STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A123	A. BUILDING _____ B. WING _____	C 02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGINALD P WHITE NURSING FACILITY	1451 NORTH LAKELAND DRIVE MERIDIAN, MS 39307

(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 Complaint Investigations (CI) at the facility from 2/10/25 through 2/12/25. CI MS #27376 was investigated for Abuse, Pressure Sores, and Quality of Care and there were no deficiencies cited related to the complaint. CI MS #27588 was investigated for Abuse and Resident Left Soiled, and CI MS #27589 was investigated for Physical Abuse and Residents Rights. During the survey, the SA determined the facility was in compliance with the requirements for participation in Medicare or Medicaid. The SA cited F600, F607 and F609 as Immediate Jeopardy (IJ) with Substandard Quality of Care (SQC) and F656 as IJ related to CI MS# 27588 and CI MS# 27589. Based on the facility's implementation of corrective actions on 1/7/25, the SA determined the IJ and SQC to be Past Non-Compliance (PNC) and the IJ was removed on 1/8/25, prior to the SA's entrance on 2/10/25. On 12/31/24, Resident #1 was physically abused by facility staff, when a Certified Nurse Assistant (CNA), dragged the resident down the hallway, by his shirt, the collar and shoulder of his jacket into his room while License Practical Nurse (LPN) #1 observed and did not intervene or call for assistance. The facility did not follow their policies regarding abuse, reporting, and did not implement interventions from the residents' person-centered care plan. During the investigation, the SA identified an Immediate Jeopardy (IJ) and Substandard of Quality of Care (SQC) which began on 12/31/24 and existed at 42 CFR(s):	F 000	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/25/2025

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F 000	Continued From page 1 483.12 Freedom from Abuse, Neglect, Exploitation (F600) 483.12(b) Implement Written Policies (F607) 483.12(c)(1) Reporting of Alleged Violations (F609) all at Scope and Severity (S/S) of "J." The SA identified IJ which began on 12/31/24 and existed at: 42 CFR: 483.12(b)(1) Comprehensive Care Plan (F656) - S/S of "J." The facility's failure to protect Resident #1 from abuse placed this resident and all residents in a situation that was likely to cause serious injury, harm, impairment, or death. Additionally, the facility's failure to intervene placed other residents at risk of similar abuse due to systemic failures in abuse prevention. The SA notified the facility's Administrator of the IJ and SQC on 2/11/25 at 4:45 PM and provided the Administrator with IJ templates. Based on the facility's implementation of corrective actions on 1/7/25, the SA determined the IJ and SQC to be Past Non-Compliance (PNC) and the IJ was removed on 1/8/25, prior to the SA's entrance on 2/10/25. At the time of the survey, the facility was licensed for 65 beds and had a census of 64 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, and exploitation as defined in this subpart. This	F 600		

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F 600	Continued From page 2 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, interviews, record review, and facility policy review, the facility failed to ensure a resident's right to be free from physical abuse by a staff member for one (1) of three (3) sampled residents. Resident #1. Resident #1 was physically abused on 12/31/24 when a Certified Nurse Assistant (CNA) #1 dragged him by his shirt, the collar, and the shoulders of his jacket up the hallway into Resident #1's room. One nurse observed the abuse and failed to intervene, allowing the abuse to escalate. The facility's failure to protect Resident #1 from abuse placed this resident and all residents in a situation that was likely to cause serious injury, harm, impairment, or death. The situation was determined to be Immediate Jeopardy and Substandard Quality of Care (SQC) that began on 12/31/24. The State Agency (SA) notified the Administrator of the IJ and SQC on 2/11/25 at 4:45 PM and provided an IJ Template. Based on the facility's implementation of corrective actions on 1/7/25, the SA determined	F 600	Past noncompliance: no plan of correction required.	

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F 600	Continued From page 3	F 600		

the IJ and SQC to be Past-Non-Compliance (PNC) and the IJ was removed on 1/8/25.

Findings include:

A review of the facility policy titled "Suspicion of Abuse, Neglect, Exploitation, Injuries of Unknown Origin, And/or Misappropriation of Funds/Property To Individuals Receiving Services/Residents," revised January 2024, revealed, " ...It is the policy ...to affirm that all Individuals Receiving Services (IRS)/Residents have a right to be free from abuse ...Definitions ...Abuse: The willful infliction of physical pain, injury, or mental anguish, unreasonable confinement or the willful deprivation of services necessary to maintain physical and mental health ...Mental Abuse: includes ...humiliation, harassment ...Prevention ...(4) ...will review, correct, and intervene in situations in which allegations of abuse, neglect ...have potentially occurred ...D. Reporting: (1) All employees ...will immediately report any of the following (a) Witness of or discovery of any situation in which suspicion exits that an IRS/Resident has been the victim of abuse ..."

