STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255207	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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 survey, for MS #15424, MS #15423, and MS #15390 from 9/12/18 through 9/13/18. During the survey, the SA determined the facility was not in compliance with the Medicare and Medicaid Requirements for Participation. MS #15424 was substantiated for abuse and reporting practices, MS # 15423 was not substantiated for quality of care, however there were substantiated environmental issues, and MS # 15390 was not substantiated for toileting issues, however there were substantiated environmental issues. The SA cited deficiencies at F600 and F921. The census at the time of entrance was 89 and the facility held a license for 120 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 by: CI MS #15424	F 600	1) Resident #2 was assessed by a	10/10/18

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

Electronically Signed | 10/02/2018

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 Based on interviews, observations, records review, facility policy and document reviews, facility investigation documents and personnel records review, the facility failed to prevent abuse for one (1) of four (4)residents reviewed, Resident #2, a cognitively impaired Resident. Licensed Practical Nurse (LPN) #1 willfully placed tape across the resident's easy chair, allegedly pulling a prank on another Nurse, Nurse Registered Nurse (RN #1). LPN #1 used language, alleged to be in a joking manner, to indicate the resident was being held for the police. RN #1 also failed to report the potential abuse in a timely manner, and instructed three (3) Certified Nursing Assistants (CNAs) not to report the incident. This incident had the potential for mental anguish for a cognitively impaired resident. Findings include: Review of the facility's "Freedom from Abuse, Neglect, and/or Exploitation Prevent Plan Education" policy document, revised 8/23/17, revealed: The resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation by anyone, including, but not limited to, facility staff...Mental abuse includes humiliation, harassment....Psychosocial harm includes extreme embarrassment, ongoing humiliation, degradation as a human being. Verbal abuse-the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. The policy defined "willful"-the individual must have	F 600	Registered Nurse (RN) on 9/3/18 and by the Social Services Director on 9/3/18. Resident #2 did not suffer any adverse effects from this practice. 2) All residents in the facility have the potential to be affected if an employee fails to or chooses not to follow facility freedom from abuse and neglect policy. All interviewable residents in the unit were interviewed by the Social Services Director on 9/4/18. All non-interviewable residents were assessed for any evidence of abuse via body audits by Nursing Staff on 9/4/18 - 9/8/18. There were no negative findings. 3) Licensed Practical Nurse (LPN) #1 was terminated on 9/6/18 and RN #1 was terminated on 9/5/18 by the Administrator. Certified Nursing Assistant (CAN) #1, #2, and #3 were disciplined on 9/5/18 by the Assistant Director Off Nursing (ADON). All staff were in-serviced on 9/4/18 and 9/5/18 by the Social Services Director on Freedom of Abuse and Neglect and the Vulnerable Adult and timely reporting allegations and/or incidents to the Administrator. 4) Human Resources Director (HR Director) will monitor orientation and/or in-service training monthly to assure compliance regarding Freedom of Abuse and Neglect and the Vulnerable Adult. New hires will continue to be in-serviced on Freedom of Abuse and Neglect and the Vulnerable Adult by the Social	

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F 600	Continued From page 2 acted deliberately, not that he/she must have intended to inflict injury or harm. The facility admitted Resident #2, on 5/23/18, with diagnoses including Post Fracture of the Neck of the Femur, repeated falls, Insomnia, Depressive Disorder, Anxiety Disorder, Osteoarthritis and Dementia with Behaviors. Review of the 8/20/18 Brief Interview for Mental Status (BIMS) score was 5, which indicated severe cognitive impairment. On 9/3/18, the facility administrator notified the Mississippi State Department of Health, Licensure and Certification (MSDH) of an allegation of Resident abuse. The notice related that the Business Office Manager (BOM) notified him on 9/3/18 at 2:52 PM, of an incident that occurred on 9/2/18, at approximately 10:35 PM. It was reported that LPN #1 had taped a chair where Resident #2 was sitting, playing a joke on RN#1. Review of the facility's investigation report indicated that RN #1 had attempted to call the Director of Nursing (DON) but she was in the Emergency Room, dealing with a health issue. The report indicated that the tape did not touch the resident, a body audit was done by an RN on 9/3/18, and a Psychosocial assessment was conducted by the Social Service Director on 9/3/18. Both reported no negative effect on the resident. The report indicated that the Administrator and the Assistant Director of Nursing (ADON) interviewed all 3 PM-11 PM staff who were working on that unit. Staff admitted that tape had been applied to the chair, and LPN #1 admitted to taping the chair as a	F 600	Services Director upon hire. Staff will be in-serviced every 6 months on Freedom of Abuse and Neglect and the Vulnerable Adult by the Social Services Director. Forty residents and/or families will be interviewed quarterly utilizing the Abaqis software program including questions regarding abuse and neglect by all Department Heads. The results of the audits will be presented by the Administrator to the Quality Assurance Committee monthly for recommendations of revision, update, or resolution to plan to ensure the plan of correction is achieved and sustained.	

