STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255303	A. BUILDING _____ B. WING _____	C 05/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR HILL REST HOME	1201 GUNTER ROAD FLORENCE, MS 39073

(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 Complaint Investigation (CI) MS #16700; CI MS #17180; and CI MS #17252 The State Agency (SA) conducted a complaint survey on 5/26/21. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid. Complaint Investigation (CI) MS #17180 was substantiated, with no Federal deficiencies cited. CI MS #16700 related to a fall with a head injury and CI MS #17252 for alleged abuse and neglect were not substantiated, however, the SA cited deficiencies at F609 for failure to report incidents of alleged abuse/neglect to the appropriate State Agencies in a timely manner, and F610 for the facility's failure to thoroughly investigate alleged abuse/neglect of a resident. The facility's census was 55 at the time of the survey.	F 000		
F 609 SS=E	Reporting of Alleged Violations CFR(s): 483.12(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	F 609		7/19/21

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

Electronically Signed | 06/30/2021

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F 609	Continued From page 1 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 appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff interviews, family interviews, and facility policy and procedure reviews, the facility failed to report all incidents of alleged abuse/neglect of a resident to the appropriate State agencies in a timely manner for three (3) of five (5) residents reviewed for incidents of abuse and neglect. Resident #1, Resident #2, and Resident #3. Findings include: The facility policy and procedure titled: "Abuse Program" dated revised May 1, 2017 stated, "It is the policy of this facility to take all steps necessary to maintain an environment free of abuse and neglect...The Administrator of designee shall report any suspected abuse and neglect...to the Department of Health as required... Individual state reporting requirements will be adhered to. The results of the facility investigation will be reported to appropriate regulatory officials within the time frames established at the state level." In an interview on 5/26/2021 at 11:00 AM, the	F 609	1. Immediate action(s) taken for the resident(s) found to have been affected include: Resident #1 incident on 1/28/20. On 1/30/20, the Director of Nursing (DON) in-serviced the nursing staff on “Effective Communications with residents and families”. On 2/23/20 the DON in-serviced the nursing staff on the facility’s abuse, neglect policy. On 3/14/20 the DON reviewed the abuse neglect in-service with nursing staff. Resident #2 incident on 5/26/20. Resident was changed by staff. Resident #3 incident on 9/14/20. The resident did not denote pain or injury following the incident. The acting DON contacted the resident’s POA on 9/16/20. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected.	

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F 609	Continued From page 2 facility Administrator (ADM) stated that the facility had none of the previous staff currently working in the facility that were working in September 2020 or March 2020. The ADM stated that the previous Administrator and the previous Director of Nursing (DON) left the facility suddenly and never returned. The current ADM stated that he took over as the new administrator in March 2021 as did the new DON. The current administrator stated that he and the current DON have no knowledge of the alleged incidents of verbal/physical abuse of residents. In an interview on 5/26/21 at 11:00 AM, with the current DON revealed that she had only been working at the facility since March 2021. The DON stated that she had no knowledge of any alleged incidents of abuse/neglect of residents. The DON stated that she would have to try and look through the records that were left by the previous staff, but was doubtful that documentation would be available since there was no staff left working at the facility that were working in 2020. The DON stated that most of the past staff had been replaced with completely different staff since she had arrived at the facility in March 2021. Resident #1: Record review of the facility Grievance Logs for 2020 revealed that there were written reports in the grievance logs that documented alleged incidents of abuse/neglect for Resident #1 on 01/28/2020 that documented that the family member had witnessed the staff bump the head of Resident #1 while pulling him up in the bed and that the staff failed to check his head. The grievance report for Resident #1 read: Summary	F 609	3. Actions taken/systems put into place to reduce the risk of future occurrence include: On 5/12/21 Briar Hill (BH) staff received Health Insurance Portability and Accountability Act of 1996 (HIPAA) Compliance training. This training covered company policies and procedures, including abuse and neglect. Beginning 4/1/21, the social worker (SW) will report new grievances daily at standup meetings. The SW, administrator and DON will review new grievances, and ensure that an adequate investigation is conducted. The administrator will ensure that allegations of, or suspected abuse are reported to the appropriate state agencies. A representative of the MS Attorney General's Office, Division of Medicaid Fraud is scheduled to in-service the facility nursing staff on abuse and neglect on 7/19/21. On 6-22-21 the Quality Assurance and Performance Improvement (QAPI) Committee met and discussed the need investigate grievances and completing accident reports and reporting to the administrator to ensure that reporting requirements are met. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: Beginning 7/5/21, The Director of Nursing Services, or Registered Nurse (RN) shift supervisor, will conduct a random audit of five (5) residents weekly for four (4) consecutive weeks. These residents will	

