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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK OF COLLINS	1315 SOUTH FIR AVE COLLINS, MS 39428

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an onsite Complaint Investigation (CI) MS #16603 on 02/10/2020 through 02/12/2020. The SA determined the facility was not in compliance with the requirements of participation for Medicare and Medicaid. The SA substantiated CI MS #16603 for verbal abuse and identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) on 02/12/2020, which began on 01/25/2020, when Certified Nursing Assistant (CNA) #1 verbally abused Resident #1, and the incident was witnessed by Registered Nurse (RN) #1 and CNA #2. CNA #1 was witnessed cursing and telling Resident #1 that she was tired of her "peeing" everywhere and not doing anything to help herself. Resident #1 stated the incident made her feel "belittled." The incident was not reported to the appropriate state agencies within two (2) hours of occurrence. CNA #1 was not removed from the building and remained in the facility working directly with residents from 01/25/2020 to 01/27/2020. The failure of the facility to protect residents by allowing a staff member to work in the facility following a witnessed incident of verbal abuse, and the failure to report the abuse within two (2) hours to State designated agencies, placed Resident #1 and other residents in a situation that was likely to cause serious injury, harm, impairment, or death. The SA notified the facility of the IJ and SQC on 2/12/2020 at 9:40 AM, and the IJ template was provided to the Administrator. The IJ and SQC existed at: 42 CFR(s): 483.12(a)(1) - Freedom from	F 000		

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

Electronically Signed | 03/18/2020

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 000	Continued From page 1 Abuse/Neglect, (F600) 42 CFR(s): 483.12(c)(1)(4) - Reporting of Alleged Violations, (F609) 42 CFR(s): 483.12(c)(2)(4) - Investigate/Prevent/Correct Alleged Violation, (F610) The facility provided a credible Removal Plan on 02/12/2020, in which the facility alleged all corrective actions were completed, and the IJ was removed on 02/12/2020. The SA validated the Removal Plan and determined the IJ was removed on 02/12/2020, prior to exit. Therefore, the scope and severity for F600, F609, and F610 were lowered to a "D" level while the facility develops and implements a plan of correction (POC) and monitors for the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. At the time of survey, the facility held a license for 60 bed, and the census was 53.	F 000		
F 600 SS=J	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-	F 600		3/23/20

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F 600	Continued From page 2 §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 resident interview, staff interview, record review, and facility policy review, the facility failed to ensure a resident was free from verbal abuse for one (1) of four (4) residents reviewed for abuse, Resident #1. On 01/25/2020, Resident #1 and Certified Nursing Assistant (CNA) #1 were involved in a verbal altercation, where CNA #1 yelled, screamed, and belittled Resident #1 in a loud voice. CNA #1 was overheard telling Resident #1 she was sick and tired of her "peeing" on herself and everywhere in the facility. The incident was witnessed by Registered Nurse (RN) #1 and CNA #2, and overheard through the call system by Licensed Practical Nurse (LPN) #1 and LPN #2. RN #1 intervened and told CNA #1 to go take a break and not to go back into Resident #1's room until she cooled off. Resident #1 was not assessed for harm after the witnessed incident of verbal abuse on 01/25/2020. CNA #1 was not sent home after the incident with Resident #1 and was allowed to continue providing direct care of residents from 01/25/2020 to 01/27/2020. The facility's failure to protect Resident #1 from verbal abuse and allow the staff member to work in the facility following a witnessed incident of verbal abuse, placed Resident #1 and other residents at risk in a situation that was likely to cause serious injury, harm, impairment, or death. The situation was determined to be an Immediate	F 600	* Certified Nursing Assistant #1 was terminated on February 3, 2020 by the Facility Administrator #1. Director of Nursing #1 assessed Resident #1 on January 28,2020 and noted Resident # 1 in good spirits with no indications of fear or withdrawn behavior. Resident #1 attended group activities on January 26th, January 27th, and January 28th, 2020. * All residents have the potential to be affected * An In-service training was initiated on January 28, 2020 by Staff Development Nurse #1, the Director of Nursing #1 and the Facility Administrator #1 to include all Registered Nurses, Licensed Practical Nurses, Certified Nursing Assistants, Housekeeping and Laundry staff, Dietary staff, Office personnel and contracted therapy department staff on the following (a) Resident Rights, (b) Accident/Incident Reporting, (c) Incident Investigation and Reporting,(d) Abuse/Neglect, e) Dignity/Respect. Staff will not be allowed to work until the proper in-service training has been conducted. The facility contacted our agency personnel provider on February 11th 2020. Agency personnel will not be allowed to work until these in-services have been conducted by licensed facility staff.	

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F 600	Continued From page 3 Jeopardy (IJ) and Substandard Quality of Care (SQC) which began on 01/25/2020 when the verbal abuse occurred. The facility's Administrator was notified of the IJ and SQC on 02/12/2020 at 9:40 AM and provided with the IJ template. An acceptable, credible Removal Plan was provided by the facility on 02/12/2020, in which the facility alleged all corrective actions were completed, and the IJ was removed on 02/12/2020. The SA validated the Removal Plan and determined that the IJ was removed on 02/12/2020, prior to exit. Therefore, the scope and severity for the IJ and SQC at 42 CFR(s): 483.12 (a)(1) F600, Freedom from Abuse and Neglect, and Exploitation, was lowered to a "D" while the facility develops and implements a plan of correction (POC) and monitors the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include: Review of the facility's "Incident Investigation and Reporting" policy, with a revision date of 05/2018, revealed: "Each resident has the right to be free from any type of abuse including verbal, sexual, mental, physical abuse, neglect, misappropriation of resident property and exploitation." The policy also revealed, Verbal Abuse is defined as the use of oral, written, or gestured language that willingly includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. A review of the facility's "Dignity and Respect"	F 600	*On February 11, 2020 all residents were interviewed in regards To psychosocial well being and physical wellbeing with no areas in need of investigation or correction. Director of Nursing #1, Staff Development Nurse #1 and Treatment Nurse #1 began to conduct care observations on February 11, 2020 across all shifts for dignity and respect. Care observations will be completed across all shifts weekly x three weeks, then bi-weekly for three months, and then monthly thereafter by Director of Nursing #1, Staff Development Nurse #1, and Treatment Nurse #1. Five cognitive residents will be interviewed weekly x three weeks beginning February 22, 2020, then bi-weekly for three months, and then monthly thereafter by Director of Nursing #1 and Social Services Director #1. The Facility Administrator of record will report all results of the established monitoring to the Quality Assurance Committee meeting for the immediate corrective plan of action of any deficient practice.	

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policy, revised 11/2017, revealed: "A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each residents individuality. The facility shall protect and promote the rights of the resident. Facility staff shall display respect when speaking with, caring for and talking about residents, as constant affirmation of their individuality and dignity as human beings."

