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M 000	Initial Comments The State Agency (SA) conducted a complaint investigation (CI) for MS #16490 and MS #16510, from 12/30/19 to 01/02/20. MS #16510 related to staffing concerns was not substantiated during the investigation. The SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged and Infirm, with a deficiency cited at M500. The SA substantiated MS #16490 for Freedom from Abuse and Neglect, and identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) 12/30/19, which began on 11/21/19, when the Assistant Director of Nursing Services (Registered Nurse (RN) #1) caused mental and verbal abuse to Resident #1 by not allowing the Certified Nursing Assistants (CNA) #1 and #2 to place the resident back to bed, when she was crying and yelling in pain. Resident #1 and her daughter (Responsible Party (RP #2), reported the allegation of abuse to the Administrator. The facility failed to investigate and report the allegation to the SA within two (2) hours of the allegation, as required. The facility failed to suspend the RN #1, and allowed him to continue to work in his capacity as the Assistant Director of Nursing Services (ADNS). This 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 12/30/19 at 4:30 PM, and the IJ template was provided to the Administrator. The IJ and SQC existed at: 45.17.2, M500 - Resident Rights (to be free of abuse)	M 000		

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M 000	Continued From page 1 The facility submitted an acceptable Removal Plan on 12/31/19, in which the facility alleged all corrective actions were completed and the IJ removed on 01/01/20. The SA validated the Removal Plan on 01/02/20 and determined the IJ was removed on 01/01/20. Therefore, the scope and severity for 45.17.2, M500 - Resident Right, was lowered to a "D" while the facility develops and implements a plan of correction and monitors for the effectiveness of the systematic changes to ensure the facility sustains compliance with regulatory requirements. The facility held a license for 120 beds, with a census of 109.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate;	M 500		1/31/20

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M 500	Continued From page 2 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 care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff	M 500		

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M 500	Continued From page 3 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; 11. is not required to perform services for the facility that are not included for therapeutic	M 500		

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M 500	Continued From page 4 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 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.	M 500		

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M 500	Continued From page 5 This Statute is not met as evidenced by: Level IV Based on resident interview, staff interview, record review and facility policy review, the facility failed to ensure a resident was free from verbal and mental abuse for one (1) of nine (9) residents reviewed for abuse, Resident #1. On 11/21/19, at or around 11:30 AM, Resident #1 reported an allegation of verbal and mental abuse against the Assistant Director of Nursing Services/Registered Nurse (RN) #1, to her daughter (Responsible Party (RP) #2) by phone, during the incident. The allegation consisted of Resident #1 was made to get up out of the bed and sit in the wheelchair, while she was in pain, and had no desire to sit up that day in the wheelchair. RN #1 would not allow Certified Nursing Assistant (CNA) #1 and CNA #2 to put Resident #1 back to bed, when she was crying and yelling out in pain. This incident occurred in Resident #1's room, and was witnessed by other staff. Resident #1 stated she felt like she was fighting for her life, and that nobody had ever made her feel that way before, in her whole life. Resident #1 stated she felt so helpless. The Administrator was notified by Resident #1's daughter (RP #2) via phone, shortly after the incident on 11/21/19. The Administrator was told by Resident #1's daughter (RP #2), she did not like the way that RN #1 had spoken to her mother (Resident #1) and stated, "You better do something with (RN #1) before I come up there and whip his ass. Don't nobody talk to my momma the way he did." The Administrator did not investigate the allegation of verbal and mental abuse, suspend the employee, or protect Resident #1 and all other residents.	M 500	* Registered Nurse #1 was suspended immediately by the Director of Nursing Services (DNS)on December 30,2019. Resident #1 was assessed for distress on December 30,2019. Resident #1's responsible representative was notified by the Administrator immediately on December 30,2019 of the allegation of abuse and the request for psychological services to evaluate Resident #1. Director of Clinical Education contacted the Medical Director on December 30,2019 and an order for Psychological Services consult was obtained to provide care for any mental anguish. The Social Services Director contacted psychological services on December 30,2019 and psychological evaluation of Resident #1 completed with no negative findings on December 31,2019. * All residents have the potential to be affected by the alleged deficient practice. Alert and oriented residents were interviewed by the Social Worker (SW) and Director of Clinical Operations (DCO), the Health Information Coordinator and the Director of Care Coordination with no other allegations of abuse on December 30,2019. * Education was started by the Director or Clinical Education (DCE) on Abuse and Neglect, Reporting and Investigations, Resident Rights and Preferences and	

