STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255105	A. BUILDING _____ B. WING _____	C 09/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF TUPELO	2273 SOUTH EASON BOULEVARD TUPELO, MS 38804

(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 Initial Comments: CI MS #18027-Substantiated S/S=D PAST Non-Compliance On 09/07/2021-09/08/2021 the State Agency (SA) conducted an onsite complaint investigation, CI MS #18027, for alleged verbal abuse of a resident by a Certified Nursing Assistant (CNA) that had occurred on 08/27/2021. The SA substantiated the allegation of verbal abuse and cited a deficiency at F600 with the Scope and Severity at a "D" level Past Non-Compliance. The SA cited Past Non-Compliance and determined that the facility was in substantial complaince with the requirements of Medicare and Medicaid as of 08/30/2021. The facility had substantiated and corrected the deficiency of alleged verbal abuse prior to the SA entering the facility on 09/07/2021. The faclility was licensed for 120 beds on 09/07/2021 and the census was 84.	F 000	Past noncompliance: no plan of correction required.	
F 600 SS=D	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-	F 600		

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

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F 600	Continued From page 1 §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: F600 S/S=D Past Non-Compliance CI MS #18027-Substantiated Interview with the facility administrator, Ms. Lisha Woodard, on 09/07/2021 at 10:30 A.M. revealed that the facility did not received the report from the resident's family until Friday 08/28/2021 at 9:45 A.M. The alleged event occurred at approximately 9:30 P.M. on Friday 08/27/2021. The resident never told any of the staff at the facility about the incident. On Saturday 08/28/2021 resident Joe Edgeworth (Res. #1) told his ex-wife that he had been physically assaulted and verbally abused. The ex-wife is a registered nurse and she immediately assessed the entire body of resident Joe Edgeworth (Res #1) and found no sign of physical assault. She then reported to the unit supervisor, Krissy Robinson, RN, what resident had told her. Krissy Robinson immediately assessed resident Edgeworth and reported the incident to the administrator and acting Director of Nursing (ADON) Latricia Sanders, RN. The facility immediately called the CNA Dominique Hill, and suspended her from work until the investigation was completed. The Facility conducted in-services to staff on 08/28/2021 concerning abuse and neglect and continued the in-services until all staff attended. The facility had an emergency QA meeting on 08/30/2021 and on 09/02/2021. The investigation	F 600	Past noncompliance: no plan of correction required.	

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and statements from all parties were conducted by the ADON and ADM. Psychosocial assessments were conducted daily with Res #1 by the Social Worker and documented in the progress notes. The physician and the family were notified of the incident on 08/28/2021 immediately after the resident reported the incident. The facility assessed the other residents of the facility that were assigned to the CNA on the evening shift of 08/27/2021. No other resident was found to have knowledge of any incidents between CNA #1 and Res #1. The MSDH office was called to report the incident on 08/28/2021 immediately following the residents assessments. All measures to prevent, protect, investigate, report, and educate were taken by the facility on 08/28/2021. ADM stated that she had to terminate the CNA because the witness was very creditable and had given a written statement that she heard CNA Hill use profane language in the presence of Res #1. Also, Res #1 has continued to give the same account of the events without waiver since it occurred on 08/27/2021.

Reviewed the facility investigation and it was thorough and did contain statements from Res #1 and CNA #2 witness, with the same events outlined by both. The termination letter in CNA #1's personnel record verified that CNA #1 was terminated on 09/03/2021. Res #1's last date of work was 08/27/2021.

Interview on 09/07/2021 at 10:55 A.M. with the Social Worker, Destiny Warren, LSW, revealed that she was told about the incident on 08/28/2021 by the RN Supervisor, Kissy Robinson. LSW contacted the Responsible Party (RP) of resident #1, his daughter, Courtney Dean

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(RP) and informed her of the alleged incident. RP stated that resident #1 had been assaulted at the Baldwin Nursing Home prior to admission to Diversicare of Tupelo. RP thought the possibly her dad had dreamed about the past incident or had thought about that incident. RP stated that she did not feel that her dad had been assaulted a second time in another nursing home. LSW stated that she has seen resident #1 daily since the incident occurred on 08/27/2021. LSW stated that resident #1 has not had any overt signs of distress or behaviors of any type. But resident #1 has not been able to give the correct names of the alleged CNA nor the correct name of any witnesses. LSW stated that she has charted in Res #1's progress notes each time she has seen and talked with Res #1. LSW stated that Res #1 is cognitively intact and has a BIMS score of 14.

Reviewed the resident council minutes and the grievance logs for the past three months (July-September 2021) with no reports of abuse documented. No reports of CNA #1 noted. No issues with resident council minutes or grievances.