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	255207	A. BUILDING _____ B. WING _____	C 09/13/2018

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F 600	Continued From page 3	F 600		

joke on RN #1 without thinking that this met the definition of abuse, and there wasn't any willful intent of harm or abuse. The report indicated that the tape was not on the chair longer than two (2) minutes. The report indicated that the LPN was suspended on 9/3/18, all three (3) CNAs suspended on 9/4/18, and the RN was suspended on 9/5/18. The report indicated that the incident was reported to the Attorney General's office, the State Agency, the Board of Nursing, the police department and the Ombudsman. The LPN's employment was terminated on 9/6/18, for taping the chair and the RN's employment terminated on 9/5/18, for failure to report timely and instructing CNAs to not report the incident. The report indicated the CNAs were counseled and re-educated for failure to report; that more serious action was not taken due to RN #1 instructed them not to report.

On 9/13/18 at 1:40 p.m. care delivered by two (2) CNAs was observed in Resident #2's room. Resident #2 was very restless and stated "I have just got started". She denied having any memory of a fall or the incident, and when asked about (name of LSW) she said she did not know her; said "I never sleep". She was very compliant with care.

An interview was conducted at 3:15 PM on 9/12/18, with CNA#1. She stated that she has worked at the facility for 14 years. She stated that she regretted what happened. She stated that she saw where LPN#1 had stretched a piece of white tape across the easy chair that Resident #2 was sitting in. She stated that Resident #2 was restless and they did not want her to fall, so they had her in the day room so they could

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F 600	Continued From page 4 observe her. She said the LPN had written "Federal Property" on the tape. CNA #1 stated that Resident #2 had removed the tape on one side of the chair, saying "I'm getting up", and LPN#1 told her to put it back on until the bail bondsman arrived. CNA #1 said they were all laughing, including Resident #2. She said the tape was removed as soon as RN #1 arrived on the unit; that she started waving her pen back and forth in the air, saying we were to wipe this out of our minds like it did not happen, that some might see it as abuse. The CNA stated that she did not think of it as abuse, it was just a joke that got blown out of proportion and no one meant any harm. RN #2 presented a roll of one (1) inch wide silk medical tape at 3:55 PM on 9/12/18, and demonstrated what happened. She sat back in the overstuffed easy chair, and stretched a piece of the tape across from arm to arm, demonstrating how it would not have touched Resident #2's body. She showed how, due to the soft fabric of the chair it was easily removed and was not considered a restraint. CNA #2 was interviewed at 4:50 PM on 9/12/18. She stated she and the others were checking their residents before the end of their shift. She said Resident #1 was in the day room because they can't prevent a fall leaving her in her room when she is restless. She stated that LPN #1 was playing a trick on RN #1. She said they all joke around with one another and laugh a lot. She described the taping on the chair and said Resident #2 was going along with the joke; said they told her it was for police protection. She said that Resident #2 took it off once but the LPN put	F 600		

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F 600	Continued From page 5	F 600		

it back. CNA #2 denied that any of them thought of it as harmful, and that Resident #2 was not upset, that she liked attention. She said she never thought of reporting it because she did not think it was wrong; that RN #1 told them not to talk about it.

CNA #3 could not be interviewed, but review of her statement, taken by RN #3 (the ADON) on 9/4/18, revealed she had been standing at the nursing station and Resident #2 was sitting in a chair in the day room. LPN #1 wanted to play a joke on RN #1, so she placed tape on the arms of the chair. The report reflected that the tape did not touch the resident and was only on the chair one (1) - two (2) minutes and Resident #2 was laughing. She said they did not report it because the RN said not to report it.

