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
	75VT	A. BUILDING: _____ B. WING _____	04/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BLUFFS REHABILITATION AND HEALTHCARE C	2850 PORTER'S CHAPEL ROAD VICKSBURG, MS 39180

(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 Based on administrative review, on 5/20/19, this 2567 was revised. The State Agency (SA) conducted a State Licensure survey, along with complaint surveys, MS #15825 and MS #15824 from 04/22/19 through 04/26/19. The complaints were not substantiated, however, during the survey the SA determined the facility was not in compliance with the Mississippi Regulations for Minimum Standards for Institutions for Aged or Infirm, with related deficiencies cited at M500, M620, M655 and M735. The SA identified an IJ and Substandard Quality of Care (SQC) on 4/25/19, which began on 4/3/19, when Resident #14 reported an allegation of abuse against Licensed Practical Nurse (LPN) #1. At approximately 9:50 PM, it was reported that Resident #14 was verbally abused by Licensed Practical Nurse (LPN) #1. The allegation consisted of Resident #14 using derogatory names towards LPN #1. LPN #1 responded to the resident by using the same derogatory names. This occurred and was witnessed around the nursing station. LPN #3 stated she heard LPN #1 say, "If I'm a bitch, you are a bitch. It takes one to know one". LPN #2 stated she heard LPN #1 say "Mother Fucker". LPN #1 was immediately suspended, abuse in-services and the abuse investigation was initiated. LPN #1 was allowed to return to work on 4/17/19, after abuse had been substantiated by facility investigation, thus not protecting the residents of the facility from further abuse. Resident #14 refused medications from LPN #1 after she returned to the facility and was assigned to the same hall with Resident #14. He made statements that he was afraid of what LPN #1	M 000		

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M 000	Continued From page 1	M 000		

might do. The facility also failed to report the abuse to the appropriate State Agencies within two (2) hours of the allegation, as required.

The failure of the facility to protect residents and allow a staff member to work in the facility following investigation of a witnessed incident of verbal abuse, and failure to report the abuse within two (2) hours to State designated agencies, placed Resident #14 and other residents in a situation that was likely to cause serious injury, harm, impairment, or death.

The facility's Administrator was notified of the IJ and SQC on 4/25/19, at 10:00 AM, and the IJ template was provided to the Administrator.

The IJ and SQC existed at:
45.17.2; M500-Resident Rights-(to be free of abuse)

The facility provided a credible Removal Plan on 4/26/19, in which the facility alleged all corrective actions were completed as of 4/25/19, and the IJ was removed on 4/26/19.

The State Agency (SA) validated the Removal Plan and determined the IJ was removed on 4/26/19, prior to exit. Therefore, the scope and severity for 45.17.2; M500-Resident Rights, was lowered to a "Level II", while the facility develops and implements a plan of correction and monitors the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements.

The SA also cited M620, M655 and M735, which were not at the IJ level.

The census at the time of survey was 98 and the

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M 000	Continued From page 2 facility held a license for 120 beds.	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 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	M 500		5/31/19

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M 500	Continued From page 3 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 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.	M 500		

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M 500	Continued From page 4 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 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	M 500		

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M 500	Continued From page 5 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 IV Based on resident interview, staff interview, record review and facility policy review, the facility failed to ensure a resident was free from verbal abuse for one (1) of 24 residents reviewed for abuse, Resident #14. On 4/3/19, at approximately 9:50 PM, Resident #14 reported an allegation of verbal abuse against Licensed Practical Nurse (LPN) #1. The allegation consisted of Resident #14 using derogatory names towards LPN #1. LPN #1 responded to the resident by using the same derogatory names. This occurred around the	M 500	M500 Resident Rights 1. Resident #14 was interviewed on 5/15/19 by Corporate Clinical Specialist regarding abuse/neglect concerns; Resident #14 denies any other instances of abuse or neglect. LPN#1 was terminated on 4/25/2019. 2.Facility Residents have the potential to be affected by deficit practice. Residents with Brief Interview for Mental Status (BIMS) scores of 12 or higher were interviewed by Director of Nursing/Human Resources/Minimum Data Set Registered	

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M 500	Continued From page 6 nursing station and was witnessed by other staff. LPN #3 stated she heard LPN #1 say "If I'm a bitch, you are a bitch. It takes one to know one". LPN #2 stated she heard LPN #1 say "Mother Fucker". The Administrator was notified by LPN #2 at approximately 10:00 PM. LPN #1 was suspended, however, was allowed to return to work on 4/17/19, and allowed to work on the same assigned hall where Resident #14 resided. The resident refused to take medications from LPN #1, stating he did not trust her. The facility's failure to protect Resident #14 from verbal abuse and allow a staff member to work in the facility following investigation of an incident of witnessed verbal abuse, placed Resident #14 and other residents at risk in a situation that was likely to cause serious injury, harm, impairment, or death. The situation was determined to be an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which began on 4/3/19, when the verbal abuse occurred. The facility's Administrator was notified of the IJ and SQC on 4/25/19, at 10:00 AM, and provided with the IJ template. An acceptable credible Removal Plan was provided by the facility on 4/26/19, in which the facility alleged all corrective actions were completed as of 4/25/19, and the IJ was removed on 4/26/19. The State Agency (SA) validated the Removal Plan and determined that the IJ was removed on 4/26/19, prior to exit. Therefore, the scope and severity for the IJ and SQC at M500-Resident Rights was lowered to a "Level II", while the facility develops and implements a plan of correction and monitors the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements.	M 500	Nurses/Staff Development Coordinator/Activity Director/Social Services under the direction of the Administrator and Director of Nursing, on 4/29/19, regarding concerns of abuse or neglect; no concerns noted. Facility staff were interviewed beginning on 4/27/19 by Director of Nursing/Human Resources/Minimum Data Set Registered Nurses/Staff Development Coordinator/Activity Director/Social Services/Business Office Manager/Corporate Clinical Specialist Registered Nurse/Case Mix Specialist Registered Nurse/Regional Vice President, regarding concerns of abuse or neglect; no concerns noted. 3. On 4/26/19,Regional Vice President educated facility Administrator on requirements of abuse/neglect prohibition policy including reporting requirements. Beginning 4/27/19,facility staff participated in abuse/neglect questionnaires to determine knowledge retention on abuse/neglect prohibition training; individuals who could not answer each question correctly were provided one-to-one additional training. Beginning on 4/30/19, facility staff were in-serviced by Corporate Clinical Specialist/Director of Nursing regarding abuse and neglect prohibition policy, reporting concerns regarding abuse and/or neglect immediately, two hour required reporting timeframe by the facility to the Mississippi State Department of Health, Licensure and Certification, protecting residents immediately following allegation of abuse/neglect. On 5/6/19, representative	

