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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REST HAVEN HEALTH AND REHABILITATION	103 CUNNINGHAM DRIVE RIPLEY, MS 38663

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F 000	INITIAL COMMENTS The State Agency (SA) conducted two (2) complaint investigations (CI MS#23705 and CI MS #24072) at the facility from 2/7/24 through 2/8/24. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid Services. The SA identified non-compliance and cited F565 for CI MS#23705 and CI MS #24072 for failure to resolve resident grievances regarding verbal abuse and for resident allegations of verbal abuse cited F600 for verbal abuse from a staff member toward a resident. The census at the time of the survey was 43 with a bed capacity of 60 beds.	F 000		
F 585 SS=E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information	F 585		3/1/24

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

Electronically Signed | 03/01/2024

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F 585	Continued From page 1 on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;	F 585		

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F 585	Continued From page 2 (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, record review and facility policy review, the facility failed to resolve resident's grievances regarding allegations of verbal abuse from the	F 585	1. On 2/8/2024, grievances were reported by Resident #1, Resident #2, Resident #5, Resident #6, and Resident #7. The reported grievances stated that	

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F 585	Continued From page 3 staff for five (5) of 10 residents reviewed for unresolved grievances. Residents #1, Resident #2, Resident #5, Resident #6 and Resident #7. Findings Include: Review of the facility policy titled "Grievance/Concern/Comments" with a revision date of 12/2021 revealed under "Standard ...Residents and their family members may voice grievances to the facility or other agency/entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal The facility will make prompt efforts to resolve grievances." Resident #1 During an observation and interview on 2/7/24 at 7:40 PM, with Resident #1 revealed there was one Certified Nurse Assistant (CNA) that had talked ugly to her and other residents. She stated one night recently she was sleeping, and her arm hit the top of her overbed table and knocked a drink off and spilled it on the floor. She revealed that when she used her call light and CNA #1 came to her room. She told her what had happened and the CNA told her that she told her she wasn't cleaning that up. CNA #1 went and got a towel and brought it back and told her to get up and clean it up. She stated that she could not get herself out of bed to do that and that made her cry. She revealed CNA #1 did end up cleaning the spill. She stated she reported this incident to the Administrator and the Director of Nurses (DON). Record review of Resident #1 "Admission Record" revealed the resident was admitted to the facility on 12/31/23 with a medical diagnosis	F 585	Certified Nursing Assistant (CNA) #1 talked and treated them inappropriately. As a result of these allegations reported on 2/8/2024, Certified Nursing Assistant (CNA)#1 placed on suspension pending investigation on 2/8/2024. Certified Nursing Assistant (CNA) #1 was terminated on 2/9/2024, as a result of the investigation findings. Resident #1, Resident #2, Resident #5, Resident #6, and resident #7 grievances were investigated and resolved. The Director of Nursing interviewed each resident again on 2/9/2024 with no new concerns or grievances to report. 2. On 2/9/2024, the Administrator and Director of Nursing (DON) identified and interviewed a total 26 of 43 residents who had the ability of being interview regarding the reporting of Certified Nursing Assistant (CAN#1) allegedly treating them inappropriately. All residents have the potential of being affected by this practice of not resolving grievance in a reasonable manner. 3. The administrator and Director of Nursing interviewed 26 residents to note any additional grievances. No other grievance was reported at the time. The Administrator and Director of Nursing were in-serviced on 2/28/2024 by the Corporate Compliance Officer on the facility's standard, Grievance Concern Comment Standard. Additional education on the Grievance Concern Comment Standard was provided to 7 of 7 dietary staff, 6 of 6 housekeeping staff, 2 of 2 maintenance staff, and 18 of 18 nursing department staff by the Nurse Educator.	