LPN #1 returned a call for interview on 9/13/18 at 3:03 PM. She apologized for using bad judgment in a joke; said she did not consider it as abuse, just playing around with a co-worker. She said she put tape on the chair, that it did not touch Resident #2, that the resident took it off at one time, and that it was not in place more than two (2) minutes. She said she met with a nurse from the Board of Nursing the day before and explained that it did not harm Resident #2, that Resident #2 was laughing with the rest of us. LPN #1 said she is so ashamed, that she did not mean any harm.

RN #3 (ADON) was interviewed on 9/13/18 at 3:24 PM. She stated that RN #1 called RN #4 around 1:00 AM on 9/3/18; that RN #4 called the DON who said it was okay for LPN #1 to finish her shift, and she, the DON, would come in the

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F 600	Continued From page 6	F 600		

next day. The DON was in the Emergency Room with intravenous Morphine for pain, waiting for gallbladder surgery. The ADON said they tried to call her (ADON), but her cell phone was not working the night it happened. She said when she found out on Monday morning she called and suspended LPN #1, did a body audit on Resident #2, called the State Agency and notified the AG's office. RN #3 said they notified the police, who came in and interviewed Resident #2. The ADON said they suspended the CNAs but later realized they were not direct participants, but they got disciplined for not reporting potential abuse. She stated no harm was done to Resident #2 and no harm was intended. She stated they decided to terminate the two (2) nurses; LPN#1 for the act and RN #1 for failure to notify the on-call nurse for almost three (3) hours about the event. She said LPN #1 was something of a prankster and did not see the potential harm and that the residents loved her.

RN #1 returned the phone call at 11:00 AM on 9/14/18. She was upset, crying at times and vented for 30 minutes. She said she did notify the RN supervisor. She stated she regretted the episode, and while LPN #1 thought it was a joke, she did not find it funny. She said that Resident #2 did not understand what happened.

The Licensed Social Worker (LSW) was interviewed at 10:30 AM on 9/12/18. She said the resident is her Aunt, she was a mall walker, and now with Dementia, who could recall walking a mile a day at the mall. She stated that Resident #2 keeps trying to get up; that she's in the facility because she fell before coming here and broke her hip. She said that she came to the facility on

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F 600	Continued From page 7 Monday (Labor Day) to see her, and Resident #2 did not know (couldn't recall) anything about what happened. Review of Resident #2's medical record documentation, revealed a progress note by the LSW on 9/4/18 at 11:50 AM, revealed the Brief Interview for Mental Status (BIMS) score was 3 out of 15, indicative of severe impairment. The note revealed that she got upset because she can't remember things. A note by an RN on 9/4/18 at 1:34 PM, revealed Resident #2 was sitting in the day area in no acute distress, pleasantly confused with vital signs within normal limits. A later note by the LSW on 9/6/18 at 2:34 PM, revealed she followed up to assess anxiousness and nervousness. The note indicated no recollection of anything asked her nor anything that happened on Sunday evening. Review of Resident #2's care plan revealed a risk for falls, confusion, lack of awareness of safety needs, Dementia and a history of falls with a fracture a few months back. Personnel records for all five (5) staff involved in the incident were reviewed. All five (5) were certified or licensed, all five (5) had been trained in abuse and neglect and vulnerable adult, code of conduct, signed job descriptions, and were cleared with criminal record checks. The Administrator presented individualized signed in-service documents for all five (5) staff, acknowledging they have been trained in Freedom of Abuse and Neglect and the Vulnerable Adult. He said he does not have them sign one sheet, but individual ones so they can be filed in their record.	F 600		

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	255207	A. BUILDING _____ B. WING _____	C 09/13/2018

