STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255273	A. BUILDING _____ B. WING _____	C 12/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HILL NURSING CENTER	927 COOPER RD JACKSON, MS 39212

(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 a complaint investigation, MS #15560, from 11/28/18-12/4/18. The facility reported that Resident #1 was abused by Certified Nurse Aide (CNA) #1 and #2 and Neglected by Licensed Practical Nurse (LPN) #1 on 11/15/18. There is video of part of the incident. All three (3) employees were terminated from employment. Abuse was not substantiated. Neglect was substantiated against LPN #1 for not assisting Resident #1 when he was on the floor. The facility failed to report the incident timely. During the survey the SA determined the facility was not in compliance with the Medicare and Medicaid Requirements for Participation and cited deficiencies at F600 and F609. The census was 79 and the facility held a license for 87 beds.	F 000		
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- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced	F 600		1/10/19

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

Electronically Signed | 01/11/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 600	Continued From page 1 by: Based on record review, video review, policy/procedure review, and staff interview, the facility failed to prevent neglect of one (1) of five (5) residents reviewed (Resident #1) as evidenced by Licensed Practical Nurse (LPN) #1 walked past Resident #1 as he lay on the floor and Certified Nurse #1 and Certified Nurse #2 were attempting to prevent him from hurting himself and others. LPN #1 walked past Resident #1 twice and did not attempt to help the CNA's or attempt to get Resident #1 of of the floor. Findings include: Policy/procedure review on 11/29/18, last revised May 2017, revealed the facility policy for Neglect revealed "Our residents have the right to be free from abuse, neglect, misappropriation of resident property, corporal punishment and involuntary seclusion." The policy revealed the signs of physical neglect to include "Caregiver indifference to resident's personal care and needs". Resident #1 was admitted to the facility on 10/1/18 with the diagnoses of Major Depressive Disorder, Cerebral Infarct without residual deficits, Transient Cerebral Ischemic Attack (TIA), Dysphagia, Aphasia, Intercostal Neuropathy and unspecified chest pain. The Minimum Data Set (MDS) for admission with an Assessment Reference Date (ARD) of 10/8/18, revealed a Brief Interview of Mental Status of a 12, which indicated moderate cognitive impairment. The resident required minimal assistance with decision making. No behaviors were noted on the MDS. Record review of the incident report, dated	F 600	By Submitting the enclosed material, Forest Hill Nursing Center is not admitting the truth or accuracy of any specific finding or allegations. Forest Hill Nursing Center reserves the right to contest the findings as part of any proceedings and submit these responses pursuant to our Regulatory Obligations. On January 10, 2019, The Quality Assurance Committee (QA) Committee met to discuss the Corrective Actions to be taken to answer and correct the deficiencies found and noted on the complaint investigation. 1) All employees were in-serviced by the Staffing Coordinator on Abuse, Neglect and Exploitation beginning November 16,2018 and was completed on November 19,2018. Licensed Practical Nurse (LPN) #1 was terminated on November 16,2018. Resident #1 was sent to the hospital at 12:41am on November 16, 2018 and returned on November 16, 2018 at 4:49am. He returned without injury. Resident #1 involved in this deficient practice was not harmed or caused an un-due illness. On November 16, 2018, the Director of Nurses, the Administrator, and the Facility Medical Director participated in an emergency QA meeting. All parties discussed the appropriate plan of correction to be implemented. The Plan of Correction was approved on November 16, 2018. On November 16, 2018, during stand-up morning meeting, the	

