STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255160	A. BUILDING _____ B. WING _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANIEL HEALTH CARE INC DBA THE MEADOWS	1905 SOUTH ADAMS STREET FULTON, MS 38843

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual re-certification survey at the facility from 11/28/23 through 11/30/23. During the survey, the SA determined that the facility was not in compliance with Medicare and Medicaid regulations for participation and cited regulatory deficiencies F600, F640, F645 and F758. Complaint Investigation (CI) MS#23082 was investigated related to Quality of Care/treatment, facility staffing and nurses services and the facility was found to be in compliance. A facility reported incident (FRI) CI MS#23341 was investigated related to resident abuse and the facility was found to not be in compliance and was cited F600. Census at the time of survey was 122 and the facility has beds for 130 residents.	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 physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced	F 600		1/12/24

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

Electronically Signed | 12/21/2023

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F 600	Continued From page 1 by: Based on staff interviews, record review and facility policy review the facility failed to ensure that one (1) of 24 sampled residents was protected from verbal abuse. Resident #268 Findings Include: Record review of the Facility's "Abuse, Neglect, or Exploitation Policy" with revised date of November 21, 2017, documented, "It is the policy of this facility that all residents will be free from abuse, neglect, and exploitation following the guidelines in the Vulnerable Adult Act ..." On 11/28/23 at 12:40 PM, an interview with Director of Nursing (DON), revealed that on 10/30/23, it was reported to her that Certified Nursing Assistant (CNA) #1 had spoken inappropriately to a resident. She revealed that it was told to her that CNA #1 and CNA #2 were in Resident #268's room helping her pack up her personal items for resident to be moved into a different room, due to resident testing positive for covid. The DON revealed that while conducting the investigation, it was revealed to her that while the two CNAs were packing up resident's personal items, the resident had asked for a pillow and CNA #1 responded with "Shut the "F***" (explicit language) up." DON revealed that upon interview with CNA #2, she revealed that she knew this should be reported and went to the supervisor immediately after she finished taking care of the resident. The DON revealed that Resident #268 called the Director of Rehabilitation (DOR), and immediately reported the incident. The DON revealed that the DOR went straight to the Registered Nurse (RN) Supervisor, reported it and by the time CNA #2	F 600	F600 Statements contained herein are intended for purposes of compliance with Federal and State law regarding responses to the Statement of Deficiencies. The language herein is not intended to be used by any third party, it is solely for the purposes of compliance with participation requirements of Medicare and Medicaid. 1. On 10/30/23, Director of Nursing (DON) investigated statement regarding CNA #1 verbalizing ("shut the f*** up") to Resident #268. Both Resident #268 and CNA #2 (who witnessed the statement) affirmed that CNA #1 did in fact make the statement. DON met with CNA #1 and she was terminated immediately. Resident #268 no longer resides in this facility and was discharged on 10/30/23 per her request prior to the event occurring. 2. ~All residents in this facility have the potential to be affected by this deficient practice. ~The DON and Quality Assurance(QA) Nurses conducted interviews with each resident regarding the care and services that they receive. There were no other allegations of abuse or inappropriate care made as a result of those interviews. All interviews conducted with residents were completed on 11/22/23. 3.	

