STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255136	A. BUILDING _____ B. WING _____	C 02/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUPELO NURSING AND REHABILITATION CENTER	1901 BRIAR RIDGE ROAD TUPELO, MS 38804

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F 000	INITIAL COMMENTS On February 18, 2025 the State Agency (SA) conducted an onsite complaint investigation (CI) MS #27502 for alleged verbal abuse. The SA determined that the facility was not in compliance with the requirements for participation in Medicare and Medicaid and a harm level deficiency was cited at F600. The facility was licensed for 120 beds and the census was 114.	F 000		
F 600 SS=G	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 record reviews, resident and staff interviews, facility policy review, the facility failed to ensure a resident's right to be free from abuse and reprisal by staff. Resident #1 was verbally abused and confronted by Licensed Practical Nurse (LPN #1) for reporting that she had not received pain medications in a time when	F 600	Please consider this Plan of Correction as Tupelo Nursing and Rehabilitation Center LLC credible allegation of compliance. This Plan of Correction in response to the statement of deficiencies demonstrates our good faith and desire to continue to improve the quality of care	3/17/25

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

Electronically Signed | 03/03/2025

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 600	Continued From page 1 Resident #1 asked for them. Resident #1 was one (1) of three (3) residents reviewed for abuse and neglect. Findings include: The facility undated policy titled "Abuse Prevention" revealed, "The facility is committed to protecting the residents from abuse by anyone including, but not necessarily limited to: facility staff ... a) Abuse: Willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. This includes the deprivation by an individual, including a care taker of goods or services are necessary to attain or maintain physical, mental and psychosocial well-being. b) Verbal abuse: 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 ..." Interview on 02/18/25 at 12:25 PM with the facility Administrator (ADM)/ Executive Director (ED) revealed that the facility had conducted a full investigation of the alleged verbal abuse reported by Resident #1 and the facility did not substantiate any abuse, but they did substantiate "poor customer service." The facility found that Licensed Practical Nurse (LPN) #1 delivered poor customer service when Resident #1 asked for her pain medications. The facility suspended the nurse from work while the investigation was conducted. The facility issued a written "class one" reprimand to LPN #1 for "poor customer service." The ADM presented supporting investigation materials and written statements	F 600	and services rendered to our residents. This Plan of Correction constitutes a written allegation of substantial compliance under Federal Medicare & Medicaid requirements. The facility will provide all residents to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined to include but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraints not required to treat the resident's medical symptoms. 1. On 12/31/2024 Resident #1 was interviewed by Executive Director (ED) and Social Service Director regarding concerns with Licensed Practical Nurse (LPN) #1. Resident #1 was assessed for post traumatic stress disorder, and monitored for emotional change in condition by Social Service Director . LPN # 1 was suspended on 12/31/2024 and no longer allowed in Resident #1 room. Resident # 1 discharged home 1/15/2025 with no further incidents. 2. All residents cared for by LPN #1 have the potential to be affected. 3. On 12/31/2024, Social Service Director conducted interviews with cognitive residents receiving care from LPN #1, and there were no other allegations or inappropriate care issues made as a result of those interviews.	

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F 600	Continued From page 2 that the facility had gathered during their facility investigation dated 01/03/2025 and signed by the ADM/ED and the Director of Nursing (DON). Interview on 02/18/25 at 12:45 PM with the Director of Nursing (DON) revealed that she and the ADM had investigated the incident and that they had suspended LPN #1 until the investigation was completed. The facility issued written discipline to LPN #1 for "poor customer service." The facility also pulled LPN #1 from working the rehabilitation unit and she was not allowed to work on that unit any longer. DON stated that Resident #1 was a short-term rehab resident and was admitted to the facility for rehab from a tibia fracture. DON stated that Resident #1 was cognitive and was a good historian and had a Brief Interview of Mental Status (BIMS) score of 15 which indicated that she was intact cognitively. Record review of the facility investigation dated 1/03/25 revealed: "Conclusion: After a thorough investigation, (name of facility) was unable to substantiate abuse or neglect. This was based on interviews with residents and staff members. It was determined that the nurse exhibited poor customer service in explaining how the medications are given and asking her about anything that was reported." Record review of the Admission Record of Resident #1 revealed that she had admission dates of 2/01/24 and a second admission date of 12/24/24 with diagnoses of Unspecified fracture of upper end of left tibia, subsequent encounter for closed fracture with routine healing; Type 2 Diabetes; Chronic Obstructive Pulmonary	F 600	On 12/31/2024, the Staff Development Coordinator initiated in-service for all staff on abuse and neglect to include customer service. On 2/19/2025 , the Staff Development Coordinator, initiated abuse in-service to include abuse, verbal, sexual, physical, mental, neglect, misappropriation of resident property, involuntary seclusion, exploitation, mistreatment, or confrontational and intimidating behavior to be completed by 3/3/2025. On 2/19/2025, the Executive Director contacted an outside agent to do a mandatory in-service with facility on the different types of abuse and the disciplinary actions resulting from substantiated abuse cases. This in-service is scheduled 3/10/2025. On 2/26/2025, the Social Service Director interviewed all cognitive residents on abuse, and concerns with medications and any issues with care to include, intimidating behavior, disparaging and derogatory terms or gestures, with oral or written communication between residents and staff. All interviews completed on 2/27/2025 with no issues reported. On 2/26/2025, the Executive Director completed in-service and education with Social Services, Unit Managers, Director of Nursing, Assistant Director of Nursing, and Minimum Data Set Nurses (MDS) on trauma screening and the importance of any positive trauma screens to be	

