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M 000	Initial Comments A COVID-19 Focused Infection Control Survey and three (3) Complaint Investigations (CI) #17266, CI #17194 and CI # 17200, was conducted by the State Agency (SA) on 12/8/20. CI #17266 was not substantiated for quality of care. CI #17194 was not substantiated for quality of care. The SA determined the facility was not in compliance with the Minimum Standards of Operation for Institutions for the Aged or Infirm, state licensure requirements, and CI #17200 was substantiated for verbal abuse. The facility was cited M 500 at Level II when Patient Care Assistant (PCA) #1 verbally abused Resident #1. The census was 126 and the facility has a license for 126 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 rate; 3. is assured of adequate and appropriate	M 500		2/2/21

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M 500	Continued From page 1 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 changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion,	M 500		

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M 500	Continued From page 2 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 facility that are not included for therapeutic purposes in his plan of care;	M 500		

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M 500	Continued From page 3 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 the fullest exercise of these rights. This Statute is not met as evidenced by: Level II	M 500	Responses to the cited deficiencies do not	

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M 500	Continued From page 4 Based on staff interviews, record review, facility policy and facility investigation review, the facility failed to ensure Resident #1 was free from verbal abuse for one (1) of four (4) residents reviewed for verbal abuse. Resident #1. Findings include: A review of the facility's policy, "Prevention of Resident Abuse, Neglect, Mistreatment or Misappropriation of Property", revised 12/2017, revealed each resident has the right to be free from verbal, sexual, physical and mental abuse; corporal punishment; involuntary seclusion; mistreatment of any kind, exploitation, and misappropriation of property. Verbal abuse includes the use of oral, written, or gestured communication, or sounds, to residents within hearing distance, regardless of age, ability to comprehend, or disability. A review of the facility's self-reported incident revealed on 7/21/20, at 11:00 AM, the Patient Care Assistant (PCA) #2 was physically present in Resident #1 room when she heard PCA #1, exchanging words with Resident #1 and called PCA #1 a "bitch" and "whore". PCA #1 then called Resident #1 a "bitch/flipped him off", then said, "you're a bitch, I should slap your ass." On 7/21/20, following the incident, PCA #2 reported the incident to the Administrator. On 7/21/20, at 12:40 PM, the Risk Manager (RM) investigated the incident and suspended PCA #1, pending investigation then later terminated PCA #1. The facility findings indicated that abuse occurred. The RM notified the Responsible Representative (RR), State Licensing Agency (SA) on 7/21/20 at 1:34 PM, Law Enforcement Agency on 7/23/20, and the Attorney General Office (AGO) on	M 500	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. 1. Resident #1 was assessed by Risk Manager on July 21, 2020, no negative findings noted. Psychosocial well-being was reviewed by Social Service Director on July 21, 2020. PCA#1 was immediately suspended on July 21, 2020 and terminated on July 27, 2020 after investigation was completed. 2. Personal Care Assistant #1 cared for ten residents that day. Interviews were completed on July 21, 2020 by Administrator with six (6) residents to determine if there were any other potential residents affected and no further issues were noted. 3. Facility staff were inserviced on facility policy "Prevention of Resident Abuse, Neglect, Mistreatment or Misappropriation of Resident Property, Elder Act by Risk Manager beginning July 21, 2020 and ending July 27, 2020. Administrator, Director of Nursing or Risk Manager will make courtesy rounds once per week beginning July 27, 2020 times three weeks and then monthly times three months to discuss any concerns regarding verbal abuse. 4. Any concerns noted will be reported Administrator / Director of Nursing immediately. In the event there are	

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M 500	Continued From page 5 7/23/20. The facility began in-servicing staff on abuse. On 12/8/20, at 3:20 PM, in an interview with the Administrator revealed PCA #1 and PCA #2 are no longer employed within facility. The SA questioned if PCA #1 was written up/reported to nurse aide registry. The Administrator stated they did not notify the nurse aide registry because PCA #1 was a Personal Care Attendant and according to Temporary Covid-19 Personal Care Attendant (Waiver Aide), they did not have to be certified and PCA #1 was not certified. On 12/8/20, at 3:45 PM, attempted to phone PCA #1 and PCA #2, left voice mail messages, received no return call. On 12/8/20, at 3:55 PM, in an interview with the Area Ombudsman revealed he had not received any complaints from the Residents regarding the facility. On 12/8/20, at 4:05 PM, this surveyor phoned the Attorney General's Office (AGO) and was informed the investigation has been closed. On 12/9/20, at 9:00 AM, an interview with the Responsible Representative revealed his mother, who has now expired, was notified of the incident on 7/21/20. On 12/9/20, at 9:30 AM, in an interview with Resident #1, he stated he would holler at staff sometimes and he is okay since the incident with no concerns. Resident #1 revealed he hollered at the girl that was helping him and she hollered back at him and they both called each other dirty	M 500	findings, Risk Manager will bring findings to Quality Assurance Performance Improvement Committee to review and follow up for any concerns monthly times three months.	

