

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

PRINTED: 12/09/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A162	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/21/2024
NAME OF PROVIDER OR SUPPLIER SHEARER-RICHARDSON MEMORIAL NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 512 ROCKWELL DRIVE OKOLONA, MS 38860		
(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 #26980) at the facility from 11/20/24 through 11/21/24. The SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F603 at a "G" for involuntary seclusion and F609 for failure to report allegations of abuse timely as required. The census at the time of the survey was 67 with a license for 73 beds.	F 000			
F 603 SS=G	Free from Involuntary Seclusion CFR(s): 483.12(a)(1) §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. §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 interviews, record review, and facility policy review, the facility failed to ensure a resident's right to be free from abuse including involuntary seclusion, verbal abuse and unreasonable confinement by staff members physically restraining a resident for one (1) of three (3)	F 603	12/03/2024 the plan of care for Resident #1 has been updated to include; offer/assist to toilet every 30 minutes and upon request, staff to avoid keeping her waiting due to her Huntington's causing her to feel that she needs to move her bowels frequently. All staff to be		12/6/24

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

TITLE

(X6) DATE

Electronically Signed

11/29/2024

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 603	Continued From page 1 residents sampled. Resident #1. Findings include: Record review of facility policy titled, "Abuse, Neglect and Exploitation", dated 3/17/23, revealed, "It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect., 'Abuse' means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse... Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. ... 'Verbal Abuse' means the use of oral, written or gestured communication or sounds that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability...Involuntary Seclusion refers to the separation of a resident from...his/her room...against the resident's will..." During an interview with the Administrator on 11/20/24 at 9:15 AM, it was revealed that the incident occurred on 10/30/24 around 6:00 PM and was reported by Resident #3 to the Administrator the next morning on 10/31/24. She stated after viewing the video footage and interviewing residents and staff, it was determined that the resident was confined to her chair and made to stay in the lobby area and was not allowed to go to the bathroom by two staff members.	F 603	inserviced on resident abuse with emphasis on involuntary seclusion by 12/06/2024. Allow resident to go to her room if she desires, can encourage her to stay in public areas but respect her wishes if she choose to go to her room. Upon review of the facility census it was identified that forty-two (42) of forty-three (43) residents could have possibly been affected by the stated deficient practice . On 11/04/2024 Licensed Practical Nurse #1 and Registered Nurse #1 were terminated from employment. Beginning 10/31/2024 through 11/04/2024 the Social Director interviewed 26 residents with a Brief Interview for Mental Status (BIMS) score of 8 or greater on the above identified unit to identify any concerns regarding residents' rights and abuse with no negative findings reported. By 12/06/2024 all staff will be in- serviced on the facilities policy Abuse, Neglect and Exploitation with emphasis on the freedom from involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms by 12/06/2024. As of 11/28/2024 75% of staff have completed the stated in-service. Any staff who has not received the in-service on or before 12/06/2024 will be removed from the schedule until the in-service is completed. Beginning 11/25/2024 and ending 12/06/2024 the Social Director will interview a total of thirty-four Residents that have been identified with a BIMS score of 8 or greater to ensure that they		

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F 603	Continued From page 2 An interview with Resident #3 on 11/20/24 at 12:25 PM, revealed she was in the lobby area when this incident occurred between Resident #1 and Registered Nurse (RN) #1 and Licensed Practical Nurse (LPN) #1. She stated Resident #1 needed to go to the bathroom and LPN #1 held her in the chair and yelled at her and told her to stay in the chair and that she was not leaving. Then, RN #1 wrapped her arms around resident from behind and held her in the chair. They yelled at her and were telling her that they were going to send her out to the hospital. Resident #1 was moving a lot and trying to get them to let her go. Resident #3 stated, "That really hurt me to see them treat her that way. I had to get out of there because I couldn't watch that." An interview with Resident #2 on 11/20/24 at 12:40 PM, revealed he also witnessed this incident in the lobby, and he reported it the next day. He stated it started when the resident told LPN #1 that she needed to go to her room to go to the bathroom, but LPN #1 told her she had just gone and not done anything, so she was not going back and to stay in her chair. The resident moved her chair towards the door several times, but LPN #1 brought her back to the lobby area each time. LPN #1 told another staff member to close the doors that led from the lobby to the hallway so Resident #1 could not leave. He stated LPN #1 took the resident's hands and held them together in front of the resident and tried to hold her arms on the resident's chest to keep her in her chair. She yelled at the resident to sit down, she was not going to her room, she was going to be sent out, and she was tired of her doing this. At that point, RN #1 came and held the resident from behind with her arms wrapped	F 603	have not personally been affected or observed the stated deficient practice. On 11/26/2024 the Administrator discussed the survey findings with the Resident Counsel attendees and reviewed the facilities policies on Resident's Right and Abuse, Neglect and Exploitation. Beginning 11/29/2024, the Social Director will be responsible for ensuring that all new hires are educated on resident abuse within 5 days of hire as evidenced by employee signature page from the Abuse, Neglect and Exploitation policy placed in the employees personnel file, with Business Office Manager confirming compliance upon receipt of personnel file. The Quality Assurance Performance Improvement (QAPI) Committee met on 11/27/2024 and developed a Performance Improvement Plan (PIP) regarding resident abuse, reporting and the expectations of staff training. The Quality Assurance (QA) Nurse will be responsible for monitoring effectiveness of PIP beginning 11/27/2024 through the Quality Assurance Performance Improvement (QAPI) program as outlined per review of all new hire records at least one day a month for 3 months to ensure the forms are present in the personnel files. QA to be monitored weekly beginning the week of 11/27/2024 during the weekly QAPI meeting and continuing weekly through 01/31/2024. Any negative findings found will be reported to the Administrator immediately for further action(s). Results of the findings will be discussed by the QA committee including the Medical Director		