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F 600	Continued From page 2 11/16/18, and the facility's written report, dated 11/21/18, revealed CNA #1 found Resident #1 asleep in a bed that was not assigned to him. She stated she attempted to wake him and he jumped up off of the bed and attempted to choke her. She yelled for help and CNA #2 came to assist. Resident #1 fell backwards into the window of the room breaking a window pane as he was being combative. Both CNA #1 and CNA#2 walked Resident #1 out of this room and up the hall with each holding an arm of Resident #1. As they approached the nurse's station of this unit, CNA #1 is observed on video trying to hold back the arms of Resident #1 behind his back. CNA #1 and CNA #2 are then seen lowering Resident #1 to the floor. There are nurses at the nursing station that do not appear to notice what is happening. There is staff on the hall that do not attempt to intervene. Licensed Practical Nurse #1, assigned to Resident #1, walked past the three (3) on the floor to the nurse's station then back down the hall past the three (3) on the floor without assisting the resident or the two (2) CNA's. Resident #1 is sent to the hospital for an evaluation. He returns later in the early morning hours without injuries. The Administrator and Director of Nurses (DON) are notified by staff of the incident and both go to the facility at that time. The Administrator goes to the hospital to check on Resident #1. The DON begins the investigation. The written report (11/21/18) noted that Resident #1 alleged staff verbally told him to get his black ass (N) out of that bed and choked him. Review of the video provided by the facility on 11/29/18, revealed on 11/15/18, three (3) people on the floor of the facility. These individuals were identified by the Administrator as being CNA #1,	F 600	Administrator in-serviced all department heads on Abuse and Neglect of Vulnerable Adults. The Preventing Abuse and Neglect Policy was reviewed with the staff by the Administrator on November 16,2018. On December 5, 2018, Social Work Consultant and Social Work Director in-serviced staff on Residents Rights, Abuse, Neglect, Anger Management, and Stress Management. On December 5, 2018, The Social Work Consultant and Social Work Director interviewed fourteen residents. The purpose of the interviews was to explore and confirm feelings of individual residents regarding the care they received from nursing staff. The general tone of the responses was positive with residents acknowledging that overall the care they received was good. No resident voiced concerns about their safety. 2) The Director of Nurses determined that Licensed Practical Nurse (LPN)#1 was on medication cart #3. Twenty-Five residents in the facility had the potential of being affected by the deficient practice based on the residents assigned to Licensed Practical Nurse #1. 3)All employees were in-serviced by the Staffing Coordinator, Unit Managers, and Unit Supervisors on Abuse, Neglect and Exploitation using the power-point supplied by the Mississippi Attorney Generals Office on November 28, 2018. On November 28, 2018, all employees watched two units, Module II on What is Abuse and Module V on Preventing	

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F 600	Continued From page 3 CNA #2 and Resident #1. the Administrator then identified a staff member as LPN #1 that walked past the three (3) people on the floor, went to the nurses station, and then turned around and walked out of camera sight, without providing assistance or intervening with the situation. Interview with Licensed Practical Nurse #1 on 12/3/18 at 12:45 PM, revealed she was Resident #1's assigned nurse on 11/5/18 on the 3:00 PM - 11:00 PM shift on Unit II. She stated, "Someone told me he jumped on two (2) Nurse's Aides. I went to Unit 1 and saw him and two (2) CNA's sitting on the floor." "I went back to my unit. No, I didn't tell anyone to get off the floor. No, I didn't ask what happened. I didn't see how anyone got on the floor. No one looked injured." Interview with the DON on 11/28/18 at 12:30 PM, revealed that LPN #1 was terminated for neglect for walking by Resident #1 on the floor and walking back to her unit without assisting him.	F 600	Abuse, of the video Hand-in-hand video produced by Centers for Medicare & Medicaid Services(CMS). 4. All new employees will receive in-service training by the Human Resources Director on Abuse, Neglect and Exploitation upon hire. They will also watch the video Hand-in-Hand produced by CMS. Current employees will receive training on Abuse, Neglect and Exploitation quarterly each year by the Staffing Coordinator. The Hand-in-hand video's two units, Module II on What is Abuse and Module V on Preventing Abuse, will be shown as part of the training during the year. The Staffing Coordinator will report to the QA Committee quarterly. The QA Committee will monitor training and make recommendations as needed.	
F 609 SS=D	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	F 609		1/10/19

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F 609	Continued From page 4 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 appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, policy/procedure review and staff interview, the facility failed to report an allegation of abuse and neglect to the appropriate state agencies (Board of Nursing) and failed to report to the State Survey Agency an allegation of abuse within a two (2) hour period after the Administrator or Designee was notified of the allegation for one (1) of five (5) residents reviewed (Resident #1). This was evidenced by: The Administrator and Director of Nurses were both notified of an allegation of abuse and neglect on 11/15/18 around 11:37 PM, that Resident #1 was allegedly abused by Certified Nurse Aid (CNA) #1 and Certified Nurse Aide #2 when he became combative and the two (2) CNA's attempted to prevent him from hurting himself and others and LPN #1 did not attempt to intervene or get the resident off the floor. The two (2) CNAs had been accused on abusing the resident. The allegation wasn't reported until 11/16/18, around 10:00 AM.	F 609	On January 10, 2019, The Quality Assurance (QA) Committee met to discuss the Corrective Actions to be taken to answer and correct the deficiencies found and noted on the complaint investigation. 1) All staff were in-serviced by the Administrator and Staffing Coordinator beginning on January 03,2019 the reporting requirement of any incident involving Abuse, Neglect, Exploitation or Mistreatment, including injuries of unknown source, as well as misappropriations of Resident property. All incidents will be reported immediately to the Administrator. If the events that cause the allegation involve Abuse or result in serious bodily injury the Administrator will report to the appropriate State and Federal Agencies within 2 hours. The Director of Nursing will be	