A record review of the "Investigative Summary Report", dated 1/7/25, revealed that on 12/31/24 at 2:21 PM, Resident #1 was dragged on the floor by CNA #1. The resident was assessed on 1/3/25 when the allegation was submitted, and the Director of Nurses (DON) was notified. It was reported on 1/3/25 that on 12/31/24, CNA #1 dragged Resident #1 on the floor by the neck of his shirt to his room because the resident positioned himself on the floor in the hallway near the nurse's station. The resident was observed lying on the floor, hitting his head, and refusing to keep his protective helmet on. The investigation

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into the allegation yielded evidence that CNA #1 did drag the resident by the neck and shoulder sections of his jacket up the hallway into his room. Staff were placed on administrative leave pending the investigation and following the investigation, CNA #1 and License Practical Nurse (LPN) #1 were terminated on 1/7/25.

A record review of LPN #1's written statement, dated 1/6/25, revealed that on 12/31/24 between 2:00 PM and 2:30 PM, Resident #1 was banging his head against the wall. CNA #1 proceeded to grab the resident by his neck and sweatshirt and drag him to his room. She felt like she was choking him, and she felt like this was abuse. She reported to the security officer and attempted to notify her DON, but she was not in her office.

On 2/10/25 at 2:00 PM, during an observation and interview, Resident #1 was lying in his bed and sat up to speak during the interview. He confirmed that he remembered the CNA who dragged him down the hall. He stated that she did not hurt him but commented that she didn't have to drag him "like an old rag." Resident #1 explained that he was embarrassed by the CNA's actions. He reported that he often hits his head on the wall or the floor because he normally wants something and that is his way of getting attention from the staff, but on this day (12/31/24), he was dragged to his room by the CNA.

On 2/10/25 at 2:35 PM, in an interview with the Campus Safety Officer, he confirmed he was working on 12/31/24, but stated he did not witness the event. He explained that an LPN approached him on 12/31/24 and asked him generalized questions about physical abuse, but

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she did not inform him of the incident that had occurred. He advised her to inform her immediate supervisor if she had questions on the definition of physical abuse. He reported he was not aware of the incident until the investigation began on 1/3/25.

On 2/10/25 at 2:43 PM, during an interview with the Housekeeper, he confirmed that he witnessed Resident #1 being pulled by his clothing down the hall approximately 20 feet by a staff member. He stated he did not report the episode to his manager because he assumed the other staff would have reported it. Still, he was placed on administrative leave following the episode and attended many in-services on reporting following the episode.

On 2/10/25 at 3:00 PM, during an observation of the surveillance video with the Administrator present, on 12/31/24 at 2:07 PM, CNA #1 was observed dragging/pulling Resident #1 by his arm/sleeve of his clothes, right side, approximately 16 feet to his room, and LPN #1 was observed walking beside the resident and the CNA.

On 2/11/25 at 12:01 PM, during an interview with Registered Nurse (RN) #1, she confirmed that on 1/3/25, LPN #1 informed her that CNA #1 pulled Resident #1 down the hallway on the floor by his clothes because he was banging his head on the floor. LPN #1 stated that she attempted to re-direct him and place his helmet on, but he refused the helmet. LPN #1 revealed she attempted to notify security and the DON of the incident, but the DON wasn't available, so she didn't report it until her next shift on 1/3/25. RN #1 confirmed that the facility's policy is to report

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any abuse to a supervisor, DON, or Administrator. RN #1 stated that LPN #1 and CNA #1 did not treat Resident #1 with respect or dignity.

On 2/11/25 at 12:30 PM, during an interview with CNA #2, she confirmed Resident #1 was her assigned resident on 12/31/24. She revealed that she witnessed CNA #1 drag the resident down the hallway but stated that she did not have time to intervene. She reported the event was over in just a few seconds. LPN #1 advised her that she was going to report the episode to security campus, so CNA #2 did not report the episode to any supervisor.

On 2/11/25 at 1:00 PM, during a phone interview with CNA #1, she confirmed that she dragged Resident #1 down the hallway by his clothing. She said that Resident #1 was not her assigned resident, but he was sitting on the floor between two doors, and it was difficult for residents to get through the doorways. CNA #1 explained Resident #1 had had this behavior in the past to get attention, so she grabbed his clothes and pulled him about 20 feet to his room. She was not trying to do anything intentional to hurt him and she was not being vindictive, but he was hitting his head on the floor and the wall. CNA #1 confirmed that Resident #1 was not her assigned resident and she did not attempt to redirect him, nor offer him food or water. She explained that she just "responded", and she did not think of the outcome. CNA #1 expressed remorse and commented that she has been very upset since the incident.