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F 585	Continued From page 4 that included Urinary Tract Infection. Record review of Resident #1's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/17/24 revealed in Section C a Brief Interview for Mental Status (BIMS) score of 15, which indicates the resident is cognitively intact. Resident #2 During an interview and observation on 2/8/24 at 8:45 AM, with Resident #2 he stated the only problem he has had was with CNA #1 on the night shift, is that she is young. Resident #2 stated ," I just don't think she knows how to talk to people, because she talks short and ugly to people at times." He revealed that normally the day shift makes his bed, but one day they forgot, and he was trying to make it up around 6:30 PM that night and had asked CNA #1 to help him. He stated that she told him she was passing snacks, and it would have to wait. He stated that he asked her if passing snacks was more important than helping him get his bed made so he could lay down and as she walked out of his room she said, "Make it yourself". Record review of Resident #2's "Admission Record" revealed the resident was admitted to the facility on 8/8/23 with medical diagnoses that included Unspecified Combined Systolic (Congestive) and Diastolic (Congestive) Heart Failure. Record review of Resident #2's MDS with an ARD of 11/14/23 revealed in Section C a BIMS score of 15, which indicates the resident is cognitively intact.	F 585	On 2/9/2024 the QAPI committee reviewed the “Grievance Concern Standard and no recommended changes were made to the standard. All new hire employees will receive training on Grievance Concern Comment Standard upon hire, annually and as need basis. The grievance concern log will be maintained by Social Services Director. Logs will be reviewed at least monthly by the Quality Assurance Performance Committee. 4. The Director of Nursing or the Social Service Director will conduct four resident interviews weekly for 30 days beginning 2/9/2024 and then monthly for three months to ensure compliance with the Grievance Concern Comment Standard. Any concerns noted will be logged immediately and reported to the Facility Administrator for evaluation and correction in compliance with reporting requirements. The findings of the interviews will be reported to Quality Assurance Committee beginning 2/29/2024 and then monthly times 3 months. The interviews will be reviewed by the Interdisciplinary Team and Quality Assurance Committee which consists of the Administrator, Director of Nursing, RN Supervisors, Dietary Manager, Nurse Educator, Medical Records Nurse, Social Service Director, Activity Director, and Medical Director to ensure compliance with reporting alleged reportable incidents. The QA Committee will make necessary recommendations as needed.	

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Resident #5

During an interview and observation on 2/8/24 at 8:30 AM, with Resident #5 revealed some of the CNA's talk ugly to her and one time they cussed at her. Resident #5 stated "but I don't remember their names."

Record review of Resident #5 "Admission Record" revealed the resident was admitted to the facility on 7/26/23 with medical diagnoses that included Acute or Chronic Systolic (Congestive) Heart Failure.

Record review of Resident #5's MDS with an ARD of 10/30/23 revealed in Section C a BIMS score of 14, which indicates the resident is cognitively intact.

Resident #6

During an interview on 2/8/24 at 10:50 AM, with Registered Nurse (RN) #2 revealed that Resident #6 had reported to her last week that CNA #1, the aide on the night shift talks ugly and treats her ugly and that she reported this to the DON and informed the resident that she could talk with the Social Worker about it the next day.

During an interview on 2/8/24 at 12:00 PM, with Resident #6 she stated that her only issue has been with CNA #1 on the night shift and that she talks ugly to her and tells her to stay off her call light so much at night. She stated that CNA #1 threatens her and says they will send her to behavioral health if she does not do what they tell her to do. She stated that she has reported this issue to the DON and RN #2 and stated, "Please tell me you are going to do something about this."

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Record review of a note dated 2/3/24 at 15:26 (3:26 PM) revealed "Type: eMAR-Medication Administration Note" revealed "(Proper name of CNA #1) and the other girl that works with her. They are thick as thieves, and they always threaten they are gonna get me sent off to behavioral. I don't know why they treat me like they do ...DON was aware ..."

Record review of Resident #6's "Admission Record" revealed the resident was admitted to the facility on 2/16/23 with medical diagnoses that included Type 2 Diabetes Mellitus with other Diabetic Neurological Complications.

Record review of Resident #6's MDS with an ARD of 1/18/24 revealed in Section C a BIMS score of 13, which indicates the resident is cognitively intact.