Interview on 09/07/2021 at 12:40 P.M. with Resident (Res #1) revealed that on a Friday night (08/27/2021) he had been at therapy and the therapist rolled him back to his room at approximately 3:30 P.M. He told the therapist that he needed to use the toilet and she told resident to wait at the door of the toilet until she could get his Certified Nursing Assistant (CNA) to come help him. He waited for approximately 3 hours for help and no one came. He did not use his call light system to summon help because he was waiting in his wheel chair like the therapist had asked him to do. He stated that the CNA,

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whose name he could not recall, came in his room mad. She went in to the bathroom area and wet a towel and came and wiped his "behind" area with the wet towel and then balled it up and threw it at him hitting him in the head with the wet dirty towel. Res #1 stated that the wet towel hit him with great force and hurt his neck and face. CNA was telling Res #1 that he could help himself and he told her he was paralyzed and could not roll over by him self and could not use his left arm. CNA was rough placing Res #1 in the bed and she pushed him with her hand real hard in the middle of his back with such force it nearly tossed him off the bed and pushed him into the side rail. CNA told Res #1 to roll over on his side and he again told her he could not roll by him self and she replied "I am not your slave and I am not your Bitch" you must be from the old days when things were different and she was not going to be treated like a slave. Res #1 stated that he told CNA that race had nothing to do with any thing and that he was not referring to the old days or to anything, he was trying to tell her that he needed help and was not able to do things for himself because he had no use of his left side. He stated that the CNA then backed away telling him that he was going to report him to the office, and she left the room. Res #1 stated that his cell phone/ipad was not charged and he was unable to make a call. He had asked the staff to take him to the nursing station to use the telephone and no staff would get him out of bed to place a call for help. Res #1 stated that he wanted to call the police at 911 to issue a report of assault but had no way until the next morning when he called his ex-wife and she reported the incident for him. Res #1 denied being afraid, Res #1 denied feeling unsafe. Res #1 stated that this was an isolated event at this nursing home. Res #1 stated that

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while he was at another Nursing Home he was assaulted by a CNA at that facility and the CNA had been terminated and he was discharged home to his daughter's house to live until coming to the facility.

Observation on 09/07/2021 at 1:00 P.M. of Res #1 revealed a small built male sitting in a wheel chair in his room watching the television of his roommate. His television was not on. Resident #1 was dressed in knee length shorts and socks with a t-shit. He had left sided atrophy of the left arm and left leg. His right leg was nervously shaking up and down rapidly as he talked, indicating he was anxious. Res #1 denied feeling anxious, denied feeling unsafe, and denied being fearful of his surroundings. Res #1 was cognitive and presented with clear thoughts and good command of English language. He was able to recall the events of the alleged incident in the same order as he had reported to the ADM on 08/28/2021. His story of the events of the incident of 08/27/2021 had not changed.

Record review of Res #1's BIMS revealed a BIMS score of 14, which indicated that he was cognitively intact. Res #1's face sheet revealed that Res #1 was 67 years old with a date of birth of 09/01/1954. Residents written statement dated 08/28/2021 was the same facts and details as he currently recalled on 09/07/2021.

Interview on 09/07/2021 at 1:00 P.M. with CNA #2 witness, currently working the 3-11 shift, but had worked most all shift and has been a CNA at the nursing home for 34 years. CNA #2 stated that when she arrived in the room on 08/27/2021 to help place Res #1 in the bed that CNA #1 had placed Res #1 in the bed by herself. CNA #2 was

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the "partner" of CNA #1 and had been for several months. They work in teams to comply with the facility procedures of two (2) person assistance. CNA #1 stated that Res #1 was already in the bed when she arrived to the room and all she heard was CNA #1 saying "I am not a slave or a bitch." I am on my way to call the supervisor to report. CNA #1 left the room and CNA #2 assumed that CNA 1 was reporting the incident because Res #1 was upset. CNA #2 confirmed her written statement that she gave to the ADM on 08/28/2021. CNA #2 stated that CNA #1 should not have talked to the Res #1 in that tone and should not have said what she heard her say. CNA #2 stated that she had never witnessed CNA #1 talk like that before and had no knowledge of any incidents prior to this one. CNA #2 stated that she had worked with CNA #1 for months and there had never been any problems. CNA #2 stated that CNA #1 was a good CNA. CNA #2 confirmed that they had been in-serviced regularly on abuse and neglect. CNA #2 confirmed that the facility In-serviced the staff on abuse and negelect and tone of voice starting on Saturday 08/28/2021. CNA #2 stated that she would not have a problem with CNA #1 caring for her family or for her, even after the alleged incident on 08/27/2021.

Interview on 09/07/2021 at 1:18 P.M. with Responsible Party (RP) revealed that Res #1 had been in another Nursing Home and had been assaulted by a CNA while there. The ordeal was tragic to Res #1 and to the family. RP stated that she had been contacted by the facility and told that a CNA at the facility had been rough with Res #1 and that Res #1 had stated that there was a verbal confrontation. RP stated that the details that she had been given came from her father

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and not from the facility. RP stated that she was not of the belief that Res #1 was assaulted but she had some concerns that the staff was not attentive enough to Res #1's needs and were slow to deliver care. RP stated that Res #1 was paralyzed on his left side and had had two (2) strokes that left him disabled and unable to fully care for himself. RP stated that she had called several times to speak to a supervisor, and had yet to have a return call. She stated that she talked to the Social Worker about the alleged incident but was not given details. RP denied that Res #1 had been physically assaulted. RP stated that the facility had contacted her about the alleged incident on Saturday 08/28/2021.