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M 500	Continued From page 6 The facility's failure to protect Resident #1 from verbal and mental abuse, and allow a staff member to work in the facility, following an incident of witnessed verbal and mental 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 Jeopardy (IJ) and Substandard Quality of Care (SQC) which began on 11/21/19, when the verbal and mental abuse occurred. The facility's Administrator was notified of the IJ and SQC on 12/30/19 at 4:30 PM and provided with the IJ template. An acceptable credible Removal Plan was provided by the facility on 12/31/19, in which the facility alleged all corrective actions were completed as of 12/31/19, and the IJ was removed on 01/01/20. The State Agency (SA) validated the Removal Plan and determined that the IJ was removed on 01/02/20, prior to exit. Therefore, the scope and severity for the IJ and SQC at M500 -Resident Rights was lowered to a "Level II", 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 "Abuse, Neglect, Misappropriation, Exploitation Policy", dated 01/19, revealed: Abuse: The willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting physical harm, pain or mental anguish. Mental Abuse: is the use of verbal or nonverbal conduct which causes or has	M 500	Customer Service on December 30,2019. Systemic changes include monthly education and orientation by the Administrator or Director of Clinical Education Nurse to all staff regarding Abuse and Neglect, Reporting and Investigating allegations of abuse, customer service and residents' rights ongoing from December 30,2019. December 30,2019 and ongoing,grievances and/or allegations will be reviewed and investigated at Daily Stand up Meeting by the Administrator/Director of Nursing Services with follow up as needed. * December 30, 2019 and ongoing, Social Services Director/Administrator will maintain a log of all grievances and/or allegations as well as the grievance forms. The grievance and/or allegations will be reviewed and investigated five times per week at Daily Stand up by the Administrator/Director of Nursing Services. Notification of response to grievances will be brought to the Quality Assurance Performance Improvement (QAPI) monthly for two months. The Administrator/Director of Nursing Services/Social Service Director will conduct resident interviews December 30,2019 and ongoing to ensure no allegations of abuse/neglect or failure to acknowledge residents' rights and findings will be reviewed five times per week at Daily Startup Meeting. Interview findings	

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M 500	Continued From page 7 the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation. Investigation: The Administrator will oversee in conducting an internal investigation against any violation/alleged violation of abuse and report the results of the investigation to the enforcement agency, the state survey and the certification agency within five days of the incident. Investigations will be prompt, comprehensive and responsive to the situation and founded conclusions. The investigation will include, but not limited to: Identification and removal of the alleged person. Interviews of all persons involved, witnesses, alleged victim, and follow up resolution and measures to prevent repeat incidents. Review of an anonymous complaint allegation, submitted to the SA on 12/23/19, documented on 11/20/19, the Assistant Director of Nursing Services made Resident #1 cry. Review of the facility "Customer Concern/Grievance Communication Form", dated 11/21/19 and signed by the Administrator, revealed: Resident #1 concerned with approach of Assistant Director of Nursing (ADON)/RN #1 motivating her to do therapy. Administrator, Director of Rehab (DOR) and ADON/RN #1 met with resident to talk about concerns with therapy goals and motivation of ADON/RN #1. Talked with ADON/RN #1 and therapy about approach and different forms of encouragement. Customer (Resident #1) contacted for follow up on 11/21/19. On 12/30/19 at 10:00 AM, during an interview with Resident #1, she stated, the incident happened about a month or two ago and she was not sure of the date. Resident #1 stated, "They (facility) are trying to sweep it under the rug."	M 500	will be brought to the Quality Assurance and Performance Improvement(QAPI) monthly for two months.	