In an interview with the Administrator on 2/11/25 at 3:40 PM, he confirmed that upon reviewing the video surveillance, CNA #1 dragged Resident #1

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by his shirt/jacket to his room. He stated that this incident was a form of physical abuse and that LPN #1, who was present, should have intervened to stop the situation.

During an interview with the DON on 2/11/25 at 4:00 PM, confirmed that following a review of the video surveillance, CNA #1 did drag Resident #1 on the floor by his clothing down the hall and placed him in his room.

A record review of the "Face Sheet," revealed the facility admitted Resident #1 on 8/7/24 with current diagnoses including Epilepsy, Bipolar Disorder, and Mild Intellectual Disabilities.

A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/5/24, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated his cognition was moderately impaired. Further review revealed his vision was severely impaired.

The facility implemented the following Corrective Action Plan prior to the State Agency's entrance on 2/10/25:

The Quality Assurance (Quality Assurance) Committee held an Emergency QA Meeting on 1/7/2025. The Quality Assurance Committee discussed the description of the incident. The QA committee discussed and approved training that was provided beginning on 1/3/25 at the beginning of the shift to all staff on Resident Rights, Suspicion of Abuse, Neglect, Exploitation, Injuries of Unknown Origin, and misappropriation of funds/Property to Individuals Receiving Services/Residents and Resident # 1 behavior

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Intervention protocol.

The additional will be monitored per staff for continued effectiveness as follows:

Abuse/Neglect Policy & Adherence to Care Plan.

Quality of correction will also be monitored by observing interventions and interactions with patients 5 (five) days a week for 8 (eight) weeks by Nurse Manager and four Nurse Supervisor, beginning on 1/21/25.

Findings will be reported to QAPI (Quality Assurance Performance Improvement), beginning 2/13/25 times two months.

On 1/3/25, all supervisors began training all the oncoming staff before the start of their shift on Resident Rights, Suspicion of Abuse, Neglect, Exploitation, Injuries of Unknown Origin, or Misappropriation of Funds/Property to Individuals Receiving Services/Residents, and Resident #1 Behavioral Intervention Protocol. No employee was allowed to work until there was in-service.

On 1/3/2025 CNA #1 and License Practical Nurse (LPN)#1 were placed on administrative leave pending completion of the investigation. LPN #1 was terminated from employment on 1/7/25 for observing physical abuse and failing to report it in a timely manner. CNA #1 was terminated from employment effective 1/7/25 for physically abusing Resident #1.

The Investigator notified the State Agency by telephone on 1/3/25, the Attorney General's Office in writing of the incident on 1/3/25.

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F 600	Continued From page 9 Supervisors began In-servicing all employees on 1/3/25 prior to the beginning their shift. The in-services were completed on 1/7/25. The facility alleges all corrective actions were completed on 1/7/25 and the IJ removed on 1/8/25 prior to the State Agency's entrance on 2/10/25. Validation: The SA validated on 2/12/25, through interview and record review, that all corrective actions had been implemented as of 1/7/25, and the facility was in compliance as of 1/8/25, prior to the SA's entrance on 2/10/25.	F 600		
F 607 SS=J	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the	F 607		

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F 607	Continued From page 10 Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to implement its abuse policy, allowing an abusive act to occur without staff intervening or prompt reporting for one (1) of three (3) sampled residents. Resident #1. Resident #1 was physically abused on 12/31/24 when Certified Nurse Assistant (CNA) #1 dragged him by his shirt, the collar, and the shoulders of his jacket up the hallway into Resident #1 room. One nurse observed the abuse and failed to intervene, allowing the abuse to escalate. The facility's failure to implement abuse policies and protect Resident #1 from physical abuse and the facility's failure to intervene placed this resident and all residents in a situation that was likely to cause serious injury, harm, impairment, or death. The situation was determined to be Immediate Jeopardy and Substandard Quality of Care (SQC). The State Agency (SA) notified the Administrator of the IJ and SQC on 2/11/25 at 4:45 PM and provided an IJ Template.	F 607	Past noncompliance: no plan of correction required.	

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Based on the facility's implementation of corrective actions on 1/7/25, the SA determined the IJ and SQC to be Past-Non-Compliance (PNC) and the IJ was removed on 1/8/25.