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F 600	Continued From page 3 Disease; and Repeated Falls. Record review of Resident #1's Minimum Data Set (MDS) with an Assessment Reference Date of 12/31/24 revealed a BIMS score of 15, indicating that Resident #1 was cognitively intact. Interview on 02/18/25 at 1:20 PM with the Director of the Rehabilitation (DOR) Department revealed that she had two (2) rehab therapy staff members that had reported to her that LPN #1 had spoken harshly and in a demeaning tone to Resident #1. The DOR stated that she stood behind her staff and supported them, and she had full confidence in the statements that the rehab therapy staff had made in the incident involving Resident #1 and LPN #1 and she believed the statements were true and accurate. She stated that the Speech Therapist (ST) had been a witness to the "harsh" tone and "confrontational" manner in which LPN #1 had used toward Resident #1. She also stated that the Physical Therapy Assistant (PTA) had gone in to assist Resident #1 when he found her crying and upset due to the confronting manner of LPN #1 towards her. The DOR stated that both staff had provided the facility with written statements about their account of the incident. The DOR confirmed that the rehab department had a policy that they would not deliver services to residents complaining of pain and that they would request pain medications prior to rehab services with residents. She stated that the ST had delivered the message to LPN #1 that Resident #1 was requesting pain medications prior to the physical therapy sessions and that LPN #1 denied that the ST had made the pain medication request. Interview on 2/18/25 at 4:00 PM with the ST	F 600	followed up with a plan of care to ensure reactions to traumatic events are treated. On 2/26/2025, the Director of Nursing and Human Resource personnel terminated the employment of LPN #1. 4. Beginning 2/27/2025, the Director of Nursing (DON) and, or Assistant Director of Nursing (ADON) will audit daily progress notes, new orders and 24-hour reports to identify suspicious events of residents occurrences, patterns and trends that may constitute abuse, verbal, sexual , physical, mental, neglect, misappropriation of resident property, involuntary seclusion, exploitation, mistreatment, or confrontational and intimidating behavior five times a week for four weeks, then three times a week for four weeks, then weekly times four weeks to ensure abuse has not occurred. On 2/27/2025, the Director of Nursing and, or Assistant Director of Nursing completed 100% trauma screen audits on all residents to ensure plan of care is in place to treat traumatic events. Beginning 2/27/2025, the Director of Nursing and, or Assistant Director of Nursing will audit all new trauma screens five times a week for four weeks, then three times a week for four weeks, then weekly times four weeks to ensure plan of care is in place to treat traumatic events. Beginning 3/7/2025, the audits will be	

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F 600	Continued From page 4 revealed that she was in Resident #1's room with her on 12/31/24 at approximately 7:30 AM and LPN #1 came in and began to "yell at the resident." ST stated that LPN #1 loudly told Resident #1 that she should never have called the front desk to complain on her and that she had not asked for her the pain medications. ST stated that she interrupted and told LPN #1 that she herself had come to her on the day before and had requested pain medications for the resident prior to therapy and LPN #1 told her, "No you never told me she requested medications." LPN #1 continued to tell Resident #1 that she had to request the medications and that she had not requested them and that she should not have called the front desk and complained about her. ST stated that she was trying to defuse the situation and asked to move on because LPN #1 was very rude and hostile toward Resident #1 and she was not going to argue with LPN in front of the resident, because she could tell it was upsetting the resident already how LPN #1 was acting towards her. ST stated that Resident #1 began to cry and shake after LPN #1 confronted her. ST stated that she gave the facility a written statement of the accounts of the incident that she witnessed. The interview on 2/18/25 at 2:45 PM with the PTA revealed that on 12/31/24 he had gone into Resident #1's room and found her crying and upset. When he asked her what was wrong and why she was upset and crying she stated that LPN #1 had "blessed her out." Resident #1 stated that she felt "unsafe" around LPN #1, and she never wanted her to come into her room again. PTA stated that he gave a written statement to the facility as to what Resident #1 had told him and that she had requested that LPN	F 600	reviewed weekly by the Executive Director for completeness and accuracy. A Quality Assurance and Performance Improvement (QAPI) meeting is scheduled 3/14/2025 to review audits, and to monitor the Quality Improvement categories to ensure solutions are sustained to prevent further occurrences utilizing A Quality Improvement Initiative (QII) Plan-Do-Study-Act (PDSA) worksheet identifying the Root Cause Analysis from Survey Exit on 2/18/2025. The Executive Director will forward audits to Quality Assurance Committee monthly times three months for review beginning 3/26/2025. The Quality Assurance Committee will make recommendation for continuation of audits or discontinuation based upon results achieved.	

