STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255092	A. BUILDING _____ B. WING _____	C 09/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOYINGTON HEALTH AND REHABILITATION	1530 BROAD AVE GULFPORT, MS 39501

(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 Boyington Health and Rehabilitation Center - 255092 Survey 9/2/2020 - 9/3/2020 Laura Castiglia - 41306 Initial Comments: The State Agency (SA) conducted an abbreviated/partial extended survey investigating MS CI 17019 beginning 9/2/2020 till 9/3/2020. Concerns identified in the complaint were related to abuse Resident #1. The facility self-reported incident of Resident #1 became combative during a shower and became combative and was yelling and cursing staff. Resident #1 hit a staff member and in response, the staff member struck Resident #1 across the chest with an open hand. These concerns were substantiated and a deficiency was cited at F550, F600 and F609 at a "D" level. During the survey the SA determined the facility was not in substantial compliance with requirements for participation in Medicare and Medicaid. The facility had a census of 111 at the time of the complaint survey with a license for 180 beds.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that	F 550		10/4/20

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

Electronically Signed | 10/21/2020

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F 550	Continued From page 1 promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on responsible party interview, staff interview, record review, and policy review w the facility failed to notify the resident representative of resident abuse for one (1) out of four (4) record ' s reviewed. On 8/26/2020 at approximately 10:00 AM, Resident #1 was receiving a shower when she	F 550	Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged in the statement of deficiencies. This Plan of Correction is prepared solely as a matter of compliance with the Federal and State Law.	

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F 550	Continued From page 2 started yelling, cursing, and struck License Practical Nurse (LPN) #1. The LPN #1 then struck Resident #1 across her chest with an open hand. The allegation of physical abuse happened in shower room, hall one (1) and witnessed by three (3) Certified Nursing Assistants. Following the allegation of physical abuse, the LPN #1 left the shower room. The Administrator was notified by CNA #1 and all staff was immediately suspended following the investigation, then LPN #1 was terminated. Findings include: A review of the facility policy entitled, "Change in resident ' s Condition or Status (Notification of Change)" Revision: 10/2019, revealed: The Center shall promptly notify the resident, his or her attending physician, and representative of changes in the resident ' s condition/status. 2. Unless otherwise instructed by the resident, the Nurse Supervisor will notify the resident ' s or representative when: A. The resident is involved in any accident or incident which results in an injury including injuries of an unknown source. A review of the Facility Reported Incident (FRI), dated 8/27/2020, CNA #1 reported to Administrator. On 8/26/2020 at approximately 10:00 AM, Resident #1 was receiving a shower when she started yelling, cursing, and struck License Practical Nurse (LPN) #1. The LPN #1 then struck Resident #1 across her chest with an open hand. The allegation of physical abuse happened in shower room, hall one (1) and witnessed by three (3) Certified Nursing Assistants. Following LPN #1 striking Resident #, LPN #1 left the shower room. CNA #1 reported the incident to the Administrator on 8/27/20. The	F 550	1. Resident Representative was notified by Administrator on September 2, 2020. 2. Audit completed on September 4, 2020 by Administrator of allegations of abuse / neglect over the past three months to determine any others with potential of being affected. One resident had the potential to be affected and the facility had already reported the concern to Ms. State Department of Health. 3. Social Service Director in-serviced staff on facility policy, "Prevention of Resident Abuse, Neglect, Mistreatment or Misappropriation of Property", Elder Justice Act to include timely notification to Resident Representative beginning August 27, 2020 and ending September 3, 2020. 4. Risk Manager will audit incident reports beginning September 7, 2020 for timely notification of Resident Representative weekly times four weeks then monthly times three months. Findings will be brought to the Quality Assurance Performance Improvement Committee (QAPI) meeting to review and follow up for any recommendations.	