Findings include:

A review of the facility policy titled "Suspicion of Abuse, Neglect, Exploitation, Injuries of Unknown Origin, And/or Misappropriation of Funds/Property To Individuals Receiving Services/Residents," revised January 2024, revealed, " ...It is the policy ...to affirm that all Individuals Receiving Services (IRS)/Residents have a right to be free from abuse ...Definitions ...Abuse: The willful infliction of physical pain, injury, or mental anguish, unreasonable confinement or the willful deprivation of services necessary to maintain physical and mental health ...Mental Abuse: includes ...humiliation, harassment ...Prevention ...(4) ...will review, correct, and intervene in situations in which allegations of abuse, neglect ...have potentially occurred ...D. Reporting: (1) All employees ...will immediately report any of the following (a) Witness of or discovery of any situation in which suspicion exits that an IRS/Resident has been the victim of abuse ..."

A record review of the "Investigative Summary Report", dated 1/7/25, revealed that on 12/31/24 at 2:21 PM, Resident #1 was dragged on the floor by CNA #1. The resident was assessed on 1/3/25 when the allegation was submitted, and the Director of Nurses (DON) was notified. It was reported on 1/3/25 that on 12/31/24, CNA #1 dragged Resident #1 on the floor by the neck of his shirt to his room because the resident positioned himself on the floor in the hallway near the nurse's station. The resident was observed

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lying on the floor, hitting his head, and refusing to keep his protective helmet on. The investigation into the allegation yielded evidence that CNA #1 did drag the resident by the neck and shoulder sections of his jacket up the hallway into his room. Staff were placed on administrative leave pending the investigation and following the investigation, CNA #1 and License Practical Nurse (LPN) #1 were terminated on 1/7/25.

A record review of LPN #1's written statement, dated 1/6/25, revealed that on 12/31/24 between 2:00 PM and 2:30 PM, Resident #1 was banging his head against the wall. CNA #1 proceeded to grab the resident by his neck and sweatshirt and drag him to his room. She felt like she was choking him, and she felt like this was abuse. She reported to the security officer and attempted to notify the Director of Nursing (DON), but she was not in her office.

During an observation and interview, on 2/10/25 at 2:00 PM, Resident #1 was lying in his bed. He confirmed that a CNA dragged him down the hall. He stated that it did not hurt but commented that she didn't have to drag him "like an old rag." Resident #1 explained that he was embarrassed by the CNA's actions. He reported that he often hits his head on the wall or the floor because he normally wants something and that is his way of getting attention from the staff, but on this day (12/31/24), he was dragged to his room by the CNA.

During an interview on 2/10/25 at 2:35 PM, the Campus Safety Officer, confirmed he was working on 12/31/24, but stated he did not witness the event. He explained that an LPN approached him on 12/31/24 and asked him

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generalized questions about physical abuse, but she did not inform him of the incident that had occurred. He advised her to inform her immediate supervisor if she had questions on the definition of physical abuse. He reported he was not aware of the incident until the investigation began on 1/3/25.

During an interview on 2/10/25 at 2:43 PM, the Housekeeper confirmed that he witnessed Resident #1 being pulled by his clothing down the hall by a staff member. He stated he did not stop the situation because he felt it was not his place because there was a CNA and LPN present during the situation.

During an observation of the video surveillance with the Administrator on 2/10/25 at 3:00 PM, on 12/31/24 at 2:07 PM, CNA #1 was observed dragging/pulling Resident #1 by his arm/sleeve of his clothes, right side, approximately 16 feet to his room, and LPN #1 was observed walking beside the resident and CNA.

During an interview on 2/11/25 at 12:30 PM, CNA #2 confirmed Resident #1 was her assigned resident on 12/31/24. She revealed that she witnessed CNA #1 drag the resident down the hallway but stated that she did not have time to intervene. She reported the event was over in just a few seconds. LPN #1 advised CNA #2 that she was going to report the episode to security campus, so CNA #2 did not report the episode to any supervisor.

During a phone interview on 2/11/25 at 1:00 PM, CNA #1 confirmed that she dragged Resident #1 down the hallway by his clothing. She said that Resident #1 was not her assigned resident, but

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he was sitting on the floor between two doors, and it was difficult for residents to get through the doorways. CNA #1 explained Resident #1 had this behavior in the past to get attention, so she grabbed his clothes and pulled him about 20 feet to his room. She was not trying to do anything intentional to hurt him and she was not being vindictive, but he was hitting his head on the floor and the wall. CNA #1 confirmed that Resident #1 was not her assigned resident and she did not attempt to redirect him, nor offer him food or water. She explained that she just "responded", and she did not think of the outcome. CNA #1 expressed remorse and commented that she has been very upset since the incident.

During an interview with the Administrator on 2/11/25 at 3:40 PM, he confirmed that upon reviewing the video surveillance, CNA #1 dragged Resident #1 by his shirt/jacket to his room. He stated that this incident was a form of physical abuse and that LPN #1, who was present, should have intervened to stop the situation, they were both educated on abuse prior to the incident.

