STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255288	A. BUILDING _____ B. WING _____	C 11/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF QUITMAN	**191 HIGHWAY 511 EAST QUITMAN, MS 39355**

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F 000	INITIAL COMMENTS The State Agency (SA) conducted Complaint Investigations (CIs), MS #22897 and MS #23204, at the facility, from 11/27/23 through 11/28/23. CI MS #22897 was investigated for improper incontinent care products for residents and there were no citations related to this complaint. The SA also investigated the Facility Reported Incident (FRI), MS #23204, related to employee-to-resident verbal abuse. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F600 related to CI MS # 23204. Based on the facility's implementation of corrective actions on 10/20/23, the State Agency (SA) determined the deficiency to be Past Non-Compliance (PNC) and the deficiency was corrected as of 10/21/23, prior to the SA's first entrance on 11/27/23. The facility was licensed for 120 beds and had a census of 93 at the time of the survey.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or	F 600		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 12/05/2023

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F 600	Continued From page 1 physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review, facility investigation, and policy review, the facility failed to protect a resident from verbal abuse for one (1) of four (4) residents sampled. Resident #1 Findings include: A review of the facility's policy, "Abuse, Neglect, Misappropriation Policy," dated January 2019 revealed, " ...Purpose: To prohibit and prevent abuse, neglect, exploitation, ...Definitions ...Verbal abuse includes the use of oral, written, or gestured communication, or sounds, to residents within hearing distance ..." A record review of the "Investigation Template", dated 10/24/2023, revealed on 10/20/23, the Administrator was in her office when she overheard Certified Nurse Assistant (CNA) #1 being disrespectful when yelling at Resident #1 to "be still" with profanity used. Several other residents heard the encounter with CNA #1 and Resident #1. CNA #1 admitted to using profanity to Resident #1... "Actions taken post investigation: ... CNA (Proper Name) was terminated due to poor customer service ..." A record review of the handwritten statement, dated 10/23/23, and signed by CNA #1 indicated that CNA #1 said to Resident #1, " ...why don't he stay his ass at the table ...", and "I know I shouldn't have said that to him." On 11/27/23 at 12:15 PM, during an interview with the Administrator, she confirmed that on	F 600	Past noncompliance: no plan of correction required.	

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F 600	Continued From page 2	F 600		

10/20/23, CNA #1 used a loud tone with profanity while speaking to Resident #1. She immediately escorted CNA #1 to clock out and out of the building, placing her on suspension pending the investigation. With the assistance of Registered Nurse (RN) #1 as her witness, the Administrator discussed the incident with CNA #1. CNA #1 admitted to saying, "Why don't he stay his ass at the table." The Administrator reported the incident to State Agency (SA), the Medicaid Fraud Control Unit of the Attorney General's Office (AGO), and the local police department. She stated the facility provided in-services regarding abuse prevention and dementia training to all staff and had a Quality Assurance Performance Improvement (QAPI) meeting to discuss the event and what measures would be implemented.

During a phone interview on 11/27/23 at 2:10 PM, CNA #1 confirmed that she stated to Resident #1, "Stay your ass at the table," because she was trying to redirect him that meal trays were being served. She stated that she couldn't believe what came out of her mouth and she knew better than to curse the resident. CNA #1 confirmed she had attended many in-services on abuse and resident rights before this incident occurred.

On 11/27/23 at 2:58 PM, during an interview with Registered Nurse (RN) #1, she revealed on 10/20/23, she assisted the Administrator in escorting CNA #1 out of the building. RN #1 confirmed CNA #1 admitted to cursing Resident #1 to at the dining room table.

A record review of the personnel file for CNA #1 revealed a transcript of courses attended, which included courses completed on 8/29/23 of "Abuse and Neglect", "Abuse Neglect Misappropriation

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F 600	Continued From page 3	F 600		

Exploitation Policy", and "Elder Justice Act Reporting Requirements."

Record review of the "Admission Record" revealed the facility admitted Resident #1 on 6/28/21 with diagnoses including Alzheimer's Disease and Dementia.

Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/16/23, revealed a staff interview was required for assessment and his cognitive skills for daily decision making were severely impaired.

Based on the facility's implementation of corrective actions on 10/20/23, the State Agency (SA) determined the deficiency to be Past Non-Compliance (PNC) and the deficiency was corrected as of 10/21/23, prior to the SA's first entrance on 11/27/23.

Validation:
On 11/28/23, the SA validated through staff interviews, record review, and facility policy review the facility began an immediate investigation when the incident occurred.

A review of the emergency QAPI meeting minutes revealed the facility held a QAPI meeting on 10/21/23 at 5:16 PM, in which the Infection Preventionist (IP) was out of the facility for this emergency meeting and the Medical Director attended via phone. The SA verified through an interview with the DON and Social Services Director that they attended the QAPI meeting to discuss the situation and the facility policies related to abuse were discussed and no changes needed. The QAPI meeting concluded that the Plan of Correction was to in-service all staff,

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F 600	Continued From page 4 terminate the employee, and have a resident council meeting. The SA reviewed in-service sign-in sheets that began on 10/20/23 related to abuse prevention and dementia training and the Administrator conducted in-services in which she had every employee sign the policies on abuse prevention and dementia training. On 11/28/23, the SA verified the facility reported the verbal abuse to SA and the AGO on 10/20/23.	F 600		