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	255105	A. BUILDING _____ B. WING _____	C 01/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF TUPELO	2273 SOUTH EASON BOULEVARD TUPELO, MS 38804

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F 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 requirements of participation in Medicare and Medicaid. 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 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: 42 CFR(s): 483.12(a)(1) - Freedom from Abuse/Neglect, (F600)	F 000		

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

Electronically Signed | 02/10/2020

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F 000	Continued From page 1 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 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 42 CFR(s): 483.12(a)(1) - Freedom from Abuse/Neglect, (F600); 42 CFR(s) 483.12(c)(1)(4) - Reporting of Alleged Violations, (F609); and 42 CFR(s): 483.12(c)(2)(4) - Investigate/Prevent/Correct Alleged Violation (F610), were 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.	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.	F 600		1/31/20

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F 600	Continued From page 2 §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on 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	F 600	* Registered Nurse #1 was suspended immediately by the Director of Nursing Services (DNS)on December 30,2019. Resident #1 was assessed for distress. 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	

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F 600	Continued From page 3 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. 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 42 CFR(s): 483.12(a)(1) F600, Freedom from Abuse, Neglect, and Exploitation, 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:	F 600	30,2019. * Education was started by the Director or Clinical Education (DCE) on Abuse and Neglect, Reporting and Investigations, Resident Rights and Preferences and 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. 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. * On 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. December 30,2019 and ongoing, 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 begin conducting resident interviews on	

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F 600	Continued From page 4 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 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	F 600	December 30,2019 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 will be brought to the Quality Assurance and Performance Improvement(QAPI) monthly for two months.	

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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." 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

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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. 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

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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 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

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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 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

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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 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

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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) 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

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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.

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

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(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 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

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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 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

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#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.

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

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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.

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

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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.

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.

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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 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,

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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 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

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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, 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

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F 600	Continued From page 20 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.	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 procedures.	F 609		1/31/20

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F 609	Continued From page 21 §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) hour required timeframe, for one (1) of nine (9) residents reviewed, 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 (ADNS)/Registered Nurse (RN #1), to her daughter by phone, during the incident. The allegation consisted of Resident #1 was made to get up out of the bed, sit in the wheelchair, while she was in pain and had no desire to sit up in the wheelchair; and 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. 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; and she felt so helpless. The Administrator was notified by Resident #1's daughter (Responsible Party (RP) #1) by phone, shortly after the incident occurred. The Administrator did not investigate the allegation, suspend the employee (RN #1), or protect Resident #1 and all other residents. The failure of the facility to notify the appropriate	F 609	* Registered Nurse #1 was suspended immediately by the Director of Nursing Services (DNS)on December 30,2019. Resident #1 was assessed for distress. Resident #1's responsible representative was notified by the Administrator immediately on December 30,2019 of the allegation of abuse and on December 30, 2019 a request for psychological services to evaluate Resident #1 was made. 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 psych 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	

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F 609	Continued From page 22 state agencies in a timely manner of an allegation of verbal and mental abuse and ensure that proper measures had been addressed, and allowing the 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 42 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 "Abuse, Neglect, Misappropriation, Exploitation Policy," dated 01/19, revealed, Investigation: The Administrator	F 609	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 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 on 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, the 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. December 30, 2019 and ongoing,the Administrator/Director of Nursing	

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F 609	Continued From page 23 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. Reporting: Immediately reporting all alleged violations to the Administrator, designee, state agency, and all other required agencies within specified timeframes. Review of an anonymous complaint allegation, MS #16510, submitted to the SA on 12/23/19, documented on 11/20/19 RN #1 made Resident #1 cry. Review of the facility's "Customer Concern/Grievance Communication Form," dated 11/21/19 and completed by the Administrator, revealed: Resident #1 was concerned with approach of Assistant Director of Nursing (ADON)/RN #1 motivating her to do therapy. Administrator, Director of Rehab (DOR) and ADON met with resident to talk about concerns with therapy goals and motivation of ADON. The Administrator talked with ADON 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, "This happened	F 609	Services/Social Service Director will conduct resident interviews 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 will be brought to the Quality Assurance and Performance Improvement(QAPI) monthly for two months.	