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F 609	Continued From page 3 Statement of Grievance: " (name of witness) stated that the staff bumped the resident's head in the bed and failed to check it (name of witness) stated that they all went back and fourth conversing about the bed arrangement." Steps Taken to Investigate the Grievance: "The DON spoke to the staff and received statements from them." Summary of Pertinent Findings or Conclusions: "The DON Staff Development will do an Inservice on effective communication with the staff." Decision: "Grievance was confirmed. (Describe resolution.) Inserviced Staff" The grievance reports did not document the name or names of any staff involved in the incident of 01/28/2020. The record review did reveal that on 01/30/2020 an inservice and staff sign in sheet was documented and signed by 11 staff members. The title of the in-service on 01/28/2020 was documented by the DON and was titled: "Effective communication with residents and families" The record review of the grievance reports did not provide the names of the staff involved nor how many staff were involved. No staff names were given and/or documented in the social workers records and/or facility grievance reports. Record review of Resident #1's closed record Face Sheet revealed that he was admitted to the facility on 11/18/2019. The closed record Discharge Summary revealed that Resident #1 was discharged on 02/10/2020. Resident #1 had medical diagnoses that included Enterocolitis; Anxiety Disorders; Hypertension;Morbid (severe) obesity; Acute respiratory failure. Record review of the Minimum Data Set MDS Coordinator's Brief Interview of Mental Status (BIMS) report dated 1/9/2020 revealed Resident	F 609	be assessed and interviewed to ensure that any injuries are identified are properly investigated and reported to the administrator. This plan of correction will be monitored at the bimonthly Quality Assurance meeting beginning 7/5/21 for six (6) months.	

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#1 had a BIMS score of 4, which indicated severe cognitive deficits.

Record review of an inservice conducted by the DON, dated 1/30/20 and titled "Effective Communication with Residents and Families" revealed there were 11 staff signatures on the sign in sheet.

Interview on 5/26/2021 at 12:30 PM, with a family member of Resident #1,revealed that she was at the facility visiting Resident #1 when staff (unknown names) pulled Resident #1 up from under his arms and bumped his head on the head board of Resident #1's bed. The family member did not know the names of staff and she feels that the situation was upsetting. She stated that this incident happened prior to the Covid-19 pandemic and that it was in January 2020 prior to Resident #1's death in February 2020. The family member stated that Resident #1 was a very sick man and he was paralyzed and was totally dependent upon others for all of his needs. She stated that Resident #1 was transferred to the hospital in February 2020 from the nursing home and that Resident #1 died in the hospital due to his poor health not because of the facility bumping his head.

Interview on 05/26/21 at 1:00 PM,. with (RR) of Resident #1 revealed that she was sitting in resident #1's room on 01/28/2020 when she noticed that Resident #1 was sliding down in the bed, and he needed to be changed due to the fact that he had soiled himself. The head of the bed was elevated which was causing Resident #1 to slide down in the bed. RR stated that she pushed the call light to get staff to come and change Resident #1, adjust the bed and to