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M 500	Continued From page 8 Resident #1 began to cry and was emotionally upset recalling the event. Resident #1 stated on that day (11/21/19), she really didn't want to get up at all, because she had been awake all night with spasms in her legs. Resident #1 revealed RN #1 told her she needed to get up, so she allowed Certified Nursing Assistant (CNA) #1 and CNA #2 to get her up with the lift and they placed her in her wheelchair in her room. Resident #1 stated she was in a lot of pain in her right leg, and felt like she was sliding out of the wheelchair. Resident #1 revealed she asked to be placed back in the bed. Resident #1 stated Certified Nursing Assistant (CNA) #1 and CNA #2 went into the hallway to get the lift and was stopped by RN #1. Resident #1 stated, RN #1 took the lift back out of the room, and wouldn't let the CNAs put her back to bed. Resident #1 stated she called her daughter (Responsible Party (RP) #2), and while she was telling her daugher what was going on, RN #1 took her cell phone and wouldn't give it back to her. Resident #1 stated RN #1 went out of the room to talk to her daughter. Resident #1 revealed RN #1 came back in the room, and gave her phone back, but her daughter had hung up. Resident #1 stated she had called her daughter, because she knew her daughter would stop RN #1 from treating her this way. Resident #1 stated RN #1 always had smart comments, but had never acted like he did that day, and was out of control. Resident #1 stated, "Nobody had ever made me feel that way before in my whole life. I felt like I was fighting for my life. I felt so helpless, and he knew I couldn't do anything to stop him because I'm paralyzed." Resident #1 stated RN #1 told the staff not to listen to her or her family, and to listen to him because he was the boss. Resident #1 stated CNA #1 wanted to put her back to bed, and was about to cry, because RN #1 wouldn't let her.	M 500		

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Resident #1 stated the Administrator came to her room, the same day this incident occurred, because her daughter had left a message for her. Resident #1 stated the Administrator told her RN #1 didn't mean anything by that, and she needed for them to be friends.

During an interview, on 12/30/19 at 1:00 PM, CNA #1 revealed around lunchtime on 11/21/19, RN #1 asked them (CNAs) to get Resident #1 up. CNA #1 stated after they got Resident #1 up, she began begging to be put back to bed, after about five minutes. CNA #1 stated Resident #1 was crying, so they went and got the lift. CNA #1 stated RN #1 stopped them, and told them to go on and pass out the trays. CNA #1 stated RN #1 told them that he was their boss, and they do what he said to do. CNA #1 stated RN #1 stayed in Resident #1's room and that they (RN #1 and Resident #1) could be heard yelling at each other, all the way to the nurse's desk. CNA #1 stated Resident #1 was crying, screaming and cussing at Resident #1. CNA #1 was emotional and crying while recalling the incident. CNA #1 stated, "I felt so helpless and I was upset that she (Resident #1) was crying and begging to go back to bed, and he (RN #1) wouldn't allow us to put her to bed. I was fearful of him and I asked him how is that right that you get to treat her that way." CNA stated RN #1 replied, "Because I'm the boss." CNA #1 stated Resident #1 had never been out of the bed, other than to go to the shower and the resident was scared. CNA #1 stated, since RN #1 had come on board, he wanted Resident #1 to get up and sit up. CNA #1 stated Resident #1 was almost falling out of her chair before RN #1 would let them (CNAs) put her back to bed, which was about 30-45 minutes later. CNA #1 stated she didn't know what else to do, so she went and got the phone numbers for the Ombudsman and the

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SA, and put them in Resident #1's phone.

On 12/30/19 at 1:10 PM, an interview with the Administrator, confirmed she did not have an investigation report regarding the allegation of abuse for Resident #1, which occurred on 11/21/19. The Administrator stated, it wasn't an allegation of abuse. The Administrator stated she talked to Resident #1 , but she didn't write anything down. The Administrator stated Resident #1 wasn't upset. The Administrator revealed she didn't get a statement from RN #1.
The Administrator stated she didn't investigate the incident as abuse, because it wasn't. The Administrator stated RN #1 was just motivating Resident #1. The Administrator confirmed she had received a call from the resident's daughter. The Administrator stated the resident's daughter was concerned, and didn't like the way RN #1 had talked to her mother. The Administrator stated Resident 1's daughter (RP #2) said if she didn't do something about it, then she was coming to the facility. The Administrator stated, "I didn't think there was anything to it, because she never showed up."

During an interview, on 12/30/19 at 1:10 PM, the Director of Nursing (DON) confirmed she was on vacation the week of 11/19/19 through 11/26/19, and RN #1 was serving as the interim DON while she was away. The DON stated she had never heard any complaints or concerns about RN #1.

