STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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M 000	Initial Comments The State Agency (SA) conducted two (2) Complaint Investigations (CI MS #27064 and CI MS #27213), at the facility from 12/11/24 through 12/12/24. During the survey, the SA determined that the facility was not in compliance with the requirements with the Mississippi Regulations for Minimum Standards for Institutions for the Aged or Infirm related to CI MS #27213 for resident rights and cited M 500. The SA did not find deficient practice for CI MS#27064. The census at the time of the survey was 59 with a bed capacity of 66 beds.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his	M 500		1/16/25

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M 500	Continued From page 1 medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal;	M 500		

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M 500	Continued From page 2 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other	M 500		

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M 500	Continued From page 3 residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level II Pattern Based on staff and resident interviews, record	M 500	1. On 12/12/2024, Resident #1 was assessed by the Administrator and DON for any negative outcomes of the incident.	

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M 500	Continued From page 4 review, and facility policy review, the facility failed to honor a resident's right to be treated with dignity and respect for two (2) of four (4) residents reviewed for resident rights. Resident #1 and #3 Findings include: Record review of the facility policy titled, "Resident Rights", dated 7/24/23, revealed, "Employees shall treat all residents with kindness, respect, and dignity. ... 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. a dignified existence; b. be treated with respect, kindness, and dignity". Resident #1 During an interview on 12/11/24 at 11:50 AM, Resident #1 stated there was an incident where she was made to feel like a "nobody" and was pushed in her wheelchair by Registered Nurse (RN) #1. She stated she was putting the phone back at the nurses' station and was speaking to the Dietary Manager when RN #1 came up and told her, in a very rude way, to get out of that area because only staff were allowed there and then pushed her wheelchair with force. Resident #1 stated she told RN #1, "Don't push me and don't touch me or my chair!". She stated she also told RN #1 that if the rules were changed, they needed to inform the residents since she had been going behind the desk to use the phone since she had been in the facility. She revealed she continued by telling RN#1 that this was her home and not a prison. She stated she was not physically harmed but felt upset that she was scolded like that.	M 500	Resident #1 was pleasant, happy and showed no signs of distress. On 12/12/2024, Resident #3 was assessed by the Administrator and DON for any negative outcomes of the incident. Resident #3 was pleasant, happy and showed no signs of distress. Beginning 12/12/2024, the facility will ensure that all alleged allegations involving abuse, neglect, exploitation, mistreatment, violations of resident rights and/or the exercise of rights including injuries of unknown origin and misappropriation of resident property will be reported immediately to Administrator and Director of Nursing (DON). The Administrator or DON will then immediately report allegations to the State Agency and all appropriate agencies within the appropriate time frame. All allegations will be investigated by the Administrator and/or DON and a report of the full investigation will be sent to the State Agency and all appropriate agencies upon conclusion with corrective actions. Newly hired staff will be educated in orientation regarding Resident Rights and how to report any violation of Resident Rights immediately to appropriate parties. 2. All residents have the potential to be affected by the alleged deficient practice. 3. The DON began in-service of present staff on Resident Rights and how to report any violations of Residents Rights on 12/11/2024 and concluded in-service training on 12/12/2024. The DON will continue to train/in-service as needed thereafter with present and future staffing.	

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M 500	Continued From page 5 An interview with the Dietary Manager on 12/11/24 at 1:45 PM confirmed she was at the nurses' station when the incident between Resident #1 and RN #1 occurred, and she reported this to the social worker. She confirmed that Resident #1 was returning the phone to the desk and RN #1 came up and told her she could not be back there. She stated that the resident told RN#1 that she was just putting up the phone and RN#1 said you cannot be behind the desk. She revealed that RN#1 squeezed between Resident #1's chair and the nurses' station wall which might have pushed Resident #1's chair, but she did not see RN #1 intentionally push the chair. She stated the resident was "visibly upset" and said she felt like "a prisoner" and that she had rights, then rolled back to her room. She stated she understood why the resident was so upset since this was her home and she had every right to use the phone. She stated that RN#1 was not yelling but the way it came out did sound rude and should have been worded differently. During a phone interview on 12/11/24 at 4:45 PM, RN#1 confirmed she upset Resident #1 and stated that she never meant to hurt Resident #1's feelings or to make her feel bad in any way. She stated she was speaking to the staff and not directly to the resident to remind staff of the confidential information that had to be protected. She stated she did not push the resident, and the resident propelled herself to her room. She revealed she did not realize there was a concern until she was told that Resident #1 was upset so she and the Director of Nursing (DON) went to apologize immediately. She stated she realizes now that even though she was not speaking directly to the resident, the resident was there and heard everything that was said. She admitted that it was not respectful to speak about that when the	M 500	4. All allegations of violations of Resident Rights will be thoroughly investigated by the Administrator and/or DON. Social Services will continue to oversee the Grievance Process and will report any Resident Rights grievances to the Administrator or DON immediately for investigation. On 12/12/2024, the Social Services Director began reporting all grievances to the Administrator daily in stand-up meetings to ensure facility compliance with reporting allegations. The Administrator will interview a sample of 5 residents, including Resident #1 and Resident #3, in the facility weekly beginning 12/13/2024 for 12 weeks to ensure all residents are safe from violations of Resident Rights. The Administrator will report findings to the Quality Assurance and Performance Improvement Committee on 1/7/2025 and monthly for 3 months.	