Review of a complaint, submitted to the State Crimes Submission website by the facility's Administrator, dated 01/28/2020, revealed, the State Ombudsman reported concerns of verbal abuse, to the facility's Administrator, which involved a staff member and Resident #1. The report documented Resident #1 stated she felt belittled by remarks made regarding her incontinent episodes.

Review of the facility's "Employee Warning Report" for CNA #1, dated 01/26/2020, revealed, Registered Nurse (RN) #1 documented "Date of Violation 01/25/2020, Time 1:00 PM", Yelling and arguing with resident in her room about toileting." The report was signed by RN #1 and dated 01/26/2020. The report was signed by the facility's Administrator, but undated.

Record review of Resident #1's medical record revealed there was no documentation of an assessment completed on 01/25/2020 following the witnessed incident of verbal abuse. There was no documentation between the dates of 01/25/2020 and 02/11/2020 of Resident #1's Responsible Party being notified of the incident which occurred on 01/25/2020.

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During an interview, on 02/10/2020 at 2:00 PM, the Director of Nursing (DON) revealed she was notified on Sunday, 01/26/2020 regarding the incident between Resident #1 and CNA #1. The DON stated she told the nurse to write up the incident, slide it under her door, and that she would investigate the incident on Monday, 01/27/2020. The DON stated staff did not use the terminology "abuse" when the incident was reported to her. The DON confirmed CNA #1 continued to work in the facility from 01/25/2020 to 01/27/2020 and was not reassigned or sent home as a result of the incident on 01/25/2020.

During an interview, on 02/10/2020 at 2:30 PM, the facility Administrator (ADM) stated the Ombudsman reported the incident of verbal abuse, which occurred on 01/25/2020, to her on Monday, 01/27/2020. The ADM stated she did not know anything about the alleged verbal abuse, until the Ombudsman told her of concerns she had regarding an incident that had occurred between Resident #1 and CNA #1. The ADM stated CNA #1 was not reassigned to another hall or asked to leave the building on the day of the incident (01/25/2020) and continued to work at the facility until 01/27/2020. The ADM confirmed it was the facility's policy to send any staff home that was involved in an investigation or alleged to be accused of abuse. The ADM revealed there was no documentation of Resident #1 being assessed following the incident on 01/25/2020.

During an interview, on 02/10/2020 at 2:45 PM, Resident #1 stated CNA #1 came to her room on 01/25/2020 and started yelling and cussing at her, saying she had left urine up and down the hall, and that she could help herself. Resident #1

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stated CNA #1 was "belittling" her. Resident #1 revealed she raised her hands and told CNA #1 she didn't want to hear another word she had to say. Resident #1 stated CNA#1 got louder. Resident #1 stated CNA #2 was in the room and witnessed the argument. Resident #1 stated CNA #2 went and got the nurse, and the nurse called CNA #1 out into the hall. Resident #1 stated CNA #1 continued working in the building working with residents, a few days after the incident. Resident #1 revealed she felt "uneasy" and a little "fearful" with CNA #1 still working. Resident #1 stated the Ombudsman came to see her a few days after the incident, and she told the Ombudsman about what happened between her and CNA #1. Resident #1 stated she hated that it took telling the Ombudsman in order to get the yelling and fussing to stop. Resident #1 stated the whole thing was "upsetting" to her for days afterwards, but she was okay now.

During an interview via telephone, on 02/10/2020 at 4:00 PM, RN #1 revealed she was the treatment nurse on the day of the incident (01/25/2020) between Resident #1 and CNA #1. RN #1 revealed she was in another resident's room when she heard CNA #1 and Resident #1 yelling and screaming extremely loud at each other. RN #1 revealed CNA #1 told Resident #1 that she was tired of her "peeing" everywhere and that she had "peed" on another resident's foot and down the hall. RN#1 stated CNA #1 spoke to Resident #1 in a harsh tone. RN #1 stated she told CNA #1 to come out of Resident #1's room and go take a break, and not to go back into the resident's room until she cooled off. RN #1 revealed she did not assess Resident #1, and "assumed" LPN #1 had assessed her since she was assigned to the hall where Resident #1

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resided. RN #1 stated she called the DON on Sunday, 01/26/2020, and was told to write the incident up and push it under her office door. RN #1 revealed the DON told her she would handle the situation when she returned to work on Monday 01/27/2020.

During an interview via telephone, on 02/10/2020 at 4:45 PM, LPN #1 revealed she was the charge nurse on weekends. LPN #1 stated on the day of the incident (01/25/2020), she and LPN #2 were sitting at the nurse's desk charting and heard an argument over the intercom call system. LPN #1 revealed she and LPN #2 went down the hall and saw RN #1 standing outside of Resident #1's room talking to CNA #1. LPN #1 stated she assumed RN #1 had handled the situation. LPN #1 stated she did not assess Resident #1 or any residents and did not reassign CNA #1 to a different area after the incident occurred.

On 02/11/2020 at 2:00 PM, during an interview with the facility's Social Service Designee (SSD), she revealed that she had never been asked to talk with Resident #1 and she had never evaluated or spoken to Resident #1 about any incidents that had occurred between Resident #1 and any staff members. SSD stated that on Monday morning 01/27/2020 at the Stand Up meeting, the DON announced she had been given some information about an incident between a resident and a CNA. The SSD revealed no details were shared about the incident, only that they would be conducting an investigation. The SSD confirmed the Ombudsman was at the facility on 01/28/2020. The SSD revealed they had a Quality Assurance (QA) on 01/28/2020 and there was no discussion about an incident occurring between Resident #1

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and any CNA. The SSD stated she had heard through the "grapevine" that a CNA had cussed out Resident #1 in her room for wetting herself.

During an interview, on 02/11/2020 at 3:26 PM, the State Ombudsman (SO) confirmed she visited the facility on Tuesday, 01/28/2020, and had an exit meeting at approximately 3:00 PM with the facility's ADM. The SO stated she reported to the ADM, that Resident #1 voiced being "upset" about an incident that had occurred between her and CNA #1 on 01/25/2020. The SO stated Resident #1 told her that she was fussed at because of wetting herself and it was "hurtful" and embarrassed her.

