STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255148	A. BUILDING _____ B. WING _____	C 02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLANDS REHABILITATION AND HEALTHCARE CENTER	**102 WOODCHASE PARK DRIVE CLINTON, MS 39056**

(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 two (2) Complaint Investigation (CI MS #27490 and CI MS #27491) at the facility on 1/23/25. The SA returned to the facility on 2/3/25 to extend the survey. During the survey, the SA determined the facility was in compliance with the requirements of participation for Medicare and Medicaid. This was based on the facility's implementation of corrective actions on 12/31/24 and was Past Non-Compliance (PNC). CI MS # 27490 was investigated regarding infection control, equipment not being maintained, and physical environment and there were no citations related to that complaint. CI MS # 27491 was a facility reported incident (FRI) and was investigated regarding resident abuse, safety, and quality of care. The facility failed to protect a resident's right to be free from physical and emotional abuse. The SA cited F600 and F609 related to this FRI. The facility's failure to protect Resident #1 when Certified Nursing Aide (CNA) #1 physically and emotionally abused Resident #1 on 12/25/24 by handling the resident roughly, spraying cold water on the resident's face, shaking the shower bed, and turning off the lights in the shower room while laughing, resulted in the resident reporting that he felt "sad, taken advantage of, and a little afraid" and the facility did not immediately remove the abuser from the facility. The facility's failure to report the abuse within the required timeframe when Licensed Practical Nurse (LPN) #1 witnessed the physical and emotional abuse of Resident #1 on 12/25/24 but the facility did not report it to the State Agency until 12/30/24, delayed the facility's ability to protect this resident from further harm.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/11/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255148	A. BUILDING _____ B. WING _____	C 02/03/2025

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F 000	Continued From page 1 During the investigation of the FRI, the SA identified Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which began on 12/25/24 and existed at: 42 CFR(s): 483.12 Freedom from Abuse, Neglect, Exploitation (F600) - Scope and Severity of "J" 42 CFR(s): 483.12(c)(1) Reporting of Alleged Violations (F609) - Scope and Severity of "J" The abuser was not immediately removed from the facility which left Resident #1 and other residents in a situation that was likely to result in ongoing serious injury, serious harm, serious impairment, or death. The SA notified the facility's Administrator of the IJ and SQC on 2/3/25 at 2:40 PM and provided the Administrator with the IJ templates. Based on the facility's implementation of corrective actions on 12/31/24, the SA determined the IJ and SQC to be Past Non-Compliance (PNC) and the IJ was removed on 1/1/25, prior to the SA's entrance on 1/23/25. At the time of the survey, the facility was licensed for 145 beds and had a census of 141 residents.	F 000		
F 600 SS=J	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,	F 600		

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F 600	Continued From page 2 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 interviews, record review, and facility policy review, the facility failed to protect the residents' right to be free from physical abuse from a staff member for one (1) of five (5) sampled residents. Resident #1 Resident #1 was physically and emotionally abused on 12/25/24 when Certified Nursing Aide (CNA) #1 handled him roughly, sprayed cold water on his face, and turned out the lights in the shower room, while laughing. The facility's failure to protect resulted in Resident #1 reporting he felt "sad, taken advantage of, and a little afraid." Additionally, the facility's failure to immediately remove CNA #1 from the facility placed this resident and other residents in a situation that was likely to result in ongoing serious injury, serious harm, serious impairment, or death. The situation was determined to be Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC). The State Agency (SA) notified the Administrator of the IJ and SQC on 2/3/25 at 2:40 PM and provided an IJ Template.	F 600	Past noncompliance: no plan of correction required.	

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F 600	Continued From page 3	F 600		

Based on the facility's implementation of corrective actions on 12/31/24, the SA determined the IJ and SQC to be Past-Non-Compliance (PNC) and the IJ was removed on 1/1/25 prior to the SA's entrance on 1/23/25.

