STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255252	A. BUILDING _____ B. WING _____	C 06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MS CARE CENTER OF GREENVILLE	1221 EAST UNION STREET GREENVILLE, MS 38703

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F 000	INITIAL COMMENTS The State Agency (SA) conducted a complaint investigation (CI MS# 25025, CI MS# 25242, CI MS# 25274, CI MS# 25344, and CI MS# 25352) at the facility on 6/3/24. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid Services. The SA identified non-compliance and cited F 609 for CI MS# 25352 for failure to report a resident's allegation of abuse. The facility was in compliance and there were no deficiencies cited for CI MS# 25025 related to quality of care, CI MS# 25242 or CI MS# 25274 related to abuse, or CI MS# 25344 related to physical environment. The census at the time of the survey was 85 with a bed capacity of 90 beds.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides	F 609		7/19/24

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

Electronically Signed | 06/19/2024

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 609	Continued From page 1 for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §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 resident and staff interview, record review and facility policy review the facility failed to report an allegation of abuse when a resident reported that a Certified Nursing Assistant (CNA) balled up her fist, placed her knuckles into the resident's thigh and twisted for one (1) of eight (8) residents reviewed for abuse. Resident #1. Findings include: Record review of the facility policy, titled "Freedom from Abuse, Neglect and Exploitation" revealed, "It is the policy of the facility to provide services based on the following requirement ...Reporting of Alleged Violations ...The facility will ensure that all alleged violations involving abuse ...are reported immediately, but not later that 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury... to the Administrator of the facility and State Survey Agency, Adult Protective Services and local law enforcement in accordance with state law ..." A record review of the facility "Resident Incident Report" for Resident #1, dated 5/26/24 and	F 609	F609 1.Address how corrective action(s) will be accomplished for those residents found to have been effected by the deficient practice; -Resident #1 incident was reported to state and other corresponding officials related to allegations of abuse on 6/3/2024. 2. Address how the facility will identify other residents having the potential to be effected by the same deficient practice; -All residents have the potential to be effected by stated deficiency; no similar findings and/or negative effects have been identified by this alleged deficient practice as evidence by resident interviews conducted by the Director of nursing on 5/27/2024. 3. Address what measures will be put into place or systemic changes made to	

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F 609	Continued From page 2 completed by Licensed Practical Nurse (LPN) #1, revealed that on 5/26/24, Resident #1 reported that CNA #2, who changed her on the previous shift balled up her fist and placed her knuckles into her thigh and twisted, and pointed at her left thigh. A record review of a witness statement from CNA #1, dated and timed 5/26/24 at 1:10 AM, revealed that Resident #1 told her that on 5/26/24 at 10:30 PM, the CNA took her knuckle and pushed it into the back of her left thigh. In an interview with Resident #1 on 6/3/24 at 2:06 PM, stated that she could not remember the day but when CNA #2 was turning her to clean her up it felt like she was pushing her in the thigh with her fist. During a telephone interview with LPN #1 on 6/3/24 at 2:45 PM, she confirmed that on 5/26/25 around 1:15 AM, CNA #1 informed her that Resident #1 stated that on the previous shift CNA #2 balled up her fist and placed her knuckles into her thigh and twisted. LPN #1 stated that she followed-up with Resident #1 and the resident verified that CNA #2 balled up her fist, placed her knuckles into her thigh and twisted. She stated that she was concerned about the report from the resident and notified the on-call Registered Nurse (RN) because it was an allegation of abuse. In an interview with RN #1 on 6/3/24 at 3:15 PM, she verified that she was the on-call RN on 5/26/24. She stated she received notification from LPN #1 on 5/26/24, of Resident #1's allegation of CNA #2 balling up her fist, placing her knuckles	F 609	ensure that the deficient practice will not recur; -Abuse and neglect policy on reporting was reviewed by Administrator with Director of Nursing on 6/4/2024 and no revisions were necessary. -Staff was in-serviced by Staff Development nurse on the abuse and neglect policy on 6/4/2024. -Facility will continue to educate on abuse and neglect. This includes reporting allegations of abuse or neglect immediately to the administrator and Director of Nursing. -DON and/or Administrator will report allegations of abuse accordingly and in a timely manner. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. -Director of Nursing or social services will review resident progress notes and incidents 5 times weekly beginning on 6/17/2024 for 3 months then 3 times weekly for 3 months and as warranted to ensure all reportable incidents are reported and reported timely. This will be signed off on weekly by Administrator for the duration. QA will review monthly for six months. QA will meet again on July	

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F 609	Continued From page 3 into her thigh and twisting. She stated that on 5/26/24 at 6:00 AM, Resident #1 told her that CNA #2 had come into the room to clean her up and asked her to grab the rail and hold herself. Resident #1 then told RN #1 that she felt CNA #2's fist smash into her left thigh. RN #1 stated that she notified the Administrator and Director of Nursing (DON) immediately because Resident #1's statement was an allegation of abuse. On 6/3/24 at 3:25 PM, during an interview with the DON, she verified that she received a report of Resident #1's allegation from RN #1 on 5/26/24. She stated that the facility did not report Resident #1's complaint of CNA #2 balling up her fist, placing her knuckles into her thigh and twisting because the resident has a history of making false accusations and on completion of their investigation, they could not validate the incident occurred. The DON agreed that Resident #1's complaint should have been considered an allegation of abuse and should have been reported as such. In an interview with the Administrator on 6/3/24 at 4:30 PM, she stated that Resident #1's complaint was not reported because they did not feel it was an allegation of abuse. A record review of the "Face Sheet" for Resident #1 revealed that the facility admitted the resident on 1/23/2017 with a diagnosis of Flaccid Hemiplegia affecting left non-dominant side. A record review of Resident #1's Quarterly Minimum Data Set (MDS), dated 4/29/24, revealed a Brief Interview for Mental Status (BIMS) score of 14, indicating Resident #1 was cognitively intact.	F 609	17 2024 to review findings. -Findings will be reported at the monthly Quality Assurance meeting and the need for continued audits will be determined based on the audit findings. 5. Indicate the date(s) the corrective action(s) will be completed -Date of compliance is 6/19/2024	

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