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M 500	Continued From page 7 Findings include: Review of the facility's policy titled "Abuse Prohibition Policy", Revision: 03/18/2019, revealed: This protocol was intended to assist in the prevention of abuse, neglect and misappropriation of property. Each resident has the right to be free from abuse, mistreatment, neglect, corporal punishment, involuntary seclusion and financial abuse. Policy: 1. The facility will prohibit neglect, mental or physical abuse, including involuntary seclusion and the misappropriation of property or finances of residents. Review of the facility policy "Abuse Program", Revision 11/2017, revealed,....Investigation: 1. The facility will thoroughly investigate all alleged violations and take appropriate actions. 2. The Abuse Coordinator will report such allegations to the state agency in accordance with state law. The Abuse Coordinator will report all allegations of abuse,...within two (2) hours of the allegation... Protection: 1. All residents will be immediately protected from harm... Statement of Policy, Regarding the Reporting of Abuse and Associate Acknowledgement,....Remember our policy is all residents and patients of this nursing home are to be treated with dignity and respect at all times, under all circumstances. Mistreatment or abuse of any nature will not be tolerated... Review of a Facility Reported Incident (FRI), dated 4/5/19, revealed staff statements concerning an allegation of verbal abuse by an employee, Licensed Practical Nurse (LPN) #1, toward Resident #14 that occurred on 4/3/19. LPN #4 reported that on 4/3/19, at 9:50 PM, Resident #14 was tapping his hand on the	M 500	of the Mississippi Attorney Generals Office provided in-service to facility staff in regards to abuse/neglect prevention, reporting, Vulnerable Adults Act, Medicaid Fraud, types of abuse. On 5/22/19,Corporate Support Administrator/Registered Nurse in-serviced facility staff on Abuse and Neglect Prohibition program including but not limited to the requirement to protect residents, if a staff is involved, they will be suspended, facility is required to report to authorities within two (2) hour time frame, facility is required to conduct a thorough investigation and findings of investigation could lead to staff termination. A Quality Assurance Performance Improvement committee meeting was held on 5/22/19 with the Administrator, the Director of Nursing, the Corporate Clinical Specialist and Medical Director to review the statement of deficiencies and plan of correction; no further recommendations were made. 4. Beginning on 5/27/19, facility department heads including Social Services, Activities, Nursing Leadership, Business Office Manager, Minimum Data Set nurses, Lead Certified Nursing Assistant (C.N.A.), Dietary Manager, Admissions Director, will interview residents in their respective facility areas weekly for twelve (12) weeks, in regards to concerns related to care or treatment from staff related to abuse and/or neglect issues; any negative concern will be immediately reported to the Administrator or Director of Nursing for further intervention. Beginning on 5/27/19, the	

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M 500	Continued From page 8 counter to get the nurse's attention. Resident #14 wanted a snack and to use the cordless phone, but it was not charged. Resident #14 became agitated and began hitting the nurse's station desk loudly with the palm of his hand and snatched papers from a chart on the desk attempting to read them. Resident #14 cursed LPN #1 who cursed him in return. This was witnessed by LPN #2 and LPN #3, who stated that LPN #1 used profanity such as "Mother Fucker", and "If I'm a bitch, you are a bitch. It takes one to know one". LPN #1 was suspended pending investigation. On 04/22/19, at 4:03 PM, during an interview with Resident #14, he stated, "Everything is okay except for that woman who pushed me up against that wall". He stated this happened about two (2) weeks ago and her name was (LPN #1 Proper Name). He stated "If y'all don't do anything about it, I will". Resident #14 stated that he did not trust LPN #1 after she shoved him into a wall and hurt his left foot. He said he refused to take any medication or receive any care from her after that stating, "No telling what she might do". The resident had an angry tone and expression. He stated that he could not recall exactly what was said, but that he cursed her and she cursed him back. He stated that he stands by his original statement to LPN #4, given on 4/3/19. Review of the resident's statement, documented in the facility's investigation, taken by LPN #4 on 4/3/19 at 9:50 PM, revealed Resident #14 stated he was tapping his hand on the counter to get the nurse's attention. He stated the nurse got up from the desk and pushed his wheelchair into the wall by the DON's office on the 300 hall. Resident stated he hit his foot on the wall. Resident stated he cursed the nurse and the nurse cursed him	M 500	Administrator will review the incident log weekly to ensure reportable events have been investigated and reported as required. Beginning on 5/27/19, the Administrator will review the grievance log weekly to ensure any allegations have been investigated and reported as required. A report will be submitted by the Administrator to the Quality Assurance Performance Improvement committee monthly for three (3) months for review and recommendations. The Administrator is responsible for monitoring and compliance.	

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M 500	Continued From page 9	M 500		

back, got her purse, and left the building.

On 04/23/19, at 8:04 PM, an interview with LPN #4 revealed that she was working on the hall and that she did not witness the alleged abuse but was told about it by LPN #2. She stated she obtained a statement from Resident #14. She stated that he reported he had cursed LPN #1 and that she cursed him back and pushed him into the wall, hurting his foot. LPN #4 stated that she examined the resident's foot and did not notice any injury or swelling that was unusual for him. She stated he always had lymphedema, but there was no unusual swelling.

On 04/23/19, at 8:16 PM, during a phone interview with LPN #2, she stated at approximately 8:15-8:20 PM, on 4/3/19, that she walked up to the nurse's station from the 200 Hall. LPN #1 was sitting at the desk working on charting and Resident #14 was sitting across from LPN #1 in his wheelchair at the nurse's station hitting the top of the desk with the palm of his hand very loudly. LPN #2 stated that she told Resident #14 that she had sensitive ears and that it was hurting her ears and asked him to stop and he stopped. She stated that LPN #1 had told her that Resident #14 was pulling orders out of charts and she had to move them. LPN #2 proceeded through the nurse's station and toward the 500 Hall to the treatment cart when she overheard LPN #1, say, "Bitch, I got your bitch, you Mother Fucker". She stated that LPN #1 left the facility a few minutes later (no more than 5 minutes) and that she called the Administrator to report the incident and reported it to Resident #14's Charge Nurse, LPN #4. She stated that three (3) or four (4) other residents were sitting in the area. Resident #45 and Resident #13 were the ones she remembered. She stated Resident #45 might

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be interviewable, but Resident #13 wouldn't recall anything.

Review of the signed and documented statement from LPN #2, from the facility's investigation, (not dated) revealed LPN #1 stated, "Mother Fucker", while at the nurse's station, but LPN #2 didn't know who she was talking to. It was noted in further documentation that LPN #2 saw another Resident at the station, (Resident #13), who had a documented interview by the Administrator on 4/4/19, in which the resident denied hearing profanity.

