

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/21/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255164	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/25/2024
NAME OF PROVIDER OR SUPPLIER JEFFERSON COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 910 MAIN STREET FAYETTE, MS 39069		
(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) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey along with two (2) Complaint Investigations (CI MS #23613 and CI MS #23794) at the facility from 01/23/24 through 01/25/23. The SA investigated CI MS #23613 for neglect of pressure wounds and there were no citations related to the CI. The SA investigated CI MS #23794 for abuse and misappropriation of property and cited F602 and F610. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F700.	F 000			
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 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. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to protect a resident's right to be free from misappropriation of property and exploitation for one (1) of fourteen (14) sampled residents. Resident #40 Findings include:	F 602	1. On December 18, 2023 the Director of Nursing and Assistant Director of Nursing interviewed Resident #40 for a concern and were informed of the allegations. Immediately the allegation of abuse was reported to law enforcement, state licensure, state attorney general, ombudsman and administrator. On December 18, 2023 staff were in-serviced		3/1/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

02/09/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 602	Continued From page 1 Review of the facility's policy titled, "Abuse, Neglect and Exploitation", with a revision date of 4/17, revealed, "Policy: Each resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation ...Residents must not be subject to abuse by anyone, including, but not limited to; facility staff, other residents ...Policy Explanation and Compliance Guidelines...9. "Exploitation" means taking advantage of a resident for personal gain through the use of manipulation, intimidation, threats, or coercion ..." A review of the facility's "Vulnerable Adult Act", undated, revealed, " ...Any nursing home resident is considered to be a vulnerable adult ...the following situation are considered CRIME OF ABUSE against vulnerable adults ...theft or misuse of a resident's personal belongings, personal funds, or bank accounts ..." A record review of the "Reportable Incident Form" dated 12/18/23, revealed the Director of Nursing (DON) began an investigation because Resident #40 reported that she had several incidents where she had given staff members money or allowed them to use her debit card. Resident #40 stated that she helped Certified Nurse Aide (CNA) #2 because she had three small children. The resident stated that she gave them money of her own free will. The resident stated that she sent CNA #3 to a local sandwich shop to get her something and she allowed her to buy something for herself. Both CNAs denied taking money from the resident and both CNAs were placed on suspension pending the completion of the investigation. The facility held a Quality Assurance and Performance Improvement (QAPI) meeting to discuss the allegation and the	F 602	on Abuse and Neglect by Registered Charge Nurse with a focus on Misappropriation of funds and Exploitation. The Certified Nursing Assistant #2 and Certified Nursing Assistant #3 were contacted via phone and were suspended from duty pending investigation. 2. On January 24, 2024 all residents were interviewed by the Social Services Director regarding Abuse and Neglect with a focus on Misappropriation of funds and exploitation. There were no other residents identified that were affected. 3. Facility staff were educated on the policy of Abuse & Neglect with a focus on Misappropriation of Funds and exploitation by the Staff Development Nurse on January 24, 2024. Staff will be educated every month by the Director of Nursing and Administrator on the policy for Abuse and Neglect with a focus on Misappropriation and Exploitation times two months. Newly hired employees will be educated on the policy for Abuse and Neglect with focus on Misappropriation and Exploitation upon hire and every month for the next two months by the Director of Nursing. 4. The Social Services Director began meeting with each resident on January 24, 2024 and will continue weekly times two months to discuss Abuse and Neglect to identify concerns regarding Abuse and Neglect. Weekly interviews may be stopped once the three months are over if		