During an interview with the DON on 2/11/25 at 4:00 PM, confirmed that following a review of the video surveillance, CNA #1 did drag Resident #1 on the floor by his clothing down the hall and placed him in his room. LPN #1 should have stopped the physical abuse.

A record review of the "Face Sheet," revealed the facility admitted Resident #1 on 8/7/24 with current diagnoses including Epilepsy, Bipolar Disorder, and Mild Intellectual Disabilities.

A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of

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11/5/24, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated his cognition was moderately impaired. Further review revealed his vision was severely impaired.

The facility implemented the following Corrective Action Plan prior to the State Agency's entrance on 2/10/25:

The Quality Assurance (Quality Assurance) Committee held an Emergency QA Meeting on 1/7/2025. The Quality Assurance Committee discussed the description of the incident. The QA committee discussed and approved training that was provided beginning on 1/3/25 at the beginning of the shift to all staff on Resident Rights, Suspicion of Abuse, Neglect, Exploitation, Injuries of Unknown Origin, and misappropriation of funds/Property to Individuals Receiving Services/Residents and Resident # 1 behavior Intervention protocol.

The additional will be monitored per staff for continued effectiveness as it follows: Abuse/Neglect Policy & Adherence to Care Plan.

Quality of corrections will be monitored daily by using a minimum of 5 (five) staff interviews per day 5 (five) days a week for 8 (eight) weeks by Nurse Manager and four Nurse Supervisors, beginning on 1/21/25.

Quality of correction will also be monitored by observing interventions and interactions with patients 5 (five) days a week for 8 (eight) weeks by Nurse Manager and four Nurse Supervisosr, beginning on 1/21/25.

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Findings will be reported to QAPI (Quality Assurance Performance Improvement), beginning 2/13/25 times two months.

On 1/3/25, all supervisors began training all the oncoming staff before the start of their shift on Resident Rights, Suspicion of Abuse, Neglect, Exploitation, Injuries of Unknown Origin, or Misappropriation of Funds/Property to Individuals Receiving Services/Residents, and Resident #1 Behavioral Intervention Protocol. No employee was allowed to work until there was in-service.

On 1/3/2025 CNAs #1 and License Practical Nurse (LPN)#1 were placed on administrative leave pending completion of the investigation. LPN #1 was terminated from employment on 1/7/25 for observing physical abuse and failing to report it in a timely manner. CNA #1 was terminated from employment effective 1/7/25 for physically abusing Resident #1.

The Investigator notified the State Agency by telephone on 1/3/25, the Attorney General's Office in writing of the incident on 1/3/25.

Supervisors began In-servicing all employees on 1/3/25 prior to the beginning their shift. The in-services were completed on 1/7/25. The Immediate Jeopardy was removed on 1/8/25. The facility alleges all corrective actions were completed on 1/7/25 and the Immediate Jeopardy was removed on 1/8/25 prior to the state department of health entrance on 2/10/25.

The facility alleges all corrective actions were completed on 1/7/25 and the IJ removed on 1/8/25 prior to the state agency's entrance on 2/10/25.

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F 607	Continued From page 17 Validation: The SA validated on 2/12/25, through interview and record review, that all corrective actions had been implemented as of 1/7/25, and the facility was in compliance as of 1/8/25, prior to the SA's entrance on 2/10/25.	F 607		
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 accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified	F 609		

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appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
Based on observation, interviews, record review, and facility policy review, the facility failed to report abuse in a timely manner for one (1) of three (3) sampled residents. Resident #1.

Resident #1 was physically abused on 12/31/24 when a Certified Nurse Assistant (CNA) #1 dragged him by his shirt, the collar, and the shoulders of his jacket up the hallway into Resident #1 room. One nurse observed the abuse and failed to report it to the Director of Nursing (DON) or other staff.

The facility's failure to report Resident #1's abuse placed this resident and all residents in a situation that was likely to cause serious injury, harm, impairment, or death.

The situation was determined to be Immediate Jeopardy and Substandard Quality of Care (SQC) which began on 12/31/24. The State Agency (SA) notified the Administrator of the IJ and SQC on 2/11/25 at 4:45 PM and provided an IJ Template.

Based on the facility's implementation of corrective actions on 1/7/25, the SA determined the IJ and SQC to be Past-Non-Compliance (PNC) and the IJ was removed on 1/8/25.

Findings include:

A review of the facility policy titled "Suspicion of Abuse, Neglect, Exploitation, Injuries of Unknown Origin, And/or Misappropriation of Funds/Property To Individuals Receiving Services/Residents," revised January 2024, revealed, " ...It is the

Past noncompliance: no plan of correction required.

