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
	61BC	A. BUILDING: _____ B. WING _____	C 07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON COURT	100 BURNHAM ROAD BRANDON, MS 39042

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M 000	Initial Comments The State Agency (SA) conducted a Complaint Investigation (CI), MS #23096, MS #23929, MS #25202, MS #25457, MS#25633, MS #25981, MS#25988, MS #26014, MS #26016, and MS #26018, at the facility from 7/28/24 through 7/31/23. MS #23929 was investigated related to Administration. MS #25202 was investigated related to Resident Rights and Infection Control. MS #25457 was investigated regarding Quality of Care related to lack of responsible party notification of change. MS #25633 was investigated related to Physical Environment. MS #25981 was investigated related to Nursing Services. MS #25988 was investigated related to Physical Environment and Resident Rights. MS #26014 was investigated related to Infection Control. MS #26016 was investigated related to Resident Abuse and Resident Neglect. MS #26018 was investigated related to Physical Environment and Resident Abuse. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirement. The SA cited M500 related to MS #25988, MS #25202, and MS #26018.	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	M 500		9/2/24

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M 500	Continued From page 1 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 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	M 500		

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M 500	Continued From page 2 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 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;	M 500		

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M 500	Continued From page 3 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 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	M 500		

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M 500	Continued From page 4 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: Based on observations, interviews, and facility policy review, the facility failed to ensure residents were provided with sufficient bath linens for one (1) of three (3) days of observation, failed to ensure that two (2) of nine (9) residents sampled had the opportunity to exercise their autonomy regarding preferences related to choice of bathing schedules and clothing, and failed to ensure consent was received from residents prior to changing private insurance plans to another insurance company for one (1) of nine (9) sampled residents. Residents #1, #2, and #3 Lack of Sufficient Bath Linens: Record review of the facility policy titled "Laundry Infection Control-Department Responsibilities," reviewed 08/21, revealed, " ... The Laundry Department will supply a sufficient quantity of linen for proper resident care and comfort ..." On 7/30/24 at 9:50 AM observation and an interview with Resident #2 revealed that she had not had any washcloths to use on the morning of 7/30/24. She said the Certified Nurse Aides (CNAs) told her there were no clean washcloths. She said that prevented her from being able to "wash up" and get into her wheelchair at her preferred time. Observation revealed there were	M 500	1. On 7/30/2024, linens were not yet in the building due to a delay in housekeeping. Fresh linens and towels were immediately transported to the main building where residents are housed upon notification of the shortage. 2. 83 out of 83 residents have the potential to be affected by this deficient practice. 3. On 8/1/2024, this facility began a new contract for both housekeeping and laundry services. The new housekeeping supervisor performed an in-service with laundry staff on 8/7/2024 on linen distribution and job responsibilities. All nursing staff in the building were in-serviced on 8/14/2024 by the Staff Development Nurse regarding our Resident□s Rights Policy and communicating needs to the laundry staff if supplies is insufficient. 4. Beginning 8/5/24, the housekeeping Supervisor will perform a morning and afternoon inventory of linen and towels on both floors using the Linen and Towel Building Inventory Sheet. This will be conducted five (5) days per week for four (4) weeks then three (3) times per week	

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M 500	Continued From page 5 no washcloths in the room or attached bathroom of Resident #2. On 7/30/24 at 10:00 AM observation revealed there were no clean washcloths or bath towels in the linen closets on the first or second floor and there were no clean washcloths or bath towels on the four (4) clean linen carts on the hall. On 7/30/23 at 10:08 AM observations and an interview with Resident #1 revealed she had just received AM care and assistance to transfer into her wheelchair because she had to wait for clean linens to be delivered from the laundry. She stated she preferred to get up earlier and the reason she was told she was not able to get up at the time of her choosing was because there were no clean washcloths or bath towels. She said she preferred to "get washed up" and then get dressed and then get up in her wheelchair with staff assistance, as that was her usual routine. She confirmed that she had not been able to get up when she preferred on 7/30/24 or wear the clothes she preferred on 7/30/24 because she said the staff told her there was not adequate clean washcloths or towels for a bed bath and the clothes she preferred had not been returned from the laundry. She confirmed that the clothes she preferred to wear had been sent to the laundry several days before. Observation revealed there were no washcloths or bath towels in the room or attached bathroom of Resident #1. On 7/30/24 during an interview at 10:20 AM, CNA #2 revealed that Resident #1 and Resident #2 had to wait past their preferred time to have AM care/bed bath and get up because there were no clean washcloths or bath towels available on the morning of 7/30/24.	M 500	for four (4) weeks. Beginning 8/5/2024, The 100 Hall Nurse and the 300 Hall Nurse will monitor that the facility has sufficient linen and towels five (5) days per week for four (4) weeks then three (3) times per week for four (4) weeks using the Rounds Flow Record form. Any areas of concern will be corrected and forwarded by the Administrator and Director of Nurses to the Quality Assessment and Improvement Committee for review and follow up including any needed corrective action or changes to the current plan at least quarterly. Additional training and/or disciplinary action will be considered as warranted. A Quality Assessment and Assurance Committee meeting was held on 8/5/2024. The next Quality Assessment and Assurance meeting will convene on 9/2/24.	