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F 600	Continued From page 8 Review of the facility's "Code of Conduct", signed by LPN #1 on 5/10/08, revealed: Employees are expected to conduct themselves in a positive manner...treating all residents, visitors and co-workers in a courteous manner; refraining from behavior or conduct that is offensive, undesirable, disorderly, immoral, or indecent and reporting to managers behaviors by co-workers, residents or suppliers.	F 600		
F 921 SS=F	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: CI MS #15390, CI MS #1542. Based on observation and interview, the facility failed to maintain the facility in a manner to provide a sanitary and comfortable environment for residents. Furniture was scarred and peeling, paint was patched in some areas, wall crumbling, doors scarred and tiles stained and scratched, for two (2) of two (2) Units. These observations were prevalent throughout the facility. Findings include: 0n 9/12/18 at 10:50 AM, observation on the North Unit, revealed in Room 25, the wall at the baseboard near the air conditioner was crumbling and poorly patched. Room 32 had patches in the popcorn ceiling and the bathroom had a yellow/gold colored streak on the white wall from	F 921	1) North Unit: Room 25 the wall at the baseboard near the air conditioner will be repaired and painted, Room 32 ceiling and bathroom wall with the yellow/gold streak will be repaired and painted, Room 10 furniture will be replaced/reconditioned, Room 1 ceiling and molding will be repaired and painted and furniture will be replaced/reconditioned, Room 26 ceiling and wall will be scraped and repainted, and Room 14 wall by Bed #1 will be repaired and painted and night stand, TV/dresser will be replaced/reconditioned. The door coming out of the North Unit will be stained. The 7 tiles in the corridor outside the Infection Control Nurse's office and the 10 tiles in the hallway on the South Unit will be	10/10/18

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F 921	Continued From page 9 a suspected water leak. The floor was dry. In Room 10, the furniture was badly scraped and scarred at the bottom. Observation of the corridor door, leading out of the North Unit, was badly scarred. In the corridor, outside the office of the Infection Control Nurse's (ICN) office, there were seven (7) floor tiles darkened and scarred. The ICN stated there were access panels underneath those tiles. Observation continued to the in the hallway on the South Unit where there were 10 floor tiles that were discolored and scarred. The Nurse stated that this area also has access panels underneath the tiles. Observation on 9/12/18 at 2:30 PM, revealed the paint on the wall in South Unit, Room 20, was patched in two (2) areas and on 9/13/18 at 11:40 AM, the bathroom tile, near the tub and under the sink, was badly stained. Observation on 9/13/18 at 10:40 AM, revealed the popcorn ceiling was patched near the seam by the privacy curtain rail, paint was stripped off the molding, there was a crack in the paint above the television and the veneer was scarred and peeling at the base of the furniture in Room 1, North Unit. Observation on 9/13/18 at 10:50 AM, in room 26 of the North Unit, revealed a small area above the television about eight (8)-10 inches long where the popcorn ceiling texture was crumbling near the wall and there were approximately 10 inch cracks on the wall near the ceiling above the light. On 9/13/18 at 11:40 AM, observation on the	F 921	replaced. South Unit Room 20 wall will be repaired and painted and bathroom tile near tub and under the sink will be stripped and waxed. All repairs will be completed by the Maintenance Director and construction crew. Completion date for all of the above will be 10/10/18. 2). All residents have the potential to be affected. Administrator and Maintenance Director completed 100% rounds of the whole building to identify any other areas of concern. Any areas identified will also be included in the correction plan by 10/10/18. 3) The Maintenance Director will be in-serviced on maintaining a monthly inspection checklist form including ceiling, and furniture inspections on 10/1/18 by the Regional Director of [name of construction company]. 4) Weekly rounds x 4 weeks will be conducted by the Administrator to monitor for any environmental concerns and monthly thereafter. The findings of the audits will be presented by the Administrator to the Quality Assurance Committee monthly for recommendations of revisions, updates, or resolution to plan to ensure the plan of correction is achieved and sustained.	

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F 921	Continued From page 10 North Unit revealed there was a dark areas on the wall by the ceiling by Bed #1,of Room 14, and the bottom of the night stand and the bottom of the television stand/dresser was badly scarred, with the veneer stripped showing a white surface underneath. On the environmental tours, these findings were indicative of a majority of rooms in the facility. No evidence of mold was observed and an interview with the Maintenance Supervisor at 10:50 AM on 9/13/18, revealed they had tests run and there was no mold in the facility. He confirmed the findings of the environmental issues.	F 921		

MSDH - Health Facilities Licensure and Certification

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	30PL	A. BUILDING: _____ B. WING _____	C 09/13/2018