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re-position Resident #1 in the bed. RR stated that no one answered the call light after it was pushed for a long period of time (in excess of 30 minutes) so she left the room to go to the nursing station to get help. RR told the nurse that she had used the call system and that it had been over 30 minutes and no one had come to assist with changing Resident #1 and to reposition him in the bed. RR stated that the nurse went and got staff from the break room to go and assist Resident #1. RR stated that the two (2) staff that came to Resident #1's room were angry when they came in and was angry that their breaks had been interrupted to assist Resident #1. RR stated that the staff were rough with handling Resident #1. She stated they pulled him from under his arms with such force that his head hit the head board and made a loud bump and he yelled out in pain. RR stated that they did not check Resident #1 and did not report his head getting bumped nor did they assess him or his bumped head. RR stated that she did not know the names of the staff but it was two (2) staff and RR never saw either of them again after the incident. RR reported the incident to the DON and she thought that maybe they had been disciplined and or terminated for the rough manner in which they handled Resident #1.

The record review of Resident #1 Grievance Report revealed no evidence of the alleged incident of 01/28/2020 being reported to the appropriate State agencies as documented in the facility policy and procedure under the section of the policy titled: "Investigations".

Resident #2:

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Record review of the facility grievance logs maintained by the social worker contained a written report for Resident #2 which alleged that on 05/26/2020 the resident asked the staff to be changed and the staff stated "I have thirty other people and you will have to wait your turn."Resident #2 wasn't changed for hours. The grievance report for Resident #2 documented: Summary Statement of Grievance: "Family stated that the resident went without getting changed for hours. The staff told the resident to wait her turn via family member." Steps Taken to Investigate the Grievance: "Talked to staff -Inservice Staff" Summary of Pertinent Findings or Conclusions: "No staff admitted to saying it. Inserviced staff on effective communication and answering residents request in a timely manner." Decision: "Grievance was confirmed. (Describe resolution.) Inservice staff on effective communication." The record review of the grievance report did not reveal the names of any staff involved with the incident of 05/26/2020. There was no evidence on 05/26/2021 that the incident had been reported to the appropriate State agencies in a timely manner.

Record review of the Face Sheet for Resident #2 revealed that she had an admission date of 04/28/2020 and had been discharged home with family on 08/06/2020.

Record review of the Minimum Data Set MDS Coordinator's Brief Interview of Mental Status (BIMS) report dated 5/19/20 revealed Resident #2 had a BIMS score of 14 which indicated that Resident #2 was cognitively intact.

On 5/26/21 at 1:45 PM, attempted to interview the RR via telephone. The RR did not answer the

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telephone and no voice mail was available. .

Interview on 05/26/2021 at 5:00 PM. with the MDS nurse revealed that he was the only employee currently working at the facility that was working in the facility in 2020. MDS nurse had no knowledge of Resident #2's alleged incident on 05/26/2020.

Resident #3:

Record review of the facility grievance logs/reports, revealed a grievance placed by Resident #3's grandson, for alleged verbal and physical abuse/neglect of Resident #3 dated 09/14/2020 for Resident #3. The grievance report dated 09/14/2020 read: "(Name of Grandson) stated that the person helping his Grandmother (Resident #3) after waking her up grabbed her and pulled her up." Date Complaint/Grievance Occurred: weekend Summary Statement of Grievance: " (Name of Grandson of Resident #3) stated that he was outside the window while on the phone with nurse and that she said wake up wake up your grandson is here. He tapped on the window saying "don't talk to her like that" and she pulled Resident #3 by her arm. Steps Taken to Investigate the Grievance: "Social spooked with nurse and listened to the grandson. Social also spoke with the Power of Attorney(POA) and Corporate nurse." Decision : Grievance was confirmed. (Describe resolution.) "State came in on Monday 14th about a previous concern of the resident the resident stated that she had no problems with anything that everything was fine."

Interview on 05/26/21 at 12:00 PM, with the Ombudsman, revealed that she had received a

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report from the grandson, for Resident #3. The Ombudsman stated that the grandson reported that he witnessed the staff member (no last name) verbally abuse and physically abuse his grandmother as he was at his grandmother's window awaiting a window visit during Covid-19 restrictions on 09/13/2020. The Ombudsman stated that she reported the alleged abuse of Resident #3 to the appropriate State agencies as soon as she received the report from the family on 09/30/2020.