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policy ...to affirm that all Individuals Receiving Services (IRS)/Residents have a right to be free from abuse ...Definitions ...Abuse: The willful infliction of physical pain, injury, or mental anguish, unreasonable confinement or the willful deprivation of services necessary to maintain physical and mental health ...Mental Abuse: includes ...humiliation, harassment ...Prevention ...(4) ...will review, correct, and intervene in situations in which allegations of abuse, neglect ...have potentially occurred ...D. Reporting: (1) All employees ...will immediately report any of the following (a) Witness of or discovery of any situation in which suspicion exits that an IRS/Resident has been the victim of abuse ..."

A record review of LPN #1's written statement, dated 1/6/25, revealed that on 12/31/24 between 2:00 PM and 2:30 PM, Resident #1 was banging his head against the wall. CNA #1 proceeded to grab the resident by his neck and sweatshirt and drag him to his room. She felt like she was choking him, and she felt like this was abuse. She reported to the security officer and attempted to notify her DON, but she was not in her office.

A record review of the "Investigative Summary Report" revealed that on 12/31/24 at 2:21 PM, Resident #1 was dragged on the floor by CNA #1. The resident was assessed on 1/3/25 when the allegation was submitted, and the Director of Nurses (DON) was notified. It was reported on 1/3/25 that on 12/31/24, CNA #1 dragged Resident #1 on the floor by the neck of his shirt to his room because the resident positioned himself on the floor in the hallway near the nurse's station. The resident was observed lying on the floor, hitting his head, and refusing to keep his protective helmet on. The investigation into the

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allegation yielded evidence that CNA #1 did drag the resident by the neck and shoulder sections of his jacket up the hallway into his room. Staff were placed on administrative leave pending investigation. Following the investigation, CNA #1 and License Practical Nurse (LPN) #1 were terminated on 1/7/25.

At 2:43 PM on 2/10/25, during an interview with the Housekeeper, he confirmed that he did not report the abuse he witnessed to his manager because he assumed the other staff would have reported it.

At 3:00 PM on 2/10/25, the SA observed surveillance video with the Administrator present. On 12/31/24 at 2:07 PM, CNA #1 was observed dragging/pulling Resident #1 by his arm/sleeve of his clothes, right side, approximately 16 feet to his room, and LPN #1 was observed walking beside the Resident #1 and CNA #1.

At 12:01 PM on 2/11/25, during an interview with Registered Nurse (RN) #1, she confirmed that LPN #1 did not report that she had witnessed abuse of Resident #1 on 12/31/24 until 1/3/25, which was her next scheduled shift. RN #1 confirmed that the facility's policy is to immediately report any abuse to a supervisor, DON, or Administrator.

At 12:30 PM on 2/11/25, during an interview with CNA #2, she confirmed Resident #1 was her assigned resident on 12/31/24. She revealed that she witnessed CNA #1 drag the resident down the hallway but stated that she did not have time to intervene. She reported the event was over in just a few seconds. LPN #1 advised her that she was going to report the episode to security

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campus, so CNA #2 did not report the episode to any supervisor.

At 1:00 PM on 2/11/25, during a phone interview CNA #1, she confirmed she had dragged Resident #1 down the hallway by his clothing. CNA #1 stated that she did not report what had occurred on 12/31/24.

At 3:40 PM on 2/11/25, in an interview with the Administrator , he confirmed that staff should have reported the abuse of Resident #1 immediately when it occurred on 12/31/24.

At 4:00 PM on 2/11/25 during an interview with the DON, she confirmed the facility staff did not report the abuse of Resident #1 immediately and that it was not reported until 1/3/25. Following a review of the video surveillance, CNA #1 did drag Resident #1 on the floor by his clothing down the hall and placed him in his room. She stated that facility staff should have reported it to administrative staff when it happened.

A record review of the "Face Sheet," revealed the facility admitted Resident #1 on 8/7/24 with current diagnoses including Epilepsy, Bipolar Disorder, and Mild Intellectual Disabilities.

A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/5/24, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated his cognition was moderately impaired.

The facility implemented the following Corrective Action Plan prior to the State Agency's entrance on 2/10/25:

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The Quality Assurance (Quality Assurance) Committee held an Emergency QA Meeting on 1/7/2025. The Quality Assurance Committee discussed the description of the incident. The QA committee discussed and approved training that was provided beginning on 1/3/25 at the beginning of the shift to all staff on Resident Rights, Suspicion of Abuse, Neglect, Exploitation, Injuries of Unknown Origin, and misappropriation of funds/Property to Individuals Receiving Services/Residents and Resident # 1 behavior Intervention protocol.