Findings include:

A review of the facility's, "Abuse Prohibition Policy" dated 5/17/24, revealed, "Intent: This protocol was intended to assist in the prevention of abuse ...Policy:1. The facility will prohibit neglect, mental or physical abuse ..."

A record review of the "Admission Record" revealed the facility admitted Resident #1 on 8/22/24 with diagnoses including Hypertension and Depression.

A record review of the Comprehensive Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/29/24 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated he was cognitively intact.

A record review of the facility's investigation, dated 1/2/25, revealed that on 12/30/24, the Director of Nursing (DON) received notification that a CNA had handled a resident roughly during activities of daily living (ADL) care, which included spraying a resident in the face with cold water and turning the light off in the shower room prior to exiting the room, leaving another employee and the resident in darkness. The incident occurred on 12/25/24. A review of the corrective actions revealed the facility put immediate actions in place including suspending and terminating the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 600	Continued From page 4	F 600		

perpetrator and the facility's Administrator. The resident was provided support and reassurance, a body audit was conducted, and the allegation was reported, and appropriate notifications, including law enforcement were made. Life Satisfactions Rounds and Peer reviews were initiated, and Trauma Assessment was performed on Resident #1. A Quality Assurance Performance Improvement (QAPI) committee meeting was held on 12/31/24. In-services were completed on abuse, resident rights, and vulnerable the adult act.

A record review of the "Witness Statement", completed by Licensed Practical Nurse (LPN) #1 and signed on 12/26/24, revealed, "I, (Proper Name of LPN #1), witnessed CNA (name not provided) cause emotional abuse to resident (Proper Name of Resident #1). While giving the resident a shower, CNA turned on the shower and sprayed the resident in the face with the water. Resident hollered out loudly, telling CNA to stop. Writer also told CNA not to do it anymore. CNA roughly wiped the resident's body parts. Resident started crying for CNA to stop and please let her (writer) do my shower. Writer told CNA she would take over with the shower. Writer asked CNA to just spray the soap off. CNA then turned the water from warm to cold and began spraying the resident. Resident began to scream, telling CNA the water is too cold. CNA only laughed and told the resident he will be ok. CNA began to shake the resident's bed side to side roughly. Resident began to scream 'stop.' Writer also told CNA to stop and that the resident could fall off the shower bed. CNA replied, 'it's your wheels screeching.' Also, while writer was drying the resident off, CNA went and turned the lights off, causing darkness. Both writer and the

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F 600	Continued From page 5	F 600		

resident screamed, telling CNA to stop. CNA just laughed it off. When writer got done dressing the resident, I asked CNA how he would transfer the resident back to bed without a sling because he wet the previously one up, he replied, 'watch this, he's going to roll and go for a ride.' CNA put the shower bed beside the resident's bed and told resident, 'your about to roll on your stomach then to your back' and proceeded to push the resident from the shower bed to his bed. Writer walked out."

A record review of the timecard for CNA #1 revealed he worked at the facility from 6:30 AM to 7:00 PM on 12/25/24 and 12/26/24. He also worked from 6:30 AM to 4:45 PM on 12/30/24, which was after the abuse occurred on 12/25/24.

On 1/23/25 at 9:46 AM, during an interview with Resident #1, he recalled the incident in the shower and explained CNA #1 roughly handled him roughly and sprayed cold water on his face. He stated that he told CNA #1 it was cold, and CNA #1 laughed in response. Later, when CNA #1 began drying him off, it hurt and at that point, the nurse intervened and took over, which felt much better to him. He expressed that he was not afraid or upset, but the incident did make him feel sad that he was taken advantage of. CNA #1 did not take care of him anymore after that.