Resident #7

During an observation and interview on 2/7/24 at 7:50 PM, with CNA #1, CNA #2 and CNA #3 revealed that they were the three CNA's working the night shift and they revealed they have had in-services on abuse. During this interview while in the hallway, Resident #7 was self-propelling her wheelchair and when she passed, she stated to the CNA's, "I need to go to the bathroom." CNA #1 responded quickly to the resident, "Well you're gonna have to wait until I get done talking."

During an interview on 2/7/24 at 8:00 PM, with RN #1, was informed of the manner and tone that CNA #1 had used in response to Resident #7. RN #1 confirmed "that could be verbal abuse to a resident." She stated " That is not an appropriate

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way to talk to residents."

During an interview on 2/7/24 at 8:05 PM, with CNA #1 she confirmed that she had told Resident #7 she would have to wait until she was done talking when the resident asked to be helped to the bathroom. She stated that she did not mean it to sound rude and admits that she has been in-serviced on verbal abuse. She revealed that she had only had one complaint from a resident about her and that one complaint was from Resident #1. She had complained that I had knocked a drink off of her table, but I did not do that. She did it, but I did cleaned it up and I told the Director of Nursing (DON) that I cleaned it up.

During an interview on 2/8/24 at 11:40 AM, with Licensed Practical Nurse (LPN)/Social Services confirmed that she had some complaints on CNA #1 talking ugly to the residents and that Resident #7 filed a formal grievance around the first of January that CNA #1 had refused to get her up that morning and talked ugly to her. She stated that on 1/7/24 Resident #2 came to her office to complain about CNA #1, and she asked him if he could wait to let her get the DON and the Administrator in there so they could hear, and he agreed. She revealed that the DON and the Administrator came to her office and the resident revealed that CNA #1 was passing snacks around 6:30 PM and when he asked her to help him make his bed, she told him she was busy passing snacks. She stated that the resident told them that he asked her if passing snacks that early was as important as helping him make his bed and then as she walked out of the room, she rudely told the resident to make it up himself. She revealed that Resident #1 complained to her on 2/6/24 about CNA #1 and that the resident

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complained that she had accidentally spilled her drink and CNA #1 told her "You going to get that up". She stated that she asked the resident if she wanted to talk with the DON or the Administrator and the resident stated no that she already had, and they were going to take care of it.

During an interview on 2/8/24 at 12:30 PM, with Resident #7 confirmed that CNA #1 told her she would "Have to wait until she was done talking" when she told her she needed to go to the bathroom last night. She stated that CNA #1 was rude but that wasn't the first time, and she is used to it from her. She revealed that she had complained about it to a lot of people, "but it does no good; nothing gets done." She revealed she just don't say anything anymore. She stated that she is supposed to go to the bathroom every 2 hours and usually goes at 4:30,and she has told CNA #1 this. CNA #1 told her that she was not coming straight to her as soon as she came on duty to take her to the bathroom, so she knows to not even ask until around the time she ask last night (around 8 PM). She confirmed that she filed a formal grievance back in January of this year, because the night CNAs that included CNA #1 came in her room around 4 AM and told her if she did not get up right then, then she would have to wait until day shift got there to get up. She stated that she was supposed to get up around 5:30 AM and they never came back to get her up. She confirmed that this had been reported to the Social Worker, Administrator, the DON, and some of the other nursing staff but could not remember their names.

Record review of Resident #7 "Admission Record" revealed the resident was admitted to the facility on 3/13/20 with medical diagnoses that

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included Type 2 Diabetes Mellitus without Complications.

Record review of Resident #7's MDS with an ARD of 10/30/23 revealed in Section C a BIMS score of 15, which indicates the resident is cognitively intact.

Record review of the "Grievance/Concern/Comment Report" dated 1/2/24 revealed a formal grievance was filed regarding CNAs on the night shift not getting Resident #7 out of bed as requested.

During an interview on 2/8/24 at 9:30 AM, with the CNA Supervisor revealed there has been one complaint from a resident back in November 2023 or December about night shift CNA #1 being rude to a resident and that she reported it to the DON and she took care of it.