The additional will be monitored per staff for continued effectiveness as it follows: Abuse/Neglect Policy & Adherence to Care Plan.

Quality of corrections will be monitored daily by using a minimum of 5 (five) staff interviews per day 5 (five) days a week for 8 (eight) weeks by Nurse Manager and four Nurse Supervisors, beginning on 1/21/25.

Quality of correction will also be monitored by observing interventions and interactions with patients 5 (five) days a week for 8 (eight) weeks by Nurse Manager and four Nurse Supervisor, beginning on 1/21/25.

Findings will be reported to QAPI (Quality Assurance Performance Improvement), beginning 2/13/25 times two months.

On 1/3/25, all supervisors began training all the oncoming staff before the start of their shift on Resident Rights, Suspicion of Abuse, Neglect, Exploitation, Injuries of Unknown Origin, or Misappropriation of Funds/Property to Individuals

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Receiving Services/Residents, and Resident #1 Behavioral Intervention Protocol. No employee was allowed to work until there was in-service.

On 1/3/2025 CNAs #1 and License Practical Nurse (LPN)#1 were placed on administrative leave pending completion of the investigation. LPN #1 was terminated from employment on 1/7/25 for observing physical abuse and failing to report it in a timely manner. CNA #1 was terminated from employment effective 1/7/25 for physically abusing Resident #1.

The Investigator notified the State Agency by telephone on 1/3/25, the Attorney General's Office in writing of the incident on 1/3/25.

Supervisors began In-servicing all employees on 1/3/25 prior to the beginning their shift. The in-services were completed on 1/7/25. The Immediate Jeopardy was removed on 1/8/25. The facility alleges all corrective actions were completed on 1/7/25 and the Immediate Jeopardy was removed on 1/8/25 prior to the state department of health entrance on 2/10/25.

The facility alleges all corrective actions were completed on 1/7/25 and the IJ removed on 1/8/25 prior to the state agency's entrance on 2/10/25.

Validation:

The SA validated on 2/12/25, through interview and record review, that all corrective actions had been implemented as of 1/7/25, and the facility was in compliance as of 1/8/25, prior to the SA's entrance on 2/10/25.

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F 656	Continued From page 24	F 656		
F 656 SS=J	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate	F 656		

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(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 656	Continued From page 25 entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to implement comprehensive care plan interventions for a resident with behaviors for one (1) of three (3) sampled residents. Resident #1. Resident #1 was physically abused on 12/31/24 when Certified Nurse Assistant (CNA) #1 dragged him by his shirt, the collar, and the shoulders of his jacket up the hallway into Resident #1 room. One nurse observed the abuse and failed to intervene, allowing the abuse to escalate. The facility's failure to implement the care plan interventions placed this resident and all residents in a situation that was likely to cause serious injury, harm, impairment, or death. The situation was determined to be an Immediate Jeopardy (IJ) that began on 12/31/24. The State Agency (SA) notified the Administrator of the IJ on 2/11/25 at 4:45 PM and provided an IJ Template. Based on the facility's implementation of corrective actions on 1/7/25, the SA determined the IJ to be Past-Non-Compliance (PNC) and the IJ was removed on 1/8/25, prior to the SA's	F 656	Past noncompliance: no plan of correction required.	

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	25A123	A. BUILDING _____ B. WING _____	C 02/12/2025

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entrance on 2/10/25.

Findings include:

A review of the facility policy titled "Interdisciplinary Care Plan Team," with a reauthorized date of August 2024, revealed, " ...The purpose of the team is to define and coordinate the treatment for each resident ..."

A record review of the Care Plan revealed, " ...Problem Onset 8/31/24: Potential For Mood and Behavioral Problem ..." with a goal of "Resident will not have increased and mood behavior problem during the quarter," 5/3/25. " ...Approaches: Resident to wear helmet at all times when out of bed for safety (D/T) due to hitting head on floors/walls. Redirect resident if he has inappropriate behaviors and involve him in activities ..."

A record review of the "Investigative Summary Report", dated 1/7/25, revealed that on 12/31/24 at 2:21 PM, Resident #1 was dragged on the floor by CNA #1. The resident was assessed on 1/3/25 when the allegation was submitted, and the Director of Nurses (DON) was notified. It was reported on 1/3/25 that on 12/31/24, CNA #1 dragged Resident #1 on the floor by the neck of his shirt to his room because the resident positioned himself on the floor in the hallway near the nurse's station. The resident was observed lying on the floor, hitting his head, and refusing to keep his protective helmet on. The investigation into the allegation yielded evidence that CNA #1 did drag the resident by the neck and shoulder sections of his jacket up the hallway into his room. Staff were placed on administrative leave pending the investigation and following the

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investigation, CNA #1 and License Practical Nurse (LPN) #1 were terminated on 1/7/25.

