STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A190	A. BUILDING _____ B. WING _____	C 02/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TALLAHATCHIE GENERAL HOSP ECF	201 SOUTH MARKET ST CHARLESTON, MS 38921

(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 on site complaint investigation (CI) for a facility reported incident, CI MS #23719, which alleged that a facility staff member had verbally abused a resident after a fall with no injuries on 2/15/24. The State Agency (SA) identified an isolated incident of verbal abuse to Res #1 by a facility staff (CNA#1) which began on 12/19/23. Based on the facility's implementation of corrective actions on 12/19/23-12/21/23 the SA determined that the isolated incident was Past Non Compliance (PNC) and was fully corrected on 12/21/23, prior to the SA's entrance on 02/15/24. The SA determined that the facility was in compliance with the requirements for participation in Medicare and Medicaid. Deficiencies were cited at F600 for Abuse and Neglect at a Scope and Severity (S/S) of "D" (isolated) Past Non Compliance (PNC). The facility was licensed for 98 beds and the census was 87 on 12/15/24.	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-	F 600		

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

Electronically Signed | 02/26/2024

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F 600	Continued From page 1 §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record reviews, staff interviews, resident interviews, and policy and procedure review, the facility failed to prevent Resident #1, a vulnerable adult, from being verbally abused by Certified Nursing Assistant (CNA) #1. Resident #1 was one (1) of three (3) residents reviewed for abuse/neglect. Findings include: Review of the facility's policy titled : "CMS definition of Abuse and Neglect" dated 12/20/23 and signed by the facility's Acting Director of Nursing read: "Abuse" The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting in physical harm, pain, or mental anguish." Record Review of the facility's written investigation conducted on 12/19/24 revealed that at approximately 10:30 PM the Director of Nursing (DON) was notified that CNA #1 was assisting resident (Res #1) when Resident #1 fell to the floor during a wheelchair to bed transfer. CNA #1 reported to the nurse supervisor, Licensed Practical Nurse (LPN #1) that he needed assistance and that Resident #1 was on the floor. LPN #1 assessed Resident #1 and found no injuries. Nurses proper name (LPN #2) and another CNA , (CNA #2) went to assist with Resident #1. Resident #1 was upset and began yelling out at the staff as a result of the fall. CNA #1 pointed his finger in the face of Resident #1 and said "who do you think you are talking too, it	F 600	Past noncompliance: no plan of correction required.	

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F 600	Continued From page 2	F 600		

sure ain't me cause I ain't got nothing to lose." CNA #1 was confronted by the nurse supervisor (LPN #1) and was asked to leave the facility until a thorough investigation could be conducted. CNA #1 replied: "I quit." The facility attempted to reach CNA #1 several times to no avail. The record review revealed that the facility reported the incident as verbal abuse to the State Agency (SA). The written facility investigation contained 3 witness statements from CNA #2; LPN #1; and LPN #2. All 3 witnesses heard and saw CNA #1 verbally abuse Resident #1, in an intimidating manner. The facility reported to the State Agency on 12/20/23 that verbal abuse had occurred to Resident #1 by CNA #1.

Interview on 02/15/24 at 3:09 PM, with LPN #2 revealed that she was the medication nurse on the second shift on the evening of 12/19/23. She was asked to assist with Resident #1 who was on the floor of his room after a fall. She stated that she, LPN #1 (nurse supervisor), CNA #1 and CNA #2 were in the process of placing the sling for the full body lift, under Resident #1 when CNA #1 accidentally bumped the leg of Resident #1, he then yelled out and was hollering and cursing. CNA #1 then "got up in the resident's face", pointed his finger at Resident #1 and in a loud intimidating tone told Resident #1 that he better not be yelling at him. LPN #2 stated that since the incident had happened so long ago, that the exact words of CNA #1 she could not remember. LPN #2 stated that all she could clearly remember was the inappropriate manner that CNA #1 spoke to Resident #1. LPN #2 confirmed that she felt that CNA #1 was verbally abusive to Resident #1.

Interview on 02/15/24 at 3:30 PM with CNA #2

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F 600	Continued From page 3	F 600		

revealed that she had been asked to assist in the fall of Resident #1 along with CNA #1, LPN#1 and LPN #2. CNA #2 stated that CNA #1 was verbally abusive to Resident #1 and had yelled up close in the face of Resident #1 as the four (4) of them were assisting to get Resident #1 off the floor after a fall. CNA #2 stated that LPN #1 tried to council with CNA #1 and he got mad and clocked out and did not come back. CNA #2 stated that LPN #1 and LPN #2 along with her had witnessed CNA #1 verbally and in a threatening manner, abuse Resident #1 on 12/19/24.