On 12/30/19 at 12:50 PM, during an interview with the Physical Therapist (PT), she stated Resident #1 began therapy on 10/22/19 with a desire to sit up in her wheelchair for about an hour by Thanksgiving. The PT stated they (Therapy) had her up several times a week for about an hour. The PT stated there were some

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days Resident #1 didn't feel like getting up, so they would try again the next day. The PT confirmed she had heard about the incident that occurred between Resident #1 and the RN #1. The PT confirmed restorative recommendations for Resident #1 were written on 11/13/19, for the resident to sit up at least one hour daily, with precautions due to occasional muscle spasms in right leg and to perform passive range of motion to right leg.

Review of the "Therapy to Restorative Nursing Recommendations," for Resident #1, dated 11/13/19, revealed: Able to sit up in manual chair at least one hour daily, increase out of bed time as able past one hour. Precautions: Occasional muscle spasms in right leg greater than left leg.

Review of the "Physical Therapy PT Evaluation and Plan of Treatment," for Resident #1, dated 10/22/19, documented, the reason for referral to therapy was due to increased desire for out of bed activity and clearance by (MD) Medical Director to get up in the chair. Resident #1 was being evaluated for functional mobility and had been bedridden greater than a year, with multiple pressure breakdown to bilateral breasts, back area, right lateral leg, sacral area.

Review of Resident #1's "Physical Therapy PT Discharge Summary," dated 11/20/19, documented, Discharge 11/20/19: Patient unable to sit unsupported and is a total assist time two (persons). Discharge Recommendations: restorative program progress out of bed, up in chair tolerance.

On 12/30/19 at 2:15 PM, during an interview, the Therapy Director (TD) stated she had received a text from the Administrator, on the day of the

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incident, around 4:00 PM, requesting her to get RN #1 and come to the Administrator's office. The TD stated the Administrator told them she had received a call from Resident #1's daughter, and that she was upset with RN #1. The TD revealed the Administrator wanted to know she would go with her and RN #1, to Resident 1's room, to address what was wrong. The Therapy Director confirmed, Resident #1 was crying and upset, and told the Administrator she wouldn't wish on anybody, to be in that much pain and to be treated the way she had been treated by RN #1. The TD stated she remained in the room the whole time the Administrator talked to the resident, and that Resident #1 continued crying and was emotional. The TD stated she had never seen Resident #1 that emotional and upset before, and tried to calm her down.

On 12/30/19 at 2:30 PM, during a phone interview, CNA #2 confirmed RN #1 would not allow her and CNA #1 to put Resident #1 back to bed. CNA #2 stated RN #1 was telling Resident #1, she was not going back to bed. CNA #2 confirmed Resident #1 was crying and upset. CNA #2 stated RN #1 could have handled the incident a lot better than he did. CNA #2 revealed she didn't reported the incident to anyone. CNA #2 stated, "It wouldn't do any good to report it to the DON or the Administrator, they protect each other." CNA #2 stated RN #1 was over the CNAs.

On 12/30/19 at 3:55 PM, during an interview, RN #1 revealed he was the Assistant Director of Nursing Services (ADNS) at the facility, and the overseer of the Restorative Program. RN #1 stated, on 11/13/19, he had met with Resident #1 and her son (RP #1), and told them the goal was for Resident #1 to sit up two (2) hours, three (3)

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times a week. RN #1 stated he told Resident #1 they were going to attack this thing, and he was going to be tough on her. RN #1 stated Resident #1 began refusing to get up, so he called her son (RP #2) to let him know. RN #1 stated on 11/21/19, he went into Resident #1's room, and she had her daughter (RP #2) on the phone. RN #1 stated he told Resident #1 he was going to call her son (RP #1). RN #1 did not indicate he had taken the phone away from Resident #1. RN #1 stated after about five to ten minutes, the CNAs were trying to put Resident #1 back to bed. RN #1 stated he told the CNAs to go on and pass the trays out, and he would handle the resident. RN #1 confirmed the resident was crying and yelling . RN #1 stated Resident #1 was complaining of her right hip hurting. RN #1 stated he padded the resident in her wheelchair, and she continued to sit up, until he told the CNAs to put her back to bed after about 45 minutes or so. RN #1 stated Resident #1 wanted to go back to bed, but they had made a plan for her to get up 3 times a week and told her he was going to be tough on her. RN #1 stated, "Hindsight, I could have handled it differently. I probably did cause her mental anguish, but I don't think I abused her."