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F 550	Continued From page 3	F 550		

witness statements Resident #1 was yelling, cursing and struck LPN #1 during shower. Then LPN #1 struck Resident #1 with open hand on her chest. Resident #1 of Facility Resident Abuse on 8/26/2020 the incident occurred but was not reported to Administrator nor Director of Nursing till 8/27/2020. The injury reported was physical abuse, Resident #1 had no injuries and the medical record review did not indicate any previous or unexplained injuries on Resident #1. In the findings of the Facility revealed the LPN #1 did not mean to harm resident, it was a reflex to the resident striking LPN #1. The Facility could not substantiate any abuse. On 8/27/2020 the facility notified the following of the incident: State Agency, Ombudsman, State Licensing Agency, Law Enforcement Agency, and Attorney General Office.

On 8/27/2020 the CNA #1 reported the incident to Administrator and Director of Nursing (DON). The facility performed an investigation immediate post-incident action: findings LPN #1 did strike the resident. It was a reflex action by the LPN #1. The LPN #1 did not mean to harm the resident. Did the findings indicate that abuse occurred? No, the LPN #1 did not mean to harm the resident and it was reflex to the resident striking the nurse. The facility could substantiate any abuse. The facility notified the State Licensing Agency, Law Enforcement, and Attorney General. The facility in-serviced staff on reporting on timely manner and abuse. The facility suspended LPN #1 and later terminated. The care-plan was updated, body audit and pain assessment completed.

A record review of 8/27/20 nurses note relayed no contact with Responsible Representative (RR) informing of injury.

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F 550	Continued From page 4 On 9/2/20 at 9:00 AM an interview attempt with resident was attempted but she was non-interview able due to cognitive deficits. A record review of Resident #1, 7/24/2020 Minimum Data Set (MDS), Brief Interview for Mental Status (BIMS), section C0500, 4 (four). A record review of Resident #1 diagnosis is the following: Insomnia, Pain ankle/joint, pain in knee, Chronic obstructive Pulmonary Disease, Unspecified Dementia, Cognitive Communication Deficit, Schizoaffective disorder, Bipolar type, and Unsteadiness on feet. On 9/2/20 at 12:20 PM an interview with the Responsible Representative (RR) relayed he was not aware that his mother abuse from staff till 9/2/20 at 12:00 PM when the Administrator phone him to inform him. The State Agency (SA) relayed the complaint is under investigation. On 9/2/20 at 1:00 PM interview with Administrator relayed she did not speak with the RR till 9/2/20. The Administrator relayed she attempted to contact the RR when the alleged complaint occurred but was unsuccessful with contact. Due to these findings the SA was able to substantiate the complaint. The SA did cite the facility F-550.	F 550		
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,	F 600		10/4/20

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F 600	Continued From page 5 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 by: Based on staff interview, record review and policy review, the facility failed to ensure a resident was free from physical abuse for one (1) of four (4) residents reviewed for abuse. Resident #1. On 8/26/2020 at approximately 10:00 AM, Resident #1 was receiving a shower when she started yelling, cursing, and struck License Practical Nurse (LPN) #1. The LPN #1 then struck Resident #1 across her chest with an open hand. The allegation of physical abuse happened in shower room, hall one (1) and witnessed by three (3) Certified Nursing Assistants. Following the allegation of physical abuse, the LPN #1 left the shower room. The Administrator was notified by CNA #1 and LPN #1 was immediately suspended following the investigation, then terminated. Findings include: A review of the facility ' s policy entitled, "Prevention of Resident Abuse, Neglect,	F 600	1. Resident #1 was assessed by Assistant Director of Nursing on August 27, 2020, no negative findings noted. Psychosocial well-being was reviewed by Social Service Director on August 27, 2020. LPN #1 was immediately suspended on August 27, 2020 and terminated on September 1, 2020 after investigation was completed. 2. Interviews were completed on August 27, 2020, by Director of Nursing and Medical Records Licensed Practical Nurse with (12)twelve residents to determine if there are any other potential residents affected and no further issues were noted. 3. Facility Staff were in-serviced on facility policy "Prevention of Resident Abuse, Neglect, Mistreatment or Misappropriation of Resident Property, Elder Justice Act to include timely reporting by Social Service Director beginning August 27, 2020 and ending September 3, 2020. Center followed the Prevention of Abuse Policy	

