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
	79CH	A. BUILDING: _____ B. WING _____	C 06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILKINSON COUNTY SENIOR CARE	116 SOUTH LAFAYETTE STREET CENTREVILLE, MS 39631

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M 000	Initial Comments The State Agency (SA) conducted Complaint Investigations (CI), MS #28944, CI MS #28945 and CI MS #28946 at the facility on 6/06/25. 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 requirements. The CIs were Facility Reported Incidents (FRIs) and were investigated for abuse and residents not treated with dignity and respect and M500 was cited.	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		7/10/25

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M 500	Continued From page 1 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	M 500		

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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 interview, record review, and policy review, the facility failed to ensure residents were treated with respect and dignity for three (3) of 27 residents on A Wing. (Resident #1, Resident #2,	M 500		

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M 500	Continued From page 4 and Resident #3). Findings Included: A review of the facility's resident document, undated, revealed " ..."As a resident in a long-term care facility, you have many rights guaranteed by law ... Your rights include: A dignified and comfortable living environment ... Dignity and Respect You have the right to dignity and respect in the care you receive and the setting you live in." Resident #1 A record review of the "Admission Record" revealed the facility admitted Resident #1 on 4/11/25 with diagnoses including Atrial Fibrillation. A record review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/22/25 for Resident #1 revealed a Brief Interview for Mental Status (BIMS) score of 6, indicating severe cognitive impairment. A record review of the facility's investigation revealed that on 5/12/25, Resident #1 reported to the Social Services Director that a night shift had treated her in a rude and aggressive manner. The resident alleged that the CNA removed her call light and remote control, stating the CNA "snatched" them and threw one "over yonder." The CNA identified in the allegation (CNA #1) was suspended and removed from the resident's care assignment during the investigation. A body audit was completed and revealed no signs of injury. Upon completion of the investigation, the facility documented that no evidence of abuse was found. Medical and nurse practitioner follow-up was recommended as needed.	M 500		

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M 500	Continued From page 5 A record review of the facility "Incident Report" dated 5/12/25, revealed the Director of Nursing received a report from Social Services Director regarding unsatisfactory care being provided to Resident #1. The "Resident Description" revealed that the resident stated CNA took her call light and remote from her and made it unreachable. Resident #2 A record review of the "Admission Record" revealed the facility admitted Resident #2 on 4/24/25 and he had current diagnoses including Chronic Obstructive Pulmonary Disease. A record review of the "5-Day MDS" with an ARD of 4/30/25 revealed Resident #2 had a BIMS score of 15, indicating no cognitive impairment. A record review of the facility's investigation revealed that on 5/12/25, Resident #2 reported multiple incidents of rude and dismissive behavior by a CNA #1. The resident stated that on several occasions, the CNA responded to call lights with a stern tone, yelling phrases such as "What do you want?" and "I can't get nothing done because you keep calling me." The resident described one instance in which he requested ice, and the CNA brought a nearly empty container, placed the remaining ice on the table, and left. In another instance, the resident reported difficulty bringing up phlegm, and the CNA allegedly responded that there was nothing they could do. The resident stated he believed the CNA had a bad personality. The CNA was removed from the resident's care assignment, and an in-service on resident abuse was attempted, but the CNA	M 500		

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declined to sign.

Resident #3

A record review of the "Admission Record" revealed the facility admitted Resident #3 on 3/28/25 with diagnoses including Hemiplegia.

A record review of the "Admission MDS" with an ARD of 4/3/25 for Resident #3 revealed a BIMS score of 8, indicating severe cognitive impairment.

A record review of the facility's investigation revealed that on 5/8/25, Resident #3 reported to the Social Services Director that CNA #2 mistreated her during care. The resident alleged the CNA entered the room abruptly, did not allow time to grab the bed rails, pulled on her roughly, and referred to her as "an old woman." The CNA was immediately removed from the resident's care and suspended pending investigation. The employee received inservice training related to abuse and neglect.

A record review of the "Incident Report" dated 5/8/25 revealed Resident #3 reported CNA #2 came into her room with an attitude and snatching and pulling on her in a rough manner. Resident also reports that CNA referred to her as an old woman.