Interview on 04/23/19, at 4:30 PM, with the Administrator confirmed that LPN #1 continued to work for the facility and was scheduled to work on 4/24/19, the 7 AM-7 PM shift. On 04/24/19, at 8:33 AM, during a further interview with the Administrator, she stated that she did feel that verbal abuse had occurred based upon the statements of LPN #2 and LPN #3 obtained during the investigation for the incident with Resident #14. She stated that she had requested termination of LPN #1 from corporate, but that request was denied by Human Resources. She stated that LPN #1 was suspended from 4/3/19 - 4/17/19, and then LPN #1 was allowed to return to work on 4/17/19, after the investigation was completed, because it was determined that abuse could not be substantiated on the part of the facility. The Administrator stated that LPN #1 had been re-assigned to Resident #14 since returning to work, stating that was the hall that LPN #1 was assigned to before she was suspended, so she was re-assigned to that hall upon return on 4/17/19. The Administrator stated that LPN #1 was issued a "Final Warning" due to a previous Verbal Warning for using profanity in the common area of a sister facility.

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M 500	Continued From page 11 Review of an electronic communication, documented by the Administrator on 4/8/19, revealed a subject: Suspension. The documentation included: Attached is an allegation of verbal abuse investigation that was reported to the state and AG...Based on the other 2 LPN's statements, I would like to request termination. Review of Resident #45's MDS, with an ARD of 1/24/19, revealed a BIMS of 15. Interview with Resident #45 revealed he did not recall what was said on 4/3/19 at the nurse's station between Resident #14 and LPN #1. Record review of the Daily Assignment Sheets for 4/17/19 - 4/21/19, revealed that LPN #1 was assigned to the 300/400 Hall. Resident #14 resided on the 300 Hall. Interview with LPN #1, on 4/24/19, at 11:10 AM, in the Medical Records building, revealed that she was removed from the 300-400 Hall assignment by the Administrator earlier that morning and re-assigned to file records in a separate building. She stated that on 4/3/19, she was working on charting at the nurse's station when Resident #14 came up in his wheelchair and asked for the phone. She stated that the phone was not charged and he became angry. She stated that she asked him to leave the desk so she could finish her work and he said, "Fuck you, bitch". She stated that she did move Resident #14 away from the nurse's station toward his room, but denied hitting his foot on a wall. She stated that the resident came back to the nurse's station and began banging his hand on the desk. LPN #1 stated that she never cursed Resident #14, and that she told him, "You're cursing me out. If you want me to respect you, you've got to respect me,	M 500		

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M 500	Continued From page 12	M 500		

too." She stated that a couple of nurses walked by every now and then and Resident #45 rolled up, but that she did not know what he heard. She revealed that she had completed in-services on Abuse after coming back to work on 4/17/19. She stated that Resident #14 took meds from her on 4/17/19, but began refusing on 4/18/19, saying, "I don't want to take it, I don't trust you". LPN #1 revealed that she had been assigned to Resident #14 on 4/17/19 - 4/24/19, (after returning to work from being suspended for abuse).

Telephone interview with LPN #3 on 4/24/19 at 2:50 PM, revealed that she was down the hall when the incident occurred. She stated that she walked to the nurse's station to see what was going on because Resident #14 was beating on the desk. LPN #3 stated that LPN #1 was mad because she said Resident #14 had called her a Bitch. LPN #3 stated LPN #1 was behind the desk and Resident #14 was on the other side of the desk in his wheelchair. She stated, "She was saying something. They were going back and forth with each other but I don't recall exactly what was said."

Review of the written facility investigative statement, dated 4/5/19, for LPN #3, documented by Interim DON #1, revealed that she had walked to the nurse's station and Resident #14 was beating his hand on the desk and LPN #1 was on the computer. Documentation of the statement included, "He called her a Bitch and she said, if I'm a bitch, you are a bitch, it takes one to know one. They were arguing back and forth. I couldn't hear exactly what they said."

Record review of Progress Notes revealed, "4/18/19 14:05, Type: Gen Nurses Notes - narrative, Note Text: Writer approached the

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resident to give him his medication and he stated 'I am not taking them for you', writer in return asked Director of Nursing (DON) who was standing at the nurse's station and she gave the resident his medication, he took his medication just fine for me yesterday. Author: - LPN#1 [e-SIGNED]".

Record review of Progress Notes revealed, "4/19/2019 14:45, Type: Gen Nurses Notes - narrative, Note Text: The resident continues to refuse to take his medications from me, other nurses have been giving him his medications for me, writer continues to maintain a professional level with him, he is stating to other staff and residents that he don't trust me and stating that I pushed him into the wall, which is not true. No acute distress noted, will continue to medicate and monitor per MD orders as the resident will allow. Author: LPN #1 [e-SIGNED]".

Review of LPN #1's personnel file revealed a "Disciplinary Action Record", dated 4/24/19, that documented LPN #1 was suspended on 4/3/19, for using profanity in the presence of residents. A "Disciplinary Action Record" dated 4/25/19, documented LPN #1 was terminated related to the 4/3/19 incident of using profanity in the presence of residents. The personnel file contained a "Corrective Action Plan", dated 6/27/18, for a verbal warning of using profanity in the common area of the facility. This indicated the facility was aware of LPN's verbal profanity in the past.

Record review of the In-service Attendance record dated 12/23/18, Topic: Neglect and Abuse in Healthcare Setting, revealed that LPN #1 attended this in-service. Review of the In-Service Training Log (General), Dated 4/17/19, In-Service

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M 500	Continued From page 14 Subject: Abuse/Neglect/Hand in Hand video, revealed LPN #1 signed the log and the Statement of Policy regarding Abuse. Record review of the Disciplinary Action Record for LPN #1, dated 4/25/19, revealed that the facility terminated her employment for using profanity in the presence of residents. Review of the Admission Record revealed the facility admitted Resident #14 on 10/7/15. Diagnoses included Abnormal Posture, Acute Pain, Edema, Aneurysm of Unspecified Site, Hypertension, Other Seizures, Diabetes Mellitus, Hemiplegia, Unspecified Affecting Left Non-dominant Side, and Dysphagia following Cerebral Infarction. Review of the Minimum Data Set (MDS) Quarterly Assessment with an Assessment Reference Date (ARD) of 1/2/19, revealed that the resident had a Brief Interview for Mental Status (BIMS) of 14, indicating intact cognitive skills for daily decision making. The facility submitted an acceptable Removal Plan on 4/26/19, for the IJ. Review of the facility's Removal Plan revealed the facility took the following corrective actions to remove the IJ prior to exit: 1. The facility failed to assure the resident was free from verbal abuse and failed to report the abuse within the required two (2) hour reporting period, failing to keep the resident safe. On April 3, 2019, at approximately 10:00 PM, Resident #14 reported an allegation of verbal abuse against Licensed Practical Nurse (LPN) #1. The allegation consisted of the Resident #14 using a	M 500		

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derogatory name towards LPN #1. LPN #1 responded to the resident by using the same derogatory name. This occurred around the nursing station. LPN #3 stated she heard LPN #1 say "If I'm a bitch, you are a bitch. It takes one to know one" at the nurses station. LPN #2 stated she heard LPN #1 say "Mother Fucker". The Administrator was immediately notified by LPN #2 at approximately 10:00 PM. LPN #1 was immediately suspended, abuse in-services and the abuse investigation was initiated.