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F 602	Continued From page 2 recommendation was to continue the investigation. In-services of the Abuse and Neglect Policy were initiated for staff. A record review of the "Face Sheet" revealed the facility admitted Resident #40 on 8/12/23 and she had current medical diagnoses including Right Heart Failure and Morbid Obesity. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/14/2023, revealed Resident #40 had a Brief Interview for Mental Status (BIMS) score of 13 which indicated she was cognitively intact. On 1/23/24 at 10:46 AM, in an observation and interview with Resident #40, she reported that CNA #2 frequently entered her room while on the phone with her boyfriend and she would overhear her complaining to him about needing money to care for her two children and the one she was presently pregnant with. The resident expressed that she understood what it is like to raise children independently while struggling financially, so she volunteered to assist CNA #2 by sending her some money via Cash App (a mobile payment service). She stated that CNA #2 provided her Cash App username, and she gave her \$75.00. An observation of the information on Resident #40's cell phone revealed a Cash app transaction for \$75 to CNA #2 on 9/25/23 at 11:51 AM. The resident stated that the CNA returned to her room again after the baby was born, and they began to talk about her baby. She stated that during the chat, CNA #2 mentioned that she had nothing for her newborn baby and so she ordered CNA #2 a \$50 (Proper Name) online retail gift card, so she could buy some things for her baby. She stated that the card was mailed to the facility,	F 602	no further allegations are made in the prior thirty days. The overall process as outlined in the plan of correction will continue on an ongoing basis for two months. The findings will be reviewed by the Quality Assurance Improvement Committee on 02/29/2024 and the next two Quality Assurance Improvement Performance Committee meetings times two months. Any changes will be made as found necessary to maintain substantial compliance.		

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F 602	Continued From page 3 and when it arrived, she gave it to CNA #2. An observation of the resident's (Proper Name) of online retailer account on her cell phone revealed a transaction, dated 11/28/23 for \$50.00. The resident also stated that she told the DON about the gifts, but it was not to get anyone in trouble; however, she knew that CNA #2 got suspended for a few days. Resident #40 stated that when CNA #2 returned to work, she came into her room and gave her home address to Resident #40, indicating that she should send all future purchases for the baby to her home address rather than to the facility. An observation of Resident #40's "Notes" application on her cell phone revealed a mailing address had been entered on 12/17/23. Resident #40 stated that she would also allow CNA #3 to use her bank card to purchase herself (Resident #40) and CNA #3 food. An observation of electronic transactions on Resident #40's cell phone revealed transactions on 12/3/23 for \$18.33 to (Proper Name) of sandwich shop and \$10.87 to (Proper Name) of a liquor store which she stated was purchased with her card by CNA #3. The resident stated that she did not drink or smoke and indicated that the transaction for the liquor store was for CNA #3. In addition, the resident stated that she provided CNA #3 with her bank card for gas for her car on 11/27/23. An observation of the transaction on Resident #40's cell phone revealed a transaction for \$26.02 (Proper Name) of local convenience store and was dated 11/28/23. The resident pointed out that the transaction occurred on 11/27/23 but did not post to her account until 11/28/23. CNA #3 On 1/24/24 at 1:51 PM, in a phone interview with	F 602			

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F 602	Continued From page 4 Certified Nursing Assistant #3 (CNA), she claimed that 12/3/23 Resident #40 asked her to pick up lunch from (Proper Name) of sandwich shop. CNA #3 agreed to go but declined to get lunch for herself. She stated that she went out multiple times for Resident #40 and used the resident's bank card to buy food for her because she did not think it was a problem. CNA #3 denied using the resident's card at the convenience and the liquor store. CNA #3 verified that she understood the meaning of exploitation and vulnerable adults, but she disputed that using the resident's card to buy the resident something did not resemble exploitation. She stated she was suspended pending a facility investigation. However, following the investigation, she stated that she was asked to come back to work but was unable to do so due to her child's illness. A record review of the "Time/Attendance Detail" report revealed CNA #3 clocked in on 11/27/23 at 2:57 PM and clocked out 7:37 PM. She clocked back in at 8:01 PM and clocked out at 10:30 PM. On 12/3/23, CNA #3 clocked in at 2:57 PM and out at 7:41 PM, and clocked in at 8:04 PM and out at 10:21 PM A record review of the "Transaction Details" for Resident #40's prepaid banking card revealed a transaction dated 11/28/23 at 7:49 AM for \$26.02 to (Proper Name) of local convenience store. A record review of the banking transactions on 12/3/23 for Resident #40 revealed a transaction for \$10.87 for (Proper Name) liquor store and \$18.33 for (Proper Name) sandwich shop. A record review of the "Vulnerable Adult Act"	F 602			