A record review of a written statement from LPN #3, dated May 7, 2023, revealed that upon entering Resident #3's room, CNA #3 was present and preparing to assist with care following a bowel movement. LPN #3 explained the purpose of the care to Resident #3, who reportedly said "OK" while grabbing her brief. CNA #3 held the resident's hand during care and

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said, "Stop, don't do that, we are trying to change you."

A record review of a statement signed by CNA #2 revealed that during care on 5/7/25, Resident #3 pulled back and forth and touched the CNA inappropriately, including grabbing the CNA's backside, breast, and pulling hair. The CNA reported asking the resident to stop multiple times, but the behavior continued. The statement noted that a nurse entered the room, assessed the situation, and spoke with the resident, who stated the CNA had spoken to her rudely.

On 6/6/25 at 11:40 AM, during an interview with Resident #3, she stated she could not recall the exact date, but during the night shift, her CNA had been very rude and impatient. She stated the CNA held her hands so she could not stabilize or help reposition herself during incontinence care. She said the CNA spoke to her sternly and told her to "stop it." Resident #3 explained she did not want to be spoken to like a child and told the CNA to leave her room and not return.

On 6/6/25 at 11:52 AM, during an interview with Resident #3's family member, she stated she visited almost daily and was present on 5/8/25 when Resident #3 reported the night shift CNA was rude, had a nasty attitude, and was no longer welcome in her room. The family member described the treatment as disrespectful and said she immediately reported the complaint to the Social Services Director (SSD).

On 6/6/25 at 12:10 PM, during an interview with Resident #1, she stated she had no memory of any incident or disrespectful treatment.

On 6/6/25 at 12:50 PM, during an interview with

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the SSD, she was notified of an allegation by Resident #3 on 5/8/25 when Resident #3's sister came to her office. She said Resident #3 reported CNA #2 had been rude, pulled her across the bed, and would not let her hold the bedrail. The SSD said the resident told her to tell the CNA not to return. The SSD also recalled that on 5/8/25, CNA #3 and the Activity Director brought her to Resident #1's room where Resident #1 named CNA #1 and complained that she had entered the room, moved her call light, bed control, and television remote. The SSD said Resident #1 appeared visibly angry. The SSD further stated that on 5/12/25, she was exiting Resident #1's room when Resident #2's daughter told her to speak with Resident #2. She and the Activity Director entered his room, and Resident #2 stated that CNA #1 had been stern and unpleasant over the past two (2) weeks, including that morning. He reported coughing and pushing his call light prior to daylight, and CNA #1 responded by saying there was nothing she could do and left. He described CNA #1 as unpleasant and rude.

On 6/6/25 at 2:59 PM, during an interview with the Activity Director, she stated that on 5/8/25 at approximately 8:30 AM, she checked on Resident #1, who reported CNA #1 was rude, moved her call light, and had a bad attitude. She described the resident as visibly angry. The Activity Director also stated she was present when Resident #2 reported on 5/12/25 that CNA #1 responded loudly and tersely when he used the call light around 5:45 AM, stating "What?" and "There's nothing I can do."

On 6/6/25 at 4:07 PM, during a telephone interview, CNA #1 denied all allegations and stated she had worked on A Hall during the night

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M 500	Continued From page 9 shift on 5/8/25. She said Resident #2 used the call light to request repositioning and that she told him she was in the middle of something and would return. She denied being assigned to or entering the room of Resident #1 on 5/11/25 or 5/12/25. On 6/6/25 at 5:23 PM, during an interview with the Director of Nursing (DON), she stated that multiple residents reported being treated disrespectfully by CNAs during the night shifts of 5/8/25 and 5/12/25. She confirmed concerns related to attitude, tone, and demeanor of CNA #1 and CNA #2 and that the three (3) residents identified these CNAs as speaking in a disrespectful manner. On 6/6/25 at 5:30 PM, during an interview with the Administrator, she confirmed CNA #2 received one-on-one inservice training on resident rights and abuse/neglect prevention on 5/12/25, and CNA #1 was terminated due to multiple complaints. She confirmed the investigation substantiated the residents' complaints regarding rude behavior.	M 500		