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M 000	Initial Comments The State Agency (SA) conducted a complaint survey, MS #15424, MS #15423, and MS #15390 from 9/12/18 through 9/13/18. During the survey the SA determined the facility was not in compliance with the Mississippi Regulations for Minimum Standards for Institutions for Aged or Infirm. MS #15424 was substantiated for abuse and reporting practices, MS #15423 was not substantiated for quality of care, however there were substantiated environmental issues, and MS # 15390 was not substantiated for toileting issues, however there were substantiated environmental issues. The SA cited deficiencies at M500 and M1010. The census at the time of entrance was 89 and the facility held a license for 120 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	M 500		10/10/18

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	30PL	A. BUILDING: _____ B. WING _____	C 09/13/2018

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PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

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M 500	Continued From page 1 services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be 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	M 500		

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M 500	Continued From page 2 care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the 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;	M 500		

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M 500	Continued From page 3 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious	M 500		

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M 500	Continued From page 4 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 CI MS #15424 Based on interviews, observations, records review, facility policy and document reviews, facility investigation documents and personnel records review, the facility failed to prevent abuse for one (1) of four (4)residents reviewed, Resident #2, a cognitively impaired Resident. Licensed Practical Nurse (LPN) #1 placed tape across the resident's easy chair, allegedly pulling a prank on another Nurse, Nurse Registered Nurse (RN #1). LPN #1 used language, alleged to be in a joking manner, to indicate the resident was being held for the police. RN #1 also failed to report the potential abuse in a timely manner, and instructed three (3) Certified Nursing Assistants (CNAs) not to report the incident. Findings include: Review of the facility's "Freedom from Abuse, Neglect, and/or Exploitation Prevent Plan Education" policy document, revised 8/23/17, revealed: The resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation by anyone, including, but not limited to, facility staff...Mental abuse includes humiliation, harassment....Psychosocial harm includes extreme embarrassment, ongoing humiliation, degradation as a human being. Verbal abuse-the use of oral, written or gestured	M 500	1) Resident #2 was assessed by a Registered Nurse (RN) on 9/3/18 and by the Social Services Director on 9/3/18. Resident #2 did not suffer any adverse effects from this practice. 2) All residents in the facility have the potential to be affected if an employee fails to or chooses not to follow facility freedom from abuse and neglect policy. All interviewable residents in the unit were interviewed by the Social Services Director on 9/4/18. All non-interviewable residents were assessed for any evidence of abuse via body audits by Nursing Staff on 9/4/18 - 9/8/18. There were no negative findings. 3) Licensed Practical Nurse (LPN) #1 was terminated on 9/6/18 and RN #1 was terminated on 9/5/18 by the Administrator. Certified Nursing Assistant (CAN) #1, #2, and #3 were disciplined on 9/5/18 by the Assistant Director Off Nursing (ADON). All staff were in-serviced on 9/4/18 and 9/5/18 by the Social Services Director on Freedom of Abuse and Neglect and the Vulnerable Adult and timely reporting allegations and/or incidents to the Administrator. 4) Human Resources Director (HR Director) will monitor orientation and/or	

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M 500	Continued From page 5 language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. The policy defined "willful"-the individual must have acted deliberately, not that he/she must have intended to inflict injury or harm. The facility admitted Resident #2, on 5/23/18, with diagnoses including Post Fracture of the Neck of the Femur, repeated falls, Insomnia, Depressive Disorder, Anxiety Disorder, Osteoarthritis and Dementia with Behaviors. Review of the 8/20/18 Brief Interview for Mental Status (BIMS) score was 5, which indicated severe cognitive impairment. On 9/3/18, the facility administrator notified the Mississippi State Department of Health, Licensure and Certification (MSDH) of an allegation of Resident abuse. The notice related that the Business Office Manager (BOM) notified him on 9/3/18 at 2:52 PM, of an incident that occurred on 9/2/18, at approximately 10:35 PM. It was reported that LPN #1 had taped a chair where Resident #2 was sitting, playing a joke on RN#1. Review of the facility's investigation report indicated that RN #1 had attempted to call the Director of Nursing (DON) but she was in the Emergency Room, dealing with a health issue. The report indicated that the tape did not touch the resident, a body audit was done by an RN on 9/3/18, and a Psychosocial assessment was conducted by the Social Service Director on 9/3/18. Both reported no negative effect on the resident. The report indicated that the Administrator and the Assistant Director of	M 500	in-service training monthly to assure compliance regarding Freedom of Abuse and Neglect and the Vulnerable Adult. New hires will continue to be in-serviced on Freedom of Abuse and Neglect and the Vulnerable Adult by the Social Services Director upon hire. Staff will be in-serviced every 6 months on Freedom of Abuse and Neglect and the Vulnerable Adult by the Social Services Director. Forty residents and/or families will be interviewed quarterly utilizing the Abaqis software program including questions regarding abuse and neglect by all Department Heads. The results of the audits will be presented by the Administrator to the Quality Assurance Committee monthly for recommendations of revision, update, or resolution to plan to ensure the plan of correction is achieved and sustained.	