An interview on 02/12/2020 at 11:30 AM, with CNA #1, revealed that on 01/25/2020 at approximately 1:00 PM, she was involved in an argument with Resident #1. CNA #1 confirmed that they both cussed each other and that the argument got loud between the both of them. CNA #1 confirmed RN #1 heard the loud argument, and asked her to step away, go on break to cool off, and not to go back in Resident #1's room until she was calm. CNA #1 confirmed that CNA #2 was in the room and witnessed the argument between her and Resident #1. CNA #1 confirmed LPN #2 had come down the hall and also heard the argument. CNA #1 revealed LPN #2 stood in the hallway outside the room of Resident #1 and talked with her. CNA #1 stated LPN #2 was always very helpful to her and that she was a good supervisor. CNA #1 further stated she assumed LPN #2 had written the incident up and had given it to the DON. CNA #1 confirmed she worked her entire shifts on 01/25/2020, 01/26/2020, and 01/27/2020. CNA #1 confirmed she was never reassigned nor asked to leave the

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building on 01/25/2020, 01/26/2020, and 01/27/2020. CNA #1 stated that no one ever asked her about the argument between herself and Resident #1 until approximately 11:30 AM on 01/27/2020, when the DON asked her to write a statement as to what happened between her and Resident #1 on 1/25/2020. CNA #1 stated the DON did not talk to her about the incident, but just asked her to write a statement. CNA #1 was scheduled off on 01/28/2020 and 01/29/2020. CNA #1 revealed the ADM called her on 01/30/2020 and told her there was an investigation and not to return to work until the investigation was over.

On 02/12/2020 at 2:00 PM, during an interview, CNA #2 confirmed she was in the room with CNA #1 and Resident #1, on 01/25/2020, when they got into it an argument. CNA #2 revealed Resident #1 had turned on her call light to request assistance to be changed. CNA #2 stated CNA #1 saw puddles of "pee" in the hall and dining room and told Resident #1 she should have called and asked for help before "peeing" everywhere. CNA #2 revealed Resident #1 put her hands up and told CNA #1 she was tired of her mouth and didn't want to hear another word. CNA #2 stated CNA #1 began cursing at Resident #1. CNA #2 stated she couldn't remember all the curse words that were used, but for sure "Damn it" being used a few times. CNA #2 confirmed RN #1 heard the argument and told CNA #1 to go on break.

A record review of CNA #1's personnel records, revealed CNA #1 was hired by the facility on 07/31/2018. CNA #1 was in-serviced and trained on Abuse and Neglect, the Elder Justice Act, Vulnerable Adult Act, and Accident/ Incident

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Reporting on 09/03/2019.

Record review of the facility's document titled "Termination Report" for CNA#1, revealed it was signed by the ADM and dated 02/05/2020. The termination date was effective as of 02/03/2020 for violation of policy and misconduct. The report did not contain a signature or date for CNA #1.

A review of the facility's Admission Record for Resident #1, revealed, an admission date of 10/05/2016. Admission Diagnoses included Hemiplegia following Cerebrovascular Disease, Hyperlipidemia, Chronic Obstructive Pulmonary Disease, and Non-ST Elevation (INSTEMI) Myocardial Infarction, and Type 2 Diabetes Mellitus with Foot Ulcer.

Review of Resident #1's Quarterly Minimum Data Set (MDS) Assessment, with an Assessment Date (ARD) of 11/25/2019, revealed she had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognitive skills for daily decision making.

The facility submitted an acceptable Removal Plan on 02/12/2020, for the IJ and SQC.

Review and validation of the facility's Removal Plan revealed the facility took the following corrective actions to remove the IJ prior to exit on 02/12/2020.

1. On January 25, 2020, while making rounds at approximately 1:00 PM, Registered Nurse #1 overheard Certified Nursing Assistant #1 yelling at Resident #1 from the inside of the resident's room. Registered Nurse #1 stated she instructed Certified Nursing Assistant #1 to take a break and

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removed her from the resident immediately. Registered Nurse #1 stated she notified Director of Nursing #1 on January 26, 2020 of the occurrence at approximately 2:00 PM. Director of Nursing #1 instructed Registered Nurse #1 to complete a disciplinary action with Certified Nursing Assistant #1.

2. On January 28, 2020, Ombudsman #1 reported to the Facility Administrator #1 of an allegation of verbal abuse reported by Resident #1. Resident #1 reported to Ombudsman #1 that Certified Nursing Assistant #1 yelled at her while providing incontinent care during the day shift hours of Saturday, January 25, 2020.

3. A written warning was completed by Director of Nursing #1 and reviewed with Certified Nursing Assistant #1 on January 27, 2020 regarding unsatisfactory behavior towards a resident on January 25, 2020.

4. The Facility Administrator #1 suspended Certified Nursing Assistant #1 on January 28, 2020 pending investigation. Certified Nursing Assistant #1 was terminated on February 3, 2020 by the Facility Administrator #1. As of February 11, 2020, Resident #1 remains in good spirits with no psychosocial changes noted.

5. Director of Nursing #1 assessed Resident #1 on January 28, 2020 at approximately 2:15 PM. Resident#1 was in good spirits with no indications of fear or withdrawn behavior. Resident #1 attended group activities on January 26th, January 27th, and January 28th, 2020.

6. The Facility Administrator #1 notified the local authorities on January 28, 2020 at approximately

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4:45 PM. The Facility Administrator #1 notified the Mississippi State Department of Health and the Mississippi Attorney General's office on January 28, 2020 at approximately 4:55 PM.

7. A Quality Assurance meeting was held on February 11, 2020 at approximately 4:00 PM to discuss Verbal Abuse and investigations. The facility Quality Assurance Committee members which consisted of Facility Administrator #1, Director of Nursing #1, Infection Control Prevention Officer #1, Medical Director #1, Social Services Director #1, Assessment Nurse #1, Treatment Nurse #1 and Staff Development Nurse #1, Activity Director #1, Housekeeping Supervisor #1. Topics discussed include: (a) Resident Rights, (b) Accident/Incident Reporting, (c) Incident Investigation and Reporting, (d) Abuse/Neglect, e) Dignity/Respect. The Facility Action Plan was reviewed and approved by the Quality Assurance Committee Members.

The SA validated the facility's Removal Plan and determined that the facility took the appropriate measures to correct the IJ. The validation was confirmed through staff interviews, Residents interviews, Responsible Party interview, Ombudsman interview, and record review on 2/12/2020 prior to exit from the facility.

1. The SA validated Resident #1 was not free from verbal abuse and the facility failed to remove the perpetrator from the building following a witnessed account of verbal abuse that was witnessed by RN #1 and CNA #2 toward Resident #1 by CNA #1 on 01/25/2020 at approximately 1:00 PM. The facility failed to provide for the safety of Resident #1 and all 53 residents of the facility.

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2. The SA validated through interview and record review that CNA #1 was allowed to work in direct resident care with residents in the facility for eight (8) hour shifts on Saturday 01/25/2020; Sunday 01/26/2020; and Monday 01/27/2020. The facility did not perform assessments of the residents in the facility and of Resident #1 and did not provide for their safety by completing assessments and removing the perpetrator from the building. The facility did not report the verbal abuse within two (2) hours of the witnessed verbal abuse toward Resident #1.