Interview on 05/26/2021 at 12:15 PM, with the grandson of Resident #3, he stated that he did not like what he saw through Resident #3's window. He stated that the staff member was a nurse and she was loud and angry sounding and that she grabbed his grandmother by the arm and pulled very hard attempting to pull her up by her arms. The Grandson stated that he witnessed verbal and physical abuse of his Grandmother through the window. He stated that his grandmother was totally blind and was lying in her bed when he came for a window visit during Covid-19, because he was not allowed inside the building. He stated that when he tapped on the window to get the nurse to stop her abuse, she stopped when she saw him witness what she was doing to his Grand mother. He stated that he asked the DON to not allow that nurse (did not know last name, only that she was a nurse) to work with his Grand- mother because of how she abused her. The Grandson stated that because his Grandmother is totally blind and has numerous high level care issues and poor health, there have been several concerns with the quality of care his grand mother received at the facility. He stated that his mother is now totally responsible for his Grandmother and that his

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mother is now the RR.

Record review of the Accident and Incident (A&I) reports from January 2020-December 2020 contained no documentation of the alleged verbal/physical abuse on 09/13/2020 for Resident #3. There were no A&I's found for Resident #1's alleged incident of 01/28/2020. No documentation found in the facility records that the appropriate State agencies were notified of the incidents for Residents #1, #2, and #3.

Interview with the DON on 5/26/21 at 2:00 PM, confirmed that the A&I documentation had been reviewed and there was no A&I reports and no investigation reports/documentation for the alleged incident of 09/13/2020 of Resident #3. The DON stated that she had searched all through the documentation and through Resident #3's medical record and was unable to obtain any information of an event on 09/13/2020 and no investigation and no A&I for 9/13/2020 was found. The DON stated that the Corporate nurse had no information that the State agencies were notified in a timely manner after the alleged abuse incidents of Resident #1, #2, or #3.

Record review of the Face Sheet for Resident #3, revealed that she was admitted to the facility on 05/18/2018.
Resident #3 had medical diagnoses which included Alzheimer's Disease, unspecified; Cognitive Communication deficit; Major Depression; and Anxiety Disorder; and Repeated Falls.

Record review of the Minimum Data Set MDS Coordinator's Brief Interview of Mental Status (BIMS) report dated 7/20/2020 revealed Resident

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F 609	Continued From page 10 #3 had a BIMS score of 11,which indicated she had some mild cognitive impairments Interview on 05/26/2021 at 4:30 PM. with the Licensed Master Social Work (LMSW), revealed that she was newly employed at the facility in December 2020. The LMSW confirmed that she was responsible for the grievances and displayed a large book of reported grievances that she was responsible for maintaining. LMSW stated that she had no names of staff involved in the alleged incidents of abuse that were maintained in the grievance reports for resident #1, #2, or #3.	F 609		
F 610 SS=E	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §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 appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record reveiws, staff interviews, facility policy review, and family interviews, the facility	F 610	1. Immediate action(s) taken for the resident(s) found to have been affected	7/19/21