MSDH - Health Facilities Licensure and Certification

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M 500	Continued From page 6 Nursing (ADON) interviewed all 3 PM-11 PM staff who were working on that unit. Staff admitted that tape had been applied to the chair, and LPN #1 admitted to taping the chair as a joke on RN #1 without thinking that this met the definition of abuse, and there wasn't any willful intent of harm or abuse. The report indicated that the tape was not on the chair longer than two (2) minutes. The report indicated that the LPN was suspended on 9/3/18, all three (3) CNAs suspended on 9/4/18, and the RN was suspended on 9/5/18. The report indicated that the incident was reported to the Attorney General's office, the State Agency, the Board of Nursing, the police department and the Ombudsman. The LPN's employment was terminated on 9/6/18, for taping the chair and the RN's employment terminated on 9/5/18, for failure to report timely and instructing CNAs to not report the incident. The report indicated the CNAs were counseled and re-educated for failure to report; that more serious action was not taken due to RN #1 instructed them not to report. On 9/13/18 at 1:40 p.m. care delivered by two (2) CNAs was observed in Resident #2's room. Resident #2 was very restless and stated "I have just got started". She denied having any memory of a fall or the incident, and when asked about (name of LSW) she said she did not know her; said "I never sleep". She was very compliant with care. An interview was conducted at 3:15 PM on 9/12/18, with CNA#1. She stated that she has worked at the facility for 14 years. She stated that she regretted what happened. She stated that she saw where LPN#1 had stretched a piece of white tape across the easy chair that Resident	M 500		

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M 500	Continued From page 7 #2 was sitting in. She stated that Resident #2 was restless and they did not want her to fall, so they had her in the day room so they could observe her. She said the LPN had written "Federal Property" on the tape. CNA #1 stated that Resident #2 had removed the tape on one side of the chair, saying "I'm getting up", and LPN#1 told her to put it back on until the bail bondsman arrived. CNA #1 said they were all laughing, including Resident #2. She said the tape was removed as soon as RN #1 arrived on the unit; that she started waving her pen back and forth in the air, saying we were to wipe this out of our minds like it did not happen, that some might see it as abuse. The CNA stated that she did not think of it as abuse, it was just a joke that got blown out of proportion and no one meant any harm. RN #2 presented a roll of one (1) inch wide silk medical tape at 3:55 PM on 9/12/18, and demonstrated what happened. She sat back in the overstuffed easy chair, and stretched a piece of the tape across from arm to arm, demonstrating how it would not have touched Resident #2's body. She showed how, due to the soft fabric of the chair it was easily removed and was not considered a restraint. CNA #2 was interviewed at 4:50 PM on 9/12/18. She stated she and the others were checking their residents before the end of their shift. She said Resident #1 was in the day room because they can't prevent a fall leaving her in her room when she is restless. She stated that LPN #1 was playing a trick on RN #1. She said they all joke around with one another and laugh a lot. She described the taping on the chair and said Resident #2 was going along with the joke; said	M 500		

