Mississippi State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **01/15/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REST HAVEN HEALTH AND REHABILITATION	**103 CUNNINGHAM DRIVE , RIPLEY, Mississippi, 38663**

(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
M0000	Initial Comments The State Agency (SA) conducted a Complaint Investigation (CI) MS #2705741 at the facility on 1/15/26. During the survey, the SA determined the facility was not in compliance with the Mississippi Regulations for Minimum Standards for Institutions for the Aged or Infirm. The SA investigated the complaint for resident rights and cited M500. The census at the time of the survey was 49 and they held a license 60 beds.	M0000		
M0500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be	M0500		

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

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M0500	Continued from page 1 limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the	M0500		

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M0500	Continued from page 2 emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and	M0500		

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M0500	Continued from page 3 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on resident and staff interview, record review, video camera footage review, and facility policy review, the facility failed to ensure a resident's right to be treated with dignity and respect was honored for one (1) of three (3) residents sampled. Resident #1. Findings Include: Review of the facility policy, "Resident Rights and Dignity Management" with a review date of 9/2025, under "Standard" revealed that "It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment that maintains or enhances resident's quality of life by recognizing each resident's individuality...." An interview with Administrator (ADM) on 01/15/26 at 9:25 AM, revealed that Resident #1 came into his office on 12/30/25 at approximately 1:40 PM and reported that Certified Nursing Assistant (CNA) #1 had been rude and disrespectful to her and told her to “shut up.” Administrator revealed that he watched the video camera footage and confirmed that it was true. He revealed that camera footage revealed that on 12/30/25 at 1:15 PM, Resident #1 was observed yelling down the hall for staff to take her to the restroom and CNA #1 stated they were getting on his nerves with this impatient stuff, and a few words later told her to “Shut up.” ADM revealed that Resident #1 was impatient and could be impulsive sometimes, but the staff had to understand how to deal with her and treat her with respect. He also agreed that CNA #1 failed to treat Resident #1 with dignity and respect and that was her right. He revealed that he called CNA #1 into the office and suspended him immediately and during the investigation CNA #1 resigned. An observation of video camera footage with ADM on 01/15/26 at 9:35 AM revealed that on 12/30/25 at 1:15 PM, Resident #1 was sitting in her wheelchair asking	M0500		

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M0500	Continued from page 4 for help to go to the restroom. A male staff member, who ADM identified as CNA #1, approached Resident #1, spoke to her using a rude tone and told the resident to "Shut up" and after a few other words from Resident #1, he stated to her again, "Hush your mouth." CNA #1 then walked away from Resident #1 and two other staff members assisted her. An interview on 01/15/26 at 10:40 AM with Assistant Director of Nursing (ADON), revealed that Resident #1 was very impulsive and often demanding, wanting what she asked for right then. ADON revealed that Resident #1 would often press her call light and go immediately out into the hall to find someone to help her. ADON revealed that they had issues with her being impatient about going to the bathroom because she was a two-person assist with a lift. She revealed that they could not always stop immediately what they were doing with other residents to attend to her needs and that upset her. ADON revealed that CNA #1 should never have approached Resident #1 with that behavior like he did, that he should have stepped away from the situation and allowed someone else to take over. She also revealed that Resident #1 does know how to "push them to anger" but they should always treat the resident with dignity and respect regardless because that was her right that should have been honored. An interview on 01/15/26 at 11:00 AM with Resident #1, revealed that on 12/30/25, there was an incident where a CNA failed to treat her with dignity and respect. She revealed that she pressed the call light for someone to come in and help her to the bathroom. Resident #1 revealed that she did not have patience, and when she wanted something, she wanted it right then. She revealed that when she pressed her call light, she wheeled herself out into the hall and asked CNA #1 to take her to the bathroom. Resident #1 revealed that she and CNA #1 had words, and he told her to shut up and she stated, "I guess I said something he didn't like." Resident #1 revealed that two other CNAs came in and took her to the restroom after that, and she confirmed that she went straight to ADM office and reported it. She also revealed that CNA #1 was normally kind and stated, "I love him to death because he doesn't make me wait." She also revealed that she and CNA #1 always picked on each other and stated, "He's a very good aid but he must have been having a bad day." Resident #1 revealed that she felt safe there and she hated that CNA #1 was no longer there. A phone interview on 01/15/26 at 11:45 AM with CNA #1, revealed that he resigned his position at the facility after the verbal altercation he had with Resident #1.	M0500		

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M0500	Continued from page 5 He revealed that on 12/30/25, Resident #1 was on one of her rants, was upset and yelling out in the hall for someone to take her to the bathroom. He revealed that Resident #1 was not assigned to him that day, but he agreed to assist her to the bathroom when he finished taking care of the resident he was with. CNA #1 revealed that two other CNAs had asked her 15 minutes prior to that time if she needed to go to the bathroom and she declined. He revealed that when he walked up to Resident #1, she was mouthing off and he confirmed that he told her to shut up. He revealed that he got the lift and brought it into her room and she continued mouthing off at him. CNA #1 confirmed that he told her to shut up and to hush her mouth and that it was unprofessional of him to do so. He revealed that he should have walked away and let someone else take over. CNA #1 stated that he was sorry for the way he handled the situation and he should have treated her with respect and dignity and not been rude to her. He revealed that she reported it to the Administrator, and ADM sent him home pending the investigation and he turned in his resignation. Record review of an “In-Service” on Customer Service, Resident Rights, and Abuse was completed on 08/13/25 and 08/15/25 and CNA #1 attended. Record review of CNA #1’s “Record of Counseling” dated 12/30/25 documented that he was suspended pending investigation of the alleged verbal abuse towards a resident. Record review of Resident #1’s “Admission Record” revealed an admission date of 03/13/20 and that she had diagnoses that included Type 2 Diabetes Mellitus and Unspecified Sequelae of Cerebral Infarction. Record review of Resident #1’s Quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 12/19/25 under Section C revealed a Brief Interview for Mental Status (BIMS) Score of 15 which indicated that she had no cognitive deficits.	M0500		