Review of the "Order Summary Report" for Resident #1, revealed an order dated 05/31/19, for Norco (Hydrocodone-Acetaminophen) 10-325 milligrams give one (1) tablet via Percutaneous Endoscopic Gastrostomy (PEG) tube every four (4) hours as needed for pain

Review of Resident #1's Medication Administration Record for November 2019, revealed on 11/21/19, the resident was given Norco) 10-325 milligrams 1 tablet for pain at 4:46 AM and 9:28 AM, with pain levels documented at six (6) and seven (7), on a scale of 1-10.

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M 500	Continued From page 14 On 12/31/19 at 9:58 AM, during an interview with the Regional Nurse Consultant (RNC), she stated she received a call from the Minimum Data Set (MDS) Nurse, at approximately 9:30 PM on 12/02/19. The RNC stated, the MDS Nurse asked if anyone had said anything to her about RN #1 making a resident cry. The RNC stated " I said no." The RNC revealed she called the Administrator, within five minutes, and asked her if she knew anything about this incident. The RNC stated the Administrator said she had done a grievance. The RNC stated the Administrator told her Resident #1's daughter had called and said the resident was upset. The RNC stated she then told the Administrator to go to Resident #1's room the next day, and talk to her. The RNC revealed, the Administrator called her back the following day, and informed her Resident #1 was crying and upset, because she didn't like how RN #1 was motivating her. On 12/31/19 at 10:30 AM, during an interview with Resident #1's son (RP #1) at the facility (Resident 1's room), and with the resident's daughter (RP#2) by phone, RP #1 stated he was not aware of the full story of what had occurred on 11/21/19. RP #1 stated he got a phone call from his sister (RP #2), and she told him she had left a message for the Administrator, and that he needed to go to the facility to see what was going on. RP #1 stated his sister told him their mother (Resident #1) had called her and was upset about how RN #1 talked to her. RP #1 stated he came to the facility, but RN #1 told him he and Resident #1 just had a conversation, and RN #1 made it sound like it wasn't a big deal. Resident #1 stated to RP #1, during the interview, she called RP #2 because she didn't want to upset him, and she knew RP #2 would take care of RN #1. RP #2	M 500		

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confirmed by phone interview, she was upset about how RN #1 had talked to her mother. RP #2 stated she had left a message for the Administrator to call her, but the Administrator never called her back.

During an interview, on 12/31/19 at 11:15 AM, Resident #1's Nurse Practitioner (NP) confirmed that she was not aware of the incident that occurred on 11/21/19. The NP stated, "This is the first that I've heard about it, and I've been her NP for years."

On 12/31/19 at 3:45 PM, an interview with Resident #1's primary Physician (Physician #1), revealed he was not aware of the incident and no one had called or informed him of the situation.

On 01/02/20 at 2:40 PM, during an interview with the MDS Nurse, she stated the staff knew the incident had been reported to the Administrator, and the CNAs were upset Resident #1 had been made to cry by RN #1. The MDS Nurse stated it was extremely out of Resident #1's character to be that upset. The MDS nurse stated, they (staff) didn't see anything being done about the incident, so she called the MDS corporate person, and she then called the Regional Nurse Consultant.

During an interview, on 01/02/20 at 2:00 PM, the Receptionist confirmed she had taken the phone call on 11/21/19, from Resident #1's daughter. The Receptionist stated RP #1 wanted to speak with the Administrator right away, and that RP #2 was upset, because she didn't like how RN #1 talked to her mother and wanted somebody to take care of it. The Receptionist stated she went and told the Administrator right away that RP #2 had called, and was upset. The Receptionist stated she didn't know if the Administrator had