3. The SA validated through interview and record review with RN #1 that she reported that verbal abuse via telephone to the DON and completed a written report of the incident and pushed it under the office door of the DON. The SA validated through interviews and record reviews that the facility conducted In-Service Training on Abuse, Neglect, and Reporting of Incidents prior to exit on 2/12/2020.

4. The SA validated on 02/12/2020 through interviews with staff that a Quality Assurance (QA) Committee Meeting was held on 02/11/2020 at approximately 4:00 PM to discuss the incident of verbal abuse that was witnessed toward Resident #1 on 01/25/2020. All QA members required were in attendance.

5. The SA validated on 02/20/2020 through interviews with the Staff Development Nurse (RN#3) that she was conducting the in-service training and returning to the facility after hours and on weekends to conduct in-service training Abuse, Neglect, and Reporting of incidents as well as safety of all Residents. The RN#3

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F 600	Continued From page 14 confirmed through interview that no staff member will be allowed to return to work before in-services / trainings were completed. 6. The SA validated on 02/12/2020 through staff and resident interviews and record review that all 53 residents residing in the facility had been assessed by facility staff for abuse, and neglect, and verbal abuse and safety. As well as psychosocial wellbeing and physical wellbeing. 7. The SA validated on 02/12/2020 through interviews and record reviews that the corrective actions were put into place by the facility on February 11, 2020. The IJ was removed on 2/12/2020 prior to exit.	F 600		
F 609 SS=J	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve 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	F 609		3/23/20

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F 609	Continued From page 15 procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, record review, and facility policy review, the facility failed to report an allegation of staff to resident abuse within the two (2) hours required time frame, for one (1) of four (4) residents reviewed, Resident #1. On 01/25/2020, at approximately 1:00 PM, Resident #1 and Certified Nursing Assistant (CNA) #1 were involved in a verbal altercation in the resident's room. The incident began when Resident #1 called for assistance to get changed after having an incontinent episode. CNA #1 and CNA #2 responded to the resident's room, and an argument took place at that time. CNA #1 was witnessed yelling and cursing at Resident #1. CNA #1 used the language "Damn it" and "I'm tired of you "peeing everywhere" and told Resident #1 that she had "peed all down the halls" and had "peed on another resident's feet." The incident was witnessed by Registered Nurse (RN) #1 and CNA #2, and also overheard through the call system by Licensed Practical Nurse (LPN) #1 and LPN #2. CNA #1 was allowed to continue providing direct care of residents from 01/25/2020 to 01/27/2020. The incident was not reported on 01/25/2020, to the appropriate state agencies within the required two (2) hour time	F 609	* The Facility Administrator #1 notified the local authorities, the Mississippi State Department of Health and the Mississippi Attorney General□s office on January 28, 2020 of an allegation of verbal abuse. Certified Nursing Assistant #1 was terminated on February 3, 2020 by the Facility Administrator #1. * All residents have the potential to be affected * An In-service training was initiated on January 28, 2020 by Staff Development Nurse #1, the Director of Nursing #1 and the Facility Administrator #1 to include all Registered Nurses, Licensed Practical Nurses, Certified Nursing Assistants, Housekeeping and Laundry staff, Dietary staff, Office personnel and contracted therapy department staff on the following (a) Resident Rights, (b) Accident/Incident Reporting, (c) Incident Investigation and Reporting,(d) Abuse/Neglect,(e) Dignity/Respect. Staff will not be allowed to work until the proper in-service training has been conducted. The facility contacted our agency personnel provider	

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F 609	Continued From page 16 frame. The facility did not report the incident of verbal abuse to the State Agency until 02/04/2020 at 3:53 PM, which was approximately nine (9) days later. The facility's failure to notify the appropriate authorities, including the Responsible Party (RP) of Resident #1 and to immediately remove the perpetrator of a witnessed incident of verbal abuse, and ensure proper measures had been addressed, placed Resident #1 and all residents of the facility at risk for the likelihood of serious injury, harm, impairment, or death. The situation was determined to be an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which began on 01/25/2020, when the staff witnessed verbal abuse of Resident #1. The facility's Administrator (ADM) was notified of the IJ and SQC on 02/12/2020 at 9:40 AM and provided with the IJ template. An acceptable credible Removal Plan was provided by the facility on 02/12/2020, in which the facility alleged all corrective actions were completed, and the IJ was removed on 02/12/2020. The State Agency (SA) validated the Removal Plan and determined the IJ was removed on 02/12/2020 prior to exit. Therefore, the scope and severity for the IJ and SQC at CFR(s): 483.12 (c)(1)(4), Reporting of Alleged Violations, F609, was lowered to a "D" while the facility develops and implements a plan of correction and monitors the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include: Review of the facility's "Incident Investigation and	F 609	on February 11th 2020. Agency personnel will not be allowed to work until these in-services have been conducted by licensed facility staff. *The Facility Quality Assurance Committee will review all incident and accident reports monthly x three months for timely reporting to officials in accordance with state law. Any area of deficient practice shall have an immediate corrective plan of action.	

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Reporting" policy, revised 05/2018, revealed: "The facility administrator shall ensure that any incident involving an allegation or suspicion of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported not later than 2 hours after allegation is made to local law enforcement and the state agency, if the events that cause the allegation involve abuse or result in serious bodily injury 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." The policy also revealed, the facility would take all necessary steps to prevent recurrence and/or further potential abuse, any employee of the facility involved in incidents of abuse, would be suspended pending investigation until such time as the facility investigation is complete. During and after the investigation, the residents will be protected from harm through frequent supervision by staff. The final result of the investigation is to be reported to the Corporate Compliance Officer, Regional Supervisor and appropriate officials in accordance with state law, within 72 hours after the event per fax and certified mail, or per specific state guidelines.

Review of the records provided by the facility, revealed an "Employee Warning Report" for CNA #1, dated 01/26/2020 and completed by RN #1, regarding an incident which occurred on 01/25/2020 at 1:00 PM. The report documented "Yelling and arguing with resident in her room about toileting." The report was signed by the Administrator and undated.

Review of a complaint report, submitted via the

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State Crimes Submission website, revealed the facility's Administrator reported the incident of verbal abuse on 01/28/2020. The Administrator revealed in the report that the State Ombudsman had reported concerns of verbal abuse to her, which involved a staff member and Resident #1.

A review of the State Agency (SA) records, revealed the facility faxed the investigation report to the SA on 02/03/2020, which was nine (9) days after the witnessed verbal abuse that had occurred on 01/25/2020 between Resident #1 and CNA #1.