At 11:18 AM on 1/23/25, during a phone interview with LPN #1, she recalled the incident involving CNA #1, where she witnessed as he began to get the resident from the bed. As he did so, he placed both his hands on the sides of the bed and shook it from side to side. She told him to stop because the resident could fall off the bed. He complied, but in response, CNA #1 thought it was funny and

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F 600	Continued From page 6	F 600		

stated, "He will be alright." After that, CNA #1 wheeled the resident out to the shower room and into the stall and she was there to assist as well. At that time, he took off the resident's gown, turned on the water, and sprayed the resident in the face with the shower sprayer. LPN#1 yelled, "What are you doing? The water is still cold!" She observed Resident #1's face grimace as if he was in pain, and he then stated, "It's cold, it's cold." She asked CNA #1 why he did that, but he shrugged her off and waited until the water warmed up. LPN#1 began to lather the resident's body with body wash while CNA #1 sprayed him down with warm water. After CNA #1 finished, he grabbed a towel and began to wipe the resident down roughly. The resident said, "It hurts," so she commanded CNA#1 to stop, and let her handle it. She then took the towel and began to wipe the resident gently. She indicated that CNA #1 continued to laugh it off, and turned the lights off, she and the resident screamed, and he turned them back on.

On 1/23/25 at 12:02 PM in an interview with the current Administrator, she revealed the incident occurred with the previous Administrator, but she was aware of the situation. During the investigation, the facility determined that the event occurred and terminated CNA #1 and the Administrator.

On 1/23/25 at 1:12 PM, during a phone interview, CNA #1 revealed that he has worked at the facility for the past two years. He explained that he is aware but does not know the source of the allegations regarding Resident #1. He confirmed that a nurse he does not know and claims to have never seen before assisted him while he was showering the resident. He stated that he does

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WOODLANDS REHABILITATION AND HEALTHCARE CENTER	102 WOODCHASE PARK DRIVE CLINTON, MS 39056

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F 600	Continued From page 7	F 600		

not recall spraying cold water on the resident's face, adding that all he remembers is the resident saying the water was too hot. He reiterated, "I did not do anything to the resident." CNA #1 further explains that the Administrator never spoke with him about anything. All he knows is that on 12/30/24, he was told to go home because an investigation had been opened regarding him. He stated that he did not ask what it was about nor was he informed, and a few days later, someone from Human Resources called him and told him he was fired.

On 1/23/25, at 1:36 PM, during an interview with the DON, she revealed that the incident occurred on 12/25/24, however, she did not learn about it until Monday, 12/30/24. She immediately suspended CNA#1 and began inservicing staff as the they were not allowed to work until in serviced on abuse and neglect. The Administrator was on vacation at the time. She indicated that she could not readily remember if CNA #1 had been written up for similar actions and was surprised that he would be accused of such behavior. She noted that he had been working with the same group of men for at least three (3) or four (4) months and that during her interviews after the event, the men spoke fondly of him, although she did add that he "plays a lot."

On 1/23/25 at 2:57 PM, in a phone interview with the previous Administrator, she explained that she worked on 12/26/24 and 12/27/24, which were on Thursday and Friday, and then she was off for vacation. During that time, LPN #1 came to talk with her and informed her about the incident with CNA #1 and Resident #1, mentioning that the CNA had the water set too cold during the shower. The former Administrator

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WOODLANDS REHABILITATION AND HEALTHCARE CENTER	102 WOODCHASE PARK DRIVE CLINTON, MS 39056

(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 600	Continued From page 8	F 600		

explained that was all LPN #1 said about the situation, so she instructed the nurse to write a statement and put it in her box. Afterward, she went to interview Resident #1 while he was sitting outside his door, and he denied that anything had happened to him other than the shower being cold. She asked him if someone had hurt him, and he specifically said "No." She then told the resident that she would speak with the CNA anyway, and the resident seemed concerned, asking, "What are you going to talk with him about?" She reassured the resident that there was nothing to worry about. The Administrator stated she then attempted to interview CNA #1 by calling him on the phone, but he did not answer and was not scheduled to work that day. She noted that the written statement by LPN #1 was completely different from what she had verbally reported. She stated she was surprised to be suspended and later terminated regarding this event.