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M 500	Continued From page 16 handled the situation or not. Review of a document titled, "Position Description", dated 05/28/19 and signed by the Administrator, revealed: Serve as the center abuse coordinator. Strive to ensure the safety of all residents within the center; ensures education and understanding of all team members of abuse recognition, protecting and reporting responsibilities; responds swiftly to any allegation of abuse, neglect, or misappropriation by protecting, investigating and making any required reporting. Review of the facility's personnel file for RN #1, revealed he was hired on 09/23/19, and had no prior disciplines or any corrective actions in his employee file. Review of an In-service Attendance Record, dated 11/07/19, with a topic on Abuse, Neglect, Misappropriation and Exploitation, revealed RN #1 was in attendance. This in-service was held two (2) weeks prior to the incident with Resident #1. Review of the Admission Record, revealed the facility admitted Resident #1 on 10/01/18. Diagnoses included Paraplegia, Morbid Obesity, Major Depressive Disorder, Dependence on other enabling machines and devices, Contracture Right Hip and Contracture Right Knee. Review of Resident #1's Quarterly MDS Assessment, with an Assessment Reference Date (ARD) of 11/25/19, revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognitive skills for daily decision making.	M 500		

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M 500	Continued From page 17 The facility submitted an acceptable Removal Plan on 12/31/19, for the IJ. Review of the facility's Removal Plan revealed the facility took the following corrective actions to remove the IJ prior to exit. 1. The facility failed to protect a resident from abuse and neglect on 11/21/19, when the Assistant Director of Nursing (Registered Nurse (RN) #1) would not place Resident #1 back to bed when she was crying and yelling in pain. RN #1 refused to allow the Certified Nurse Assistant (CNA) staff to assist the resident. RN #1 continued to practice in his role, after the resident suffered from mental anguish, which caused psychosocial harm to Resident #1. The Administrator knew of the incident on 11/21/19 but failed to protect the resident by suspending RN #1, thoroughly investigate the incident, or report the incident to the Mississippi State Department of Health within two hours of the allegation of abuse. 2. Quality Assurance Performance Improvement (QAPI) meeting was held on December 30, 2019 at 5:30 PM. Systemic changes and monitoring were developed, presented and approved by Administrator (Adm), Director of Nursing Services (DNS), Nurse Consultant and Clinical Education Nurse, and Medical Director. Systemic changes include monthly education and orientation by the Administrator or Director of Clinical Education to all staff regarding Abuse and Neglect, Reporting and Investigation allegations of abuse, customer service and residents' rights. Grievances and/or allegations will be reviewed and investigated at Daily Stand up by the Adm/DNS/Designee with follow up as needed.	M 500		

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M 500	Continued From page 18 3. The Administrator (ADM) called the MS State Department of Health regarding an allegation of abuse and initiated an investigation on December 30, 2019. 4. The Assistant Director of Nursing (ADNS)/RN#1 was suspended pending an investigation on December 30, 2019 by the DNS. 5. The Mississippi State Board of Nursing was notified on December 31, 2019 related to the ADNS's abuse and neglect. 6. Medical Director was notified by the Director of Clinical Education on December 30, 2019 at 4:30 PM. 7. Psychological Services consult was ordered by the Medical Director for Resident #1 to be evaluated and provide care for any mental anguish. The Social Worker called the Psychological Services on December 30, 2019 at 4:45 PM. 8. Resident #1's responsible party was notified by the Administrator on December 30, 2019 at 6:00 PM of the abuse allegation and the request for psychological services to evaluate Resident #1. 9. Alert and oriented residents were interviewed on December 30, 2019 between 4:00-6:00 PM for any feelings of mental anguish or concerns with care by the Social Worker (SW) and Director of Clinical Operations (DCO), the Health Information Coordinator and the Director of Care Coordination with no other allegations of abuse. 10. The Administrator reported the allegation of abuse to the Attorney General's office on December 30, 2019 at 4:24 PM.	M 500		