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#1 never come into her room again. Resident #1 had her face in her hands crying and she voiced that she was bothered and upset by the manner in which LPN #1 had talked to her. Resident #1 was a cognitive resident, and she presented as a resident that was truthful. I trusted that what she was telling me was what had happened.

Interview on 2/18/25 at 4:15 PM with LPN #1 revealed that she had been sent home on 12/31/24 for the facility to conduct an investigation after Resident #1 had told the facility that she was not getting her medications timely. LPN #1 stated that her supervisor, LPN #2, had come to her and told her that Resident #1 had called the front desk and issued complaints that she was not getting her pain medications. LPN #1 stated that the resident had to request the medications, and she had not made a request for pain medications to her. LPN #1 stated that she told Resident #1 that she would need to turn on her call light and ask her for her pain medications because they were not scheduled, they were as needed (PRN) medications. LPN stated that she returned to work after her suspension, and she received in-services regarding customer service skills.

Interview on 2/18/25 at 1:45 PM with the LPN #2 Supervisor confirmed that she was the supervisor for all the LPN's and that LPN #1 was one of the LPN's that she supervised. LPN #2 stated that she remembered Resident #1 well and that she was a cognitive resident that was admitted to the short-term unit for rehab. LPN #2 denied knowledge of Resident #1's complaints against LPN #1 and stated that she has no knowledge that Resident #1 had called the front desk issuing complaints against LPN #1 on 12/31/24. LPN #2

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stated that she had been in-serviced numerous times on the facility "Abuse Prevention Policy," and stated that verbal abuse did include tone of your voice and body language. She stated that confronting a resident about issuing complaints was abuse and could also be considered "bullying." LPN #2 stated that LPN #1 should never have confronted Resident #1 and asked her about calling the front desk to complain about her. LPN #2 stated Resident #1 was not the type of individual to be untruthful, and that she was unaware that LPN #1 had given a written statement to the facility that she had told LPN #1 that Resident #1 was complaining to the front desk that LPN #1 was not giving her pain medications. LPN #2 stated that LPN #1's written statement to the facility was not true because she had not told her that the resident had complained about her, because she did not know at that time.

An interview on 2/18/25 at 2:50 PM with Resident #1 revealed that she had been a resident of the facility on two (2) different occasions. She stated that she had problems with LPN #1 on more than one occasion for not getting her pain medications in a timely manner. Resident #1 stated that she had been a City Police Officer for over 20 years and had to retire early due to a fall and some health issues. She stated that in all her 20 years with the police department she had never had anyone talk so badly to her like LPN #1 had talked to her. She stated that she got tired of sending someone up to ask for her pain medications, so she called the front desk and complained about her not giving her pain medications every six hours after she had asked for them. Resident #1 stated that the CNA's answered the call lights, and she would tell them to please go and ask the nurse for her pain

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medications. Resident stated that she was admitted to the facility after a fall and fracture for rehab and was a short-term rehab resident. She stated that she needed her pain medications prior to physical therapy and that LPN #1 was well aware of this yet she continued to delay giving the medications. Resident stated that ST was in her room on one occasion and had witnessed the "demeaning" loud tone and "degrading" manner that LPN #1 spoke to her. LPN #1 "would come to my room and ball me out." LPN #1 "Told me that she was doing the best that she could and that I was a damn liar. I felt mentally and emotionally unsafe and she had me shook. I was not physically afraid of her, but I was emotionally harmed by her." She told me that I had no business calling the front desk and telling the front office about her. Resident #1 stated that she had all "her marbles" and if LPN #1 talked to her in such a hostile manner how did she talk to those that had fewer mental abilities. Resident #1 stated that on 12/31/24 she requested that LPN #1 not be allowed in her room ever again. Resident #1 stated that she was discharged from the facility on 1/15/25 and LPN #1 was never in her room again after that day.