On 2/3/25 at 10:00 AM, in a follow up interview with Resident #1, he recalled being a "little afraid" when CNA #1 was shaking the shower bed because he could have fallen. He acknowledged that he was sprayed in the face but was most upset about being wiped and handled roughly. Resident #1 confirmed that he did cry out during the shower for CNA #1 to stop and that it was several days before anyone at the facility asked him any questions about it.

On 2/3/25 at 10:18 AM in a follow-up interview with LPN #1, she stated that the event occurred on 12/25/24 in the afternoon, and she thought it may have been after 3:00 PM. She explained both she and CNA #1 were working a 12 hour shift that day. She stated that CNA #1's behavior

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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WOODLANDS REHABILITATION AND HEALTHCARE CENTER	102 WOODCHASE PARK DRIVE CLINTON, MS 39056

(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 600	Continued From page 9	F 600		

in the shower room scared her because it seemed odd to her. LPN #1 could not recall if CNA#1 was in the resident's room after the shower when she left the room, but she immediately reported what had happened to Registered Nurse (RN) #1 who was the charge nurse. She explained RN #1 was at the nurses station when she reported the abuse and there were other staff members that were there and may have heard her report. She reported everything that happened in the shower room to the charge nurse. LPN #1 further explained that on the following day, 12/26/24, she was working at the facility and the Administrator was there. She reported the CNA's abusive behavior to the Administrator at that time, who instructed her to write a statement. She wrote the statement and handed it directly to the Administrator and did not put it in a box. She said the Administrator did not ask her any questions about it.

On 2/3/25 at 10:53 AM, in a phone interview with LPN #2, she stated that on 12/25/24, she walked up on RN #1 and LPN #1 as they were discussing the incident that occurred in the shower room with Resident #1 and CNA #1. She explained that LPN #1 was upset, but she was not sure of everything that was said because she was passing by and just heard part of the conversation. LPN #2 was unsure of how many days CNA #1 worked after 12/25/24.

On 2/3/25 at 11:33 AM, in a phone interview with CNA #2, she stated that she was working on 12/25/24. She explained that she worked close to the shower room and recalled hearing noises and hollering from the shower room. She described it as "kind of unusual" but that CNA #1 always talked loudly. She stated that she saw

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	255148	A. BUILDING _____ B. WING _____	C 02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLANDS REHABILITATION AND HEALTHCARE CENTER	102 WOODCHASE PARK DRIVE CLINTON, MS 39056

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F 600	Continued From page 10	F 600		

LPN #1 and RN #1 talking but did not hear much of the conversation. She said that LPN #1 was upset and was saying she "couldn't believe" what was happening.

On 2/3/25 at 11:45 AM, in an interview with RN #1, she stated that she left the facility on 12/25/24 around 1:30 PM to 2:00 PM and denied being at the facility when the event occurred. She stated she did not hear about it until the next day (12/26/24) when LPN #1 told her about it and said she was going to report it to the Administrator. She said that the nurse did not go in detail, but said she was uncomfortable with what had happened.

On 2/3/25 at 1:00 PM, in an interview with the current Administrator and the DON, they confirmed the CNA continued to work his shift on 12/25/24 and he also worked on 12/26/24 and until around 4:00 PM on 12/30/24. The DON stated she received the call from corporate around 4:00 PM inquiring if the allegation was reported to the SA. She was unaware of the incident because she was off the week of Christmas. The DON and Administrator stated that as part of their investigation they conducted interviews regarding the nurse's inaction. The nurse (LPN #1) said that she reported the incident immediately, but when they interviewed the charge nurse, she denied this. They felt like it was a "she said, she said" situation and was unable to find out where the breakdown occurred. They said they interviewed the staff that worked on 12/25/24, but none of them stated they heard LPN #1 telling the charge nurse about the abuse.