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M 500	Continued From page 6 On 7/30/24 during an interview at 10:23 AM, CNA #3 revealed that Resident #1 and Resident #2 had to wait past their preferred time to have AM care/bed bath and get up because there were no clean washcloths or bath towels available on the morning of 7/30/24. On 7/30/24 at 2:00 PM an interview with the Housekeeping Supervisor revealed that the facility had adequate linens, and added, "but we are behind today". She confirmed that the CNAs had to wait for linens to complete the laundering process to have clean linens on 7/30/34. On 7/31/24 at 1:00 PM an interview with the Administrator revealed that he confirmed that it was the responsibility of the facility to ensure that all residents had clean linens available for their care in accordance with their preferred routine for rising, showering/bathing, dressing and other activities of daily living. He confirmed that there were residents that did not have access to clean linens on the morning of 7/30/24. Record review of the Face Sheet for Resident #1 revealed that the facility admitted the resident on 5/06/22 and the resident had diagnoses of atrial fibrillation, congestive heart failure, chronic peripheral venous insufficiency. Record review of the Quarterly Minimum Data Set (MDS) with ARD 6/13/24 for Resident #1 revealed she had a Brief Interview for Mental Status (BIMS) score of 13, which indicated no cognitive impairment. Record review of the Face Sheet for Resident #2 revealed the facility admitted the resident on 10/27/21 and the resident had diagnoses of end stage renal disease, hypertension and	M 500		

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M 500	Continued From page 7	M 500		

osteoarthritis.

Record review of the Quarterly MDS with ARD 6/06/24 for Resident #2 revealed she had a BIMS score of 15, which indicated no cognitive impairment.

Unable to Exercise Rights Related to Personal Preferences:

Record review of the facility's policy titled "Resident's Rights Policy," reviewed 12/23, revealed "Every resident in this facility has the right to: ...Retire and rise in accordance with reasonable requests ..."

On 7/30/24 at 9:50 AM, during an observation and interview with Resident #2, the resident stated that she did not have any washcloths to use on the morning of 7/30/24. She said the CNAs told her there were no clean washcloths. She said that prevented her from being able to "wash up" and get into her wheelchair at her preferred time. Observation revealed there were no washcloths in the room or attached bathroom of Resident #2.

On 7/30/24 at 10:00 AM observation revealed there were no clean washcloths or bath towels in the linen closets on the first or second floor and there were no clean washcloths or bath towels on the four (4) clean linen carts on the hall.

On 7/30/23 at 10:08 AM, during an observation and an interview with Resident #1, she complained she had just received AM care and assistance to transfer into her wheelchair because she had to wait for clean linens to be delivered from the laundry. She stated she preferred to get up earlier and the reason she

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M 500	Continued From page 8 was told she was not able to get up at the time of her choosing was because there were no clean washcloths or bath towels. She said she preferred to bathe and then get dressed before staff assisted her to get up in her wheelchair, as this was her usual routine. She confirmed that she had not been able to wear the clothes she preferred on 7/30/24 because the clothes she preferred had not been returned from the laundry. She said that there were dresses she preferred to wear but wanted a slip or undershirt to wear beneath them and that none of her slips or undershirts had been returned from the laundry. She confirmed that the clothes she preferred to wear had been sent to the laundry several days before. Observation revealed there were no washcloths or bath towels in the room or attached bathroom of Resident #1. On 7/30/24 during an interview at 10:20 AM, CNA #2 revealed that Resident #1 and Resident #2 had to wait past their preferred time to have AM care/bed bath and get up because there were no clean washcloths or bath towels available on the morning of 7/30/24. The CNA confirmed that Resident #1's personal clothes of choice were not in her room and had not been returned from the laundry. She explained that Resident #1 had multiple slips and undershirts but none in her room. On 7/30/24 during an interview at 10:23 AM, CNA #3 confirmed that Resident #1 and Resident #2 had to wait past their preferred time to have AM care/bed bath and get up because there were no clean washcloths or bath towels available on the morning of 7/30/24. She confirmed that she and CNA #2 had searched for a slip or undershirt for Resident #1 and were unable to find any for her to wear.	M 500		