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F 602	Continued From page 5 document revealed CNA #3 was trained by the facility regarding the vulnerable adult act on 2/12/2016. CNA #2 On 1/24/24 at 2:26 PM, in a phone interview with CNA #2, she acknowledged that she was suspended from her position as a CNA because she received \$75.00 via cash app from Resident #40 on 9/25/23. She stated that it all began when she entered the resident's room to provide care. She stated that after the resident saw she was pregnant, she asked if she could buy something for the baby. CNA #2 stated that she told the resident she did not want her to do so, but the resident insisted and sent the money away. CNA #2 stated that it slipped her mind to notify the Administrator that she had received the money. CNA #2 acknowledged that she did not return the money to Resident #40. CNA #2 denied that Resident #40 had given her a \$50.00 (Proper Name) online retail gift card. She was unable to explain how Resident #40 had her home address. CNA #2 confirmed that she returned to work after the facility's investigation was completed and she currently worked the 3 PM to 11 PM shift. A record review of the "Time/Attendance Detail" report revealed CNA #2 clocked in on 11/28/23 at 3:18 PM and clocked out 8:52 PM. She clocked back in at 9:06 PM and clocked out at 11:36 PM. On 12/17/23, CNA #3 clocked in at 3:05 PM and out at 11:33 PM. A record review of the Cash App screenshot on Resident #40's cell phone revealed a payment of \$75 on 9/25 (2023) at 11:51 AM to CNA #2's Username.	F 602			

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F 602	Continued From page 6 A record review of the "Order Details" dated 11/28/23, revealed a transaction for \$50 for a gift from an online retailer with the "Purchase Details" indicating the gift card was from Resident #40 with a "Message" of "Hope you enjoy this gift card!" A record review of the "Notes" application screenshot on Resident #40's phone revealed a note dated 12/17/23 at 4:39 PM of a home address. A record review of the "Application for Employment" for CNA #2, dated 3/31/23, revealed the home address indicated on the application matched the home address that was entered in the Notes application of Resident #40's cell phone. A record review of the "Vulnerable Adult Act" document revealed CNA #2 was trained by the facility regarding the vulnerable adult act on 4/18/2023. In an interview on 1/25/24 at 8:20 AM, with the Administrator, she confirmed knowledge of the incident involving CNA #2, CNA #3, and Resident #40. She revealed that she did not believe that Resident #40 was exploited by the CNAs based on her understanding of the company policies and because Resident #40 had a high BIMS score. The Administrator explained that the previous Director of Nursing (DON) wrote the entire investigation, and she was not involved in the initial investigation because she had been out of the building for three (3) days. Upon her return to the facility, she said she and the DON consulted with their Board Attorney and all agreed	F 602			

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F 602	Continued From page 7 that the resident was of sound mind with a high BIMS score and that she was not exploited. As a result, she could not substantiate the complaint and approved CNA #2 and CNA #3 to return to work after their 3-day suspension. She explained CNA #2 returned to work, however CNA #3 elected not to return to work.	F 602			
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to provide appropriate corrective action to prevent further potential misappropriation and exploitation by allowing a Certified Nurse Aide (CNA #2) access to a previous victim (Resident #40) for one (1) of 14 sampled residents.	F 610	1. On December 18, 2023 the Director of Nursing and Assistant Director of Nursing interviewed Resident #40 for a concern and were informed of the allegations. Immediately the allegation of abuse was reported to law enforcement, state licensure, state attorney general, ombudsman and administrator. On	3/1/24	