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F 609	Continued From page 5 Findings include: Policy/procedure review of the facility's policy, "Preventing Resident Abuse", last revised on May 2017, revealed they are to report allegations of abuse/neglect no later than two (2) hours after forming a suspicion and if the suspicion results in serious bodily injury or not later than 24 hours. Record review of the incident report, dated 11/16/18, and the written report to the State Agency, dated 11/21/18, revealed CNA #1 found Resident #1 asleep in a bed that was not assigned to him. She stated she attempted to wake him and he jumped up off of the bed and attempted to choke her. She yelled for help and CNA #2 came to assist. Resident #1 fell backwards into the window of the room breaking a window pane as he was being combative. Both CNA #1 and CNA#2 walked resident #1 out of this room and up the hall with one each holding an arm of Resident #1. As they approached the nurse's station of this unit, CNA #1 is observed on video trying to hold back the arms of Resident #1 behind his back. CNA #1 and CNA #2 are then seen lowering Resident #1 to the floor. There are nurses at the units nursing station that do not appear to notice what is happening. There is staff on the hall that do not attempt to intervene. Licensed Practical Nurse #1, assigned to Resident #1, walks past the three (3) people on the floor to the nurse's station then back down the hall past the three (3) on the floor without assisting the resident or the CNA's. Resident #1 is sent to the hospital for an evaluation. He returns later in the early morning hours without injuries. The Administrator and Director of Nurses are notified by staff of the incident and both go to the facility at that time. The administrator goes to	F 609	in-serviced on the reporting requirements of the appropriate state agencies (Board of Nursing) and the State Survey Agency of any allegations or suspicions of Abuse, Neglect, and Exploitation to include the regulatory reporting of two hours. The completion date of January 10,2019. 2) On January 10,2019, a review was made by the Administrator to determine the number of residents affected by this deficient practice. All 79 residents in the facility have the potential of being affected by this deficient practice. 3) All Unit Managers will review each employee's knowledge by quizzing each employee beginning on January 10, 2019 on the two hour reporting requirement. If any employee's knowledge is deficient, the employee will receive additional training. Administrator will review all incidents reports daily. The Unit Managers will report findings to the QA Committee. The QA Committee will make recommendations as needed. 4) All new employees will receive Abuse, Neglect, Exploitation and the reporting of incidents training upon hire by the Human Resources Director. All current employees will receive in-service training on reporting requirement quarterly each year by the Staffing Coordinator. The Staffing Coordinator will report finding to the quarterly QA Committee meetings. Findings will be discussed in the quarterly QA meetings with the committee making recommendations as needed.	

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F 609	Continued From page 6	F 609		

the hospital to check on Resident #1. The DON begins the investigation. The written Report (11/21/18) also noted Resident #1 alleged he had been told by staff to "Get his black ass (N) out of this bed" and that he had been choked by staff.

Review of the Departmental Notes, dated 11/16/18 at 2:04 AM, revealed around 11:15 PM (11/15/18), Resident #1 became combative with two (2) CNAs, broke a window, and they escorted him down the hall and resident was taken to the floor. No injury was noted. Noted documentation revealed the DON was notified of the incident at 11:37 PM (11/15/18).

Review of the Emergency Room Note, dated 11/16/18 at 1:30 AM, revealed Resident #1 reported staff at the nursing home was mean to him. Further documentation at 2:10 AM, revealed: "Discussion with the nursing home staff revealed that patient was the victim in the incident and as the staff member involved has been terminated, patient can safely return to nursing home facility."

Documentation, provided by the facility revealed the facility Administrator or Designee did not call the State Survey Agency hotline until 11/16/18, at approximately 1:54 PM. The Attorney general's office was contacted by written report dated 11/16/18 at 3:46 PM. The facility investigation alleged abuse by CNA #1 and CNA #2 towards Resident #1 and neglect by LPN #1 for not assisting Resident #1. CNA #1, CNA #2 and LPN #1 were terminated related to the findings of the facility investigation. The State Board of Nursing was not contacted by the facility regarding the neglect by LPN #1 until after the State Survey Agency has entered the facility on 11/28/18, to begin the state investigation.

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An interview with the DON on 11/28/18 at 12:30 PM, revealed "No, we did not report this to the BON (board of nursing). We reported it to the AG (Attorney General) and Licensure and Certification."