Interview on 09/07/2021 at 4:20 P.M. with nursing supervisor RN #1. She stated that she worked 10:00 A.M.-6:00 P.M. Monday-Friday but was working on Saturday August 28. 2021, when the ex-wife of Res #1 told her that Res #1 had been physically assaulted by CNA #1. RN #1 stated that Res #1 had not reported the incident to any one at the facility. The incident was first learned about on 08/28/2021 at 9:45 A.M. when ex-wife reported to RN #1. RN #1 immediately assessed resident and found no signs of physical abuse. RN #1 immediately began in-services with staff at the facility and called the ADON and ADM to report the alleged incidnet. The investigation was begun and assessments were completed on Saturday 8/28/2021. The alleged incident was called in to the State agencies at 12:00 P.M. on Saturday 8/28/2021, approximately one and a half hours after it was reported to the RN #1 Supervisor. RN #1 called CNA #1 and told her that she was on suspension and was not to return to the facility until the investigation was compelted and she was notified.

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Interview on 08/08/2021 at 11:30 A.M. with Certified Nursing Assistant (CNA #1) revealed that she went in to Res #1's room to check on him and he began cussing at her and aggressively calling her names and telling her that he had been waiting on someone to come help him for over two (2) hours. Res #1 was sitting in his wheel chair and next to the toilet area. He had not used his call light/system and had not used his personal ipad/cell phone. Res #1 told CNA #1 that she was a slave and worked for him and that she was a "bitch." CNA #1 stated that when she was trying to reassure Res #1 that she would be happy to help him, he escalated. CNA stated that Res #1 did allow her to assist in changing him and when she changed his brief he was not wet. CNA #1 stated that CNA #2 came in to help assist with Res #1 and CNA #1 left and never went back into Res #1's room. CNA #1 stated that she was sent home on suspensions until the investigation was concluded. CNA #1 stated that CNA #2 came in to assist Res #1 after he had called CNA #1 a "bitch and a slave." CNA #1 stated that she had been a CNA since 2008 and had worked at the facility since January 2021 full time and had recently in July of 2021 begun PRN (as needed) employment. CNA stated that this was the first time she had been accused by a resident of verbal and/or physical abuse. CNA #1 denied throwing a wet towel on Res #1 and denied verbal abuse. CNA #1 stated that she felt that Res #1 was having flash backs of the incident he had at another facility and that he over reacted. CNA #1 stated that she felt that the alleged incident was a misunderstanding. CNA #1 confiremed that she was suspended and sent home while the facility investigated the incident. CNA #1 stated that

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while she was out on suspension, she had been terminated on 09/03/2021.

Record reveiw revealed that the facility had called the alleged incident of abuse in to the State Agencies (SA) on 08/28/2021 at 12:00 P.M.

Record review revealed that the facility held a Quality Assurance (QA) committee meeting on Monday 08/30/2021 at 10:35 A.M. to discuss the Allegation of Abuse and to review the facility's policy and procedure for Abuse and Neglect. The QA committee did not make any policy and procedure revisions on 08/30/2021 during the QA committee meeting. The QA sign in sheet was obtained and the required committee members all were in attendance including the Medical Director.

Record reveiw revealed that the In-services were begun on 08/28/2021 shortly after the incident was reported. The facility In-serviced all staff on Abuse and Neglect and the investigation was completed and all corrections were made by 08/30/2021.

Reviewed the resident council meeting minutes for the past three (3) months and reviewed the grievance logs for the past three (3) months. There were no incidents of abuse and/or neglect reported.

Record review, observation, and interviews revealed that the facility had followed their policies and procedures for abuse and neglect and investigations.

Interviewed all residents on sample with no concerns voiced no knowledge of any resident abuse. No voiced fears of unsafety. Only

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concern of verbal and physical abuse was voiced by Res #1.

Record review of CNA #1's personnel records revealed no prior disciplinary actions taken. Date of Hire was 1/26/2021 for CNA #1.
Staffing grid for 08/15-8/31/2021 was obtained and reviewed. No Staffing concerns were noted.

The facility had subtainted the verbal abuse of Res #1 by CNA #1 and had terminated CNA #1 while she was out on suspension. CNA #1 was suspended from the facility on Saturday 08/28/2021. CNA #1 received her termination notice on 09/03/2021.

The facility had made all corrections and had fully investigated the incident on 08/30/2021. The facility was cited as Past Non-Compliance. The facility had corrected the deficiency prior to the State Agency (SA) entering the building on 09/07/2021 to investigate CI MS #18027.