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F 600	Continued From page 2 finished up with the resident and made it to administration, the RN Supervisor was already in the room interviewing with resident. The DON revealed that she and the Administrator (ADM) interviewed CNA #2 to get her account of the incident and she confirmed that CNA #1 had in fact said what resident reported she said. The DON revealed that CNA #1 was called in for questioning and denied the accusation; but, due to being heard and reported by Resident #268 and witnessed by CNA #2, CNA #1 was terminated, and she left the building immediately. DON revealed that she reported the incident to the State Agency and to the Attorney General's Office. On 11/28/23 at 2:50 PM, an interview with Director of Rehabilitation (DOR), revealed that she had known Resident #268 for years prior to resident coming to the facility and she (resident) felt comfortable talking to her. DOR revealed that on 10/30/23, Resident #268 was being moved from one room to another due to testing positive for Covid and that she (DOR) was called by this resident to come to her room. The DOR revealed that the resident reported to her (DOR) that a CNA had told her to "shut the 'F***' (explicit language) up" and that the resident said it back to her. DOR revealed that the resident had told her that CNA #1 was at the head of the bed and CNA #2 was towards the foot of the bed to the side and they were moving bed and all into the other room. DOR revealed that she went straight to the RN Supervisor, reported it, and she (DOR) stated, "We don't tolerate that." DOR revealed that they immediately started investigating, interviewing and that CNA #1 was terminated that same day.	F 600	~The QA Committee reviewed the Abuse and Neglect policy and procedure on 12/12/23 with no recommended changes to the policy. ~The Administrator/DON/ and/or Department Supervisor will immediately be notified of any allegation of abuse/neglect. An investigation will be initiated immediately, and the alleged abuser will be suspended from the facility until the outcome of the investigation is complete. ~QA Nurses/DON/ and/or Social Services Department will meet with each resident weekly beginning 12/18/23 to discuss their care and address any concerns for the next 3 months. Any allegations of abuse or inappropriate care will be reported to the DON and/or Administrator. ~All full-time staff have been in-serviced on Abuse, Neglect, and Exploitation that was held by the Attorney General Office on 12/12/23. All part-time employees will be in-serviced prior to their next scheduled shift. ~All staff will continue to be educated and in-serviced on types of abuse, neglect and exploitation upon hire, on a quarterly basis, and as needed to ensure that proper education and facility policy is followed. 4. ~QA Nurses/DON and/or Social Services will meet with each resident weekly	

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F 600	Continued From page 3 On 11/29/23 at 9:00 AM, an interview with CNA #2, revealed that on 10/30/23, she (CNA #2) and CNA #1 were getting Resident #268's personal things together to get her moved into another room because she had tested positive for COVID. CNA #2 revealed that Resident #268 had hip issues, was lying in her bed and they were moving bed and all to the other room. She revealed that Resident #268 had asked for her pillow which was near CNA #1, and she told her no. CNA #2 revealed that Resident #268 asked repeatedly for her pillow and then CNA #1 said to resident, "Just shut the f**** (explicit language) up!" She revealed that the resident heard what she had said and repeated back to her with, "you shut the f*** up" and CNA #1 still didn't get the pillow resident had asked for. CNA #2 revealed that the resident seemed mad, and the way CNA #1 had talked to her was disrespectful and rude and stated, "I was shocked that she said it." CNA #2 revealed that CNA #1 could come across as rude sometimes, but she had never witnessed anything like this with her. CNA #2 revealed that CNA #1 left the room after this, and she continued to provide care to the resident making sure she was comfortable in bed and that she had what she needed. CNA #2 revealed that when she left Resident #268's room, she went to report the incident. CNA #2 revealed that Resident #268 had called the DOR to her room and told her what happened immediately after she left her and before she was able to find her supervisor. On 11/29/23 at 9:30 AM, an interview with the RN Supervisor revealed that he was working on 10/30/23 when the alleged verbal abuse by CNA #1 to Resident #268 occurred. He revealed that Resident #268 called the Director of	F 600	beginning on 12/18/23 to discuss their care and address any concerns for the next 3 months. Any allegations of abuse or inappropriate care will be reported to the DON and/or Administrator. ~The DON will bring any allegations of abuse and ongoing investigations to the monthly QA Meeting beginning 1/11/24, including the timing of the notification made to the state agency for further review and recommendations by the QA Committee. The QA Committee may decide to stop the weekly resident interviews with the QA Nurses/DON and/or Social Services once the 3 months is over and when no further abuse allegations have resulted in the prior 30 days. ~The overall process as outlined in the Plan of Correction will continue on an ongoing basis. ~The Administrator is responsible for the implementation and monitoring of this process.	

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Rehabilitation, reported that CNA #1 had cursed her and that she had cursed her (CNA #1) back. RN Supervisor revealed that he spoke with CNA #1, and she denied the allegation. RN Supervisor revealed that he went with CNA #1 into Resident #268's room, and she denied saying it yet again. RN Supervisor revealed that he then spoke with CNA #2 who was a witness to the incident, and she confirmed that CNA #1 had cursed the resident. RN Supervisor revealed that he had never seen this kind of behavior with CNA #1 and that she no longer worked here.