An interview with the DON on 11/29/18 at 11:00 AM, revealed the BON was notified regarding the allegation of neglect by LPN #1 on 11/28/18 at approximately 4:00-5:00 PM.

An interview with the Administrator on 11/29/18 at 12:00 PM, revealed the incident/allegation happened on 11/15/18 and the DON reported the incident the next morning on 11/16/18. The Administrator stated, "We watched the incident video between 9:00-10:00 AM and the DON called the hotline after that."

Resident #1 was admitted to the facility on 10/1/18 with the diagnoses of major depressive disorder, personal history of TIA's and cerebral infarct without residual deficits, transient cerebral ischemic attack, dysphagia, aphasia, intercostal neuropathy and unspecified chest pain. The minimum data set for admission with an assessment reference date of 10/8/18 revealed a brief interview of mental status of a 12 meaning resident requires minimal assistance with decision making. No behaviors were noted.

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M 000	Initial Comments The State Agency (SA) conducted a complaint investigation, MS #15560, from 11/28/18-12/4/18. The facility reported that Resident #1 was abused by Certified Nurse Aide (CNA) #1 and #2 and Neglected by Licensed Practical Nurse (LPN) #1 on 11/15/18. There is video of part of the incident. All three (3) employees were terminated from employment. Abuse was not substantiated. Neglect was substantiated against LPN #1 for not assisting Resident #1 when he was on the floor. The facility failed to report the incident timely. The SA determined the facility was not in compliance with the Mississippi Regulations for Minimum Standards for Institutions for Aged or Infirm with deficiencies cited at M500. The census was 79 and the facility held a license for 87 beds.	M 000		
M 500	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	M 500		1/10/19

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M 500	Continued From page 1 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 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	M 500		

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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 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

MSDH - Health Facilities Licensure and Certification

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	25CR	A. BUILDING: _____ B. WING _____	C 12/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HILL NURSING CENTER	927 COOPER RD JACKSON, MS 39212

(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) COMPLETE DATE
M 500	Continued From page 3	M 500		

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

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

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M 500	Continued From page 4 the fullest exercise of these rights. This Statute is not met as evidenced by: Level II Based on record review, video review, policy/procedure review, and staff interview, the facility failed to honor resident rights to prevent neglect of one (1) of five (5) residents reviewed (Resident #1) as evidenced by Licensed Practical Nurse (LPN) #1 walked past Resident #1 as he lay on the floor and Certified Nurse #1 and Certified Nurse #2 were attempting to prevent him from hurting himself and others. LPN #1 walked past Resident #1 twice and did not attempt to help the CNA's or attempt to get Resident #1 of of the floor. Findings include: Policy/procedure review on 11/29/18, last revised May 2017, revealed the facility policy for Neglect revealed "Our residents have the right to be free from abuse, neglect, misappropriation of resident property, corporal punishment and involuntary seclusion." The policy revealed the signs of physical neglect to include "Caregiver indifference to resident's personal care and needs". Resident #1 was admitted to the facility on 10/1/18 with the diagnosis of Major Depressive Disorder, Cerebral Infarct without residual deficits, Transient Cerebral Ischemic Attack (TIA), Dysphagia, Aphasia, Intercostal Neuropathy and unspecified chest pain. The Minimum Data Set (MDS) for admission with an Assessment Reference Date (ARD) of 10/8/18, revealed a Brief Interview of Mental Status of a 12, which indicated moderate cognitive impairment. The resident required minimal assistance with	M 500	By Submitting the enclosed material, Forest Hill Nursing Center is not admitting the truth or accuracy of any specific finding or allegations. Forest Hill Nursing Center reserves the right to contest the findings as part of any proceedings and submit these responses pursuant to our Regulatory Obligations. On January 10, 2019, The Quality Assurance Committee (QA) Committee met to discuss the Corrective Actions to be taken to answer and correct the deficiencies found and noted on the complaint investigation. 1) All employees were in-serviced by the Staffing Coordinator on Abuse, Neglect and Exploitation beginning November 16,2018 and was completed on November 19,2018. Licensed Practical Nurse (LPN) #1 was terminated on November 16,2018. Resident #1 was sent to the hospital at 12:41am on November 16, 2018 and returned on November 16, 2018 at 4:49am. He returned without injury. Resident #1 involved in this deficient practice was not harmed or caused an un-due illness. On November 16, 2018, the Director of Nurses, the Administrator, and the Facility Medical Director participated in an emergency QA meeting. All parties discussed the appropriate plan of correction to be implemented. The Plan of Correction was approved on November 16, 2018. On November 16, 2018, during stand-up morning meeting, the	