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M 500	Continued From page 19 11. The Administrator was suspended by the Vice President of Operations pending an investigation on December 31, 2019 at 1:30 PM. 12. The local Police Department was notified 2:45 PM on December 31, 2019. 13. Six (6) Registered Nurses (RN), Five (5) Licensed Practical Nurses (LPNs), 13 Certified Nursing Assistants (CNAs), 1 Workforce Manager, and 1 Social Service Coordinator (SSC), 1 Human Resources (HR), 1 Business Office Manager (BOM), 8 Therapy staff, 1 Maintenance staff, were educated by the Director of Clinical Education (DCE) beginning December 30, 2019 at 3:30 PM on Abuse and Neglect, Reporting and Investigations, Residents Rights and Preferences, and Customer Service. 14. No employee will work until education is completed. 15. The Administrator was educated on December 30, 2019 at 5:30 PM by the Senior Director of Clinical Operations on Abuse and Neglect, Reporting and Investigations, Residents' Rights and Preferences and Customer Service. The facility alleges the Immediate Jeopardy was removed as of January 1, 2020. The SA validated the facility's Removal Plan and determined the facility took the following actions to correct the IJ: 1. The State Agency validated that Resident #1 was free from abuse and neglect that occurred on 11/21/19 when the Assistant Director of Nursing/Registered Nurse (RN) #1 would not	M 500		

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place Resident #1 back to bed when she was crying and yelling in pain and the ADNS refused to allow the Certified Nurse Assistants (C.N.A) staff to assist the resident. The ADNS continued to practice in his role after the resident suffered from mental anguish, which caused psychosocial harm to Resident #1. The Administrator knew of the incident on 11/21/19 and failed to protect the resident by suspending the ADNS, thoroughly investigate the incident, or report the incident to the Mississippi State Department of Health within two hours of the allegation of abuse.

2. The SA validated through record review and interviews the Quality Assurance Performance Improvement (QAPI) meeting was held on December 30, 2019 at 5:30 PM. Systemic changes and monitoring were developed, presented and approved by Administrator (Adm), Director of Nursing Services (DNS), Nurse Consultant and Clinical Education Nurse, and Medical Director. Systemic changes include monthly education and orientation by the Administrator or Director of Clinical Education to all staff regarding Abuse and Neglect, Reporting and Investigation allegations of abuse, customer service and residents' rights. Grievances and/or allegations will be reviewed and investigated at Daily Stand up by the Adm/DNS/Designee with follow up as needed. The systemic changes were discussed at the QAPI meeting at 5:30 PM.

3. The SA validated through interview the Administrator (ADM) called the MS State Department of Health regarding an allegation of abuse and initiated an investigation on December 30, 2019.

4. The SA validated through documentation the Assistant Director of Nursing (ADNS) was

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M 500	Continued From page 21 suspended pending an investigation on December 30, 2019 by the DNS. 5. The SA validated through documentation the Mississippi State Board of Nursing was notified on December 31, 2019 related to the ADNS's abuse and neglect. 6. The SA validated through interview the Medical Director was notified by the Director of Clinical Education on December 30, 2019 at 4:30 PM. 7. The SA validated though documentation the Psychological Services consult was ordered by the Medical Director for Resident #1 to be evaluated and provided care for any mental anguish. The Social Worker called the Psychological Services on December 30, 2019 at 4:45 PM. 8. The SA validated through interview Resident #1's responsible party was notified by the Administrator on December 30, 2019 at 6:00 PM of the abuse allegation and the request for psychological services to evaluate Resident #1. 9. The SA validated through documentation and interviews alert and oriented residents were interviewed on December 30, 2019 between 4:00-6:00 PM for any feelings of mental anguish or concerns with care by the Social Worker (SW) and Director of Clinical Operations (DCO), the Health Information Coordinator and the Director of Care Coordination with no other allegations of abuse. 10. The SA validated through documentation the Administrator reported the allegation of abuse to the Attorney General's office on December 30,	M 500		

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M 500	Continued From page 22 2019 at 4:24 PM. 11. The SA validated through documentation the Administrator was suspended by the Vice President of Operations pending an investigation on December 31, 2019 at 1:30 PM. 12. The SA validated through documentation the local Police Department was notified at 2:45 PM on December 31, 2019. 13. The SA validated through interviews with the Nursing, Dietary, Housekeeping, Social Services, Therapy, Business Office and Maintenance and through documentation beginning December 30, 2019 at 3:30 PM there were in-services regarding Abuse and Neglect, Reporting and Investigations, Residents Rights and Preferences, and Customer Service being held. 14. The SA validated the Administrator was educated on December 30, 2019 at 5:30 PM by the Senior Director of Clinical Operations on Abuse and Neglect, Reporting and Investigations, Residents' Rights and Preferences and Customer Service. The SA validated that all corrective actions were completed as of 12/31/19 and the IJ was removed as of 01/01/20	M 500		