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
	NH08VC	A. BUILDING: _____ B. WING _____	C 07/22/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VAIDEN COMMUNITY LIVING CENTER	868 MULBERRY STREET VAIDEN, MS 39176

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) conducted a complaint survey, MS #16930 at the facility on 07/23/2020. During the survey, the SA determined that the facility was not in compliance with the Mississippi Regulations for Minimum Standards for Aged or Infirm. The SA substantiated the complaint for Abuse and Neglect and cited M500. The census at the time of the survey was 46, with a bed capacity of 60.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his	M 500		8/14/20

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M 500	Continued From page 1	M 500		

medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action;

4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record;

5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal;

6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the

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M 500	Continued From page 2	M 500		

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: Based on staff interview, resident interview, record review, and policy and procedure review, the facility failed to ensure Resident #1 was free from abuse and neglect, for one (1) of five (5) residents reviewed.	M 500	1.Allegation of abuse was reported immediately by the Administrator to the Mississippi State Department of Health on 7/20/20 when reported to Administrator. Certified Nursing Assistant #1 was suspended immediately pending	

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M 500	Continued From page 4 Findings include: Review of the facility's "Abuse and/or Neglect Prevention Plan Policy", dated 02/18/2009, revealed: "The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion." The policy revealed the definition of Verbal Abuse as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. A review of the facility's Accident/Incident (A/I) Report, dated 07/17/2020, completed by Licensed Practical Nurse (LPN) #1, revealed, upon making rounds, she entered Resident #1's room and noted the resident was upset. The A/I Report revealed, Resident #1 reported to LPN #1 that Certified Nursing Assistant (CNA) #1 had been rude to her. Resident #1 reported she was transferring herself to the commode by without assistance, and CNA #1 stated to her, "That's why your ass is always on the floor." On 07/23/2020 at 8:40 AM, an interview with the Administrator, revealed, she was notified of an incident that occurred between CNA #1 and Resident #1 on 07/20/2020 at approximately 12:00 noon. The Administrator stated the incident occurred on 07/17/2020, early AM, and was reported to her by the Director of Nursing (DON). The Administrator stated the employee (CNA #1) was called on 07/20/2020 and admitted to saying the word "ass" to Resident #1 and was very apologetic. The Administrator stated CNA #1's employment was terminated at that time and the incident was reported to State officials. The Administrator stated all employees had been	M 500	investigation and terminated on 7/20/20. Resident #1 was assessed immediately on 7/20/20 by the Director of Nursing and Social Worker for any physical or emotional distress with no negative outcomes found. The facility will correct the alleged deficiency by ensuring Resident #1 is safe from abuse as evidenced by no physical or emotional distress x three days monitored by Social Worker, ensuring Resident #1 feels safe in facility and educating Resident # 1 on actions taken by facility to ensure alleged deficient practice does not reoccur. 2.All residents have the potential to be affected by the alleged deficient practice. Thirteen residents able to be interviewed as evidenced by a BIMS score of 12 or above were questioned on 7/20/20 by the Administrator to ensure safety from abuse/neglect and to ensure all allegations were investigated and reported immediately. No negative findings were found. The facility will act to protect residents in similar situations by following abuse policy and prevention plan and ensuring current and newly hired staff are educated on abuse and neglect prevention plan monthly and more often as needed and understand it. Education will also include what is considered abuse and timely reporting of any abuse/neglect or suspected abuse and neglect. The Social Worker will complete weekly visits with at least five residents beginning 7/20/20 to ensure no further concerns are noted x four weeks and longer thereafter if problems are identified. If concerns are expressed, Social Worker will immediately	