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about a month or two ago, I'm not sure of the date, but they (facility) are trying to sweep it under the rug." Resident #1 began to cry and was emotionally upset recalling the event of that day. Resident #1 stated on that day she really didn't want to get up at all, because she had been awake all night with spasms in her legs, but 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 a wheelchair, in her room. After about five minutes, 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 stated she asked to be placed back in the bed, and CNA #1 and CNA #2 went into the hallway to get the lift, but was stopped by RN #1. Resident #1 stated, "He (RN #1) took the lift back out of the room and wouldn't let them put me to bed. I picked up my cell phone and called my daughter and while I was telling her what was going on, he took my cell phone from me, and he wouldn't give it back to me. He went out of the room to talk to my daughter and came back in the room and gave me my phone back, but she had hung up." Resident #1 stated she had called her daughter (Responsible Party (RP) #2) because she knew that her daughter would stop him from treating her this way. Resident #1 stated RN #1 always had smart comments, but he had never acted like he did that day; and he was out of control. Resident #1 stated, "Nobody had ever made me feel that way before, 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 me or my family and to listen to him because he was the boss." Resident #1 stated CNA #1 wanted to put her back to bed, and she was about to cry because RN #1

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wouldn't let her. 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 stated around lunch time (11:30 AM), RN #1 asked her and CNA #2 to get Resident #1 up. After they got Resident #1 up, Resident #1 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 the trays out, and that he was their boss and they better do what he said. CNA #1 stated RN #1 stayed in the room with Resident #1 the whole time. CNA #1 stated she could hear them (Resident #1 and RN #1) yelling at each other all the way to the nurse's desk. CNA #1 stated Resident #1 was crying, screaming and cussing at RN #1. CNA #1 became emotional and was crying, while recalling the incident. CNA #1 stated, she felt so helpless and was upset that Resident #1 was crying and begging to go back to bed, and RN #1 wouldn't allow them to put her to bed. CNA #1 stated she was fearful of him (RN #1) and had asked him how is that right that he got to treat Resident #1 that way and he said, "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 she was scared, but 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 wheelchair before RN #1 would let them (CNAs) put the resident back to bed. CNA #1 revealed it was about 30-45 minutes later. CNA #1 stated she didn't know what else to

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do, so after they got Resident #1 in the bed, she went and got the Ombudsman and the SA phone numbers and put them in Resident #1's phone. CNA #1 confirmed she did not report this incident to anyone because she was fearful of losing her job. CNA #1 stated, "He (RN #1) kept saying, I'm the boss and you better do what I say."

On 12/30/19 at 1:10 PM, during an interview with the Administrator, she confirmed she did not have an investigation report regarding this allegation of abuse. The Administrator stated, "It wasn't an allegation of abuse. I talked to Resident #1, but I didn't write anything down, she wasn't upset. I didn't get a statement from RN#1 because I didn't investigate it as abuse because it wasn't, he was just trying to motivate her." The Administrator confirmed she had received a call from the Resident #1's daughter (RP #2) and that the daughter was concerned and didn't like the way RN #1 had talked to her mother. The Administrator revealed, Resident #1's daughter said if the Administrator didn't do something about the incident, then she was coming to the facility. The Administrator stated, "I didn't think there was anything to it because she never showed up." The Administrator stated she had never had any allegations or concerns regarding RN #1. The Administrator confirmed she never reported the incident to the State Agency.

Review of a signed copy of the "Administrator Position Description," dated 05/28/19 and signed by the Administrator, documented: "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

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allegation of abuse, neglect, or misappropriation by protecting, investigating and making any required reporting."

On 12/30/19 at 2:15 PM, during an interview with the Therapy Director (TD), she stated the Administrator informed her of receiving a phone call from Resident #1's daughter regarding an incident between Resident #1 and RN #1, that caused the resident to be upset. The TD revealed the Administrator asked her to accompany her to Resident #1's room to see what was wrong. The TD stated Resident #1 was crying and upset when she and the Administrator went to her room. The TD stated Resident #1 told the Administrator that she wouldn't wish this (her condition) on anybody, to be in this much pain and to be treated this way. The TD stated the entire time she was in room, while the Administrator talked with Resident #1, the resident was crying and emotional. The TD stated she had never seen Resident #1 that emotional and upset before. The TD stated she thought the Administrator was handling the situation. and stated, "I didn't know it (incident) wasn't reported to the State. I thought that was what she was doing."