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F 610	Continued From page 8 Findings include: Review of the facility's policy, "Abuse, Neglect and Exploitation", with a revision date of 4/2017, revealed, "Policy: Each resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation ...The facility must...8. Resident Protection after Alleged Abuse, Neglect and Exploitation-The facility will make efforts to protect all residents after alleged abuse, neglect and/or exploitation..." A record review of the "Reportable Incident Form" dated 12/18/23, revealed the Director of Nursing (DON) began an investigation because Resident #40 reported that she had several incidents where she had given staff members money or allowed them to use her debit card. Resident #40 stated that she helped CNA #2 because she had three small children. The resident stated that she gave the money of her own free will. CNA #2 was placed on suspension pending the completion of the investigation. During an interview on 1/23/24 at 10:46 AM, with Resident #40, she stated that she had told the DON about money and gifts she was providing to CNA #2, but it was not to get anyone in trouble. However, she knew that CNA #2 got suspended for a few days. Resident #40 said that when CNA #2 returned to work, she came into her room and gave her home address, indicating that she may send all future purchases for the baby to her home address rather than the facility. On 1/24/24 at 2:26 PM, in a phone interview with CNA #2, she confirmed that she was suspended from her position as a CNA during the investigation related to Resident #40, and she	F 610	December 18, 2023 staff were in-serviced on Abuse and Neglect by Registered Charge Nurse with a focus on Misappropriation of funds and Exploitation. The Certified Nursing Assistant #2 and Certified Nursing Assistant #3 were contacted via phone and were suspended from duty pending investigation. 2. On January 24, 2024 all residents were interviewed by the Social Services Director regarding Abuse and Neglect with a focus on Misappropriation of funds and exploitation. There were no other residents identified that were affected. 3. Facility staff were educated on the policy of Abuse & Neglect with a focus on Misappropriation of Funds and exploitation by the Staff Development Nurse on January 24, 2024. Staff will be educated every month by the Director of Nursing and Administrator on the policy for Abuse and Neglect with a focus on Misappropriation and Exploitation times two months. Newly hired employees will be educated on the policy for Abuse and Neglect with focus on Misappropriation and Exploitation upon hire and every month for the next two months by the Director of Nursing. 4. The Social Services Director began meeting with each resident on January 24, 2024 and will continue weekly times two months to discuss Abuse and Neglect to identify concerns regarding Abuse and Neglect. Weekly interviews may be		

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F 610	Continued From page 9 returned to work after the investigation was completed. CNA #2 verified that she currently worked at the facility on the 3 PM to 11 PM shift. On 1/25/24 at 8:20 AM, in an interview with the Administrator, she confirmed knowledge of the incident related to CNA #2. She stated that Resident #40 was not exploited based on her understanding of their company policies and Resident #40's high BIMS score. She advised that the previous DON wrote the entire investigation because she had been out sick. When she returned, she consulted with the facility's Board Attorney and all agreed that the resident was of sound mind with a high BIMS score and was not a victim of exploitation. As a result, she could not substantiate the complaint and approved CNA #2 to return to work after the 3-day suspension. The Administrator added that as part of their correction plan, the CNA #2 was reassigned to another hall in the facility which was located away from the resident. The Administrator stated that although CNA #2 was reassigned, she could not guarantee that CNA #2 would not walk over to the resident's room. A record review of the "Face Sheet" revealed the facility admitted Resident #40 on 8/12/23 and she had current medical diagnoses including Right Heart Failure and Morbid obesity. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/14/2023, revealed Resident #40 had a BIMS score of 13 which indicated she was cognitively intact.	F 610	stopped once the three months are over if no further allegations are made in the prior thirty days. The overall process as outlined in the plan of correction will continue on an ongoing basis for two months. The findings will be reviewed by the Quality Assurance Improvement Committee on 02/29/2024 and the next two Quality Assurance Improvement Performance Committee meetings times two months. Any changes will be made as found necessary to maintain substantial compliance.		