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F 600	Continued From page 6 Mistreatment or Misappropriation of Property", Revised, revealed: It is the policy of this Center that each resident has the right to be from verbal, sexual, physical and mental abuse; corporal punishment; involuntary seclusion; mistreatment of any kind, exploitation, and misappropriation of property. In addition, each resident will also be protected from those practices and omissions, which if left unchecked, could lead to abuse. Further each resident will be treated with respect and dignity at all times. The Center will foster an environment that recognizes the worth and uniqueness of all individuals with regards to per-centered care to promote respect and set standards of care. Residents will not be subjected to abuse by anyone, including but not limited to, Center staff, other residents, consultants, volunteer staff, contract staff, family members, friends or others. Physical Abuse, physical abuse includes, but is not limited to hitting, slapping, punching, biting, and kicking. A review of the Facility Reported Incident (FRI), dated 8/27/2020 at 8:00 AM CNA #1 reported to Administrator, that on 8/26/2020 at approximately 10:00 AM, Resident #1 was receiving a shower when she started yelling, cursing, and struck License Practical Nurse (LPN) #1. The LPN #1 then struck Resident #1 across her chest with an open hand. The allegation of physical abuse happened in shower room, hall one (1) and witnessed by three (3) Certified Nursing Assistants. Following LPN #1 striking Resident #, LPN #1 left the shower room. CNA #1 reported the incident to the Administrator on 8/27/20. The witness statements Resident #1 was yelling, cursing and struck LPN #1 during shower. Then	F 600	and Human Resource policies for Licensed Practical Nurse #1. The three (3) Certified Nursing Assistants received one on one in-service on facility policy "Prevention of Resident Abuse, Neglect, Mistreatment or Misappropriation of Resident Property, Elder Justice Act to include timely reporting by Administrator on August 27, 2020. 4. Administrator, Director of Nursing, Assistant Director of Nursing, Staff Development and / or Risk Manager will make courtesy rounds once per week beginning September 7, 2020 to discuss any concerns regarding physical abuse. Any concerns noted will be reported to Administrator / Director of Nursing immediately. In the event there are findings, the Risk Manager will bring them to the Quality Assurance Performance Improvement Committee meeting to review and follow up for any recommendations weekly times four weeks then monthly times three months.	

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F 600	Continued From page 7	F 600		

LPN #1 struck Resident #1 with open hand on her chest. Resident #1 of Facility Resident Abuse on 8/26/2020 the incident occurred but was not reported to Administrator nor Director of Nursing till 8/27/2020. The injury reported was physical abuse, Resident #1 had no injuries and the medical record review did not indicate any previous or unexplained injuries on Resident #1. In the findings of the Facility revealed the LPN #1 did not mean to harm resident, it was a reflex to the resident striking LPN #1. The Facility could not substantiate any abuse. On 8/27/2020 the facility notified the following of the incident: State Agency, Ombudsman, Law Enforcement Agency, and Attorney General Office.

On 9/2/20 at 9:00 AM, SA attempted to interview Resident #1 but was unable due to cognitively was unsuccessful. Resident #1 was unable to recall if anyone had struck her. According to the body audit perform no bruising noted. The SA was present with Director of Nurses and did not visualize any bruising or abrasions to chest area.

On 9/2/2020 at 9:30 AM an interview with the Administrator revealed LPN #1 whom slapped Resident #1 has been employed at the facility since 12/10/2019, had no criminal record, and since employed had no altercations with staff/residents. The LPN #1 came to work on time, worked over-time as needed, cheerful mood, and had not been suspended nor had no misconduct prior to injury. The Administrator revealed the facility did not report the incident to the State Board of Nursing initially; due to, according to the "Federal Regulation of 483.13, Reporting Response" revealed, if any actions not taken by the court of law, then the facility did not have to report the incident to the State Licensure.