During an interview, on 02/10/2020 at 2:30 PM, the Administrator (ADM) revealed she had been at the facility for 18 years and this was her first case of reported verbal abuse. The ADM stated that she had no knowledge of the alleged verbal altercation involving Resident #1, until the Ombudsman visited on Monday, 01/27/2020 (The Ombudsman visited on Tuesday, 01/28/2020). The ADM confirmed CNA #1 provided direct resident care on Saturday, 01/25/2020; Sunday, 01/25/2020; and Monday, 01/27/2020, and she was not removed from the building after the witnessed verbal abuse of Resident #1 on 01/25/2020.

During an interview, on 02/10/2020 at 2:00 PM, the Director of Nursing (DON) revealed she received a telephone voice message on 01/26/2020 that indicated "a resident and a CNA got into it with each other." The DON stated after getting the message, she called the facility and told the nurse to write up the incident, slide it under her door, and that she would investigate the incident on Monday, 01/27/2020. The DON confirmed CNA #1 continued to work in the facility

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from 01/25/2020 to 01/27/2020 and was not reassigned or sent home as a result of the incident on 01/25/2020.

During an interview, on 02/10/2020 at 2:45 PM, Resident #1 revealed she had "attitudes" from a few of the CNAs on an ongoing basis. She stated the CNAs fussed at her about wetting and overfilling her "diaper" with urine. Resident #1 revealed on 01/25/2020, she had just had enough of being fussed at. Resident #1 stated CNA #1 came into her room, started yelling and cussing at her, saying she had left urine up and down the hall, and that she could help herself. Resident #1 stated CNA #1 was "belittling" her. Resident #1 revealed she raised her hands in the air and told CNA #1 to stop it and told her that she didn't want to hear another word she had to say. Resident #1 stated CNA#1 got louder, then she got louder, and they were both yelling at each other. Resident #1 stated CNA #2 was in the room when she and CNA #1 were yelling and cussing each other. Resident #1 stated CNA #2 went and got the nurse, and the nurse called CNA #1 out into the hall. Resident #1 stated CNA #1 was still in the building working with residents, a few days after the incident, and that made her feel a little "uneasy" and a little "fearful." Resident #1 stated the Ombudsman came to see her a few days after the incident, and she told the Ombudsman about the incident. Resident #1 stated she hated that it took telling the Ombudsman in order to get the yelling and fussing to stop, but she was glad it finally got the residents some help. Resident #1 revealed the whole thing was "upsetting" to her for days afterwards, but she was okay now.

During a telephone interview, on 02/10/2020 at 4:00 PM, RN #1 revealed that on 01/25/2020, she

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was doing treatments in the room next door to Resident #1. RN #1 stated she heard CNA #1 yelling and screaming loudly, in a "threatening" and "very bad tone." RN #1 stated she overheard CNA #1 saying she was tired of Resident #1 "peeing everywhere" and that the resident had "peed" down the hall and on another resident's foot. RN #1 stated she did not like the way CNA #1 was yelling at Resident #1. RN #1 confirmed she went to Resident #1's room and told CNA #1 to leave Resident #1's room, take a break, and not to go back in Resident #1's room until she cooled off. RN #1 stated she called the DON on Sunday, 01/26/2020 and reported the incident she witnessed between Resident #1 and CNA #1. RN #1 further stated the DON told her to write the incident up, push it under her office door, and she would take care of the matter when she returned to work on Monday, 01/27/2020. RN #1 stated they (nurses) were asked to have a meeting with the CNAs, but the CNAs refused to meet with the nurses. RN #1 confirmed that she did not remove CNA #1 from the building or reassign her after the witnessed verbal abuse of Resident #1. RN #1 stated she did not evaluate or check on Resident #1 after the witnessed verbal abuse occurred.

During a telephone interview, on 02/11/2020 at 3:26 PM, the State Ombudsman (SO) revealed she reported the alleged verbal abuse of Resident #1 directly to the ADM on Tuesday, 01/28/2020 at approximately 3:00 PM. The SO stated Resident #1 reported to her an argument between her and CNA #1 that had occurred on Saturday, 01/25/2020. The SO revealed the ADM told her, during her exit meeting on Tuesday, 01/28/2020, that she had no knowledge of any incidents of verbal abuse and that was the first report she had received.

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On 02/11/2020 at 2:00 PM, during an interview, the Social Services Designee (SSD) revealed the DON and the ADM announced in a Stand-Up meeting on 01/27/2020, that there had been an incident involving Resident #1 and that they would be getting interviews. The SSD stated they did not give any details of what had occurred with Resident #1. The SSD confirmed the State Ombudsman (SO) was at the facility on 01/28/2020 and talked with the ADM, which delayed a scheduled meeting. The SSD stated she had not been given any directives to evaluate Resident #1 and had not been given any information concerning the investigation of the incident which occurred on 01/25/2020 between Resident #1 and CNA #1.

An interview with the Responsible Party (RP), on 02/12/2020 at 10:50 AM, revealed no one from the facility had contacted him about the witnessed verbal abuse of Resident #1 by CNA #1 that occurred on 01/25/2020 at 1:00 PM. The RP stated the facility notified him about the incident (which occurred on 01/25/2020), at approximately 10:00 AM on 02/12/2020. The RP stated the facility told him that Resident #1 had been involved in an argument with a staff member and that the matter had been resolved.

The facility submitted an Acceptable Removal Plan on 2/12/2020, for the IJ and SQC.

Review of the facility's Removal Plan revealed the facility took the following corrective actions to remove the IJ prior to exit:

1. On January 25, 2020, while making rounds at approximately 1:00 PM, Registered Nurse #1

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overheard Certified Nursing Assistant #1 yelling at Resident #1 from the inside of the resident's room. Registered Nurse #1 stated she instructed Certified Nursing Assistant #1 to take a break and removed her from the resident immediately. Registered Nurse #1 stated she notified Director of Nursing #1 on January 26, 2020 of the occurrence at approximately 2:00 PM. Director of Nursing #1 instructed Registered Nurse #1 to complete a disciplinary action with Certified Nursing Assistant #1.

2. On January 28, 2020, Ombudsman #1 reported to the Facility Administrator #1 of an allegation of verbal abuse reported by Resident #1. Resident #1 reported to Ombudsman #1 that Certified Nursing Assistant #1 yelled at her while providing incontinent care during the day shift hours of Saturday, January 25, 2020.

3. A written warning was completed by Director of Nursing #1 and reviewed with Certified Nursing Assistant #1 on January 27, 2020 regarding unsatisfactory behavior towards a resident on January 25, 2020.

4. The Facility Administrator #1 suspended Certified Nursing Assistant #1 on January 28, 2020 pending investigation. Certified Nursing Assistant #1 was terminated on February 3, 2020 by the Facility Administrator #1. As of February 11, 2020, Resident #1 remains in good spirits with no psychosocial changes noted.