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F 610	Continued From page 11 failed to thoroughly investigate all alleged incidents of abuse/neglect for three (3) of five (5) residents reviewed for abuse and neglect. Residents #1, #2, and #3. Findings include: The facility policy titled: "Abuse Program" dated Revised May 1, 2017 read: The facility is committed to protecting the residents from abuse by anyone including, but not necessarily limited to facility staff, other residents, consultants, volunteers, sponsors, visitors, surrogates, and other care givers who provide care and services on behalf of the facility. Neglect occurs when facility staff fail to monitor and/or supervise the delivery of resident care and services to assure that care is provided as needed by residents. Neglect occurs when a facility fails to provide necessary care for residents, such as situations in which residents are left to lie in urine or feces. The facility will thoroughly investigate, under the direction of the administrator or Director of Operations/Director of Clinical Operations the time of any findings of potential abuse or neglect to determine the cause and effect, and provide protection to any alleged victims to prevent harm during the continuance of the investigation. The Administrator of designee shall report any suspected abuse and neglect outlined in this policy to the Department of Health as required. In an interview on 5/26/2021 at 11:00 AM,. the facility Administrator (ADM) stated that the facility had none of the previous staff currently working in the facility that were working in September 2020 or March 2020. ADM stated that the previous administrator and the previous Director of Nursing (DON) left the facility suddenly and never	F 610	include: Resident #1 incident on 1/28/20. On 1/30/20, the Director of Nursing (DON) in-serviced the nursing staff on “Effective Communications with residents and families”. On 2/23/20 the DON in-serviced the nursing staff on the facility’s abuse, neglect policy. On 3/14/20 the DON reviewed the abuse neglect in-service with nursing staff. Resident #2 incident on 5/26/20. Resident was changed. Resident #3 incident on 9/14/20. The resident did not denote pain or injury following the incident. The acting DON contacted the resident’s POA. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: On 5/12/21 Briar Hill (BH) staff received Health Insurance Portability and Accountability Act of 1996 (HIPAA) Compliance training. This training covered company policies and procedures, including abuse and neglect. Beginning 4/1/21 the social worker (SW) will report new grievances daily at standup meetings. The SW, administrator and DON will review new grievances, and ensure that an adequate investigation is conducted. Statements and documentation will be obtained from staff	

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F 610	Continued From page 12 returned. The current ADM stated that he took over as the new administrator in March 2021 as did the new DON. The current Administrator stated that he and the current DON have no knowledge of the alleged incidents of alleged verbal/physical abuse. The Covid -19 Pandemic caused a no visitors policy and caused numerous staff and residents to become ill. The current ADM stated that the facility utilized outside agencies for staffing during the Covid-19 pandemic in 2020 and he stated that it was doubtful that there were any current staff working in the facility that were employed in 2020. In an interview on 5/26/21 at 11:00 AM, with the current DON revealed that she had only been working at the facility since March 2021. DON stated that she had no knowledge of any alleged incidents of abuse/neglect of any resident at the facility. DON stated that she would have to try and look through the records that were left by the previous staff, but was doubtful that documentation would be available since there was no staff left working at the facility that were working in March 2020 and September 2020. Resident #1: Record review of the facility Grievance Logs for 2020 revealed that there were written reports in the Grievance Logs that documented alleged incidents of abuse/neglect for Resident #1 on 01/28/2020 that documented that the family member had witnessed the staff bump the head of Resident #1 while pulling him up in the bed and that the staff failed to check his head. The grievance report for Resident #1 read: Summary Statement of Grievance: " (Name of witness) stated that the staff bumped the resident's head	F 610	involved and have knowledge of the accident, incident and/or allegations. The administrator will ensure that allegations of, or suspected abuse are reported to the appropriate state agencies. A representative of the MS Attorney General's Office, Division of Medicaid Fraud is scheduled to in-service the facility nursing staff on abuse and neglect on 7/19/21. On 6-22-21 the Quality Assurance and Performance Improvement (QAPI) Committee met and discussed the need investigate grievances and completing accident and incident reports when warranted. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: Beginning 7/5/21, the Director of Nursing Services, or designee, will conduct a random audit of five (5) residents weekly for four (4) consecutive weeks. These residents will be assessed and interviewed to ensure that any injuries are identified, properly investigated, and reported to the appropriate people. This plan of correction will be monitored at the monthly QAPI meeting beginning 7/5/21 for six (6) months.	