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F 603	Continued From page 3 around the resident's shoulders and the resident's arms were crossed and she held her arms. The resident tried to get them to let go of her and go to the bathroom. He stated it was awful to watch, and he had never seen anything like that before with these nurses or other staff and both of these nurses seemed irritated, and the situation was out of control. An observation and interview with Resident #1 on 11/20/24 at 3:00 PM, revealed the resident sitting in her recliner in her room drinking water from her cup with jerky and uncoordinated movements. Resident #1 had a diagnosis of Huntington's disease; therefore she was extremely difficult to understand, but she continued to repeat each statement until she was understood. She stated she was in the lobby area and needed to go to the bathroom, but LPN #1 would not take her since she had just been. She attempted to propel herself to her room, but LPN #1 stopped her and pushed her back into the lobby. LPN #1 held her in the chair and yelled at her saying she was not going to her room, and she was getting sent to the hospital. Then, RN #1 held her from behind while she was sitting in her chair and would not allow her to move. She stated she had the right to go to the bathroom and to be held down was wrong and she did not like being treated that way. She denied any physical injury but stated she was emotionally bothered, and this made her angry and upset that they did this to her. She stated that the nurses sent her to the Emergency Room (ER) and she told the doctor in the ER that nothing was wrong with her that she just needed to go to the bathroom and they wouldn't allow her too. The resident confirmed that she was returned to the facility later that evening.	F 603	at the next scheduled meeting on 12/03/2024 and at the regular scheduled meetings on the third Wednesday of each month through 02/28/2024. The Administrator will be responsible for informing the governing body of any negative findings at the meetings scheduled for the third Monday of each month beginning 12/16/2024 through 02/28/2024 The QA Nurse will be responsible for reporting any negative findings at the QA Committee meetings scheduled on the third Wednesday of the month beginning 12/18/2024 through 02/28/2024.		

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F 603	Continued From page 4 During a phone interview on 11/20/24 at 3:45 PM, LPN #1 she stated Resident #1 was in the lobby area and was taken to the bathroom by a Certified Nursing Assistant (CNA) #5 and within a few minutes, she stated she needed to go to the bathroom again. CNA #5 was with another resident, and she informed Resident #1 that it would be a few minutes and the CNA would be back to take her to the bathroom. She stated the resident tried to propel herself to her room and she told her she could not go back by herself due to the risk of a fall. She stated Resident #1 got mad and was hitting and pushing and tried to throw herself out of the chair and she did hold her in the chair to keep her safe. She stated a resident does have the right to fall but she felt that it was her responsibility to keep that from happening if she could. She stated she should not have yelled at the resident or held her when she did not want to be held, but she did this to keep her safe, not to be malicious or mean. She stated she wished the situation had been handled differently, but she just did not want her to fall. LPN #1 confirmed that she was terminated from the facility related to this incident. A phone interview with CNA #1 on 11/20/24 at 4:05 PM, revealed she came up on the situation and the resident was yelling that she had to go to the bathroom and RN #1 was holding her from behind. CNA #1 did not witness the resident hitting or kicking but said it appeared to her that she was trying to free herself from being held. She stated she was shocked to see this and did not know what to think about it. During a phone interview with RN #2 on 11/20/24 at 4:15 PM, it was revealed that she and RN #1 were having shift report in the office, and they	F 603			