During an interview on 2/8/24 at 10:00 AM, with CNA #4 and CNA #5 revealed that they normally work day shift but sometimes they have to help and work night shift and that some of the residents complain about a CNA on the night shift that is rude to them but would rather not mention any names. She stated that she thinks that everyone knows it and is sure it has been reported to the DON and the Administrator.

During an interview on 2/8/24 at 1:40 PM, with the DON confirmed that all staff receive abuse in services on hire and annually unless there is an issue and then we can do one anytime in our computer in-service system. She revealed that as far as she knows there has not been an issue in order to have to do an additional abuse in-service. She admitted that she had received a

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complaint on CNA #1 on 2/6/24, but that was the first complaint she had on the staff member, and she is not aware of any more complaints on other staff regarding talking disrespectfully. She stated that Resident #1 reported an issue to her on 2/6/24 that CNA #1 talked disrespectfully to her. The DON stated she came in last night and talked to CNA #1 about that issue around 6 PM.

During an interview on 2/8/24 at 2:00 PM, with the Administrator, DON, and LPN/Social Services confirmed they had complaints about CNA #1 talking inappropriately to some of the residents. The Administrator stated that the reports he had from Resident # 1 and Resident #2 just did not seem like verbal abuse to him. Both agreed that the reports of how the CNA spoke to Resident #7 last night and how she said it was inappropriate and disrespectful. The DON confirmed at this time that she had known about the report from Resident #1 and Resident #2. When the State Agency (SA) inquired about Resident #6 and her complaint, the DON stated yes, she came into the office and also had a complaint. The DON verified that she had three (3) residents complain about how CNA #1 talked to them. The Administrator stated that CNA #1 had been talked to last night about the complaint that came in on 2/6/24 with Resident #1. The Administrator stated he was not aware that CNA #1 had told Resident #2 to make his own bed as she walked out of his room, but LPN/Social Services confirmed that he did report that to them. The Administrator confirmed that he was aware of the grievance that Resident #7 had filed about them not getting her up when she wanted to but was not aware that either one of them had told her that if she did not get up now, then she would not get up until day shift got there. He admitted that

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F 585	Continued From page 11 they would have to do an investigation and more than likely let CNA #1 go. During an interview on 2/8/24 at 2:20 PM, with LPN/Social Services confirmed that Resident #1 complained on 2/6/24, Resident #2 complained on 1/7/24 and Resident #7 filed a formal complaint on 1/3/24. Record review of the facility in-services from the last 6 months revealed there was an abuse in-service held in 1/2024 for all staff but was not attended by CNA #1. Record review of CNA#1 employee file revealed that she completed in-services on abuse on 9/25/23 and 12/11/23.	F 585		
F 600 SS=E	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 by: Based on observation, staff and resident	F 600	1. On 2/8/2024, grievances were	3/1/24

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interview, record review and facility policy review, the facility failed to ensure residents were free from verbal abuse for five (5) of 10 residents reviewed for abuse. Residents #1, Resident #2, Resident #5, Resident #6 and Resident #7.

Findings Include

Review of the facility policy titled, "Freedom of Abuse, Neglect and Exploitation" with a revision date of 11/2019 revealed " ...Standard Statement : This facility shall not condone any acts of resident mistreatment, neglect, verbal, ...or mental abuse ..."

Resident #1

An observation and interview on 2/7/24 at 7:40 PM, with Resident #1 revealed there was one Certified Nurse Assistant (CNA) that had talked ugly to her and other residents. She stated one night recently she was sleeping, and her arm hit the top of her overbed table and knocked a drink off and spilled it on the floor. She revealed that when she used her call light and CNA #1 came to her room. She told her what had happened and the CNA told her that she told her she wasn't cleaning that up. CNA #1 went and got a towel and brought it back and told her to get up and clean it up. She stated that she could not get herself out of bed to do that and that made her cry. She revealed CNA #1 did end up cleaning the spill. She stated she reported this incident to the Administrator and the Director of Nurses (DON).