2. The following parties were notified of the incident:
· Responsible party was notified April 4, 2019 at approximately 10:38 AM.
· Primary Physician was notified April 4, 2019 at 12:50 PM.
· Medical Director was notified April 4, 2019 at 11:44 AM.
· Mississippi State Department of Health was notified April 4, 2019 at 5:20 PM.
· Mississippi State Attorney General was notified April 4, 2019 at 5:01 PM.
· Mississippi State Board of Nursing was notified April 25, 2019 at 9:11 PM.

3. LPN #1 was brought back on April 17, 2019, and received an inservice on abuse, neglect, and exploitation. She was then assigned to Resident #14, thus not protecting the residents in the facility from further abuse and the facility not following their policy for abuse. LPN #1 was subsequently suspended on April 24, 2019, pending an investigation. LPN #1 was terminated on April 25, 2019, for verbal abuse against Resident #14.

4. On April 24, 2019, at approximately 9:00 AM, the Administrator removed LPN #1 from all

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M 500	Continued From page 16 resident care areas. 5. On April 24, 2019, beginning at approximately 8:00 PM, the Administrator, Director of Nursing (DON), Staff Development Coordinator (SDC), and Assistant DON initiated education with staff, including Certified Nursing Assistants, licensed nurses, housekeeping staff, business office staff, therapy staff, dietary staff and administrative staff on Abuse and Neglect Prohibition Policy, Resident Rights, reporting abuse and/or neglect within the required two (2) hour time frame. Focus was placed on immediately removing the resident from the abuse situation; reporting all allegations of abuse, neglect and exploitation to the Administrator immediately; and that any staff member accused of abuse, neglect or exploitation will be suspended immediately pending investigation. No staff member will be allowed to return to work without completing required education. Currently, 76 of 88 staff members have completed required education. 6. On April 24, 2019, beginning at approximately 8:45 PM, the Interim Director of Nursing, Corporate Clinical Specialist, Assistant Director of Nursing (ADON) and Staff Development Coordinator (SDC) provided posttest to employees in regards to Abuse and Neglect prohibition policy that was initiated on April 24, 2019, to ascertain understanding of Abuse and Neglect prohibition policy training. Any employee that was not able to answer the posttest answers correctly was provided a one-to-one (1:1)re-education at that time. No staff will be allowed to return to work without completing the required education posttest. 7. On April 24, 2019, beginning at approximately 9:15 PM, Social Worker, Human Resource	M 500		

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M 500	Continued From page 17 Director, Business Office Manager (BOM), Respiratory Therapist, Assistant BOM, Activities Director, Minimum Data Set nurses, SDC, Registered Nurse (RN) Charge Nurse interviewed forty-five (45) residents in the facility at that time, with a Brief Interview of Mental Status (BIMS) of 12 or higher, in regards to had they ever experienced any verbal or physical abuse. Findings of the interviews were reviewed by the Administrator to determine any on-going or previously unidentified allegations of abuse and/or neglect; two (2) residents relayed information from a prior incident, which was investigated and reported. No abuse was substantiated. 8. On April 24, 2019, beginning at approximately 9:00 PM, the Corporate Clinical Specialist, both MDS nurses and the Regional Case Mix Specialist reviewed clinical documentation for Resident #14, to determine any negative changes to daily routines, activity participation, socialization, meal intake; Resident #14 began refusing medication from LPN #1 on April 18, 2019. No other changes where identified with Resident #14. 9. On April 24, 2019 and April 26, 2019, the Chief Operating Officer in-serviced the Director of Field Human Resources on the policy and procedures for Abuse and Neglect. 10. On April 25, 2019 at approximately 12:30 PM, the grievance log, beginning January 1, 2019 through April 25, 2019, and incident log, beginning January 1, 2019 through April 25, 2019, were reviewed by the Administrator to identify potential allegations abuse/neglect for reporting potential. No grievances or incidence were identified as a potential allegation that had not	M 500		

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M 500	Continued From page 18 already been reported. 11. On April 25, 2019, at 2:00 PM, the Medical Director, Administrator, interim Director of Nursing, Social Services Director, Activities Director, BOM, SDC, ADON, Dietary Supervisor, Housekeeping Supervisor, Maintenance Director, HR director and Director of Rehab held a Quality Assurance Performance Improvement (QAPI) meeting following notification of Immediate Jeopardy to review steps initiated to identify any on-going or previously unreported allegations of abuse and/or neglect and to administer posttest to employees to determine understanding of education provided. There were no new policy or procedure changes. 12. Facility is alleging that all activities to remove the Immediate Jeopardy were completed as of April 25, 2019, and the Immediate Jeopardy was removed April 26, 2019. The State Agency (SA) validated the facility's Removal Plan and determined the facility took the following actions to correct the IJ: 1. The SA validated that Resident #14 was not free from verbal abuse and the facility failed to report the abuse within the required two (2) hour reporting period, failed to keep residents safe. On April 3, 2019, at approximately 10:00 PM, Resident #14 reported an allegation of verbal abuse against Licensed Practical Nurse (LPN) #1. The allegation consisted of the Resident #14 using a derogatory name towards LPN #1 and LPN #1 responded to the resident by using the same derogatory name. This occurred around the nursing station. The SA validated through interviews that LPN #3 stated she heard LPN #1 say "If I'm a bitch, you are bitch. It takes one to	M 500		

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M 500	Continued From page 19	M 500		

know one" at the nurses station. LPN #2 stated she heard LPN #1 say "Mother Fucker". The Administrator was notified by LPN #2. LPN #1 was suspended, abuse in-services and the abuse investigation was initiated.

2. The following parties were notified of the incident:
· The SA validated through interview with the Responsible Party that she was notified April 4, 2019, of the alleged abuse.
· The SA validated through interview with the Administrator and record review that the Primary Physician was notified April 4, 2019, of the alleged abuse.
· The SA validated through interview with the Medical Director that he was notified April 4, 2019, of the alleged abuse.
· The SA validated through interview with the Administrator and record review that the Mississippi State Department of Health was notified April 4, 2019, of the alleged abuse.
· The SA validated through interview with the Administrator and record review that the Mississippi State Attorney General was notified April 4, 2019, of the alleged abuse.
· The SA validated through interview with the Administrator and record review that the Mississippi State Board of Nursing was notified April 25, 2019, of the alleged abuse by LPN #1.

