loud slap to the hand. CNA #2 revealed that she and CNA #3 went immediately to the Administrator's Office and reported this to ADM and DON. CNA #2 stated, "She (CNA #1) hit someone, and this is physical abuse." CNA #2 revealed that the DON went down the hall and removed CNA #1 from the floor, and CNA #1 left that same day and hasn't been back. CNA #2 revealed that they had an in-service on Abuse after this incident and that all staff members were required to attend. On 08/16/23 at 2:45 PM, an interview with CNA #3 revealed that Resident #1 had bad behaviors and that on 08/01/23 around 3:00 PM, she, CNA #2, and CNA #1 went into Resident #1's room, assisted him to bed and changed his brief. CNA #3 revealed that Resident #1 was combative, hitting and knocking and then she heard a "hard slap". CNA #3 revealed that she didn't see it happen but heard it. CNA #3 stated, "I don't care who they are, if I see anyone hit a resident, I'm turning them in." CNA #3 revealed that she and CNA #2 made sure Resident #1 was safe and went immediately to Administrator's office and reported this abuse. CNA #3 revealed that DON went and pulled CNA #1 off the floor and CNA #1 was later terminated. CNA #3 said, "I look at these folks as my grandparents, and I don't go for abuse." Record review of the working Schedule for CNA #1, CNA #2, and CNA #3 documented that they were scheduled to work on the 2:00 PM - 10:00 PM shift on 08/01/23. Record review of time "Punch Data" for CNA #1 revealed that she clocked in at 1:52 PM on	M 500		

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M 500	Continued From page 9 08/01/23, and she clocked out at 2:51 PM on 08/01/23. Record review of "Punch Data" for CNA #2 and CNA #3 revealed that they were clocked in on 08/01/23 and worked the 2:00PM to 10:00PM shift. Record review revealed that CNA #1 was terminated on 08/01/23 for "Substantiated Abuse" of a demented resident. Record review of "Progressive Discipline Form" on CNA #1 with "Date Administered: 08/03/23" documented Termination date effective 08/01/23 due to findings of investigation. Record review of Resident #1's Admission Record revealed that the resident was admitted on 07/14/2023 with the following diagnoses to include: Idiopathic Normal Pressure Hydrocephalus, Unspecified Dementia, mild, with other Behavioral Disturbance, Generalized Anxiety Disorder, Mild Cognitive Impairment, Restlessness and Agitation, Repeated Falls, Weakness, and Other Reduced Mobility. Record review of Resident #1's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 07/21/2023 under Section C documented Brief Interview for Mental Status (BIMS) Score of 99 which indicated resident was unable to complete the interview due to significant cognitive deficits. The State Agency (SA) validated through interview with the Administrator and record review that this incident of abuse was immediately investigated by the facility Administrator on 08/01/23.	M 500		

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M 500	Continued From page 10 The SA validated through interview with the Administrator and record review that a Quality Assurance meeting was held on 08/03/23 concerning the incident of abuse that occurred on 08/01/23. The SA validated through interviews and record review of the sign in sheets that in services were conducted with all staff on Abuse and Neglect on 08/03/23. The SA validated through interview that the Nurse Manager will interview 12 different residents a day for five (5) days, then 12 residents a month for three (3) months beginning 08/03/23. The SA determined the facility was in compliance on 08/03/23 when CNA #1 was formerly terminated and in-services and investigation was concluded.	M 500		