Based on the implementation of the facility's corrective actions on 12/31/2024, the deficient

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F 600	Continued From page 11 practice was determined to be past noncompliance, and the facility was found in compliance effective 1/1/25. Validation: The SA validated on 1/23/2025, through interview and record review that all corrective actions had been implemented as of 12/31/24, and the facility was in compliance as of 1/1/25, prior to the SA's entrance on 1/23/2025.	F 600		
F 609 SS=J	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 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	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 609	Continued From page 12 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 interviews, record review, and facility policy review, the facility failed to report an allegation of abuse within the required two (2) hour timeframe for one (1) of five (5) sampled residents. Resident #1 Licensed Practical Nurse (LPN) #1 witnessed physical and emotional abuse of Resident #1 on 12/25/24, however, the facility did not report it to the State Agency (SA) until 12/30/24, delaying the facility's ability to protect the resident from further harm. The facility's failure to ensure immediate reporting increased the risk of further harm which left Resident #1 and other residents in a situation that was likely to cause serious injury, serious harm, serious impairment, or death. The situation was determined to be Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC). The State Agency (SA) notified the Administrator of the IJ and SQC on 2/3/25 at 2:40 PM and provided an IJ Template. Based on the facility's implementation of corrective actions on 12/31/24, the SA determined the IJ and SQC to be Past-Non-Compliance (PNC) and the IJ was removed on 1/1/25 prior to the SA's entrance on 1/23/25. Findings include:	F 609	Past noncompliance: no plan of correction required.	

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	255148	A. BUILDING _____ B. WING _____	C 02/03/2025

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F 609	Continued From page 13 A review of the facility policy, "Abuse Prohibition" revised 5/17/24, reveals on page 7 ..."2. The facility will report all allegations and substantiated occurrences of abuse ...to the state agency and to all other agencies as required by law ...The Abuse Coordinator will report all allegations of abuse ...immediately or within two hours of the allegation ..." A record review of the "Admission Record" revealed the facility admitted Resident #1 on 8/22/24 with diagnoses including Hypertension and Depression. A record review of the Comprehensive Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/29/24 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated he was cognitively intact. A record review of the facility's investigation, dated 1/2/25, revealed that on 12/30/24, the Director of Nursing (DON) received notification that a Certified Nursing Assistant (CNA) had handled a resident roughly during activities of daily living (ADL) care, which included spraying a resident in the face with cold water and turning the light off in the shower room prior to exiting the room, leaving another employee and the resident in darkness. The incident occurred on 12/25/24. A review of the corrective actions revealed the facility put immediate actions in place including suspending and terminating the perpetrator and the facility's Administrator. The resident was provided support and reassurance, a body audit was conducted, and the allegation was reported, and appropriate notifications were made, including law enforcement. Life Satisfactions	F 609		

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F 609	Continued From page 14	F 609		

Rounds and Peer reviews were initiated, and Trauma Assessment was performed on Resident #1. A Quality Assurance Performance Improvement (QAPI) committee meeting was held on 12/31/24. In-services were completed on abuse, resident rights, and vulnerable the adult act.

A record review of the "Witness Statement", completed by Licensed Practical Nurse (LPN) #1 and signed on 12/26/24, revealed, "I, (Proper Name of LPN #1), witnessed CNA (name not provided) cause emotional abuse to resident (Proper Name of Resident #1). While giving the resident a shower, CNA turned on the shower and sprayed the resident in the face with the water. Resident hollered out loudly, telling CNA to stop. Writer also told CNA not to do it anymore. CNA roughly wiped the resident's body parts. Resident started crying for CNA to stop and please let her (writer) do my shower. Writer told CNA she would take over with the shower. Writer asked CNA to just spray the soap off. CNA then turned the water from warm to cold and began spraying the resident. Resident began to scream, telling CNA the water is too cold. CNA only laughed and told the resident he will be ok. CNA began to shake the resident's bed side to side roughly. Resident began to scream 'stop.' Writer also told CNA to stop and that the resident could fall off the shower bed. CNA replied, 'it's your wheels screeching.' Also, while writer was drying the resident off, CNA went and turned the lights off, causing darkness. Both writer and the resident screamed, telling CNA to stop. CNA just laughed it off. When writer got done dressing the resident, I asked CNA how he would transfer the resident back to bed without a sling because he wet the previously one up, he replied, 'watch this,

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F 609	Continued From page 15	F 609		

he's going to roll and go for a ride.' CNA put the shower bed beside the resident's bed and told resident, 'you're about to roll on your stomach then to your back' and proceeded to push the resident from the shower bed to his bed. Writer walked out."