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M 500	Continued From page 5 decision making. No behaviors were noted on the MDS. Record review of the incident report, dated 11/16/18, and the facility's written report, dated 11/21/18, revealed CNA #1 found Resident #1 asleep in a bed that was not assigned to him. She stated she attempted to wake him and he jumped up off of the bed and attempted to choke her. She yelled for help and CNA #2 came to assist. Resident #1 fell backwards into the window of the room breaking a window pane as he was being combative. Both CNA #1 and CNA#2 walked Resident #1 out of this room and up the hall with each holding an arm of Resident #1. As they approached the nurse's station of this unit, CNA #1 is observed on video trying to hold back the arms of Resident #1 behind his back. CNA #1 and CNA #2 are then seen lowering Resident #1 to the floor. There are nurses at the nursing station that do not appear to notice what is happening. There is staff on the hall that do not attempt to intervene. Licensed Practical Nurse #1, assigned to Resident #1, walked past the three (3) on the floor to the nurse's station then back down the hall past the three (3) on the floor without assisting the resident or the two (2) CNA's. Resident #1 is sent to the hospital for an evaluation. He returns later in the early morning hours without injuries. The Administrator and Director of Nurses (DON) are notified by staff of the incident and both go to the facility at that time. The Administrator goes to the hospital to check on Resident #1. The DON begins the investigation. The written report (11/21/18) noted that Resident #1 alleged staff verbally told him to get his black ass (N) out of that bed and choked him. Review of the video provided by the facility on	M 500	Administrator in-serviced all department heads on Abuse and Neglect of Vulnerable Adults. The Preventing Abuse and Neglect Policy was reviewed with the staff by the Administrator on November 16,2018. On December 5, 2018, Social Work Consultant and Social Work Director in-serviced staff on Residents Rights, Abuse, Neglect, Anger Management, and Stress Management. On December 5, 2018, The Social Work Consultant and Social Work Director interviewed fourteen residents. The purpose of the interviews was to explore and confirm feelings of individual residents regarding the care they received from nursing staff. The general tone of the responses was positive with residents acknowledging that overall the care they received was good. No resident voiced concerns about their safety. 2) The Director of Nurses determined that Licensed Practical Nurse (LPN)#1 was on medication cart #3. Twenty-Five residents in the facility had the potential of being affected by the deficient practice based on the residents assigned to Licensed Practical Nurse #1. 3)All employees were in-serviced by the Staffing Coordinator, Unit Managers, and Unit Supervisors on Abuse, Neglect and Exploitation using the power-point supplied by the Mississippi Attorney Generals Office on November 28, 2018. On November 28, 2018, all employees watched two units, Module II on What is Abuse and Module V on Preventing Abuse, of the video Hand-in-hand video	

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M 500	Continued From page 6 11/29/18, revealed (11/15/18) three (3) people on the floor of the facility. These individuals were identified by the Administrator as being CNA #1, CNA #2 and Resident #1. the Administrator then identified a staff member as LPN #1 that walked past the three (3) people on the floor, went to the nurses station, and then turned around and walked out of camera sight, without providing assistance or intervening with the situation. Interview with Licensed Practical Nurse #1 on 12/3/18 at 12:45 PM, revealed she was Resident #1's assigned nurse on 11/5/18 on the 3:00 PM-11:00 PM shift on Unit II. She stated, "Someone told me he jumped on two (2) Nurse's Aides. I went to Unit 1 and saw him and two (2) CNA's sitting on the floor." "I went back to my unit. No, I didn't tell anyone to get off the floor. No, I didn't ask what happened. I didn't see how anyone got on the floor. No one looked injured." Interview with the DON on 11/28/18 at 12:30 PM, revealed that LPN #1 was terminated for neglect for walking by Resident #1 on the floor and walking back to her unit without assisting him.	M 500	produced by Centers for Medicare & Medicaid Services(CMS). 4. All new employees will receive in-service training by the Human Resources Director on Abuse, Neglect and Exploitation upon hire. They will also watch the video Hand-in-Hand produced by CMS. Current employees will receive training on Abuse, Neglect and Exploitation quarterly each year by the Staffing Coordinator. The Hand-in-hand video's two units, Module II on What is Abuse and Module V on Preventing Abuse, will be shown as part of the training during the year. The Staffing Coordinator will report to the QA Committee quarterly. The QA Committee will monitor training and make recommendations as needed.	