STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255336	A. BUILDING _____ B. WING _____	C 03/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JONES CO REST HOME	683 COUNTY HOME ROAD ELLISVILLE, MS 39437

(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 complaint survey(s), MS #16701 and MS #16707, on 03/09/2020 through 03/10/2020. During the survey, the SA did not substantiate the complaint for Quality of Care, related to an unwitnessed fall with a fracture, and cited no deficiencies. During the survey, determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid. The SA substantiated CI MS #16707 for the allegation of Abuse related to verbal abuse and cited F600. However, the SA unsubstantiated MS #16707 related to the allegation of physical abuse. At the time of survey, the facility had a census of 119, and held a license for 122 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: Based on record review, interview, and facility	F 600	Statements contained herein are	4/22/20

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

Electronically Signed | 04/20/2020

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 policy review, the facility failed to ensure a resident was free from verbal abuse, for one (1) of four (4) residents reviewed, Resident #1. Findings include: A review of the facility's, "Abuse, Neglect, and Exploitation Policy", dated 01/23/2020, revealed, verbal abuse means the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within the hearing distance regardless of their age, ability to comprehend, or disability. A review of the facility's statement, dated 03/20/2020 and signed by the Director of Nurses (DON), revealed, on 03/02/2020 at approximately 12:10 PM, Certified Nursing Assistant (CNA) #2 observed CNA #1 "slap" Resident #1 on the arm. CNA #2 reported, she and CNA #1 were providing care to Resident #1. CNA #2 revealed CNA #1 turned Resident #1 over, and the resident yelled for her to stop for fear of falling off the bed. CNA #2 stated Resident #1 slapped CNA #1, and then CNA #1 slapped Resident #1 on her right arm. CNA #2 revealed CNA #1 stated to Resident #1, "Fine, sit in your shit, I don ' t care" and walked out of the room. Review of the facility's "Historical Employee Clocking and Schedule for 03/02/2020" revealed, CNA #1 was in the facility on 03/02/2020 from 7:22 AM to 12:39 PM. A review of the facility's document titled, "Report of Termination/Hour Reduction" dated 03/03/2020, revealed, CNA #1 was suspended following an allegation of abuse towards a	F 600	intended for purposes of compliance with Federal and State laws regarding responses to Statements of Deficiencies. The language herein is not intended to be used as an admission against the facility nor is it intended to be used by any third party. It is solely for purposes of compliance with participation requirements of Medicare and Medicaid. F600 1)Certified Nursing Assistant #1 was immediately relieved from duties and interviewed on March 2, 2020 by the Director of Nurses. Certified Nursing Assistant #1 was suspended pending further investigation. The Assistant Director of Nurses completed a full body audit for Resident #1 which revealed a small fading yellow bruise to the upper right inner arm and no new injuries. The Social Worker met with Resident #1 on March 2, 2020 to assess the resident for psychosocial harm relating to the incident. No psychosocial harm was found to have occurred. Certified Nursing Assistant #1 was terminated on March 3, 2020. 2)All residents have the potential to be affected. 3)The Quality Assessment and Assurance Committee reviewed the Abuse, Neglect and Exploitation Policy on March 3, 2020, with no revisions made at that time. All staff are being in-serviced by the Staff Education Coordinator with education titled 2020 LTC Resident Abuse Prevention and Reporting- Protecting a Vulnerable Population. The in-service began on March 27, 2020 and will	

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F 600	Continued From page 2 resident. The document indicated CNA #1's last day worked was on 03/02/2020, and date terminated as of 03/03/2020. A review of a typed statement given by CNA #1, attached to the Report of Termination/Hour Reduction document, revealed, she acknowledged she stated "Well, sit in your own shit" out loud but to herself. CNA #1 revealed in the statement, that she pushed Resident #1's arm down to place it in the opposite direction, so that she could roll her over. CNA #1 revealed she was frustrated, but did not hurt her resident. During an interview, on 03/09/2020 at 8:45 AM, the Administrator revealed when she spoke to CNA #1, she admitted that she cursed Resident #1, but did not hit her. The Administrator stated CNA #1 admitted to saying that Resident #1 could "sit in her own shit" but stated she mumbled it, and did not say it directly to Resident #1. During an interview, on 03/09/2020 at 10:08 AM, CNA #2 stated she walked into Resident #1's room to see if CNA #1 needed anything. CNA #2 stated she saw Resident #1 slap CNA #1, and then CNA #1 slapped Resident #1 on her right forearm. CNA #2 revealed CNA #1 stated to Resident #1, "Whatever, you can sit in your shit, I don't care", and walked out of the room to go get a nurse. During an interview, on 03/09/2020 at 11:37 AM, CNA #1 revealed on the day of the incident (03/02/2020), she was in the room changing Resident #1. CNA #1 stated she rolled Resident #1 to one side, and the Resident #1 rolled back towards her, hitting her in the eye. CNA #1 stated she took Resident #1 by the arm, and placed it on the opposite side of the bed so that she could	F 600	continue until all staff have received the in-service. A post test with a passing score of 80% is required for completion of the in-service. All staff will have completed the education by April 22, 2020 to remain on the working schedule. An additional in-service provided by a Licensed Professional Counselor at a local behavioral health center via recorded video began on April 16, 2020. The in-service addresses Stress and Burnout among healthcare workers. All staff will have completed the education by April 22, 2020 to remain on the working schedule. 4)The Director of Nurses, Assistant Director of Nurses or Staff Education Coordinator will conduct three weekly Stress and Burnout questionnaires over the next three months. These questionnaires will be used to assess for excess stress and/or burnout amongst employees. Employees identified with increased risk of stress and/or burnout will be referred to local behavioral health services. These questionnaires will be logged on the Stress and Burnout Audit Log and will begin April 20, 2020. The Director of Nurses will present these audit logs to the Quality Assessment and Assurance Committee monthly until such time substantial compliance has been achieved as determined by the committee. The Quality Assessment and Assurance Committee will make any recommendations and/or changes if needed to ensure compliance.	

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F 600	Continued From page 3	F 600		

change her. She stated that she did not hit Resident #1. CNA #1 stated CNA #2 may not have understood what was going on with Resident #1. CNA #1 confirmed she did make the statement that Resident #1 could lie in her shit, but she mumbled it to herself, as she was going out the door to get the nurse.

A review of the facility's document titled, "Abuse, Neglect and Exploitation of Vulnerable Person Acknowledgement", revealed CNA #1 was educated on Abuse and Neglect on 10/30/2019.

During an interview, on 03/10/2020 at 9:05 AM, the Administrator stated the abuse did occur and it should have never occurred. The Administrator stated, "This is never acceptable."

On 03/10/2020 at 9:08 AM, during an interview with the DON, she stated verbal abuse did happen, and it never should have happened. She stated they have in-serviced on abuse and neglect. The DON stated they are looking at getting an outside counselor to come in and talk to staff about stress and burnout.