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M 500	Continued From page 8 they told her it was for police protection. She said that Resident #2 took it off once but the LPN put it back. CNA #2 denied that any of them thought of it as harmful, and that Resident #2 was not upset, that she liked attention. She said she never thought of reporting it because she did not think it was wrong; that RN #1 told them not to talk about it. CNA #3 could not be interviewed, but review of her statement, taken by RN #3 (the ADON) on 9/4/18, revealed she had been standing at the nursing station and Resident #2 was sitting in a chair in the day room. LPN #1 wanted to play a joke on RN #1, so she placed tape on the arms of the chair. The report reflected that the tape did not touch the resident and was only on the chair one (1) - two (2) minutes and Resident #2 was laughing. She said they did not report it because the RN said not to report it. LPN #1 returned a call for interview on 9/13/18 at 3:03 PM. She apologized for using bad judgment in a joke; said she did not consider it as abuse, just playing around with a co-worker. She said she put tape on the chair, that it did not touch Resident #2, that the resident took it off at one time, and that it was not in place more than two (2) minutes. She said she met with a nurse from the Board of Nursing the day before and explained that it did not harm Resident #2, that Resident #2 was laughing with the rest of us. LPN #1 said she is so ashamed, that she did not mean any harm. RN #3 (ADON) was interviewed on 9/13/18 at 3:24 PM. She stated that RN #1 called RN #4 around 1:00 AM on 9/3/18; that RN #4 called the DON who said it was okay for LPN #1 to finish	M 500		

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M 500	Continued From page 9 her shift, and she, the DON, would come in the next day. The DON was in the Emergency Room with intravenous Morphine for pain, waiting for gallbladder surgery. The ADON said they tried to call her (ADON), but her cell phone was not working the night it happened. She said when she found out on Monday morning she called and suspended LPN #1, did a body audit on Resident #2, called the State Agency and notified the AG's office. RN #3 said they notified the police, who came in and interviewed Resident #2. The ADON said they suspended the CNAs but later realized they were not direct participants, but they got disciplined for not reporting potential abuse. She stated no harm was done to Resident #2 and no harm was intended. She stated they decided to terminate the two (2) nurses; LPN#1 for the act and RN #1 for failure to notify the on-call nurse for almost three (3) hours about the event. She said LPN #1 was something of a prankster and did not see the potential harm and that the residents loved her. RN #1 returned the phone call at 11:00 AM on 9/14/18. She was upset, crying at times and vented for 30 minutes. She said she did notify the RN supervisor. She stated she regretted the episode, and while LPN #1 thought it was a joke, she did not find it funny. She said that Resident #2 did not understand what happened. The Licensed Social Worker (LSW) was interviewed at 10:30 AM on 9/12/18. She said the resident is her Aunt, she was a mall walker, and now with Dementia, who could recall walking a mile a day at the mall. She stated that Resident #2 keeps trying to get up; that she's in the facility because she fell before coming here and broke her hip. She said that she came to the facility on	M 500		

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M 500	Continued From page 10 Monday (Labor Day) to see her, and Resident #2 did not know (couldn't recall) anything about what happened. Review of Resident #2's medical record documentation, revealed a progress note by the LSW on 9/4/18 at 11:50 AM, revealed the Brief Interview for Mental Status (BIMS) score was 3 out of 15, indicative of severe impairment. The note revealed that she got upset because she can't remember things. A note by an RN on 9/4/18 at 1:34 PM, revealed Resident #2 was sitting in the day area in no acute distress, pleasantly confused with vital signs within normal limits. A later note by the LSW on 9/6/18 at 2:34 PM, revealed she followed up to assess anxiousness and nervousness. The note indicated no recollection of anything asked her nor anything that happened on Sunday evening. Review of Resident #2's care plan revealed a risk for falls, confusion, lack of awareness of safety needs, Dementia and a history of falls with a fracture a few months back. Personnel records for all five (5) staff involved in the incident were reviewed. All five (5) were certified or licensed, all five (5) had been trained in abuse and neglect and vulnerable adult, code of conduct, signed job descriptions, and were cleared with criminal record checks. The Administrator presented individualized signed in-service documents for all five (5) staff, acknowledging they have been trained in Freedom of Abuse and Neglect and the Vulnerable Adult. He said he does not have them sign one sheet, but individual ones so they can be filed in their record.	M 500		