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The Administrator revealed according to the police report, they were going to let the State Department of Health and Attorney General Office handle the situation. The Administrator revealed on 9/2/2020 the facility reported LPN #1 incident to the State Board of Nursing.

On 9/2/2020 at 10:00 AM an interview with the Administrator, revealed she did not report the incident on 8/26/2020 because she was not aware of the incident till 8/27/2020. Following the incident of being notified of the incident the facility performed in-services on abuse and reporting. The Administrator placed all four (4) employees on suspension till investigated, and she questioned the staff on why they did not report the incident till following day, they relayed they just didn ' t realize.

A record review all three (3) CNA and LPN #1 was suspended till the investigation was completed, following an investigation LPN #1 was terminated.

A record review on 8/27/2020 the facility notified Gulfport Police Department, report number, 20-103304. According to the police report they will let the Attorney General Office investigate the incident.

A record review on 8/27/2020 the facility notified the following: Ombudsman, State Agency, Administrator, and Attorney General Office.

On 9/2/2020 at 10:13 AM interviewed Registered Nurse (RN) #1 revealed she was aware of the incident on 8/27/2020 at 8:00 AM because no staff reported the incident on 8/26/2020. RN #1 revealed when she was notified of incident,

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investigation immediately occurred on 8/27/2020 all staff involved was placed on suspension then LPN #1 was terminated following investigation. Following the incident, the facility performed in-services on abuse and reporting to all staff.

On 9/2/2020 at 10:20 AM attempted to interview LPN #1 during a phone interview, SA left several voice mails message but did not receive a return call.

On 9/2/2020 at 11:08 AM interviewed CNA #1 revealed on the day of the incident Resident #1 was striking out to all staff assisting with bath in the shower room, when Resident #1 strike LPN #1 then LPN #1 strike Resident #1 with open hand on her chest. Then LPN #1 left the shower room and was very upset, we finished Resident #1 bath with no problems. CNA #1 revealed reported the incident the following day to the Administrator.

On 9/2/2020 at 11:40 AM interviewed CNA #2 revealed on the day of the incident I was putting on my gloves my back was turned, and I did not see LPN #1 strike anyone, but heard a noise of LPN #1 striking Resident #1. Then LPN #1 left the shower room and said, "Oh my God yall."

A record review of Resident #, 7/24/2020 Minimum Data Set (MDS), Brief Interview for Mental Status (BIMS), section C0500, 4 (four). A record review of Resident #1 diagnosis is the following: Insomnia, Pain ankle/joint, pain in knee, Chronic obstructive Pulmonary Disease, Unspecified Dementia, Cognitive Communication Deficit, Schizoaffective disorder, Bipolar type, and Unsteadiness on feet.

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F 600	Continued From page 10 A record review of Resident #1 care plan revealed, Resident #1 has episodes of refusing to allow staff to shave hair from face/refuse activities of daily living (ADL) care. According to the interventions, assist with decisions as needed, report changes in cognitive status, use short phrases and questions, and use simple direct speech. A record review the facility staff underwent the following in-services: 1) Abuse/Neglect, report all allegation immediately to Administrator, Director of Nurses, Registered Nurse, Assistant-Director of Nurse, 2) Abuse Policy, Residents who are combative and/or resist care, reporting abuse, and 3) Abuse/Neglect-Elder justice act reporting immediately. A record review of LPN #1 human resource file revealed underwent all training upon hire on abuse/neglect, reporting abuse, and had no deficiency in file. On 9/2/2020 at 12:27 PM interviewed Resident #1 Responsible Representative (RR) revealed he was not aware his mother had been slapped, the Administrator phoned him today and informed him of the procedure. On 9/2/2020 at 1:30 PM interviewed Administrator revealed she attempted to notify the RR but unsuccessful until phone call 9/2/2020. Due to these findings the SA was able to substantiate the complaint. The SA did cite the facility F-600.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4)	F 609		10/4/20