On 11/30/23 at 9:45 AM, an interview with Director of Nursing (DON) revealed that CNA #1 was terminated due to verbal abuse towards Resident #268. She revealed that verbal abuse included talking down to residents, raising voices to others, and cursing residents. She revealed that CNA #1 denied the allegation; but, DON stated, "It was witnessed by the resident and another CNA." The DON revealed that she knew that they were responsible for everyone working under them and knew that it was their job to make sure these residents were taken care of.

Record review of the facility investigation completed by the DON documented that on 10/30/23 at 12:00 PM, that CNA #1 and CNA #2 were in Resident #268's room helping pack up her personal items for resident to be moved into a different room due to resident testing positive for covid. Upon interviews during investigation process, while the CNAs were packing personal items, Resident #268 asked for a pillow and CNA #1 responded to resident with "Shut the 'F' (explicit language) up." Interview with CNA #2 revealed that she knew this was a reportable incident and had intentions of coming out to meet

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F 600	Continued From page 5	F 600		

with supervisor after she completed care for resident; but, due to the flow and quick time frame of awareness made to administration, supervisor was already in room interviewing with resident by this time. Resident #268 called DOR to her room and reported a statement made to her by CNA #1 and DOR reported said statement to RN Supervisor. Upon interview with CNA #1 with Resident #268 present and resident representative, CNA #1 denied telling Resident #268 to "shut the 'F' (explicit language) up." RN Supervisor reported the incident to Administrator and DON, who called CNA #2 into the office to get her account of the incident. CNA #2 confirmed that CNA #1 did say what Resident #268 reported she said. DON then called in CNA #1, and she denied saying said statement to Resident #268. DON told CNA #1 that Resident #268 reported it, CNA #2 confirmed witnessing her saying what was reported by resident, so her employment would be terminated. DON reviewed the policy and expectations of how to care for and treat residents and made CNA #1 aware of the severity of what she had done and how she could have handled things differently. DON reported this incident to the State Agency on 10/30/23 around 1:10 PM and online report was sent to Attorney General's (AG) office at 1:57 PM.

Record review of statement written and signed by DOR, documented that she was called to Resident #268's room and was told that the CNA #1 told her to "shut the f*** up." DOR revealed that she went and told the RN Supervisor, they (DOR and RN Supervisor) interviewed CNA #1, and she denied the accusation. CNA #2, who witnessed the incident, was then interviewed and she said that CNA #1 told patient to "shut the f up" and that she had witnessed her telling the

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F 600	Continued From page 6	F 600		

patient those exact words.

Record review of the written statement completed and signed by CNA #2 on 10/30/23 documented that CNA #2 and CNA #1 went into Resident #268's room to move the patient to Room 122. During the move, the patient was asking for a pillow, CNA #1 told the patient "No we have to wait until we get to your room." The patient asked nicely twice if she could have her pillow and CNA #1 got frustrated and told her to shut the "F" up. The patient heard CNA #1 and replied saying 'no you shut the f*** up.' After that the conversation was over and they continued to move the patient to room 122 and then left.

Record review of the written statement completed and signed by RN Supervisor on 10/30/23 documented that he was notified about Resident #268 complaint that a CNA told her to "shut the 'F***' (explicit language) up." RN Supervisor spoke with resident who verified which CNA spoke to her in that manner. CNA #1 was brought into the room with Resident #268, was questioned, and she denied saying those words. RN Supervisor revealed that CNA #2 was present and had witnessed the incident and during interview with her, she verified that CNA #1 did use those exact words in which Resident #268 indicated she said. He revealed that the DON called CNA #1 into her office in which appropriate disciplinary action was taken.

Record review of Resident #268's "Record of Admission" revealed an admission date of 10/13/2023.

Record review of Resident #268's Minimum Data Set (MDS) with Assessment Reference Date

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F 600	Continued From page 7 (ARD) of 10/19/23 under "Section C" was documented a Brief Interview for Mental Status (BIMS) Score of 14 which indicated that resident was cognitively intact. Record review of Resident #268's History and Physical (H&P) completed by the Nurse Practitioner documented that resident had the following diagnoses to include: Fracture of Unspecified part of Left Femur, History of falling, Difficulty in Walking, Presence of Left Artificial hip joint, Parkinson's Disease, Chronic Kidney Disease, and Weakness.	F 600		