STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255321	A. BUILDING _____ B. WING _____	C 12/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HATTIESBURG HEALTH & REHAB CENTER	514 BAY STREET HATTIESBURG, MS 39401

(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 a Complaint Investigation (CI) MS #16382, from 11/12/19 to 12/02/19, related to allegations of Quality of Care (QOC) and Abuse issues. The SA substantiated misappropriation of money for Resident #9, and physical abuse for Resident #16, with a citation at F600. The SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid. The facility's census during survey was 169, and the facility is licensed for 184 beds.	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 by: Based on observation, interview, record review, and policy review, the facility failed to ensure residents were free from misappropriation for one (1) of six (6) residents reviewed for Abuse/Misappropriation, Residents #9. A	F 600	1. Licensed Practical Nurse, reported to Director of Nurses verbal report of possible misappropriation of property on 10/15/19. Certified Nursing Assistant #1 was called in on 10/15/19 upon report of	1/7/20

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

Electronically Signed | 12/24/2019

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F 600	Continued From page 1 Certified Nursing Assistant (CNA) accepted money from Resident #9. The facility also failed to protect Resident #16 from resident to resident abuse. Findings include: Review of the facility's "Investigating Incidents of Theft and/or Misappropriation of Resident Property" policy, dated April 2017, revealed residents have the right to be free from theft and/or misappropriation of personal property. A review of the facility's "Protection of Residents during Abusive Investigations" policy, dated April 2017, revealed: "Our facility will protect residents from harm, reprisal, discrimination or coercion during investigations of abuse allegations." Resident #9 Review of a facility document, "Employee Warning Report", dated 10/15/19, signed by CNA #1 and the Administrator, revealed CNA #1 accepted $10.00 on 10/9/19, from a resident (Resident #9). Upon notification of CNA #1 accepting money from a resident, CNA #1 was called in to meet with the Administrator and Director of Nursing (DON), prior to her work schedule. The $10.00 was immediately refunded to the resident by the facility. The document revealed CNA #1 was placed on Administrative suspension. Review of a written statement, dated 10/15/19, signed by CNA #1, revealed she knew it was against company policy to accept anything from residents. CNA #1 documented the resident (Resident #9) offered her money, she declined at first, and then ended up taking the money. She	F 600	exchange of money with resident. CNA #1 was placed on administrative suspension on 10/15/19, while investigation was completed. Resident funds were reimbursed by facility on 10/15/19, and then employee reimbursed facility on 10/15/19. CNA #1, stated understanding of facility policy and procedure of accepted gifts per her statement dated 10/15/19.Reported to State Department of Health and Attorney General's office 10/16/19 with written report submitted on 10/18/19. On 10/15/19, upon report of a resident of resident altercation. Both residents were immediately assessed by Physician Assistant while Resident #15 was placed on, one on one monitoring. Resident #16, was noted with right eye swollen, to which x-rays obtained revealed no evidence of fracture or dislocations. Resident #15 was assessed and no injuries were noted at that time. One to one monitoring was initiated by 5:00pm on 10/15/19 at the direction of, Director of Nurses. Director of Nurses informed all staff on unit including facility supervisors of one to one status and policy at 4:45pm on 10/15/19. On 10/15/19 social Services conducted interviews with all residents in the section of CNA #1 and none were identified as giving any funds or items to staff. 2. 172 residents were identified as being at risk from this deficient practice. On 10/15/19, DON identified only Resident #15 and Resident #16 were	

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F 600	Continued From page 2	F 600		

documented her intention was not to leave with the money, but to return it to the resident. She stated it slipped her mind, until she got home and realized she still had the money. CNA #1 documented, "I know company policies is not to accept anything. My intentions was to take it back. I promise."

During an interview, on 11/14/19 at 12:00 PM, the Administrator confirmed CNA #1 accepted $10.00 for her birthday from Resident #9. The Administrator stated CNA #1 she didn't want the resident to cry and think she was ungrateful when she gave it to her, and planned to bring the money back. The Administrator stated CNA #1 returned the money, which was given back to Resident #9. The Administrator stated he disciplined CNA #1 on 10/15/19, (documented in Personnel file), and probably should have fired her, but she had not had any discipline to that nature since her employment at the facility. The Administrator stated they suspended CNA #1 for approximately a week, without pay, until it was investigated properly, and also because it is the facility's policy not to accept gifts of any kind from any resident.