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resident was there and knew she was the one being talked about. She stated that each resident should be treated with dignity and respect and even though she did not mean to upset the resident, she could see how that situation caused Resident #1 to be upset with hurt feelings.

During an interview on 12/12/24 at 9:45 AM, Certified Nursing Assistant (CNA) #1 stated she was at the nurses' station when Resident #1 came to return the phone and was speaking to the Dietary Manager. She confirmed that she heard RN #1 tell Resident #1 that she could not be behind the desk, and she needed to get out from behind there. She stated that RN#1 did not yell, but had a blunt, stern, and matter of fact tone. She stated she was charting and did not see RN#1 push her chair. She confirmed that the resident was upset and angry about the incident.

An interview with the Administrator on 12/12/24 at 10:45 AM confirmed each resident had the right to be treated with dignity and respect. She confirmed the facility failed to ensure that Resident #1's rights were honored when she felt she was scolded and reprimanded by a staff member.

Record review of Resident #1's "Admission Record" revealed the facility admitted her on 1/16/24 with medical diagnoses that included Multiple Sclerosis and Systemic Lupus Erythematosus.

Record review of Resident #1's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/7/24 revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated this resident was cognitively intact.

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M 500	Continued From page 7 Resident #3 During a record review of the Resident Council Meeting minutes, it was revealed that during the meeting on 11/26/24 there was a concern involving Resident #3. The entry on the Resident Council minutes sheet read as follows: "(Resident #4) let us know that a nurse assistant was ugly to (Resident #3) on 11/23/24 while the residents were watching the Alabama football game...I met with DON alongside (Administrator) to report the issue. They stated they would open an investigation and talk with the CNA (Certified Nursing Assistant). Resident #4 said the aid told Resident #3 she was tired of dealing with him". This was signed by the Activity Director on 11/26/24. An interview with the Activity Director on 12/11/24 at 12:15 PM confirmed that during the Resident Council meeting on 11/26/24, Resident #4 was asked by Resident #3 to tell of the incident that occurred. She stated Resident #4 said that he and Resident #3 were watching a football game in the dining room and a CNA was rude to Resident #3 telling him that she "was tired of working with him". She stated that while Resident #4 was telling of the incident that had occurred, Resident #3 was teary eyed. The Administrator was in the meeting with her, and they both went and reported it to the Director of Nursing and was told it would be investigated. During an interview on 12/11/24 at 1:30 PM, Resident #4 confirmed that he witnessed an incident where a CNA was rude to Resident #3. He stated he does not know which CNA it was. He stated this occurred during the Alabama football game on Saturday 11/23/24 and he and Resident #3 were in the dining area watching the	M 500		

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game. Resident #3 was leaning in his chair, and he went to get staff because he was concerned Resident #3 would fall. The CNA told Resident #3 something like she was "damn tired of doing this s**t" and this upset Resident #3. He stated that the next evening, Resident #3 came to him and was still upset asking if he would mention this in the next Resident Council meeting. He stated he was not sure what the facility did for this situation, but he knew they were aware it happened.

An interview with Resident #3 on 12/11/24 at 1:40 PM, confirmed that he was in the dining room watching a football game and was needing a pillow so Resident #4 went to get the staff. He thought it was CNA #2 that came to check on him and he asked her for a pillow, and she said, "No, you don't need that pillow" and "I'm tired of doing this" and did not get it for him. He stated she did not cuss at him, but it did upset him, and he thought, "Woah, oh no, that's not good" and "she should help". He stated it did upset him, that he needed something to help him be more comfortable and that care was denied. He stated it was rude and disrespectful and not sure if abusive, but it was not right and it did "make me get pretty down and upset". He confirmed that Resident #4 witnessed this and the next day after the incident he was still bothered about it and asked Resident #4 to mention it in the Resident Council meeting since he did not feel comfortable talking about it.

During a phone interview on 12/11/24 at 4:00 PM, CNA #2 revealed she was at the desk and Resident #4 came to the desk and said something was wrong with Resident #3 because he was leaning and falling from his chair. She revealed that she went to the dining room and

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M 500	Continued From page 9	M 500		

there was no concern with Resident #3's position. She revealed that she thought Resident #3 was upset due to a phone conversation with his mother and not her or the care. She stated she did not tell the resident she was tired of caring for him and would not say that to any resident.

An interview with the Administrator on 12/12/24 at 10:45 AM revealed she was aware of what was reported regarding a CNA being ugly to Resident #3 because it was reported in the Resident Council, and she was in the meeting. She stated she and the Activity Director informed the Director of Nursing who spoke with the staff involved and could not determine whether any abuse occurred. She stated that the staff interviewed told her that Resident #3 was upset since it was Thanksgiving time, and his mother had changed the date she was going to pick him up. She stated after speaking to the two staff members, she felt there were no concerns since she was told he was only upset because his mother was not going to pick him up for Thanksgiving.

Record review of Resident #3's "Admission Record" revealed the facility admitted the resident on 11/3/23 with medical diagnoses that included Cerebral Palsy.

Record review of Resident #3's MDS with an ARD of 10/11/24 revealed a BIMS score of 14 which indicated this resident was cognitively intact.

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