5. Director of Nursing #1 assessed Resident #1 on January 28, 2020 at approximately 2:15 PM. Resident#1 was in good spirits with no indications of fear or withdrawn behavior. Resident #1 attended group activities on January 26th,

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January 27th, and January 28th, 2020.

6. The Facility Administrator #1 notified the local authorities on January 28, 2020 at approximately 4:45 PM. The Facility Administrator #1 notified the Mississippi State Department of Health and the Mississippi Attorney General's office on January 28, 2020 at approximately 4:55 PM.

7. A Quality Assurance meeting was held on February 11, 2020 at approximately 4:00 PM to discuss Verbal Abuse and investigations. The facility Quality Assurance Committee members which consisted of Facility Administrator #1, Director of Nursing #1, Infection Control Prevention Officer #1, Medical Director #1, Social Services Director #1, Assessment Nurse #1, Treatment Nurse #1 and Staff Development Nurse #1, Activity Director #1, Housekeeping Supervisor #1. Topics discussed include: (a) Resident Rights, (b) Accident/Incident Reporting, (c) Incident Investigation and Reporting, (d) Abuse/Neglect, e) Dignity/Respect. The Facility Action Plan was reviewed and approved by the Quality Assurance Committee Members.

The SA validated the facility's Removal Plan and determined that the facility took the appropriate measures to correct the IJ. The validation was confirmed through staff interviews, Residents interviews, Responsible Party interview, Ombudsman interview, and record review on 2/12/2020 prior to exit from the facility.

1. The SA validated Resident #1 was not free from verbal abuse and the facility failed to remove the perpetrator from the building following a witnessed account of verbal abuse that was witnessed by RN #1 and CNA #2 toward Resident

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#1 by CNA #1 on 01/25/2020 at approximately 1:00 PM. The facility failed to provide for the safety of Resident #1 and all 53 residents of the facility.

2. The SA validated through interview and record review that CNA #1 was allowed to work in direct resident care with residents in the facility for eight (8) hour shifts on Saturday 01/25/2020; Sunday 01/26/2020; and Monday 01/27/2020. The facility did not perform assessments of the residents in the facility and of Resident #1 and did not provide for their safety by completing assessments and removing the perpetrator from the building. The facility did not report the verbal abuse within two (2) hours of the witnessed verbal abuse toward Resident #1.

3. The SA validated through interview and record review with RN #1 that she reported that verbal abuse via telephone to the DON and completed a written report of the incident and pushed it under the office door of the DON. The SA validated through interviews and record reviews that the facility conducted In-Service Training on Abuse, Neglect, and Reporting of Incidents prior to exit on 2/12/2020.

4. The SA validated on 02/12/2020 through interviews with staff that a Quality Assurance (QA) Committee Meeting was held on 02/11/2020 at approximately 4:00 PM to discuss the incident of verbal abuse that was witnessed toward Resident #1 on 01/25/2020. All QA members required were in attendance.

5. The SA validated on 02/20/2020 through interviews with the Staff Development Nurse (RN#3) that she was conducting the in-service

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F 609	Continued From page 25 training and returning to the facility after hours and on weekends to conduct in-service training Abuse, Neglect, and Reporting of incidents as well as safety of all Residents. The RN#3 confirmed through interview that no staff member will be allowed to return to work before in-services / trainings were completed. 6. The SA validated on 02/12/2020 through staff and resident interviews and record review that all 53 residents residing in the facility had been assessed by facility staff for abuse, and neglect, and verbal abuse and safety. As well as psychosocial wellbeing and physical wellbeing. 7. The SA validated on 02/12/2020 through interviews and record reviews that the corrective actions were put into place by the facility on February 11, 2020. The IJ was removed on 2/12/2020 prior to exit.	F 609		
F 610 SS=J	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §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	F 610		3/23/20

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F 610	Continued From page 26 Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, record review, and facility policy review, the facility failed investigate a witnessed incident of verbal abuse in a timely manner and prevent the potential of further abuse occurring, for one (1) of four (4) residents reviewed, Resident #1. On 01/25/2020 at approximately 1:00 PM, Resident #1 and Certified Nursing Assistant (CNA) #1 were witnessed having a verbal altercation. CNA #1 was overheard telling Resident #1 she was sick and tired of her "peeing" on herself and everywhere in the facility. The incident was witnessed by Registered Nurse (RN) #1 and CNA #2, and overheard through the call system by Licensed Practical Nurse (LPN) #1 and LPN #2. CNA #1 was allowed to continue providing direct care to residents from 01/25/2020 to 01/27/2020 and was not sent home or made to leave the building after the witnessed incident of verbal abuse towards Resident #1 on 01/25/2020. Resident #1 was not assessed for any potential harm following the incident with CNA #1. The Administrator did not initiate an investigation of the witnessed verbal abuse until 01/28/2020, after she was informed by the State Ombudsman (SO) of her concerns regarding the incident between Resident #1 and CNA #1. The facility's failure to investigate and protect Resident #1 from abuse and allow a staff member to continue work in the facility, following a witnessed incident of verbal abuse, placed Resident #1 and other residents at risk in a	F 610	* Certified Nursing Assistant #1 was terminated on February 3, 2020 by the Facility Administrator #1. Director of Nursing #1 assessed Resident #1 on January 28,2020 and noted Resident # 1 in good spirits with no indications of fear or withdrawn behavior. Resident #1 attended group activities on January 26th, January 27th, and January 28th, 2020. *All residents have the potential to be affected *An In-service training was initiated on January 28, 2020 by Staff Development Nurse #1, the Director of Nursing #1 and the Facility Administrator #1 to include all Registered Nurses, Licensed Practical Nurses, Certified Nursing Assistants, Housekeeping and Laundry staff, Dietary staff, Office personnel and contracted therapy department staff on the following (a) Resident Rights, (b) Accident/Incident Reporting, (c) Incident Investigation and Reporting,(d) Abuse/Neglect, e) Dignity/Respect. Staff will not be allowed to work until the proper in-service training has been conducted. The facility contacted our agency personnel provider on February 11th 2020. Agency personnel will not be allowed to work until these in-services have been conducted by licensed facility staff.	