On 2/11/25 at 10:09 AM, during an interview Registered Nurse (RN)/Minimum Data Set (MDS), she confirmed that she expects all staff to follow the Comprehensive Care Plans' interventions for residents. The care plans are person-centered and address residents' needs and safety. She explained that care plans are accessible to staff through care plan books at each nursing area and are reviewed periodically. The MDS nurse reported that in-service training is provided to the staff regarding following care plans, but acknowledged that some staff may not consistently follow them and disciplinary action is taken when necessary.

During an interview with the Director of Nursing on 2/11/25 at 4:00 PM, it was revealed that the unit staff should have followed the care plan interventions for the safety of Resident #1. She expected all staff to follow the residents' care plans, which are designed to provide each resident with care based on their individual needs. The DON acknowledged that Resident #1 has a documented history of self-injurious behavior (hitting his head on walls and floors), which is why he wears a helmet for protection. She confirmed that the resident's care plan includes redirection techniques, such as offering snacks, drinks, or engaging him in activities when he exhibits such behavior. She agreed that if these interventions had been implemented, the incident may have been prevented.

On 2/11/25 at 1:00 PM, during a phone interview with CNA #1, she reported that Resident #1 was not her assigned resident, so she did not follow

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the care plan on re-directing him, she just responded by dragging him to his room.

A record review of the "Face Sheet," revealed the facility admitted Resident #1 on 8/7/24 with current diagnoses including Epilepsy, Bipolar Disorder, and Mild Intellectual Disabilities.

A record review of the MDS with an Assessment Reference Date (ARD) of 11/5/24, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated his cognition was moderately impaired.

The facility implemented the following Corrective Action Plan prior to the State Agency's entrance on 2/10/25:

The Quality Assurance (Quality Assurance) Committee held an Emergency QA Meeting on 1/7/2025. The Quality Assurance Committee discussed the description of the incident. The QA committee discussed and approved training that was provided beginning on 1/3/25 at the beginning of the shift to all staff on Resident Rights, Suspicion of Abuse, Neglect, Exploitation, Injuries of Unknown Origin, and misappropriation of funds/Property to Individuals Receiving Services/Residents and Resident # 1 behavior Intervention protocol.

The additional will be monitored per staff for continued effectiveness as it follows:

Abuse/Neglect Policy & Adherence to Care Plan.

Quality of corrections will be monitored daily by using a minimum of 5 (five) staff interviews per day 5 (five) days a week for 8 (eight) weeks by

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Nurse Manager and four Nurse Supervisors, beginning on 1/21/25.

Quality of correction will also be monitored by observing interventions and interactions with patients 5 (five) days a week for 8 (eight) weeks by Nurse Manager and four Nurse Supervisor, beginning on 1/21/25.

Findings will be reported to QAPI (Quality Assurance Performance Improvement), beginning 2/13/25 times two months.

On 1/3/25, all supervisors began training all the oncoming staff before the start of their shift on Resident Rights, Suspicion of Abuse, Neglect, Exploitation, Injuries of Unknown Origin, or Misappropriation of Funds/Property to Individuals Receiving Services/Residents, and Resident #1 Behavioral Intervention Protocol. No employee was allowed to work until there was in-service.

On 1/3/2025 CNAs #1 and License Practical Nurse (LPN)#1 were placed on administrative leave pending completion of the investigation. LPN #1 was terminated from employment on 1/7/25 for observing physical abuse and failing to report it in a timely manner. CNA #1 was terminated from employment effective 1/7/25 for physically abusing Resident #1.

The Investigator notified the State Agency by telephone on 1/3/25, the Attorney General's Office in writing of the incident on 1/3/25.

Supervisors began In-servicing all employees on 1/3/25 prior to the beginning their shift. The in-services were completed on 1/7/25. The Immediate Jeopardy was removed on 1/8/25. The

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F 656	Continued From page 30 facility alleges all corrective actions were completed on 1/7/25 and the Immediate Jeopardy was removed on 1/8/25 prior to the state department of health entrance on 2/10/25. The facility alleges all corrective actions were completed on 1/7/25 and the IJ removed on 1/8/25 prior to the state agency's entrance on 2/10/25. Validation: The SA validated on 2/12/25, through interview and record review, that all corrective actions had been implemented as of 1/7/25, and the facility was in compliance as of 1/8/25, prior to the SA's entrance on 2/10/25.	F 656		