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M 500	Continued From page 11 Review of the facility's "Code of Conduct", signed by LPN #1 on 5/10/08, revealed: Employees are expected to conduct themselves in a positive manner...treating all residents, visitors and co-workers in a courteous manner; refraining from behavior or conduct that is offensive, undesirable, disorderly, immoral, or indecent and reporting to managers behaviors by co-workers, residents or suppliers.	M 500		
M1010	45.35.1 Housekeeping Facilities and Services Housekeeping Facilities and Services. 1. The physical plant shall be kept in good repair, neat, and attractive. The safety and comfort of the resident shall be the first consideration. 2. Janitor closets shall be provided with a mop-cleaning sink and be large enough in area to store house cleaning supplies and equipment. A separate janitor closet area and equipment should be provided for the food service area. This Statute is not met as evidenced by: Level II Based on observation and interview, the facility failed to maintain the facility in a manner to provide a sanitary and comfortable environment for residents. Furniture was scarred and peeling, paint was patched in some areas, wall crumbling, doors scarred and tiles stained and scratched, for two (2) of two (2) Units. These observations were prevalent throughout the facility. Findings include: 0n 9/12/18 at 10:50 AM, observation on the	M1010	1) North Unit: Room 25 the wall at the baseboard near the air conditioner will be repaired and painted, Room 32 ceiling and bathroom wall with the yellow/gold streak will be repaired and painted, Room 10 furniture will be replaced/reconditioned, Room 1 ceiling and molding will be repaired and painted and furniture will be replaced/reconditioned, Room 26 ceiling and wall will be scraped and repainted, and Room 14 wall by Bed #1 will be repaired and painted and night stand, TV/dresser will be replaced/reconditioned.	10/10/18

MSDH - Health Facilities Licensure and Certification

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M1010	Continued From page 12 North Unit, revealed in Room 25, the wall at the baseboard near the air conditioner was crumbling and poorly patched. Room 32 had patches in the popcorn ceiling and the bathroom had a yellow/gold colored streak on the white wall from a suspected water leak. The floor was dry. In Room 10, the furniture was badly scraped and scarred at the bottom. Observation of the corridor door, leading out of the North Unit, was badly scarred. In the corridor, outside the office of the Infection Control Nurse's (ICN) office, there were seven (7) floor tiles darkened and scarred. The ICN stated there were access panels underneath those tiles. Observation continued to the in the hallway on the South Unit where there were 10 floor tiles that were discolored and scarred. The Nurse stated that this area also has access panels underneath the tiles. Observation on 9/12/18 at 2:30 PM, revealed the paint on the wall in South Unit, Room 20, was patched in two (2) areas and on 9/13/18 at 11:40 AM, the bathroom tile, near the tub and under the sink, was badly stained. Observation on 9/13/18 at 10:40 AM, revealed the popcorn ceiling was patched near the seam by the privacy curtain rail, paint was stripped off the molding, there was a crack in the paint above the television and the veneer was scarred and peeling at the base of the furniture in Room 1, North Unit. Observation on 9/13/18 at 10:50 AM, in room 26 of the North Unit, revealed a small area above the television about eight (8)-10 inches long where the popcorn ceiling texture was crumbling near the wall and there were approximately 10	M1010	The door coming out of the North Unit will be stained. The 7 tiles in the corridor outside the Infection Control Nurse's office and the 10 tiles in the hallway on the South Unit will be replaced. South Unit Room 20 wall will be repaired and painted and bathroom tile near tub and under the sink will be stripped and waxed. All repairs will be completed by the Maintenance Director and construction crew. Completion date for all of the above will be 10/10/18. 2). All residents have the potential to be affected. Administrator and Maintenance Director completed 100% rounds of the whole building to identify any other areas of concern. Any areas identified will also be included in the correction plan by 10/10/18. 3) The Maintenance Director will be in-serviced on maintaining a monthly inspection checklist form including ceiling, and furniture inspections on 10/1/18 by the Regional Director of [name of construction company]. 4) Weekly rounds x 4 weeks will be conducted by the Administrator to monitor for any environmental concerns and monthly thereafter. The findings of the audits will be presented by the Administrator to the Quality Assurance Committee monthly for recommendations of revisions, updates, or resolution to plan to ensure the plan of correction is achieved and sustained.	

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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M1010	Continued From page 13 inch cracks on the wall near the ceiling above the light. On 9/13/18 at 11:40 AM, observation on the North Unit revealed there was a dark areas on the wall by the ceiling by Bed #1,of Room 14, and the bottom of the night stand and the bottom of the television stand/dresser was badly scarred, with the veneer stripped showing a white surface underneath. On the environmental tours, these findings were indicative of a majority of rooms in the facility. No evidence of mold was observed and an interview with the Maintenance Supervisor at 10:50 AM on 9/13/18, revealed they had tests run and there was no mold in the facility. He confirmed the findings of the environmental issues.	M1010		