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F 610	Continued From page 27 situation that was likely to cause serious injury, harm, impairment, or death. The situation was determined to be an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which began on 01/25/2020 when the verbal abuse occurred. The facility's Administrator was notified of the IJ and SQC on 02/12/2020 at 9:40 AM and provided with the IJ template. An acceptable, credible Removal Plan was provided by the facility on 02/12/2020, in which the facility alleged all corrective actions were completed, and the IJ was removed on 02/12/2020. The SA validated the Removal Plan and determined that the IJ was removed on 02/12/2020, prior to exit. Therefore, the scope and severity for the IJ and SQC at 42 CFR(s): 483.12 (c)(2)-(4) F610, Investigate/Prevent/Correct Alleged Violation was lowered to a "D" while the facility develops and implements a plan of correction (POC) and monitors the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include: Review of the facility's "Incident Investigation and Reporting" policy, revised 05/2018, revealed, the facility would take all necessary steps to prevent recurrence and/or further potential abuse, any employee of the facility involved in incidents of abuse, would be suspended pending investigation until such time as the facility investigation is complete. During and after the investigation, the residents will be protected from harm through frequent supervision by staff. The final result of	F 610	* Director of Nursing #1, Staff Development Nurse #1 and Treatment Nurse #1 began to conduct care observations on February 11, 2020 across all shifts for dignity and respect. Care observations will be completed across all shifts weekly x 3 weeks, then bi-weekly for three months, and then monthly thereafter by Director of Nursing #1, Staff Development Nurse #1, and Treatment Nurse #1. Five cognitive residents will be interviewed weekly x 3 beginning February 12, 2010, then bi-weekly for three months, and then monthly thereafter by Director of Nursing #1 and Social Services Director #1. The Facility Administrator of record will monitor all incident and accident investigations for completion. The Facility Administrator shall report all results of the established monitoring to the Quality Assurance Committee meeting for the immediate corrective plan of action of any deficient practice.	

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the investigation is to be reported to the Corporate Compliance Officer, Regional Supervisor, and appropriate officials in accordance with state law, within 72 hours after the event per fax and certified mail, or per specific state guidelines.

Review of a complaint report submitted to the State Crimes Submission website by the facility's Administrator, dated 01/28/2020, revealed, the State Ombudsman reported concerns of verbal abuse, to the facility's Administrator, which involved a staff member and Resident #1.

Review of the facility's investigation report, received by the State Agency (SA), revealed the report was faxed to the SA on 02/03/2020 at 5:36 PM, which was six (6) working days after the incident occurred.

Review of the facility's "Employee Warning Report" for CNA #1, dated 01/26/2020, revealed, Registered Nurse (RN) #1 documented "Date of Violation 01/25/2020, Time 1:00 PM", Yelling and arguing with resident in her room about toileting." The report was signed by RN #1 and dated 01/26/2020. The report was signed by the facility's Administrator, but undated.

A review of the facility's CNA schedule for January 2020, revealed CNA #1 was scheduled to work on 01/25/2020 through 01/27/2020.

Record review of Resident #1's medical record revealed there was no documentation of an assessment completed on 01/25/2020 following the witnessed incident of verbal abuse.

On 02/10/2020 at 2:00 PM, during an interview

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with the Director of Nursing (DON), she revealed that she was notified on Sunday, 01/26/2020 regarding an incident between Resident #1 and CNA #1. The DON stated she told the nurse to write up the incident, slide it under her door, and that she would investigate the incident on Monday, 01/27/2020. The DON confirmed CNA #1 worked at the facility from 01/25/2020 to 01/27/2020 and was not reassigned or sent home as a result of the incident on 01/25/2020.

During an interview with the facility's Administrator (ADM), on 02/10/2020 at 2:30 PM, she stated the Ombudsman reported the incident of verbal abuse between Resident #1 and CNA #1 to her on Monday, 01/27/2020. (The Ombudsman was present at the facility on Tuesday, 01/28/2020). The ADM stated she did not know anything about the alleged verbal abuse, until the Ombudsman told her of concerns she had regarding an incident that had occurred between Resident #1 and CNA #1. The ADM confirmed CNA #1 was not reassigned to another hall or asked to leave the building on the day of the incident (01/25/2020). The ADM confirmed CNA #1 continued to work at the facility until 01/27/2020. The ADM revealed it was the facility's policy to send any staff home that was involved in an investigation or alleged to be accused of abuse.

During an interview via telephone, on 02/10/2020 at 4:00 PM, RN #1 she was in another resident's room when she heard CNA #1 and Resident #1 yelling and screaming extremely loud at each other on 01/25/2020. RN #1 stated CNA #1 told Resident #1 that she was tired of her "peeing" everywhere and that she had "peed" on another resident's foot and down the hall. RN#1 revealed CNA #1 spoke to Resident #1 in a harsh tone.

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RN #1 stated she told CNA #1 to come out of Resident #1's room and go take a break, and not to go back into the resident's room until she cooled off. RN #1 stated she did not assess Resident #1, and "assumed" LPN #1 had assessed her since she was assigned to the hall where Resident #1 resided. RN #1 revealed she called the DON on Sunday, 01/26/2020, and was told to write up the incident and push it under her office door. RN #1 stated the DON told her she would handle the situation when she returned to work on Monday 01/27/2020.

Review of the facility's "Licensed Staff" job description, dated 09/19/2019 and signed by RN #1, revealed her responsibilities included to assure accurate and timely documentation of any unusual observation, incident or happening. The Job Summary included: Make rounds, evaluate the physical, emotional and social needs of the residents and provide intervention as indicated. Review of the facility's personnel records for RN #1, revealed on 09/19/2019, she signed to acknowledge reading and receiving policies and procedures on Resident Rights, Reporting Requirements of the Vulnerable Adult Act and the Mississippi Vulnerable Adult Act.

During an interview via telephone, on 02/10/2020 at 4:45 PM, LPN #1 revealed that she was kind of the leader on weekends and that all reports are sent to her to resolve. LPN #1 stated on the day of the incident (01/25/2020), she and LPN #2 were sitting at the nurse's desk charting and heard an argument over the intercom call system. LPN #1 revealed she and LPN #2 went down the hall and saw RN #1 standing outside of Resident #1's room talking to CNA #1. LPN #1 stated she assumed RN #1 had handled the situation

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between Resident #1 and CNA #1. LPN #1 revealed she never assessed any residents.

On 02/11/2020 at 2:00 PM, during an interview, the facility's Social Service Designee (SSD) revealed she had never been asked to evaluate Resident #1 or had spoken to Resident #1 about any incidents that had occurred between her and any staff members. The SSD stated during the Stand-Up meeting on 01/27/2020, the DON announced she had been given some information about an incident between a resident and a CNA, but the DON did not reveal any details about the incident. The SSD confirmed the Ombudsman was at the facility on 01/28/2020. The SSD further revealed they had a Quality Assurance (QA) on 01/28/2020, but there was no discussion about an incident occurring between Resident #1 and any CNA.