Record review of Resident #1 "Admission Record" revealed the resident was admitted to the facility on 12/31/23 with a medical diagnosis that included Urinary Tract Infection.

reported by Resident #1, Resident #2, Resident #5, Resident #6, and Resident #7. The reported grievances stated that Certified Nursing Assistant (CNA) #1 talked and treated them inappropriately. As a result of these allegations reported on 2/8/2024, Certified Nursing Assistant (CNA)#1 was placed on suspension pending investigation on 2/8/2024. Certified Nursing Assistant (CNA) #1 was terminated on 2/9/2024, as a result of the investigation findings. Resident #1, Resident #2, Resident #5, Resident #6, and resident #7 grievances were investigated and resolved. The Director of Nursing interviewed each Resident again on 2/9/2024 with no new concerns or grievances to report.

2. On 2/9/2024, the Administrator and Director of Nursing (DON) identified and interviewed a total 26 of 43 residents who have the ability of being interviewed regarding any grievance or complaint. All residents have the potential of being affected by this practice of any grievances or complaint not being responded to timely.

3. The Administrator and Director of Nursing interviewed 26 residents to identify any additional grievances not being resolved. No other grievance was reported at the time. The Administrator and Director of Nursing were in-serviced on 2/28/2024 by the Corporate Compliance Officer on the facility's standard, Freedom of Abuse Standard was provided to 7 of 7 dietary staff, 6 of 6 housekeeping staff, 2 of 2 maintenance staff, and 18 of 18 nursing department

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F 600	Continued From page 13 Record review of Resident #1's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/17/24 revealed in Section C a Brief Interview for Mental Status (BIMS) score of 15, which indicates the resident is cognitively intact. Resident #2 An interview and observation on 2/8/24 at 8:45 AM, with Resident #2 he stated the only problem he has had was with CNA #1 on the night shift, is that she is young. Resident #2 stated ," I just don't think she knows how to talk to people, because she talks short and ugly to people at times." He revealed that normally the day shift makes his bed, but one day they forgot, and he was trying to make it up around 6:30 PM that night and had asked CNA #1 to help him. He stated that she told him she was passing snacks, and it would have to wait. He stated that he asked her if passing snacks was more important than helping him get his bed made so he could lay down and as she walked out of his room she said, "Make it yourself". Record review of Resident #2's "Admission Record" revealed the resident was admitted to the facility on 8/8/23 with medical diagnoses that included Unspecified Combined Systolic (Congestive) and Diastolic (Congestive) Heart Failure. Record review of Resident #2's MDS with an ARD of 11/14/23 revealed in Section C a BIMS score of 15, which indicates the resident is cognitively intact. Resident #5	F 600	staff by the Nurse Educator. On 2/9/2024 the QAPI committee reviewed the "Standard and no recommended changes were made to the standard. All new hire employees will receive training on Freedom of Abuse Standard upon hire, annually and as need bases. Additional training on Abuse, Neglect and Exploitation was provided by state agencies on 2/28/2024. All new hire staff will receive this training upon hire, annually and as need basis. 4. The Director of Nursing or the Social Service Director will conduct four resident interviews weekly for 30 days beginning 2/9/2024 and then monthly for three months to ensure compliance with the Standard and. Any concerns noted will be logged immediately and reported to the Facility Administrator for evaluation and correction in compliance with reporting requirements. The findings of the interviews will be reported to Quality Assurance Performance Improvement Committee beginning 2/29/2024 and then monthly times 3 months. The interviews will be reviewed by the Interdisciplinary Team and Quality Assurance Performance Improvement Committee which consists of the Administrator, Director of Nursing, RN Supervisors, Dietary Manager, Nurse Educator, Medical Records Nurse, Social Service Director, Activity Director, and Medical Director to ensure compliance with reporting alleged reportable incidents. The Quality Assurance Performance Improvement Committee will make necessary recommendations as needed.	

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An interview and observation on 2/8/24 at 8:30 AM, with Resident #5 revealed some of the CNA's talk ugly to her and one time they cussed at her. Resident #5 stated "but I don't remember their names."