On 12/30/19 at 2:30 PM, during a phone interview with CNA #2, she stated RN #1 would not allow her and CNA #1 to put Resident #1 back to bed. She stated he (RN #1) was telling Resident #1, "You're not going back to bed." CNA #2 confirmed Resident #1 was crying and upset. CNA #2 stated, "He (RN #1) could have handled it a lot better than he did." The SA asked CNA#2 if she reported this incident to anyone and she stated, "It wouldn't do any good to report it to the DON or the Administrator, they protect each

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other. He is very rude, and he is not suitable for his position." CNA #2 stated RN #1 was over the CNAs.

During an interview, on 12/30/19 at 3:55 PM, RN #1 stated he was the Assistant Director of Nursing Services (ADNS) at the facility and oversees the Restorative Program. RN #1 stated on 11/13/19, he met with Resident #1 and her son (Responsible Party) and told them the goal was for the resident to sit up two (2) hours, three (3) times a week. RN #1 stated he told Resident #1, they were going to attack this thing (therapy) and that he was going to be tough on her. RN #1 stated Resident #1 refusing to get up, so he called her son to let him know. RN #1 stated on 11/21/19, he went into Resident #1's room and she was on the phone with her daughter. RN #1 stated he told Resident #1 he was going to call her son. RN #1 stated after about five (5) to ten (10) minutes, the CNAs were trying to put her back to bed. RN #1 revealed he told the CNAs to go on and that he would put Resident #1 back to bed after the trays were passed out. RN #1 further stated he would go down to Resident #1's room and handle the resident. RN #1 stated Resident #1 was crying, yelling, and saying her right hip hurt. RN #1 revealed he padded the resident in the wheelchair, and she continued to sit up until I told the CNAs to put her back to bed. The SA asked RN #1 if the resident wanted to continue to sit up and he stated, "No, but we had made a plan for her to get up three times a week and I told her I 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."

On 12/31/19 at 9:58 AM, during an interview, with

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the Regional Nurse Consultant (RNC), revealed she had received a call from the Minimum Data Set (MDS) Nurse around 9:30 PM on 12/02/19. The RNC stated the MDS Nurse asked, "Did anyone say anything to you about (RN #1) making a resident cry?" The RNC stated she told her "no". The RNC stated she then called the Administrator within five minutes and asked her if she knew anything about this incident, and the Administrator stated, "Yes, I did a grievance. Her daughter had called and said her mom was upset." The RNC stated she 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 next day and told the her "The resident was crying and upset because she didn't like how (RN #1) was motivating her."

On 12/31/19 at 10:30 AM, an interview with Resident #1's son/Responsible Party (RP) #1, at the facility and Resident #1's daughter/RP #2 by phone, revealed RP #1 was not aware of the full story of what had occurred that day (11/21/19). RP #1 stated he got a phone call from his sister and she told him that she had left a message for the Administrator, and he needed to come up to the facility to see what was going on RP #1 further revealed RP #2 stated their momma (Resident #1) had called her upset about how (RN #1) had talked to her. RP #1 stated he came to the facility, but RN #1 told him they (RN #1 and Resident #1) just had a conversation and RN #1 made it (the incident) sound like it wasn't a big deal. Resident #1 stated to the son (RP #1), while he was in the room, on 12/31/19 at 10:30 AM, that she had called her daughter (RP #2) because she didn't want to upset her son, and she knew her daughter would take care of RN#1.

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Resident #1's daughter (RP #2), confirmed by phone, she was upset about how RN#1 had talked to her mother and that she had left a message with the receptionist for the Administrator to call her, but the Administrator never called her back.

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

During an interview, on 12/31/19 at 3:45 PM, Resident #1's Primary Physician (Physician #1) stated he was not aware of the incident and had heard nothing about it.

On 01/02/20 at 2:00 PM, during an interview with the Receptionist, she stated that she had taken the phone call 11/21/19, around 11:30 AM, from Resident #1's daughter (RP #2). The Receptionist confirmed RP #2 wanted to speak with the Administrator right away. The Receptionist stated RP #2 told her she was upset because she didn't like how RN #1 talked to her mother and that she 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 confirmed she didn't know if the situation was handled or not.