3. The SA validated through interview with LPN #1 and the Administrator and record review that LPN #1 was suspended and was brought back to work on April 17, 2019, and received an inservice on abuse, neglect, and exploitation. She was then assigned to Resident #14, thus not protecting the residents in the facility from further abuse and the facility not following their policy for abuse. LPN #1 was subsequently suspended on April 24, 2019,

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pending an investigation. The SA validated that LPN #1 was terminated on April 25, 2019, for verbal abuse against Resident #14.

4. The SA validated through interview with the Administrator and LPN #1 and record review, that on April 24, 2019, the Administrator removed LPN #1 from all resident care areas and placed her in another building with Medical Records duty.

5. The SA validated through interview with the Administrator, and staff from Nursing, Dietary, Social Services, Therapy, Business Office and Housekeeping/Maintenance and record review that on April 24, 2019, beginning at approximately 8:00 PM, the Administrator, DON, SDC and ADON initiated education with staff, including Certified Nursing Assistants, licensed nurses, housekeeping staff, business office staff, therapy staff, dietary staff and administrative staff on Abuse and Neglect Prohibition Policy, Resident Rights, reporting abuse and/or neglect within the required two (2) hour time frame. Focus was placed on immediately removing the resident from the abuse situation; reporting all allegations of abuse, neglect and exploitation to the Administrator immediately; and that any staff member accused of abuse, neglect or exploitation will be suspended immediately pending investigation. No staff member was allowed to return to work, without completing required education. Currently, 76 of 88 staff members have completed required education.

6. The SA validated through interview with the Administrator and staff from Nursing, Dietary, Social Services, Therapy, Business Office and Housekeeping/Maintenance and record review that on April 24, 2019, beginning at approximately 8:45 PM, the interim Director of Nursing,

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M 500	Continued From page 21 Corporate Clinical Specialist, Assistant Director of Nursing (ADON) and Staff Development Coordinator (SDC) provided posttest to employees in regards to Abuse and Neglect prohibition policy that was initiated on April 24, 2019, to ascertain understanding of Abuse and Neglect prohibition policy training. Any employee that was not able to answer the posttest answers correctly was provided a one-to-one (1:1) re-education at that time. No staff was allowed to return to work without completing the required education posttest. 7. The SA validated through interview with the Administrator and record review that on April 24, 2019, the Social Worker, Human Resource Director, Business Office Manager (BOM), Respiratory Therapist, Assistant BOM, Activities Director, Minimum Data Set nurses, SDC, Registered Nurse (RN) Charge Nurse interviewed forty-five (45) residents in the facility at that time, with a BIMS of 12 or higher, in regards to had they ever experienced any verbal or physical abuse. Findings of the interviews were reviewed by the Administrator to determine any on-going or previously unidentified allegations of abuse and/or neglect; two (2) residents relayed information from a prior incident, which was investigated and reported. The SA validated no abuse was substantiated. 8. The SA validated through interview with the Administrator, Corporate Clinical Specialist, and one (1) MDS nurse, that on April 24, 2019, the Corporate Clinical Specialist, both MDS nurses and the Regional Case Mix Specialist reviewed clinical documentation for Resident #14, to determine any negative changes to daily routines, activity participation, socialization, meal intake; Resident #14 began refusing medication from	M 500		

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M 500	Continued From page 22 LPN #1 on April 18, 2019. No other changes where identified with Resident #14. The SA validated that Resident #14 did receive medication from other nurses. 9. The SA validated through interview with the Chief Operating Officer, and dated/signed in-service sheets, that the Director of Field Human Resources was educated on the abuse and neglect policy and procedures with emphasis of investigation and to err on the side of the resident. 10. The SA validated through interview with the Administrator and record review that on April 25, 2019, the grievance log, beginning January 1, 2019 through April 25, 2019, and incident log, beginning January 1, 2019 through April 25, 2019, were reviewed by the Administrator to identify potential allegations abuse/neglect for reporting potential. No grievances or incidence were identified as a potential allegation that had not already been reported. 11. The SA validated through interview with the Administrator and record review that on April 25, 2019, at 2:00 PM, the Medical Director, Administrator, interim Director of Nursing, Social Services Director, Activities Director, BOM, SDC, ADON, Dietary Supervisor, Housekeeping Supervisor, Maintenance Director, HR director and Director of Rehab held Quality Assurance Performance Improvement meeting following notification of Immediate Jeopardy to review steps initiated to identify any on-going or previously unreported allegations of abuse and/or neglect and to administer posttest to employees to determine understanding of education provided. There were no new policy or procedure changes.	M 500		

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M 500	Continued From page 23 12. The SA validated that all corrective actions were completed as of 4/25/19, and the IJ was removed as of 4/26/19.	M 500		
M 620	45.21.4 Urinary incontinence Urinary incontinence. Residents with urinary incontinence shall be assessed for need of bladder retraining program. An indwelling catheter will not be used unless the resident ' s clinical condition indicates that catheterization is necessary. These residents shall receive treatment and services to prevent urinary tract infections. Level II Based on observation, staff interview, and facility policy review, the facility failed to provide incontinent care in a manner to clean the resident thoroughly and prevent the possible spread of infection for one (1) of three (3) incontinent care observations, Resident #32. Findings include: Review of the facility's policy, titled, "Perineal Care", revealed the purposes of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition. The staff should wash the perineal area from front to back. Separate the labia and wash area downward from front to back. wash perineum moving from inside outward to the thighs. During an observation on 04/24/19 at 9:54 AM, of incontinent care with Certified Nursing Assistant (CNA) #8, revealed Resident #32's legs were	M 620	M620 1. Resident # 32 was evaluated by Corporate Clinical Specialist on 4/27/19 regarding amount assistance needed for incontinent care. Resident #32□s care plan was reviewed and revised by the interdisciplinary team on 5/16/19 in regards to the number of staff to provide incontinent care. Resident #32 was assessed on 4/27/2019 by Corporate Clinical Specialist with No S/S of infection, No negative findings. On 4/24/2019, CNA#8 was in-serviced on Incontinent care, infection control related incontinent care and assistance with Incontinent care by Lead Certified Nursing Assistant and Corporate Clinical Specialist. 2. On 5/19/19 care plans and Kardexes for Residents who are dependent on staff for incontinent care, were evaluated to determine if they accurately reflected the number of staff members needed to deliver incontinent and were updated by	5/31/19

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M 620	Continued From page 24	M 620		

contracted tightly. CNA #8 took a wet wipe and wiped between Resident #32's legs three (3) times. The surveyor was unable to see what part of the resident's body was cleaned with the wet wipe. CNA #8 did not spread the labia and clean the resident thoroughly.