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F 603	Continued From page 5 heard a big commotion and yelling so they went out to see what was happening. She stated LPN #1 said the resident was kicking and hitting and she needed help to hold her in her chair, so RN #1 put her arms around her from behind her to keep her from falling from the chair. She heard LPN #1 yelling at the resident that they were going to send her out and to sit down or you are going to fall. She felt they were trying to keep her safe and she did not think they meant for things to be that loud and out of control. A phone interview with CNA #2 on 11/20/24 at 4:45 PM revealed she had come into the lobby area and the lobby doors were closed and she heard the resident yelling that she needed to go to the bathroom and LPN #1 told her that she had just been to the bathroom and did not need to go again. She stated LPN #1 also cussed and yelled at the resident to calm down and she was not going to put up with this sh*t and that she was being sent out. CNA #2 observed that the resident was not combative but appeared to be trying to get loose from being held. She stated RN #1 was behind the resident and had her arms wrapped around her shoulders. She stated a CNA #3 came up and was holding her hands and talking calmly to the resident and the resident calmed down and RN #1 released her hold. She stated she had never seen anything like that, and the resident did not deserve for her caregivers to treat her that way in her home. During a phone interview on 11/21/24 at 9:45 AM, CNA #3 revealed the lobby doors were closed and when she walked through, she saw RN #1 holding the resident like a bear hug from behind and RN #1 said the resident had been hitting and kicking. RN #1 asked her to hold the resident's	F 603			

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F 603	Continued From page 6 hands so she gently placed her hands over the resident's hands, and talked calmly to her and she calmed down and RN #1 released her hold on her. She stated the ambulance came and she was taken to the hospital. A phone interview with RN #1 on 11/21/24 at 10:00 AM revealed on the evening of the incident, she and the day nurse were in the office for shift change report and they heard a commotion and yelling in the lobby area. She and the day shift nurse went into the lobby area and heard LPN #1 and Resident #1 yelling loudly and LPN #1 told Resident #1 that she needed to calm down and she was going to be sent out to the hospital. LPN #1 told her the resident had been hitting and slapping all day and she asked her to help hold her in the chair so she would not fall out while she did the paperwork for the hospital transfer. She held her from behind around her shoulders like a bear hug to keep her from falling out of the chair and the resident tried to get loose. She stated the resident had a history of fighting and attacking staff and had been to the emergency room before for this. The resident told her she needed to go to the bathroom to poop but LPN #1 said she had already been and did not do anything. CNA #3 came and held her hands and talked to her and she calmed down and she stated she released the bear hug hold on her. The ambulance arrived and she was assisted onto the gurney and was taken to the hospital. She stated with the information she had received, her first concern was to keep this resident and others safe. She stated she made a judgement call based on the information she had received and in hindsight, the situation should have been handled differently and she should not have held her in her chair. She stated when she was in the situation, all she	F 603			

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F 603	Continued From page 7 could think of was what to do to prevent a harmful fall. RN#1 confirmed that she resigned from the facility, prior to the facility terminating her. A phone interview with CNA #4 on 11/21/24 at 10:08 AM, revealed that she and CNA #1 came into the lobby and heard the commotion. RN #1 was holding the resident from behind and CNA #3 walked over to talk to the resident. She stated RN #1 and LPN #1 were screaming to "sit down" and "you're not going anywhere." The resident yelled out and tried to get loose, but she did not see the resident kick or hit. As the resident calmed down and got quiet, she said she "just needed to go to the bathroom". The ambulance arrived and she was taken to the hospital. An interview with RN #3 on 11/21/24 at 10:20 AM, revealed she had worked day shift and Resident #1 was agitated. After she ate her dinner in the dining room, she was taken to the lobby area. She stated LPN #1 was trying to calm her down and stated to the resident, "We're not doing this" and that she is "Going to send her out". She stated she did not see the part of the incident where the resident was being held, but she knew the nurses and she did not believe they meant to cause her harm. Interview with CNA #5 on 11/21/24 at 3:45 PM revealed this was a hard situation to witness. She stated the resident was held in her chair by RN #1 and LPN #1 was cussing and yelling and telling her they were going to send her out to the hospital. She stated the resident was not fighting but was trying to get out of their grip. She stated it seemed like the nurses were frustrated and it turned into a bad situation.	F 603			