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in the bed and failed to check it. (Name of witness) stated that they all went back and fourth conversing about the bed arrangement." Steps Taken to Investigate the Grievance: "The DON spoke to the staff and received statements from them." Summary of Pertinent Findings or Conclusions: "The DON Staff Development will do an Inservice on effective communication with the staff." Decision: "Grievance was confirmed. (Describe resolution.) Inserviced Staff" The grievance reports did not document the name or names of any staff involved in the incident of 01/28/2020. The record review did reveal that on 01/30/2020 an inservice and staff sign in sheet was documented and signed by 11 staff members. The title of the in-service on 01/28/2020 was documented by the DON and was titled: "Effective communication with residents and families" The record review of the grievance reports did not provide the name of the staff involved nor how many staff were involved. No staff names were given and/or documented.

Interview on 5/26/2021 at 12:30 PM with a family member, of Resident #1 revealed that she was at the facility with the Resident Representative (RR) visiting Resident #1 when staff (unknown names) pulled Resident #1 up from under his arms and bumped his head on the head board. Family mamber does not know the names of the two (2) staff that repositioned Resident #1 and bumped his head. Family member feels that the situation was upsetting.She stated that Resident #1 was a very sick man and he was paralyzed and was totally dependent upon others for all of his needs. She stated that Resident #1 was transferred to the hospital in February 2020 from the nursing home and that he died in the hospital due to his poor health, not because the facility staff bumped

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him on his head.

Interview on 05/26/21 with the RR, revealed that she was sitting in Resident #1's room on 01/28/2020 when she noticed that Resident #1 was sliding down in the bed, and he needed to be changed due to the fact that he had soiled himself. The head of the bed was elevated, which was causing him to slide down in the bed. RR stated that she pushed the call light to get staff to come and change resident #1 and to adjust the bed, and to re-position Resident #1 in the bed. She stated that she was often at the facility and would sit with Resident #1 for long periods of time because his health was so compromised. RR stated that she pushed the call system at Resient #1's bedside for staff to come and assist resident #1. RR stated that the staff were rough with handling Resident #1 and they pulled him from under his arms with such force that his head hit the head board of the bed and made a loud bump. She stated that they did not check Resident #1 and did not report his head getting bumped nor did they access him or his bumped head. RR stated that she did not know the names of the staff but it was two (2) staff and she never saw either of them again after the incident. RR reported the incident to the DON, and she thought that maybe they had been disciplined and or terminated for the rough manner in which they handled Resident #1. RR stated that she had been greatly upset by the way Resident #1 had been mistreated at the facility.

Record review of Resident #1's closed record Face Sheet revealed that he was admitted to the facility on 11/18/2019 with diagnoses which included Enterocolitis; Type 2 Diabetes; Essential Hypertension, Sepsis, and Acute respiratory

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failure. Resident #1 had been discharged from the facility on 02/10/2020.

Record review of the Minimum Data Set Coordinator Brief Interview for Mental Status report dated 1/9/20 revealed Resident #1 had a BIMS score of 4 which indicated that he had severe cognitive deficits.

Resident #2:

Interview on 5/26/2021 at 2:00 PM,. with the current facility Administartor (ADM) and the current Director of Nursing (DON) revealed that the facility had no documentation of a thourough investigation for Resident #2 and had no documentation of the alleged report of neglect/abuse of Resident #2 by staff on 05/26/2020 and had no names of the staff that were involved in the alleged incident of 05/26/2020.

Record review of the facility Grievance Logs maintained by the social worker contained a written report for resident #2 which alleged that on 05/26/2020 Resident #2 asked the staff to be changed and the staff stated, "I have thirty other people and you will have to wait your turn" and wasn't changed for hours. The Grievance Report for Resident #2 documented: Summary Statement of Grievance: "Family stated that the resident went without getting changed for hours. The staff told the resident to wait her turn via family member." Steps Taken to Investigate the Grievance: "Talked to staff -Inservice Staff" Summary of Pertinent Findings or Conclusions: "No staff admitted to saying it. Inserviced staff on effective communication and answering residents request in a timely manner." Decision:

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"Grievance was confirmed. (Describe resolution.) Inservice staff on effective communication." The record review did not reveal the names of any staff involved with the incident of 05/26/2020.