During an interview on 04/24/19 at 9:55 AM, CNA #8 revealed she didn't know how to get to the resident's perineal area without sticking her hands between Resident #32's legs and wiping the perineal area. CNA #8 confirmed because the resident is contracted and unable to open her legs, she has to feel with the wipes. CNA #8 stated that she always cleaned the resident without assistance.

During an interview on 04/24/219 at 3:30 PM, Registered Nurse (RN) #4 confirmed Resident #32 is a two (2) person extensive assist with hygiene. RN #4 stated that CNA should have gotten assistance and turned the resident onto her side and cleaned her from the backside, so that her vaginal area could be seen better and cleaned better.

Review of the facility's "Incontinent Care Skills" log revealed Certified Nursing Assistant (CNA) #8 was trained on how to provide appropriate incontinent care, dated 3/6/2019.

Review of the care plan revealed Resident #32 had a history of Urinary Tract Infections (UTI). Interventions included good hygiene practices.

A review of the facility's face sheet revealed the facility admitted Resident #32 on 03/1/18, with diagnoses, which included Urinary Tract Infection, Diabetes Mellitus, Pressure Ulcer and Anemia. A review of Resident #32's Quarterly Minimum Data

the Minimum Data Set Registered Nurses and Corporate Clinical Specialist.

3. Residents who require Incontinent care have the potential to be affected.
Facility Certified Nursing Assistants and licensed nurses were in-serviced on 5/16/19 by Staff Development Coordinator in regards to following residents care plans which will reflect the care needs and amount of support needed to provide care and on reporting resident care changes in order for care plan to be reviewed and revised. Beginning on 5/20/19 Certified Nursing Assistants were in-serviced on and performed return demonstration for hand washing and incontinent care to the Staff Development Coordinator/Lead C.N.A.
On 5/22/19 Corporate Administrator/Registered Nurse in-serviced facility staff on requirement to have a comprehensive care plan for each resident that accurately reflects resident care needs and care needed to be provided by staff and to report changes in resident care needs.

4. Beginning 5/27/19, the Director of Nursing/Staff Development Coordinator/Assistant Director of Nursing will conduct care observations on three (3) residents weekly for four (4) weeks, then monthly for three (3) months to determine if care is provided per the comprehensive care plan and determine if comprehensive care plan accurately reflects care needs; Beginning 5/27/19, Director of Nursing/Assistant Director of Nursing/Staff Development Coordinator/Registered

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M 620	Continued From page 25 Set (MDS), with an Assessment Reference Date (ARD) of 1/10/2019, revealed Resident #32 had a Brief Interview for Mental Status (BIMS) score of 99, which indicated the resident is severely cognitively impaired and/or was unable to complete the BIMS.	M 620	Nurses will perform incontinent care observations with three (3) Certified Nursing Assistants weekly for four (4) weeks, then monthly for three (3) months,concerns will be discussed with interdisciplinary team. A report will be submitted to the Quality Assurance Performance Improvement committee monthly for three (3) months for review and further recommendations by the Staff Development Coordinator. The Director of Nursing is responsible for monitoring and compliance.	
M 655	45.21.11 Special needs Special needs. Each resident with special needs shall receive proper treatment and care. These special needs shall include, but are not limited to injections; parenteral and enteral fluids; colostomy, ureterostomy, ileostomy care; tracheostomy care; tracheal suction; respiratory care; foot care; and prostheses. This Statute is not met as evidenced by: Level II Based on observation, staff interview and facility policy review, the facility failed to ensure respiratory therapy treatments were provided by the appropriate licensed personnel, designated in the plan of care, and as ordered for one (1) of (27) residents reviewed, Resident #65. Findings include: Review of Resident #65's current care plan revealed a problem with shortness of breath. One	M 655	M655 1. Resident #65 was evaluated by Licensed Nurse and assessed by Registered Nurse for any adverse reactions on 4/22/19; no concerns identified. Nebulizer mask was discarded and replaced with a new mask on 4/22/19, by Director of Nursing. Certified Nursing Assistant #1 was provided one-to-one education on 4/22/19, by Corporate Clinical Specialist and Director of Nursing regarding removing nebulizer masks being the responsibility of the licensed nurse or	5/31/19

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M 655	Continued From page 26 (1) intervention revealed to administer medications as ordered. This intervention was documented for the Licensed Nurse (LN) or Respiratory Therapist (RT) to implement. Review of the facility's policy titled, "Administering Medications", dated December 2012, revealed Medications shall be administered in a safe and timely manner, and as prescribed. Only persons licensed or permitted by this state to prepare, administer and document the administration of medications may do so. Medications must be administered in accordance with the orders, including any required time frame. The individual administering the medication will record in the resident's medical record the signature and titled of the person administering the medication. A review of the document titled, "Standard 14: Nurse Aide Scope of Practice" provided by https://secure.in.gov, revealed the Nurse Aide will not administer any medications, perform treatment or apply or remove any dressings. A review of the facility's policy titled, "Departmental (Respiratory Therapy) Prevention of Infection", dated November 2011, revealed, "The following information should be recorded in the resident chart : the date and time the respiratory therapy was performed, the type of respiratory treatment performed, the name and title of the individual who perform the respiratory therapy, if the resident refused therapy, the reason why and what was done as a result and the signature of the person recording the information". A review of Resident #65's Medication Administration Record (MAR) revealed Resident #65 received Albuterol Sul Nebulizer every six (6)	M 655	respiratory therapist and concerns should be reported to immediate supervisor; Physician/Medical Director was notified. Licensed Nurse #5 was provided one-to-one education by Corporate Clinical Specialist and Director of Nursing on 4/22/19, regarding remaining within line of sight of residents receiving nebulizer treatments, documentation requirements, cleaning and storage. 2. On 5/10/19, an audit was conducted by Medical Records Nurse related to residents of the facility with orders for nebulizer treatments. There are twenty-two (22) residents who have physician orders for nebulizer treatments and are at risk related to this deficient practice. 3. On 5/20/19, facility Certified Nursing Assistants were in-serviced by Staff Development Coordinator in regards to not removing nebulizer or oxygen masks and to report concerns regarding nebulizers or other care concerns to licensed nurse or respiratory therapist; removing nebulizer mask is not in the scope of practice for a Certified Nursing Assistant. Beginning on 5/20/19 Licensed Nurses will complete return demonstration of administration of nebulizer treatments with Staff Development Developer/Respiratory Therapist of three (3) residents with orders for nebulizer treatments, weekly for four (4) weeks, then monthly for three (3) months. On 5/20/19, Medical Records Nurse began in-servicing licensed nurses on entering nebulizer treatment orders into electronic health record system and	