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M 500	Continued From page 5 recently in-serviced on reporting abuse and neglect. The Administrator stated the staff was aware that the incident should have been reported within two (2) hours of occurrence but did not report it timely. On 07/23/2020 at 9:00 AM, an interview with Resident #1, revealed she had asked CNA #1 to take her to the bathroom this past Friday morning (07/17/2020). Resident #1 stated CNA #1 was busy at the time and came back a few minutes later. Resident #1 stated she was trying to take herself to the bathroom when CNA #1 came in and he said to her, "That's why your ass keeps falling because you won't wait for help." Resident #1 stated she told CNA #1 it was ok, that he didn't have to help her, and that she could get someone else. Resident #1 revealed CNA #1 stated, "Oh no, I'm going to help you." Resident #1 stated he (CNA #1) had never acted like that before. Resident #1 stated it hurt her feelings because he talked to her like that. Resident #1 stated, "I don't know what was wrong with him, he's never done me like that." Resident #1 reported CNA #1 did not return to her room after this incident. On 07/23/2020 at 9:30 AM, during an interview with the Director of Nursing (DON), she stated that she was notified of the incident between Resident #1 and CNA #1 on 07/20/2020. The DON stated she was on vacation and was notified upon her return to work on the 20th of July. The DON stated she and the Social Worker interviewed Resident #1. The DON revealed Resident #1 reported that she had asked CNA#1 to help her to the bathroom. The DON stated Resident #1 reported that CNA #1 stated he was busy at the time. and told her he would come back. Resident #1 stated that she tried to take herself to the bathroom but when CNA #1 came	M 500	notify Administrator and/or Director of Nursing for a full investigation. 3.Staff inserviced by Director of Nursing on 7/20/20 regarding abuse and neglect prevention plan and immediately reporting abuse or suspected abuse to direct supervisor who will then report to Administrator or Director of Nursing. All allegations of abuse and neglect or suspected abuse will be thoroughly investigated by Administrator and/or Director of Nursing. The Director of Nursing will educate current and new staff on abuse and neglect monthly and as needed. Education will include how to identify abuse and how and when to report if abuse is known or suspected. Body audits will be completed on all residents weekly by Registered Nurse or Licensed Practical Nurse beginning 7/20/20. 4.New staff hired will be educated in orientation regarding abuse/neglect policy and prevention plan and reporting abuse or suspected abuse immediately. The Director of Nursing will educate current and new staff on abuse and neglect monthly and as needed. Education will include how to identify abuse and how and when to report if abuse is known or suspected. Social Worker will interview residents weekly x four weeks and as needed thereafter to assess and ensure residents are safe from abuse/neglect and will report the findings to the Quality Assurance and Performance Improvement Committee monthly and as needed for review. Social Worker will educate residents on weekly visits regarding how,	

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M 500	Continued From page 6 in, he stated to her, "that's why your ass keeps falling, you won't wait for help." The DON stated Resident 1's feelings were hurt because CNA #1 had cursed at her. The DON stated the incident was initially reported to the LPN on duty from 7 PM to 7 AM that morning (07/17/2020), and that the LPN told her she reported it to the oncoming Registered Nurse (RN). The DON stated CNA #1 clocked out at 7:00 AM on 07/17/2020 and did not return to work. The DON stated CNA #1 was called on 07/20/2020 for a verbal statement and admitted to cursing at Resident #1. She stated CNA #1's employment was terminated at that time. The DON stated no one in Administration was notified of the incident until 07/20/2020. On 07/23/2020 at 9:40 AM, an interview with Registered Nurse (RN) #1 revealed, no one reported an incident to her that occurred between Resident #1 and CNA #1 on 07/17/2020. RN #1 denied any knowledge of the incident. During an interview, on 07/23/2020 at 10:30 AM, LPN #1 stated Resident #1 reported to her that she was trying to get on the commode and CNA #1 said to her, that's why your ass is always on the floor, you won't wait for anyone to help you. LPN #1 stated she reported the incident to RN #1 and tried to call the DON but couldn't reach her because she was on vacation. LPN #1 stated she had training on abuse and neglect and knew the incident had to be reported within 2 hrs. LPN #1 stated she was getting off work and that was why she reported it to the RN coming on. LPN #1 stated she thought the RN would report it to Administration. On 07/23/2020 at 1:15 PM, during an interview with LPN #2, he stated that he was informed on Monday 07/20/2020 that Resident #1 needed to	M 500	when and to who they should report abuse or suspected abuse. Any concerns noted during monitoring and visits will be discussed by committee in Quality Assurance and Performance Improvement meeting each month and changes will be modified as needed.	

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see him. LPN #2 stated upon entering Resident #1's room, she told him that she needed to tell him about something that happened with one of the CNAs. LPN #2 stated Resident #1 started telling him about CNA #1 cursing her. He stated he told Resident #1 that he needed to get the DON so she could tell her what happened. LPN #2 stated he left the room and reported the incident to the DON and Social Worker and they immediately went to the resident's room.

During an interview, on 07/23/2020 at 1:25 PM, the Social Worker (SW) stated she was with the DON when Resident #1 reported the incident to them which occurred between her and CNA #1. The SW stated she speaks with the residents often about abuse and neglect and encourages them to report any abuse or neglect that occurs.

On 07/23/2020 at 1:50 PM, during an interview with CNA #1, he stated that he saw Resident #1 trying to transfer herself to the bathroom and he said to her, that's why your ass is always falling on the floor, because you won't buzz for help. CNA #1 stated he told Resident #1 that he was sorry for what he had said to her. CNA #1 stated he reported to the nurse on duty what had happened, and she talked to the resident. CNA #1 stated he had been trained on abuse and neglect and understands that cursing at a resident was verbal abuse.

A review of CNA #1's time sheet, revealed, his last day worked was on 07/16/2020 with him clocking out at 6:59 AM on 07/17/2020.

Review of the facility's in-service training related to abuse and neglect, revealed, the last in-service CNA #1 attended related to abuse and neglect was on 06/10/2020.

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M 500	Continued From page 8 Review of CNA #1's Personnel Action Notice, indicated CNA #1 was terminated on 07/20/2020.	M 500		