An interview on 2/18/25 at 3:15 PM, with a Licensed Social Worker (LSW) confirmed that she believed the events outlined by Resident #1 happened and she was traumatized and harmed mentally and emotionally from the incident. LSW confirmed that she had completed a Trauma assessment dated 01/02/25 related to the incident that occurred on 12/31/24. LSW confirmed that the resident marked "Yes" that she was shaken and nervous after the encounter, that she had upset thoughts and was jumpy after the incident with LPN #1. The LSW confirmed that

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she and the ADM/ED did interview Resident #1, and she did express being upset by LPN #1, and the LSW confirmed that she conducted two (2) trauma assessments for Resident #1 and placed them in the medical record.

The interview on 2/18/25 at 3:40 PM with CNA #1 revealed that she worked from 7:00 AM until 3:00 PM on the A-hall, where Resident #1 resided. She stated that on several occasions she would answer the call light of Resident #1 when she was requesting pain medications and she confirmed that she would go tell LPN #1 that the resident was requesting pain medications, and she would tell me she was busy and would be there in a little while. CNA #1 stated that on 12/31/24, Resident #1 was crying in her room upset that LPN #1 had "talked mean" to her after asking for pain medications. CNA #1 stated that Resident #1 was an intelligent "free spirited" person and she was well aware of her surroundings and events. CNA #1 confirmed that after LPN #1 confronted Resident #1 that day she saw her upset and crying alone in her room.

Interview on 2/18/25 at 4:10 PM with CNA #2 revealed that on 12/31/24 she saw Resident #1 crying and upset after LPN #1 had left her room. Resident #1 was a cognitive and well-behaved resident and CNA #2 stated that she believed what Resident #1 had told her. Resident #1 told CNA #2 that she didn't want LPN #1 to come back in her room and that she had been loud and rude to her and had called her a liar. CNA #2 stated that she believed what Resident #1 had told her because she was visibly upset and crying.

Record review of the facility's written

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documentation contained in the personnel record of LPN #1 revealed: "Category One Violation Employee Corrective Counseling Memorandum" contained the name and position of (LPN #1) read: "Category One Warning: If a further incident of this nature occurs, your employment will be terminated. Violation 1.13 conduct widely regarded as immoral, improper, fraudulent, or otherwise inappropriate in the workplace. The nurse was accused of being confrontational with a resident regarding her PRN medications and the times that it can be given. Returned to work 1/4/25 Employees are to address the residents in a respectful manner at all times." The violation was signed by the ADM and the DON and dated 12/31/24. The violation was signed by LPN #1 and dated 1/4/25.

Record review of the handwritten statement of PTA dated 12/31/24 revealed: " Pt (patient) requested medicine from CNA prior to therapy. CNA states nursing said she was busy. Pt. states she was not within her 6-hour window prior to therapy. Pt. requested for me to close her door. Pt reports several incidents have occurred with current nurse where the nurse has been "loud, rude, and confrontational" with pt in regard to her medicine. Around 15 minutes upon leaving the room I went in to check on pt and she was in tears, when asked what happened, she states that the nurse has just left and was yelling directly at her that she knows she should have already asked for her medicine. Pt reports she feels unsafe and requests that the nurse does not come in her room again."

Record review of the handwritten statement of ST dated 12/31/24 revealed, "ST walked in approx. 730 (am) to pt's room. The nurse on A-Hall was

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talking to patient in a confrontational manner stating 'I never refused to give you pain meds. You should have never called up here and told them that. Your pain meds are PRN (as needed), so you have to request them.' ST stepped in due to observing pt's (patients) anxiousness asked, 'are you talking about yesterday because after I got done with therapy I came and told you she wanted her pain meds while you were on med pass' The nurse stated I never asked her that. The nurse continued to state that she needs to request her meds either before shift change or after."

Record review revealed that there were two (2) Trauma Screening Assessments completed on Resident #1 dated 12/25/24 and dated 1/2/25 that were completed by the LSW. The 12/25/24 Trauma Screening Assessment (prior to the incident with LPN #1 on 12/31/24) did not contain information that was conducive to trauma experienced by Resident #1. The Trauma Screening Assessment conducted on 01/2/25 (after the incident with LPN #1 on 12/31/24) completed by the LSW, revealed that Resident #1 had experienced excessive trauma. The second Trauma Assessment for Resident #1 dated 1/2/25 was positive for trauma and confirmed that the resident had "Upset thoughts; feeling upset by reminders of events; jumpy; and heightened awareness."