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M 655	Continued From page 27 hours as needed for Chronic Obstructive Pulmonary Disease. An observation on 04/22/19 at 9:25 AM, revealed Resident #65 sitting in the hallway close to the nurse's station in her wheelchair. Resident #65 appeared anxious and wheezing when she took a breath. A by-passing staff member turned and faced the nursing station toward Licensed Practical Nurse (LPN) #5 and said, "She wants a breathing treatment," and pointed to Resident #65. An observation on 04/22/19 at 9:49 AM, revealed Resident #65 sitting in her wheelchair in the doorway of her room with the nebulizer mask on her face and the nebulizer machine was turned on. LPN #5 was standing at the medication cart approximately 40 feet down from Resident #65's room. Resident #65 was yelling and trying to roll herself to the door in her wheelchair. CNA #1 was attempting to pull the resident's wheelchair back into the room since she had the nebulizer mask on. CNA #1 removed the nebulizer mask from the Resident #65's face. LPN #5 began walking toward Resident #65's room. CNA #1 told LPN #5, she removed the nebulizer mask because the resident wasn't doing right. LPN #5 asked CNA #1 if the breathing treatment was finished and CNA #1 stated, "No, but she ain't gonna do right". LPN #5 turned around and walked off from Resident #65's room back to the medication cart. When asked if the resident's breathing treatment was finished, CNA #1 stated, that it was not. After removing the nebulizer mask from Resident #65's face, CNA #1 placed the mask on the night stand in Resident #65's room. The Nebulizer mask was lying on the nebulizer machine itself, not in a bag. Observation,at this time, revealed the nebulizer machine and it had fluid in the holding chamber.	M 655	completing documentation with each new order. On 5/22/19 Corporate Administrator/Registered Nurse in-serviced facility staff in regards to Certified Nursing Assistants not removing nebulizer masks, reporting care concerns to licensed nurse, licensed nurses administering nebulizer treatments per orders, staying within line of sight of resident during administration of nebulizer and appropriately documenting nebulizer administration. 4. Beginning on 5/27/19, the Staff Development Coordinator/Respiratory Therapy Manager will conduct an audit by observation of three (3) residents with orders for nebulizer treatments, weekly for four (4) weeks, then monthly for three (3) months to validate nebulizer masks are cleaned and stored appropriately. The Staff Development Coordinator will report findings to the Quality Assurance Performance Improvement committee monthly for three (3) months for review and further recommendations. The Director of Nursing is responsible for monitoring and compliance.	

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M 655	Continued From page 28 LPN #5 was asked if she had placed the nebulizer on Resident #65 and she stated, "Yes". When ask what was in the nebulizer, LPN #5 confirmed it was Albuterol. An observation on 04/25/19 10:10 AM revealed medication still in chamber of nebulizer machine and mask still lying on the machine not bagged. An observation on 04/22/19 at 2:50 PM, revealed the nebulizer medication was still present in the holding chamber of the nebulizer mask and the mask still lying on the nebulizer machine itself, not in a bag. An interview on 04/22/19 at 02:55 PM, with LPN #5, revealed she walked to the door to see what was happening and why the resident was yelling. She stated she saw the nebulizer off the resident and asked the CNA if the breathing treatment was finished; she said, "No, she ain't gonna do right." LPN #5 stated she thought Resident #65 took the nebulizer off and didn't realize CNA #1 had taken it off. At this time, LPN #5 was ask to go into Resident #65's room and check the nebulizer. LPN #5 looked in the nebulizer holding compartment and confirmed there was medication still present in the container at this time. LPN #5 took a plastic cup and poured the medication from the machine into the cup and left out of the room and destroyed the medication by throwing the cup into the garbage on the medication cart. Medication was not finished nor attempted to be finished by LPN #5. LPN #5 verified the nebulizer mask was not in a bag upon entry to the room, but rather placed across the nebulizer machine itself. LPN #5 left Resident #65's room and returned with a bag. LPN #5 placed the nebulizer mask in the bag.	M 655		

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M 655	Continued From page 29 An interview on 04/22/19 at 3:05 PM, with CNA #1, revealed she recalled taking the nebulizer mask off of Resident #65. She stated the only reason she removed the mask was to prevent the resident from dragging the tubing because she was rolling towards the door. She stated she laid the mask on the table. An interview on 04/25/19 at 8:50 AM, with Lead CNA #5, revealed if a nebulizer is lying around, the nurse was to be notified. She stated it should be stored in a clear bag. CNA #5 stated that CNA #1 removing the nebulizer mask from Resident 65's face is not in the scope of the CNA practice. CNA #5 stated the CNA's could not mess with medications. CNA #5 stated during the Orientation Process, the different department heads come in and speak to the new CNAs and tells them what they can and cannot do within their scope of practice. She stated the information is also in the orientation packet. An interview on 04/25/19 at 9:18 AM, with Registered Nurse (RN) #4 revealed, "The CNA's are provided with a checklist in orientation of what they can or cannot do in a facility. It is not within the scope of the CNA's practice for CNA #1 to do anything with medication". An interview on 04/25/19 at 12:30 PM with Interim Director of Nursing (DON) #1 revealed "the CNA did not act within the scope of her practice by removing the nebulizer mask with medication in it". During an interview on 04/25/19 at 12:33 PM, Interim DON #1 revealed the LPN not ensuring that the resident received the full breathing treatment is not following the physician's order. She stated the LPN should have followed up with	M 655		

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M 655	Continued From page 30	M 655		

the breathing treatment medication not being given, and she should have notified the physician that the medication wasn't completely given.

Review of Resident #65's Medication Administration Record (MAR) revealed LPN #5 did not sign the MAR on 4/22/19, for the resident's Albuterol treatment being administered.

An interview on 04/25/19 at 4:23 PM, with LPN #5, revealed, "I put Albuterol in the nebulizer and placed the nebulizer on the Resident #65's face". LPN #5 stated, when asked why she didn't try to complete the breathing treatment for Resident #65, "She would have got combative if I had tried to put it back on her. That's just the way she is". When LPN #5 was ask why she didn't sign the Medication Administration Record for the Albuterol Medication, LPN #5 stated, "It wasn't signed? I guess I just forgot but it was really crazy here that day."

An interview on 04/26/19 at 4:38 PM, with the Administrator, revealed she wasn't aware that LPN #5 was down the hall from the nebulizer treatment that was in progress. She stated she wasn't aware that she did not sign the MAR until now. She stated that LPN #5 should have signed the MAR that she administered the medication and notified the RN Supervisor and the physician when it was removed from the resident and not finished.