During an interview on 1/23/25, at 1:36 PM, the DON revealed that the incident occurred on 12/25/24, however, she did not learn about it until Monday, 12/30/24. She immediately suspended the CNA and began educating staff as the they were not allowed to work until in-serviced on abuse and neglect. The Administrator was on vacation at the time.

During a phone interview on 1/23/25 at 2:57 PM, the previous Administrator explained that she worked on 12/26/24 and 12/27/24, which were on Thursday and Friday, and then she was off for vacation. During that time, LPN #1 came to talk with her and informed her about the incident with CNA #1 and Resident #1, mentioning that the CNA had the water set too cold during the shower. The former Administrator explained that was all LPN #1 said about the situation, so she instructed the nurse to write a statement and put it in her box. She noted that the written statement by LPN #1 was completely different from what she had verbally reported.

During a follow-up interview on 2/3/25 at 10:18 AM, LPN #1 she stated that the event occurred on 12/25/24 in the afternoon, and she thought it may have been after 3:00 PM. She explained she immediately reported what had happened to Registered Nurse (RN) #1 who was the charge nurse on 12/25/24. She explained RN #1 was at the nurses' station when she reported the abuse

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F 609	Continued From page 16	F 609		

and there were other staff members that were there and may have heard her report. She reported everything that happened in the shower room to the charge nurse. LPN #1 further explained that on the following day, 12/26/24, she was working at the facility and the Administrator was there. She reported CNA #1's abusive behavior to the Administrator at that time, who instructed her to write a statement. She wrote the statement and handed it directly to the Administrator and did not put it in a box. She said the Administrator did not ask her any questions about it.

During a phone interview on 2/3/25 at 10:53 AM, LPN #2 stated that on 12/25/24, she walked up on RN #1 and LPN #1 as they were discussing the incident that occurred in the shower room with Resident #1 and the CNA #1. She explained that LPN #1 was upset, but she was not sure of everything that was said because she was passing by and just heard part of the conversation.

During a phone interview on 2/3/25 at 11:33 AM, CNA #2 stated that she was working on 12/25/24. She stated that she saw LPN #1 and RN #1 talking but did not hear much of the conversation. She said that LPN #1 was upset and was saying she "couldn't believe" what was happening.

During an interview on 2/3/25 at 11:45 AM, RN #1 stated that she left the facility on 12/25/24 around 1:30 PM to 2:00 PM and denied being at the facility when the event occurred. She stated she did not hear about it until the next day (12/26/24) when LPN #1 told her about it and said she was going to report it to the Administrator. She said that LPN#1 did not go in detail, but said she was

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F 609	Continued From page 17 uncomfortable with what had happened. During an interview on 2/3/25 at 1:00 PM, with the current Administrator and the DON, the DON stated she received the call from corporate around 4:00 PM on 12/30/24 inquiring if the allegation was reported to the state agency. She was unaware of the incident because she was off the week of Christmas. The nurse (LPN #1) said that she reported the incident immediately, but when they interviewed the charge nurse, she denied this. They also reported they had interviewed the staff that worked on 12/25/24, but none of them stated they heard LPN #1 telling the charge nurse about the abuse. Based on the implementation of the facility's corrective actions on 12/31/2024, the deficient practice was determined to be past noncompliance, and the facility was found in compliance effective 1/1/25. Validation: The SA validated on 1/23/2025, through interview and record review that all corrective actions had been implemented as of 12/31/24, and the facility was in compliance as of 1/1/25, prior to the SA's entrance on 1/23/2025.	F 609		