During an interview, on 11/14/19 at 12:45 PM, with the Director of Nursing (DON) and review of the investigation, provided by the DON, the DON stated an investigation was initiated on 10/18/19, when CNA #1 allegedly received money from Resident #9. She stated the CNA was suspended, and allowed to return to work, after the investigation and advisement from the Attorney General's office, the incident would not be pursued as a crime. The DON confirmed CNA #1 accepted $10.00 from Resident #9.

involved in altercation. 2 of 172 residents have potential to be at risk from this deficient practice.

3. On 10/15/19 an in-service was conducted by Licensed Practical Nurse, Staff Development, with all staff regarding policy and procedure related to accepted gifts from residents and family. All staff were in-serviced prior to working. On 10/31/19, a QA meeting was conducted and policy and procedure related to Investigation Incidents of theft and or misappropriation of resident property, were reviewed and no changes were suggested.

On 10/16/19, Resident #15 was transported to Behavioral Health in patient services. on 10/16/19 DON reviewed policy and procedure on resident to resident altercations with Medical Director and no further changes were made.

4. Reported to State Department of Health and Attorney General's office 10/15/19 with written report submitted 10/18/19. QA Nurse to monitor for employees accepting gifts from residents or family by interviewing 10 residents monthly for 3 months. All findings of staff accepting gifts will be immediately addressed upon notification of QA Nurse by reimbursement and placing staff on administration suspension until investigation complete. No further findings as of 12/23/19.

Facility wide in-service on, resident on

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F 600	Continued From page 3 During an interview on 11/26/19 at 8:50 AM, Resident #9 revealed that she did give CNA #1 money for her birthday, because she wanted her to have it. Resident #9 stated the $10.00 was given back to her by the facility. Resident #9 stated she had never given CNA #1 anything before that day. Review of facility document titled "In-service Training for Certified Nurse Aides (CNA)" dated 6/13/19 revealed CNA #1 was in-serviced on abuse and neglect and exploitation of vulnerable adults. Resident #16 Review of an investigative report, dated 10/18/19, revealed on 10/15/19 at 4:30 PM, Resident #15 told the RN he had retrieved the remote from his roommate. The report documented Resident #16 was lying in his bed with a red area over his right eye brow. The report documented the RN Supervisor and the Physician's Assistant (PA) assessed both residents, with swelling and tenderness to Resident #16's right superior orbit of his eye; x-rays were negative for fracture. The report documented Resident #15 was assessed, with no injury, and was placed on 1:1 supervision until transport to the Geri-psych unit on 10/16/19 at 5:15 PM. A review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 9/30/19, revealed Resident #15 had a Brief Interview of Mental Status (BIMS) score of 9, which indicated moderate cognitive impairment. Record review of the Nurses Notes for Resident #15, dated 10/17/19, as a late entry for 10/15/19, by RN #1, revealed Resident #16 (Resident #15's	F 600	resident abuse was completed on 10/17/19. DON to monitor resident on resident altercations daily for 3 months by review of incident reports and any findings of those not following policy and procedure will be brought to QA for immediate review.	

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roommate), told a CNA he was hit in the face by Resident #15 twice, because of a TV remote. The note documented the RN assessed both residents and Resident #15 was placed on 1:1 observation, until transported to the behavioral unit. The report documented Resident #15 admitted to hitting Resident #16 due to taking his remote.

Record review of a facility document, "Every Shift Monitoring", revealed Resident #15 was placed on 1:1 monitoring, beginning 10/15/19 at 5:00 PM, and the monitoring ended 10/16/19 at 6:00 PM.

During an interview, on 11/18/19 at 1:37 PM, the Social Services Director (SSD) stated Resident #15 had been sent to the Geri-Psych unit twice before, for saying inappropriate things to staff members, but he had never been aggressive towards another resident until this happened with Resident #16.