Interview with the RR of Resident #2 was attempted on 5/26/21 at 1:45 PM via telephone. There was no answer to the telephone and no voice mail was available.

Record review of the Minimum Data Set Coordinator Brief Interview for Mental Status report dated 7/20/20 revealed Resident #2 had a BIMS score of 14, which indicated that she was cognitively intact.

Record review of the Face Sheet revealed Resident #2 was admitted to the facility on 04/28/2020 with diagnoses of Frontal lobe damage from a creebral infraction; Heart Failure; Chronic artrial fibrilation; Dysphagia following cerebral infraction; Type 2 diabetes; Muscle weakness; Muscle wasting and atrophy and was discharged home with family on 08/06/2020.

Resident #3:

Record review of the facility Grievance Logs/reports maintained by the facility social worker, revealed a grievance placed by Resident #3's grand son, for alleged verbal and physical abuse/neglect of resident #3 dated 09/14/2020. The grievance report dated 09/14/2020 read: "(name of gramdson) stated that the person helping his grand mother after waking her up grabbed her and pulled her up." Date Complaint/Grievance Occurred: weekend Summary Statement of Grievance: " (grandson of resident #3) stated that he was outside the

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window while on the phone with nurse and that she said wake up wake up your grandson here and he tapped on the window saying don't talk to her like that and she pulled her by her arm." Steps Taken to Investigate the Grievance: "Social spoked with nurse and listened to the grandson. Social also spoked with Power of Attorney (POA) and Corporate nurse." Decision : Grievance was confirmed. (Describe resolution.) "State came in on Monday 14th about a previous concern of the resident the resident stated that she had no problems with anything that everything was fine."

Interview on 05/26/21 at 12:00 PM, with the Ombudsman revealed that she had received a report from the grandson, for Resident #3. The Ombudsman stated that the grandson reported that he witnessed the staff member (first name given) (no last name) verbally abuse and physically abuse his grandmother as he was at his grandmother's window awaiting a window visit during Covid-19 restrictions on 09/13/2020. The Ombudsman stated that she reported the alleged abuse of Resident #3 to the appropriate State agencies as soon as she received the report from the family on 09/30/2020.

Interview on 05/26/2021 at 12:15 PM,. with grandson of Resident #3, revealed that he did not like what he saw through the window of Resident #3. He stated that the staff member was a nurse and she was loud and angry sounding and that she grabbed his grandmother by the arm and pulled very hard attempting to pull her up by her arms. The grandson stated that he witnessed verbal and physical abuse of his grand mother through the window. He stated that his grandmother was totally blind and was lying in her bed when he came for a window visit during

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Covid-19, because he was not allowed inside the building. He stated that when he tapped on the window to get the nurse to stop her abuse, she stopped when she saw him witness what she was doing to his grand mother. He stated that he asked the DON to not allow that nurse, (he gave her first name but did not know last name, only that she was a nurse) to work with his grandmother because of how she abused his grandmother. The grandson stated that because his grand mother is totally blind and has numerous high level care issues and poor health, there have been several concerns with the quality of care his grandmother received at the facility.

Record review of the Accident and Incident (A&I) reports from January 2020-December 2020 contained no documentation of the alleged verbal/physical abuse on 09/13/2020 for resident #3. There were no A&I's found for Resident #1's alleged incident of 01/28/2020. There was no facility thorough investigation found for Resident #1's incident of 01/28/2020.There was no documentation of an incident and/or investigation on 05/26/2020, in the facility records for Resident #2's incident of 05/26/2020 or any records of an A&I and thorough investigation found for Resident #3's incident of 09/13/2020. No documentation found in the facility records that the Department of Health had been notified of the incidents for Resident's #1, #2, and #3.