The SA attempted to contact LPN #1 for an interview but was unable to reach her during the investigation on 02/15/24. The SA did obtain copies of the written statements of all three (3) witnesses. The SA attempted to obtain an interview on 02/15/24 with CNA #1 to no avail.

Record review of the written statement of LPN #1 dated 12/19/23 read: "Reported to this writer of resident "fall" entered room with (CNA #1; CNA #2; and LPN #2). During placement of sling for use of total lift staff member (CNA #1) grabbed resident left leg, resident hollered out at staff not to hurt his leg, screaming "that's my sore leg" staff member (CNA #1) moved from resident side and stood over resident and hollered while pointing his finger in resident's face "who do you think your talking too, it sure aint me cause I got nothing to lose." This nurse prompted staff to be aware of communication between staff and resident during interaction. Staff member (CNA #1) exited room. Communication for education prepared. Approached staff member (CNA #1) for counseling. Staff member immediately began stating resident was cursing him. Attempted to redirect staff member regarding his actions, his

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F 600	Continued From page 4	F 600		

demeanor, and educated that he could sign the information or he needed to clock out for the evening. Staff member continued to become agitated, this nurse walked away at this time and phoned DON for further actions needed. After receiving directions from DON, staff member (CNA #1) was approached and informed he would need to clock out for the evening and reach out to (DON) in the A.M., he became agitated and began hollering at this writer that he quit and I could call and inform them. No further interaction occurred between this writer and (CNA #1)." The written statement was signed by LPN #1 and dated 12-19-23.

Interview and observation of Resident #1 on 02/15/24 at 4:00 PM, revealed Resident #1 recalled the evening of the incident on 12/19/24 as: " He talked to me real ugly and it made me feel bad, he hurt my feelings." Resident #1 stated that CNA #1 yelled at him. Resident #1 stated that CNA #1 had not worked at the facility since that event.

Record review of Resident #1's Facesheet revealed that he had been admitted to the facility on 8/20/20 and readmitted to the facility on 06/01/2021. He had diagnoses of Personal history of Traumatic Brain injury,Type 2 Diabetics; and Unspecified mood (affective) disorder; among other diagnoses.

The record review of Resident #1's (MDS) dated 01/05/24 revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated that he was not cognitively impaired.

The State Agency (SA) identified an isolated incident of verbal abuse to Res #1 by a facility

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F 600	Continued From page 5	F 600		

staff (CNA#1) which began on 12/19/23. The facility immediately put in place a corrective action plan and the deficient practice was corrected on 12/21/23.

Based on the facility's implementation of corrective actions on 12/19/23-12/21/23 the SA determined that the isolated incident was Past Non Compliance (PNC) and was fully corrected on 12/21/23, prior to the SA's entrance on 02/15/24.

Record review of the facility's action plan confirmed and validated through staff interviews, resident interviews, and record reviews that the facility's action plan had been effective and the isolated deficient practice was corrected on 12/21/23 prior to the State Agency entering the facility on 02/15/24. The facility's action plan included the following:

1-Removed the alleged perpetrator from the facility
2-Protected all the residents in the facility
3-Assessed all residents for safety and freedom from abuse/neglect
4-Contacted the facility DON and Administrator
5-Educated and In-Serviced all staff on Abuse and Neglect
6-Conducted a full thorough investigation and obtained statements from witnesses
7-Conducted a Quality Assurance (QA) meeting with the QA committee members including the Medical Director
8-Contacted the appropriate State Agencies and provided a written report of the full investigation's findings in a timely manner.
9-Conducted on-going surveillance and monitoring of all residents for signs and

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F 600	Continued From page 6 symptoms of Abuse/neglect 10-Updated and reviewed the care plans for all residents on 12/20/23. Through interviews and record reviews the SA determined that all ten (10) aspects of the facility's action plan were validated and the SA determined that the isolated incident of verbal abuse had been corrected on 12/21/23, prior to the SA's entrance to the facility on 02/15/24. The isolated deficient practice was cited at F600 S/S=D Past Non Compliance (PNC).	F 600		