Record review of Resident #5 "Admission Record" revealed the resident was admitted to the facility on 7/26/23 with medical diagnoses that included Acute or Chronic Systolic (Congestive) Heart Failure.

Record review of Resident #5's MDS with an ARD of 10/30/23 revealed in Section C a BIMS score of 14, which indicates the resident is cognitively intact.

Resident #6

An interview on 2/8/24 at 10:50 AM, with Registered Nurse (RN) #2 revealed that Resident #6 had reported to her last week that CNA #1, the aide on the night shift talks ugly and treats her ugly and that she reported this to the DON and informed the resident that she could talk with the Social Worker about it the next day.

An interview on 2/8/24 at 12:00 PM, with Resident #6 she stated that her only issue has been with CNA #1 on the night shift and that she talks ugly to her and tells her to stay off her call light so much at night. She stated that CNA #1 threatens her and says they will send her to behavioral health if she does not do what they tell her to do. She stated that she has reported this issue to the DON and RN #2 and stated, "Please tell me you are going to do something about this."

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Record review of a note dated 2/3/24 at 15:26 (3:26 PM) revealed "Type: eMAR-Medication Administration Note" revealed "(Proper name of CNA #1) and the other girl that works with her. They are thick as thieves, and they always threaten they are gonna get me sent off to behavioral. I don't know why they treat me like they do ...DON was aware ..."

Record review of Resident #6's "Admission Record" revealed the resident was admitted to the facility on 2/16/23 with medical diagnoses that included Type 2 Diabetes Mellitus with other Diabetic Neurological Complications.

Record review of Resident #6's MDS with an ARD of 1/18/24 revealed in Section C a BIMS score of 13, which indicates the resident is cognitively intact.

Resident #7

An observation and interview on 2/7/24 at 7:50 PM, with CNA #1, CNA #2 and CNA #3 revealed that they were the three CNA's working the night shift and they revealed they have had in-services on abuse. During this interview while in the hallway, Resident #7 was self-propelling her wheelchair and when she passed, she stated to the CNA's, "I need to go to the bathroom." CNA #1 responded quickly to the resident, "Well you're gonna have to wait until I get done talking."

An interview on 2/7/24 at 8:00 PM, with RN #1, was informed of the manner and tone that CNA #1 had used in response to Resident #7. RN #1 confirmed "that could be verbal abuse to a resident." She stated " That is not an appropriate way to talk to residents."

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An interview on 2/7/24 at 8:05 PM, with CNA #1 she confirmed that she had told Resident #7 she would have to wait until she was done talking when the resident asked to be helped to the bathroom. She stated that she did not mean it to sound rude and admits that she has been in-serviced on verbal abuse. She revealed that she had only had one complaint from a resident about her and that one complaint was from Resident #1. She had complained that I had knocked a drink off of her table, but I did not do that. She did it, but I did cleaned it up and I told the Director of Nursing (DON) that I cleaned it up.

An interview on 2/8/24 at 11:40 AM, with Licensed Practical Nurse (LPN)/Social Services confirmed that she had some complaints on CNA #1 talking ugly to the residents and that Resident #7 filed a formal grievance around the first of January that CNA #1 had refused to get her up that morning and talked ugly to her. She stated that on 1/7/24 Resident #2 came to her office to complain about CNA #1, and she asked him if he could wait to let her get the DON and the Administrator in there so they could hear, and he agreed. She revealed that the DON and the Administrator came to her office and the resident revealed that CNA #1 was passing snacks around 6:30 PM and when he asked her to help him make his bed, she told him she was busy passing snacks. She stated that the resident told them that he asked her if passing snacks that early was as important as helping him make his bed and then as she walked out of the room, she rudely told the resident to make it up himself. She revealed that Resident #1 complained to her on 2/6/24 about CNA #1 and that the resident complained that she had accidentally spilled her drink and CNA #1 told

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her "You going to get that up". She stated that she asked the resident if she wanted to talk with the DON or the Administrator and the resident stated no that she already had, and they were going to take care of it.