An interview on 04/26/19 at 12:15 PM, with Interim DON #3, revealed, "It is not in the Scope of Practice for CNA #1 to remove a nebulizer mask from Resident #65. CNA #1 should have went and got the nurse for assistance. LPN #5 should have evaluated the resident and then notified the Registered Nurse Supervisor for an

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M 655	Continued From page 31 assessment and then notify the physician regarding the issue. At that point the physician could make a call as to whether another treatment was necessary at that time based on the assessment. Interim DON #3 stated that LPN #5 should not have been down the hall, she should have stayed with the resident during medication administration of the breathing treatment.	M 655		
M 735	45.25.1 Medical Records Management Medical Records Management. 1. A medical record shall be maintained in accordance with accepted professional standards and practices on all residents admitted to the facility. The medical records shall be completely and accurately documented, readily accessible, and systematically organized to facilitate retrieving and compiling information. 2. A sufficient number of personnel, competent to carry out the functions of the medical record service, shall be employed. 3. The facility shall safeguard medical record information against loss, destruction, or unauthorized use. 4. All medical records shall maintain the following information: identification data and consent form; assessments of the resident's needs by all disciplines involved in the care of the resident; medical history and admission physical exam; annual physical exams; physician or nurse practitioner/physician assistant orders; observation, report of treatment, clinical findings and progress notes; and discharge summary,	M 735		5/31/19

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M 735	Continued From page 32 including the final diagnosis. 5. All entries in the medical record shall be signed and dated by the person making the entry. Authentication may include signatures, written initials, or computer entry. A list of computer codes and written signatures must be readily available and maintained under adequate safeguards. 6. All clinical information pertaining to the residents stay shall be centralized in the resident's medical records. 7. Medical records of discharged residents shall be completed within sixty (60) days following discharge. 8. Medical records are to be retained for five (5) years from the date of discharge or, in the case of a minor, until the resident reaches the age of twenty-one (21), plus an additional three (3) years. 9. A resident index, including the resident's full name and birth date, shall be maintained. This Statute is not met as evidenced by: Level II Based on observation, staff interview, and facility policy review, the facility failed to have an accurate medical record for one (1) of 24 records reviewed, Resident #65, for failure to document the respiratory treatment on the Medication Administration Record (MAR) for medication initiation/completion. Findings include:	M 735	M735 1. On 5/10/19, Medical Records licensed nurse reviewed orders for Resident #65 and corrected order entry for respiratory treatment in the electronic medication administration record. 2. Resident with respiratory treatments have the potential to be affected. On 5/10/19, Medical Records licensed nurse reviewed respiratory orders for	

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M 735	Continued From page 33 Review of the facility's policy titled, "Administering Medications", dated December 2012, revealed, "Medications should be administered in a safe and timely manner and as prescribed. As required or indicated for a medication, the individual administering the medication will record in the residents medical record the signature and title of the person administering the drug". An observation on 04/22/19 at approximately 9:49 AM, revealed Resident #65 sitting in her wheelchair in the doorway of her room with the nebulizer mask on her face and the nebulizer machine was turned on. Licensed Practical Nurse (LPN) #5 was standing at the medication cart approximately 40 feet down from Resident #65's room. LPN #5 confirmed she had placed the nebulizer on Resident #65 and confirmed the medication in the nebulizer was Albuterol. Review of Resident #65's Medication Administration Record (MAR) revealed LPN #5 did not sign the MAR on 4/22/19, for the Resident's Albuterol treatment being initiated/administered. There was no documentation that the medication had not been completed after it was initiated, or the reason why it was not completed. An interview on 04/25/19 at 4:23 PM, with LPN #5, revealed, "I put Albuterol in the nebulizer and placed the nebulizer on the resident". LPN #5 confirmed the medication was not completed during the treatment. When asked why she didn't try to complete the breathing treatment for Resident #65, LPN #5 stated the resident would have become combative if she had attempted, stating, "That's just the way she is". When LPN #5 was asked why she didn't sign the Medication Administration Record (MAR) for any part of the	M 735	twenty-two (22) residents in regards to order being entered correctly in electronic medication administration record, corrections were made as indicated. 3. On 5/20/19, licensed nurses were in-serviced by Medical Records Nurse, on required components for entering respiratory orders into electronic medication administration record and requirement to complete documentation with each treatment and how to document by exception. 4. Beginning on 5/27/19, the Director of Nursing/Assistant Director of Nursing/Staff Development Coordinator/Respiratory Therapist will conduct observations of licensed nurse completing administration of nebulizer treatments and review of documentation after treatment to ensure administration of nebulizer treatments is being documented correctly; observations will be conducted on three (3) residents weekly for four (4) weeks. The Director of Nursing will report findings to the Quality Assurance Performance Improvement committee monthly for three (3) months for review and further recommendations. The Director of Nursing is responsible for monitoring and compliance. 1.Comprehensive care plan was reviewed and revised to reflect current status for Resident # 32 related to assistance needed in regards to incontinent care on 5/16/19 by interdisciplinary team. 2. On 5/23/19 an audit was conducted by Registered Nurses for residents currently in the facility to determine if a	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	75VT	A. BUILDING: _____ B. WING _____	04/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BLUFFS REHABILITATION AND HEALTHCARE C	2850 PORTER'S CHAPEL ROAD VICKSBURG, MS 39180

(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 735	Continued From page 34 breathing treatment that Resident #65 received, she stated, "It wasn't signed? I guess I just forgot, but it was really crazy here that day." An interview on 04/25/19 at 12:33 PM, with Interim Director of Nursing (DON) #1, revealed if LPN #5 gave the Albuterol, then LPN #5 should have signed the MAR for the medication. An interview on 04/26/19 at 4:38 PM, with Administrator, revealed that she wasn't aware that LPN #5 did not sign the MAR. She stated, "She should have signed the MAR that she administered the medication and notified the Registered Nurse (RN) Supervisor and the physician when it was removed from the resident and not finished".	M 735	comprehensive care plan was completed. All residents have the potential to be affected. 3. On 5/22/19 the interdisciplinary team members were educated by Corporate Clinical Specialist in regards to requirement of each resident having comprehensive care plan that is developed by the interdisciplinary team based on assessments of resident specific care needs. On 5/22/19 Corporate Support Administrator/Registered Nurse in-serviced facility staff regarding requirement of facility to develop, implement and revise a comprehensive care plan for that addresses each residents specific care needs. 4. Beginning 5/27/19, an audit will be conducted weekly for four (4) weeks, then monthly for three (3) months by the Director of Nursing/Assistant Director of Nursing to review completion and accuracy of the comprehensive care plan for three (3) residents. A report will be submitted to the Quality Assurance Performance Improvement committee monthly for three (3) by the Director of Nursing for review and further recommendations. The Director of Nursing is responsible for monitoring and compliance.	