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F 609	Continued From page 11 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: F-609 Based on facility policy, interview, and record review the facility failed to notify the resident representative of resident abuse for one (1) out of four (4) record's reviewed. Findings include:	F 609	1. Resident Representative was notified by Administrator on September 2, 2020. 2. Audit completed on September 4, 2020 by Administrator of allegations of abuse / neglect over the past three months to determine any others with potential of being affected. One resident had the	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 12 A reviewed of the facility policy titles, "Prevention of Resident Abuse, Neglect, Mistreatment or Misappropriation of Property" Policy Statement: It is the policy of this Center that each resident has the right to be from verbal, sexual, physical and mental abuse; corporal punishment; involuntary seclusion; mistreatment of any kind, exploitation, and misappropriation of property. In addition, each resident will also be protected from those practices and omissions, which if left unchecked, could lead to abuse. Further each resident will be treated with respect and dignity at all times. The Center will foster an environment that recognizes the worth and uniqueness of all individuals with regards to per-centered care to promote respect and set standards of care. Residents will not be subjected to abuse by anyone, including but not limited to, Center staff, other residents, consultants, volunteer staff, contract staff, family members, friends or others. Physical Abuse, physical abuse includes, but is not limited to hitting, slapping, punching, biting, and kicking. The Center will notify the resident and resident representative that a report to the appropriate state agency has been made. In the record review of the facility reported incident, brief description of the event: Resident #1 was receiving a shower when she started yelling, cursing and struck License Practical Nurse (LPN), the LPN then struck the resident across Resident #1 chest with an open hand. The incident was witnessed by three (3) Certified Nursing Assistant (CNA).	F 609	potential to be affected. 3. Social Service Director in-serviced staff on facility policy, "Prevention of Resident Abuse, Neglect, Mistreatment or Misappropriation of Property", Elder Justice Act to include timely notification to Resident Representative beginning August 27, 2020 and ending September 3, 2020. Risk Manager will review incident reports for notification of resident representative after each incident report is completed. 4. Risk Manager will audit incident reports for timely notification of Resident Representative beginning September 7, 2020 weekly times four weeks then monthly times three months. Findings will be brought to the Quality Assurance Performance Improvement Committee (QAPI) meeting to review and follow up for any recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255092	A. BUILDING _____ B. WING _____	C 09/03/2020

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F 609	Continued From page 13	F 609		

In the investigation, on August 26, 2020 it was reported that Resident #1 was receiving a shower when she started yelling, cursing and struck LPN. The LPN then struck Resident #1 across her chest with an open hand. The LPN was upset, stated was a reflex that caused her to strike the resident. The LPN left the shower room.

On August 27, 2020 the CNA reported the incident to Administrator and Director of Nursing (DON). The facility performed an investigation immediate post-incident action: findings nurse did strike the resident. It was a reflex action by the nurse. The nurse did not mean to harm the resident. Did the findings indicate that abuse occurred? No, the nurse did not mean to harm the resident and it was reflex to the resident striking the nurse. The facility could substantiate any abuse. The facility notified the State Licensing Agency, Law Enforcement, and Attorney General. The facility in-serviced staff on reporting on timely manner and abuse. The LPN was suspended and later terminated. The care-plan was updated, body audit and pain assessment completed.

A record review of 8/27/20 nurses note relayed no contact with Responsible Representative (RR) following being informed of injury.

On 9/2/20 at 10:00 AM an interview attempt with resident was attempted but she was non-interviewable due to cognitive deficits.

On 9/2/20 at 12:20 PM an interview with the Responsible Representative (RR) relayed he was not aware that his mother abuse from staff till

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F 609	Continued From page 14 9/2/20 at 12:00 PM when the Administrator phone him to inform him. The State Agency (SA) relayed the complaint is under investigation. On 9/2/20 at 1:00 PM interview with Administrator relayed she did not speak with the RR till 9/2/20. The Administrator relayed she attempted to contact the RR when the alleged complaint occurred but was unsuccessful with contact.	F 609		