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M 500	Continued From page 9 On 7/30/24 at 2:00 PM an interview with the Housekeeping Supervisor revealed that the facility had adequate linens, and added, "but we are behind today". She confirmed that the CNAs had to wait for linens to complete the laundering process to have clean linens on 7/30/34. She said she did not know why Resident #1 had not gotten her slips or undershirts back from the laundry in a timely manner. On 7/31/24 at 1:00 PM an interview with the Administrator revealed that he confirmed that it was the responsibility of the facility to ensure that all residents had clean linens available for their care in accordance with their preferred routine for rising, showering/bathing, dressing and other activities of daily living. He confirmed that there were residents that did not have access to clean linens on the morning of 7/30/24 which interfered with the residents' right to autonomy and choice of schedule for bathing and getting out of bed. The Administrator stated that he was unaware that Resident #1 had personal clothing items which had not been returned to her and that the items would have to be located and returned to her or replaced by the facility to ensure she could dress according to her preference. Record review of the Face Sheet for Resident #1 revealed that the facility admitted the resident on 5/06/22 and the resident had diagnoses of atrial fibrillation, congestive heart failure, chronic peripheral venous insufficiency. Record review of the Quarterly Minimum Data Set (MDS) with ARD 6/13/24 for Resident #1 revealed she had a Brief Interview for Mental Status (BIMS) score of 13, which indicated no cognitive impairment.	M 500		

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M 500	Continued From page 10 Record review of the Face Sheet for Resident #2 revealed the facility admitted the resident on 10/27/21 and the resident had diagnoses of end stage renal disease, hypertension and osteoarthritis. Record review of the Quarterly MDS with ARD 6/06/24 for Resident #2 revealed she had a BIMS score of 15, which indicated no cognitive impairment. Lack of Consent for Changing Private Insurance: Record review of the facility provided titled "Resident Rights," reviewed 12/23, revealed, "Every resident in this facility has the right to:... Manage their personal affairs ..." On 7/30/24 at 9:35 AM, in an interview with a family member of Resident #3, he said that Resident #3 was admitted by the facility on 11/16/23 for a short term stay to receive therapy services following a fall with fracture which occurred at her home. He stated that the resident was her own Responsible Party (RP) and made her own decisions. He explained that the resident was enrolled in managed care insurance at the time of admission which allowed twenty (20) days of therapy, of which, the resident and family were aware. He stated that the resident decided to transfer to a personal care facility and discharged from the facility on 12/09/23. The family member stated that after the resident's discharge from the facility, the resident had been notified by mail of her disenrollment from managed care. The family member said that the resident was without managed care coverage for two (2) months following discharge from the facility. He acknowledged that the resident did not	M 500		

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experience injury or illness during the two months and did not suffer loss due to the disenrollment, however, it could have been detrimental to the resident's finances should she have suffered a major illness.

Record review of the Notice of Medicare Non-Coverage dated 12/06/23 and signed by Resident revealed the resident was notified that "The effective date coverage of your current skilled nursing facility services will end: 12/08/24". The document contained the resident's right to appeal against this decision and instructions on how to ask for an immediate appeal.

On 7/31/24 at 4:00 PM, in an interview with the Business Office Manager (BOM), she confirmed that she had used on-line access to Resident #3's managed care and entered information for disenrollment. She confirmed that she had no evidence or signed permission for agreement by the resident for disenrollment from her managed care insurance. She confirmed that she was not aware of any appeal requested for Resident #3 as described in the Notice of Medicare Non-Coverage. The BOM confirmed that Resident #3 was alert and oriented and was her own Responsible Party.

On 7/31/24 at 5:00 PM, during an interview with the Administrator he confirmed that the BOM had processed disenrollment for Resident #3 from her managed care insurance. He also confirmed that the facility had no written authorization by Resident #3 for disenrollment from her managed care insurance.

On 8/02/24 at 12:45 PM Resident #3 returned telephone call to SA and stated that she had not authorized disenrollment form her managed care

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M 500	Continued From page 12 insurance plan. She stated that she was made aware of her disenrollment through a letter mailed to her home address following her discharge from the facility. Record review of the Face Sheet for Resident #3 revealed the facility admitted the resident on 11/16/24 and the resident had diagnoses that included Wedge Compression Fracture of Fourth Lumbar Vertebra, Atrial Fibrillation, Macular Degeneration and Hearing Loss. Record review of the Admission Minimum Data Set (MDS), with Assessment Referral Date (ARD) 11/22/23 for Resident #3, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, which indicated no cognitive impairment.	M 500		