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M 500	Continued From page 6 names. In a review of the facility's investigation revealed PCA #1 was suspended on 7/21/20, following the incident until the investigation was completed. Following the investigation, PCA #1 was terminated on 7/27/20. Record review???In a record review on 7/21/20 at 12:25 PM, PCA #1 stated, I was changing the guy on A bed and the guy on B bed say fuck me and I say okay that fine and he told me to move his wheelchair in, I told him to give me a minute let me finish changing the people am working with and call me a hoe, and a bitch and I say okay that fine me. I pull the curtain to give private and the man was saying can you move the wheelchair bitch and I told him give me a min because I have help someone right now and I told him when I'm done, I will move the wheelchair. In a record review of PCA #1's Human Resources file revealed PCA #1 completed the required training upon hire for abuse/neglect, reporting abuse, and had no deficiencies or write ups on file. PCA #1's Human Resources file contained the state Criminal Record check, with no criminal records found. PCA #1's hire date was 7/2/20. PCA #1 was in-serviced on the Prevention from Abuse, Neglect, & Exploitation, Residents Rights, Elder Justice Act, Alzheimer's and Related Disorders Basic Information, Vulnerable Persons Act, and Protection of Resident's Personal Property. In a review the sign in sheets, the facility staff was in-serviced on Abuse/Neglect, the Elder Justice Act and how to report all allegation immediately to Administrator, Director of Nurses, Registered Nurse, and Assistant Director of Nurses. They	M 500		

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M 500	Continued From page 7 were in-serviced on the Abuse Policy, how to take care of residents who are combative and/or resist care and how to report abuse. The in-services were conducted from 7/21/20 till 7/27/20, 8/27/20 till 8/31/20, 10/8/20 till 10/9/20. In a review of the facility's Quality Assurance (QA) meetings following the abuse allegation on 7/21/20 revealed, the facility reviewed the allegation of verbal abuse. The facility's plan was to start in-servicing staff on abuse/neglect, vulnerable adults act, and following the physician orders and the resident's care plans. The following attended the QA meeting: Administrator, Director of Nurses, Assistant Director of Nurses, Unit Manager, Social Services, Activities, Medical Director, Care Plan, and Minimum Data Set (MDS) Nurse. In a review of the facility's QA meeting on 8/26/20, revealed the facility met after all the in-services had been conducted and following the care plan with no changes at this time. The Administrator, Director of Nurses, Assistant Director of Nurses, Unit Manager, Social Services, Activities, Medical Director, Care Plan, and Minimum Data Set (MDS) Nurse attended the meeting. In a review of the facility QA meeting on 9/23/20 revealed Social Services followed up with staff and residents regarding any issues of abuse-verbal and following physician orders/care plans. The Administrator, Director of Nurses, Assistant Director of Nurses, Unit Manager, Social Services, Activities, Medical Director, Care Plan, and Minimum Data Set (MDS) attended the QA meeting.	M 500		

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M 500	Continued From page 8 In a review of the facility QA meeting on 10/22/20 revealed the facility reviewed the follow up on the allegation of verbal abuse, in-services on Abuse/Neglect, Vulnerable Adults, Resident Rights and following Care Plans. The Administrator, Director of Nurses, Assistant Director of Nurses, Unit Manager, Social Services, Activities, Medical Director, Care Plan Nurse, and Minimum Data Set (MDS) Nurse attended this QA meeting. In a review of facility QA meeting on 11/18/20 revealed no issues were noted during rounds on the residents and no issues noted from Resident #1 regarding Resident Rights. The Administrator, Director of Nurses, Assistant Director of Nurses, Unit Manager, Social Services, Activities, Medical Director, Care Plan Nurse, and Minimum Data Set (MDS) Nurse attended this meeting. On 12/9/20 at 6:00 PM attempted to phone PCA #1 and PCA #2, left voice mail messages, received no return call. On 12/14/20 at 10:00 AM attempted to phone PCA #1 and PCA #2, left voice mail messages, received no return call. On 12/14/20 at 11:30 AM attempted to phone Medical Director left voice mail, received no return call. On 12/14/20 at 1:30 PM attempted to phone Medical Director left voice mail, received no return call. Resident #1 Record review of the Admission Record revealed the facility admitted Resident #1 on 9/18/20 with	M 500		

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M 500	Continued From page 9 the diagnosis of Cognitive communication deficit, Dysarthria following Cerebrovascular Deficit, Impulse Disorder, Schizophrenia, Anxiety, and Bi-polar disorder. Resident #1's Minimum Data Set (MDS), dated 10/16/20, section C0500, revealed the Brief Interview for Mental Status (BIMS) for Resident #1 had a score of 15, indicating he was cognitively intact.	M 500		