Interview with the DON on 5/26/21 at 2:00 PM,.confirmed that the A&I documentation had been reviewed and there was no A&I reports and no investigation reports/documentation for the alleged incident of 09/13/2020 of Resident #3. The DON stated that she had searched all through the documentation and through the

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medical records for Resident #3 and was unable to obtain any information of an event on 09/13/2020 and no investigation and no A&I for 9/13/2020 was found. The DON confirmed that she has not been able to locate any thorough investigations or documentation that was completed by the facility for Resident #1's incident of 01/28/2021 and none for Resident #2's incident dated 05/26/2020.The DON stated that she can not provide documentation that there were any thorough investigations completed on Resident #1, Resident #2, or Resident #3 prior to her employment at the facility in March 2021. The DON stated that she was not able to locate any documentation of an investigation or of the State agencies timely notification of the incidents for Resident #1, #2, or #3. The DON stated that she called the Corporate office to inquire with the Nurse Consultant, who had served as the Interim DON, and that she also had no knowledge and had not located any documentation for the alleged incidents of Resident #1, #2, and/or #3. The DON stated that the Corporate nurse had no information that the appropriate State agencies were notified in a timely manner after the alleged abuse incidents of Resident #1, #2, or #3.

Interview on 05/26/21 at 3:45 PM,. the current ADM revealed that he was not employed at the facility in September 2020. The ADM stated that on 09/03/2020 the former facility Administrator, at that time, had walked out of the facility and did not return to work. The ADM stated that there were no staff working in the facility currently that were working in the facility in March of 2020 or September 2020. The ADM stated that he was unable to provide any names of staff to go along with the alleged incidents of abuse/neglect for Resident #1, #2, or #3.

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Record review of the Face Sheet for Resident #3 revealed that she was admitted to the facility on 05/18/2018 with diagnoses which included Alzheimer's Disease, unspecified; Cognitive Communication deficit; Major Depression; and Anxiety Disorder and Repeated falls.

Record review of the MDS Coordinator Facility BIMS report dated7/20/20 revealed Resident #3 had a BIMS score of 11 which indicates mild cognitive impairment .

Interview on 05/26/2021 at 4:30 PM, with the facility Licensed Masters Social Worker (LMSW), revealed that she was newly employed in December 2020. LMSW confirmed that she was responsible for the grievances and displayed a large book of reported grievances that she was responsible for maintaining. LMSW stated that she had no names of staff involved in the alleged incidents of abuse that were maintained in the grievance reports for Residents #1, #2, or #3. LMSW stated that the only employee that was currently working at the facility that was employeed in 2020, during the incidents for Resident #1, #2, and #3, was the MDS nurse. LMSW stated that the non-nursing staff were all pitching in to assist with residents and to help meet their needs in the absence of nursing staff. LMSW stated that since she had come to work at the facility she had no reports of alleged abuse or neglect of a resident.

Interview with MDS Nurse on 05/26/2021 at 5:00 PM, revealed the MDS Nurse stated that he had no knowledge of the alleged incident of 01/28/2020 for Resident #1. MDS nurse stated that he did have knowledge of the nurse that was

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alleged to have verbally and physically abused resident #3 on 09/13/2020. The staff that was alleged in the incident of 09/13/2020, for Resident #3, was the current weekend Licensed Practical Nurse (LPN). MDS confirmed that the LPN was currently employed at the facility.

Interview on 05/26/2021 at 5:00 PM, with. LPN #6 via telephone, revealed that she denies receiving any discipline issued to her as a result of the incident with Resident #3 on 09/13/2020. LPN#6 stated that she did not verbally or physically abuse Resident #3 and the grandson did not see her do anything incorrect. She stated that the grandson did knock on the window at her as she was trying to awaken Resident #3. LPN#6 did confirm that Resident #3 was totally blind.LPN#6 stated that she was not suspended from work while an investigation was conducted because she was not working except on the weekends and she assumed that the facility completed the investigation during the week while she was not at work. LPN#6 does not remember if she gave a written statement as to what happened on 09/13/2020 with Resident #3. LPN#6 denies verbal and physical abuse of Resident #3 on 09/13/2020. LPN#6 stated that the grandson was mistaken in what he witnessed from the window of Resident #3's bedroom.