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F 603	Continued From page 8 During an interview on 11/21/24 at 11:40 AM, the Director of Nursing (DON) stated they were notified of the incident by a resident the day after it occurred. She stated they watched the video and interviewed staff and residents. Resident #1 was cognitive and had the right to go where she wanted to go and no one would want a resident to fall, but a resident has that right. She stated Resident #1 was physically restrained and was kept from going where she wanted to go and doing what she wanted to do, therefore her rights were violated. She stated this incident was troubling to watch on the video and in the time frame they kept her from doing what she chose, the staff could have taken her to the bathroom. She confirmed the resident was verbally abused and was secluded to remain in the chair and was held in the chair by a staff member to prevent her from going to the bathroom. During an interview on 11/21/24 at 1:45 PM, the Administrator confirmed the resident was cognitive and had the right to make decisions on what she wanted to do and the resident was upset and angry that the staff confined her and kept her from going to the bathroom. She confirmed this violated her rights and that physical restraining of a resident is part of abuse and involuntary seclusion. On observation of the video with the Administrator on 11/20/24 at 1:40 PM, revealed on 10/30/24 at 6:01 PM, the resident was brought into the lobby. LPN #1 spoke to the resident at approximately 6:03 PM, then redirected her to the lobby in front of the TV at approximately 6:04 and 6:05 PM. At approximately 6:06 PM, a CNA took the resident to the restroom just outside the lobby area and returned to the lobby at approximately 6:14 PM.	F 603			

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F 603	Continued From page 9 At approximately 6:20 PM, LPN #1 approached resident again and spoke to her and then about 6:21 LPN #1 redirected her back to the same area. At approximately 6:22 PM, Resident #1 began to roll herself backwards and LPN #1 approached and rolled her beside the exit area to B hall and the double doors were closed and LPN #1 appeared to speak with resident and touched her to keep her in place in her chair. At approximately 6:25 PM, RN #1 approached LPN #1 and resident and it appeared they talked and then RN #1 began to hold resident from behind. At 6:30 PM, while RN #1 was still holding resident, CNA #3 approached the resident and appeared to be speaking to the resident, RN #1, or both. At approximately 6:32 PM CNA #3 appeared to lay her hands over the top of Resident's hands and RN #1 released the resident. At approximately 6:33 PM, Emergency Medical Technicians arrived, and the resident was taken to the hospital by ambulance. The video verified the resident was not allowed to leave the lobby area by LPN #1 and then was held in her chair for almost eight (8) minutes by RN #1 and was not allowed to move from the area. The video verified what the witnesses had stated during their interviews to the State Agency (SA). The video did not have audio but from all the interviews and from the mannerisms of the staff in question it was determined there was yelling in part of this incident captured on the video footage. Record review of ER notes dated 10/30/24 revealed, " ...presents to the Emergency Department (ED) from the nursing facility due to aggression. Patient is alert and oriented times (x) 4 and states that she just wanted to go to the	F 603			

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NAME OF PROVIDER OR SUPPLIER SHEARER-RICHARDSON MEMORIAL NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 512 ROCKWELL DRIVE OKOLONA, MS 38860		
(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 603	Continued From page 10 bathroom, and no one helped her." Record review of Resident #1's "Admission Record" revealed the facility admitted the resident on 1/7/21 with diagnoses that included Huntington's Disease. Record review of Resident #1's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 10/29/24 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 12 which indicated the resident had moderate cognitive impairment. Record review of Resident #2's "Admission Record" revealed the facility admitted the resident on 5/28/21. Record review of Resident #2's MDS with ARD of 11/8/24 revealed the resident had a BIMS score of 15 which indicated the resident was cognitively intact. Record review of Resident #3's "Admission Record" revealed the facility admitted the resident on 12/28/20. Record review of Resident #3's MDS with ARD of 9/24/24 revealed the resident had a BIMS score of 15 which indicated the resident was cognitively intact.	F 603			
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:	F 609			12/6/24

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F 609	Continued From page 11 §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 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 observation, staff interviews, record review, and facility policy review, the facility failed to report an allegation of abuse and involuntary seclusion within the time frame required for one (1) of three (3) allegations of abuse reviewed. Resident #1 Findings include: Record review of facility policy titled, "Abuse, Neglect and Exploitation" dated 3/17/23, revealed, "It is the policy of this facility to provide protections for the health, welfare, and rights of	F 609	On 10/31/2024 Administrator spoke with Resident #1 and discussed with her that she can report to the on duty nurse of any concerns and where to locate the contact information for calling the Administrator, Director of Nursing and or Ombudsman if a situation should occur with her assigned nurse so that she can report immediately for assistance with appropriate actions to be taken. Upon review of the facility census it was identified that sixty-four (64) of sixty-five		