An interview on 2/8/24 at 12:30 PM, with Resident #7 confirmed that CNA #1 told her she would "Have to wait until she was done talking" when she told her she needed to go to the bathroom last night. She stated that CNA #1 was rude but that wasn't the first time, and she is used to it from her. She revealed that she had complained about it to a lot of people, "but it does no good; nothing gets done." She revealed she just don't say anything anymore. She stated that she is supposed to go to the bathroom every 2 hours and usually goes at 4:30,and she has told CNA #1 this. CNA #1 told her that she was not coming straight to her as soon as she came on duty to take her to the bathroom, so she knows to not even ask until around the time she ask last night (around 8 PM). She confirmed that she filed a formal grievance back in January of this year, because the night CNAs that included CNA #1 came in her room around 4 AM and told her if she did not get up right then, then she would have to wait until day shift got there to get up. She stated that she was supposed to get up around 5:30 AM and they never came back to get her up. She confirmed that this had been reported to the Social Worker, Administrator, the DON, and some of the other nursing staff but could not remember their names.

Record review of Resident #7 "Admission Record" revealed the resident was admitted to the facility on 3/13/20 with medical diagnoses that included Type 2 Diabetes Mellitus without

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Complications.

Record review of Resident #7's MDS with an ARD of 10/30/23 revealed in Section C a BIMS score of 15, which indicates the resident is cognitively intact.

Record review of the "Grievance/Concern/Comment Report" dated 1/2/24 revealed a formal grievance was filed regarding CNAs on the night shift not getting Resident #7 out of bed as requested.

An interview on 2/8/24 at 9:30 AM, with the CNA Supervisor revealed there has been one complaint from a resident back in November 2023 or December about night shift CNA #1 being rude to a resident and that she reported it to the DON and she took care of it.

An interview on 2/8/24 at 10:00 AM, with CNA #4 and CNA #5 revealed that they normally work day shift but sometimes they have to help and work night shift and that some of the residents complain about a CNA on the night shift that is rude to them but would rather not mention any names. She stated that she thinks that everyone knows it and is sure it has been reported to the DON and the Administrator.

An interview on 2/8/24 at 1:40 PM, with the DON confirmed that all staff receive abuse in services on hire and annually unless there is an issue and then we can do one anytime in our computer in-service system. She revealed that as far as she knows there has not been an issue in order to have to do an additional abuse in-service. She admitted that she had received a complaint on CNA #1 on 2/6/24, but that was the first complaint

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she had on the staff member, and she is not aware of any more complaints on other staff regarding talking disrespectfully. She stated that Resident #1 reported an issue to her on 2/6/24 that CNA #1 talked disrespectfully to her. The DON stated she came in last night and talked to CNA #1 about that issue around 6 PM.

An interview on 2/8/24 at 2:00 PM, with the Administrator, DON, and LPN/Social Services confirmed they had complaints about CNA #1 talking inappropriately to some of the residents. The Administrator stated that the reports he had from Resident # 1 and Resident #2 just did not seem like verbal abuse to him. Both agreed that the reports of how the CNA spoke to Resident #7 last night and how she said it was inappropriate and disrespectful. The DON confirmed at this time that she had known about the report from Resident #1 and Resident #2. When the State Agency (SA) inquired about Resident #6 and her complaint, the DON stated yes, she came into the office and also had a complaint. The DON verified that she had three (3) residents complain about how CNA #1 talked to them. The Administrator stated that CNA #1 had been talked to last night about the complaint that came in on 2/6/24 with Resident #1. The Administrator stated he was not aware that CNA #1 had told Resident #2 to make his own bed as she walked out of his room, but LPN/Social Services confirmed that he did report that to them. The Administrator confirmed that he was aware of the grievance that Resident #7 had filed about them not getting her up when she wanted to but was not aware that either one of them had told her that if she did not get up now, then she would not get up until day shift got there. He admitted that they would have to do an investigation and more

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