During an interview, on 02/11/2020 at 3:26 PM, the State Ombudsman (SO) revealed she had visited the facility on Tuesday, 01/28/2020. The SO revealed she told the ADM, Resident #1 had voiced being "upset" about an incident that occurred between her and CNA #1 on 01/25/2020. The SO stated Resident #1 told her she had been fussed at because of wetting herself and that the statements were "hurtful" and embarrassed her.

An interview on 02/12/2020 at 11:30 AM, with CNA #1, revealed that on 01/25/2020 at approximately 1:00 PM, she was involved in an argument with Resident #1. CNA #1 revealed that she and Resident #1 both cussed each other and that the argument got loud. CNA #1 revealed RN #1 heard the loud argument, intervened and asked her to go on break to cool off, and not to

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go back in Resident #1's room until she was calm. CNA #1 confirmed she worked her entire shifts on 01/25/2020, 01/26/2020, and 01/27/2020 and was never reassigned nor asked to leave the building on any of those days. CNA #1 revealed that no one ever asked her about the incident between her and Resident #1 until Monday, 01/27/2020. CNA #1 stated the DON asked her to write a statement about what happened on 1/25/2020, between her and Resident #1. CNA #1 revealed the DON did not talk to her about the incident, but only asked her to write a statement. CNA #1 revealed the ADM called her on 01/30/2020 and told her there was an investigation into the incident and for her not to return to work until the investigation was over.

The facility submitted an acceptable Removal Plan on 02/12/2020, for the IJ and SQC.

Review and validation of the facility's Removal Plan revealed the facility took the following corrective actions to remove the IJ prior to exit on 02/12/2020.

1. On January 25, 2020, while making rounds at approximately 1:00 PM, Registered Nurse #1 overheard Certified Nursing Assistant #1 yelling at Resident #1 from the inside of the resident's room. Registered Nurse #1 stated she instructed Certified Nursing Assistant #1 to take a break and removed her from the resident immediately. Registered Nurse #1 stated she notified Director of Nursing #1 on January 26, 2020 of the occurrence at approximately 2:00 PM. Director of Nursing #1 instructed Registered Nurse #1 to complete a disciplinary action with Certified Nursing Assistant #1.

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2. On January 28, 2020, Ombudsman #1 reported to the Facility Administrator #1 of an allegation of verbal abuse reported by Resident #1. Resident #1 reported to Ombudsman #1 that Certified Nursing Assistant #1 yelled at her while providing incontinent care during the day shift hours of Saturday, January 25, 2020.

3. A written warning was completed by Director of Nursing #1 and reviewed with Certified Nursing Assistant #1 on January 27, 2020 regarding unsatisfactory behavior towards a resident on January 25, 2020.

4. The Facility Administrator #1 suspended Certified Nursing Assistant #1 on January 28, 2020 pending investigation. Certified Nursing Assistant #1 was terminated on February 3, 2020 by the Facility Administrator #1. As of February 11, 2020, Resident #1 remains in good spirits with no psychosocial changes noted.

5. Director of Nursing #1 assessed Resident #1 on January 28, 2020 at approximately 2:15 PM. Resident#1 was in good spirits with no indications of fear or withdrawn behavior. Resident #1 attended group activities on January 26th, January 27th, and January 28th, 2020.

6. The Facility Administrator #1 notified the local authorities on January 28, 2020 at approximately 4:45 PM. The Facility Administrator #1 notified the Mississippi State Department of Health and the Mississippi Attorney General's office on January 28, 2020 at approximately 4:55 PM.

7. A Quality Assurance meeting was held on February 11, 2020 at approximately 4:00 PM to discuss Verbal Abuse and investigations. The

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facility Quality Assurance Committee members which consisted of Facility Administrator #1, Director of Nursing #1, Infection Control Prevention Officer #1, Medical Director #1, Social Services Director #1, Assessment Nurse #1, Treatment Nurse #1 and Staff Development Nurse #1, Activity Director #1, Housekeeping Supervisor #1. Topics discussed include: (a) Resident Rights, (b) Accident/Incident Reporting, (c) Incident Investigation and Reporting, (d) Abuse/Neglect, e) Dignity/Respect. The Facility Action Plan was reviewed and approved by the Quality Assurance Committee Members.

The SA validated the facility's Removal Plan and determined that the facility took the appropriate measures to correct the IJ. The validation was confirmed through staff interviews, Residents interviews, Responsible Party interview, Ombudsman interview, and record review on 2/12/2020 prior to exit from the facility.

1. The SA validated Resident #1 was not free from verbal abuse and the facility failed to remove the perpetrator from the building following a witnessed account of verbal abuse that was witnessed by RN #1 and CNA #2 toward Resident #1 by CNA #1 on 01/25/2020 at approximately 1:00 PM. The facility failed to provide for the safety of Resident #1 and all 53 residents of the facility.

2. The SA validated through interview and record review that CNA #1 was allowed to work in direct resident care with residents in the facility for eight (8) hour shifts on Saturday 01/25/2020; Sunday 01/26/2020; and Monday 01/27/2020. The facility did not perform assessments of the residents in the facility and of Resident #1 and did not provide

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for their safety by completing assessments and removing the perpetrator from the building. The facility did not report the verbal abuse within two (2) hours of the witnessed verbal abuse toward Resident #1.

3. The SA validated through interview and record review with RN #1 that she reported that verbal abuse via telephone to the DON and completed a written report of the incident and pushed it under the office door of the DON. The SA validated through interviews and record reviews that the facility conducted In-Service Training on Abuse, Neglect, and Reporting of Incidents prior to exit on 2/12/2020.

4. The SA validated on 02/12/2020 through interviews with staff that a Quality Assurance (QA) Committee Meeting was held on 02/11/2020 at approximately 4:00 PM to discuss the incident of verbal abuse that was witnessed toward Resident #1 on 01/25/2020. All QA members required were in attendance.

5. The SA validated on 02/20/2020 through interviews with the Staff Development Nurse (RN#3) that she was conducting the in-service training and returning to the facility after hours and on weekends to conduct in-service training Abuse, Neglect, and Reporting of incidents as well as safety of all Residents. The RN#3 confirmed through interview that no staff member will be allowed to return to work before in-services / trainings were completed.

6. The SA validated on 02/12/2020 through staff and resident interviews and record review that all 53 residents residing in the facility had been assessed by facility staff for abuse, and neglect,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255215	A. BUILDING _____ B. WING _____	C 02/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK OF COLLINS	1315 SOUTH FIR AVE COLLINS, MS 39428

(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 610	Continued From page 36 and verbal abuse and safety. As well as psychosocial wellbeing and physical wellbeing. 7. The SA validated on 02/12/2020 through interviews and record reviews that the corrective actions were put into place by the facility on February 11, 2020. The IJ was removed on 2/12/2020 prior to exit.	F 610		