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F 609	Continued From page 12 each resident by developing and implementing written policies and procedures that prohibit and prevent abuse ...Reporting/Response A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies ... within specified timeframes: a. 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 ..." During an interview with the Administrator on 11/20/24 at 9:15 AM, it was revealed that an allegation of abuse which occurred on 10/30/24 around 6:00 PM was reported to the Administrator by a resident on the morning of 10/31/24. The Administrator revealed this incident was investigated and was reported to the State Agency (SA) on 11/5/24 which did not meet the regulations requiring allegations of abuse to be reported within two (2) hours. She stated their investigation began on 10/31/24 and was substantiated for abuse and the employees involved were terminated. The Administrator confirmed that the facility had continued to investigate and gather statements from the witnesses and reported both nurses involved to the state board of nursing on 11/20/24. The Administrator stated that she was continuing to inservice staff on abuse and neglect and to notify her immediately if abuse or neglect was suspected and confirmed that the staff failed to do this initially. Interview with the Director of Nursing (DON) on 11/21/24 at 11:40 AM confirmed that when they were informed of the situation, they watched video, spoke with staff and residents, and	F 609	(65) residents could have possibly been affected by the stated deficient practice . On 11/21/2024 the Administrator and Director of Nursing reviewed tags F603 and F609 along with the Abuse Critical Pathway. 11/25/2024 the Administrator and Director of Nursing Services began to meet with the management team and all licensed personnel to review the facility's policy on Abuse, Neglect and Exploitation with emphasis on reporting/response of any allegation of abuse and/or serious bodily injury immediately or no later than 2 hours. As of 11/27/2024 25% of the above noted staff have been in-serviced, with anyone not attending the in-service on or before 12/06/2024 will be removed from the schedule until completed. New postings have been placed in the nurse's office on both units with contact information for reporting requirements. Beginning 11/29/2024, the Social Director will be responsible for ensuring that all management and licensed new hires are educated on resident abuse and reporting requirements within 5 days of hire as evidenced by employee signature page from the Abuse, Neglect and Exploitation policy placed in the employees personnel file, with Business Office Manager confirming compliance upon receipt of personnel file. The Quality Assurance Performance Improvement (QAPI) Committee met on 11/27/2024 and developed a Performance Improvement Plan (PIP) regarding resident abuse, reporting and the		

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F 609	Continued From page 13 investigation was initiated. The DON confirmed that the resident was physically restrained in her chair by another staff member which is a part of abuse. The DON stated that the video was only visual and had no auditory parts, but from interviews from the staff that witnessed the incident it was determined she was also verbally abused. She stated that the staff did not report this initially to her or the Administrator, but rather they were told by a resident the next morning about the incident that occurred. The DON confirmed that they waited until after the facility investigation was done and then reported it to the State Agency (SA) on 11/04/24 and she realized now that this should have been done in the time frame of 2 hours as required. On 11/21/24 at 1:45 PM the Administrator and the SA watched the video footage together and she confirmed this resident was cognitive, alert and had the right to make her own decisions on what she wants and that the staff restrained this resident and kept her from going to the bathroom and from the staff interviews gathered, she was also verbally abused by a staff member. This went against the resident's rights and physical restraining of a resident is part of abuse and the yelling and cussing and threatening to send her out gathered from interview was abusive as well. The Administrator stated that initially they just thought this was a customer service issue and not an abuse situation. Record review of Resident #1's "Admission Record" revealed the facility admitted the resident on 1/7/21 with diagnoses that included Huntington's Disease. Record review of Resident #1's Minimum Data	F 609	expectations of staff training. The Quality Assurance (QA) Nurse will be responsible for monitoring effectiveness of PIP beginning 11/27/2024 through the Quality Assurance Performance Improvement (QAPI) program as outlined per review of all new hire records at least one day a month for 3 months to ensure the forms are present in the personnel files. QA to be monitored weekly beginning the week of 11/27/2024 during the weekly QAPI meeting and continuing weekly through 01/31/2024. Any negative findings found will be reported to the Administrator immediately for further action(s). Reportable event discussed with Medical Director during (QA) on 11/20/2024. Results of the findings will be discussed by the QA committee including the Medical Director at the next scheduled meeting on 12/03/2024 and at the regular scheduled meetings on the third Wednesday of each month through 02/28/2024. The Administrator will be responsible for informing the governing body of any negative findings at the meetings scheduled for the third Monday of each month beginning 12/16/2024 through 02/28/2024 The QA Nurse will be responsible for reporting any negative findings at the QA Committee meetings scheduled on the third Wednesday of the month beginning 12/18/2024 through 02/28/2024.		

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F 609	Continued From page 14 Set (MDS) with Assessment Reference Date (ARD) of 10/29/24 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 12 which indicated the resident had moderate cognitive impairment.	F 609			