On 01/02/20 at 2:40 PM, an interview with the Minimum Data Set (MDS) Nurse, she stated the staff knew it (the incident) had been reported to the Administrator and the CNAs were upset that Resident #1 had been made to cry by RN #1.

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The MDS Nurse stated it was extremely out of Resident #1's character to be that upset. The MDS Nurse stated, "We didn't see anything being done about it, so I called my corporate person and she then called (Regional Nurse Consultant Proper Name)."

Review of RN #1's personnel file, revealed he was hired on 09/23/19, and had no prior disciplines or any corrective actions in his employee file.

A review of In-service Attendance Records, dated 11/07/19 and 12/30/19, titled "Topic: Abuse, Neglect, Misappropriation, Exploitation Policy", revealed RN #1, CNA #1 and CNA #2 attended both in-services.

Review of the Admission Record revealed the facility admitted Resident #1 on 10/01/18. Diagnosis included Paraplegia, Morbid Obesity, Major Depressive Disorder, Dependence on other enabling machines and devices, Contracture right hip and Contracture right knee.

Review of the MDS Quarterly Assessment, with an Assessment Reference Date (ARD) of 11/25/19, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) of 15, which indicated intact cognitive skills for daily decision making.

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:

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

3. The Assistant Director of Nursing (ADNS)/RN#1 was suspended pending an investigation on December 30, 2019 by the DNS.

4. The Mississippi State Board of Nursing was notified on December 31, 2019 related to the ADNS's abuse and neglect.

5. Medical Director was notified by the Director of Clinical Education on December 30, 2019 at 4:30 PM.

6. 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

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Psychological Services on December 30, 2019 at 4:45 PM.

7. 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.

8. 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.

9. The Administrator reported the allegation of abuse to the Attorney General's office on December 30, 2019 at 4:24 PM.

10. The Administrator was suspended by the Vice President of Operations pending an investigation on December 31, 2019 at 1:30 PM.

11. The local Police Department was notified 2:45 PM on December 31, 2019.

12. 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.

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13. No employee will work until education is completed.

14. 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.

15. 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 facility alleges that the Immediate Jeopardy is 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 place Resident #1 back to bed when she was crying and yelling in pain and the ADNS refused

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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 suspended pending an investigation on

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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, 2019 at 4:24 PM.

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F 609	Continued From page 37 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.	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.	F 610		1/31/20

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F 610	Continued From page 38 §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 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 investigate and prevent further potential abuse and mistreatment from occurring, after an allegation of staff to resident abuse had been made for one (1) of nine (9) residents reviewed, 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 (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 and the 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 occurred in Resident #1's room and was witnessed by other staff. Resident #1 stated that she felt like she was fighting for her life and that nobody had ever made her feel that way before in her whole life and she felt so helpless. The	F 610	* 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	

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F 610	Continued From page 39 Administrator was notified by Resident #1's daughter by phone on or around 11:30 AM when the incident occurred. The Administrator was told by Resident #1's daughter (Responsible Party (RP) #2) that she did not like the way that RN #1 had spoken to her mother 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, suspend the employee, or protect Resident #1 and all other residents. The failure of the facility to notify the appropriate state agencies in a timely manner and by not protecting residents from further mental abuse by allowing a witnessed abuse to a resident occur, and the facility allowing RN #1 to continue to work in the facility, 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 42 CFR(s): 483.12(c)(2)-(4), F610,	F 610	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 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 on 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 on December 30,2019 and ongoing. * 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	

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F 610	Continued From page 40 Investigate/Prevent/Correct Alleged Violation, 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 "Abuse, Neglect, Misappropriation, Exploitation Policy", dated 01/19, revealed, Definitions of 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 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. Reporting: Immediately reporting all alleged violations to the Administrator, designee, state agency, and all other required agencies within specified timeframes. Review of an anonymous complaint allegation, submitted to the SA on 12/23/19, documented	F 610	Services. Notification of response to grievances will be brought to the Quality Assurance Performance Improvement (QAPI) monthly for two months. December 30 and ongoing, Administrator/Director of Nursing Services/Social Service Director will conduct resident interviews 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 will be brought to the Quality Assurance and Performance Improvement(QAPI) monthly for two months.	

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that on 11/20/19 the Assistant Director of Nursing Services (RN #1) made Resident #1 cry.

Review of the facility's "Customer Concern/Grievance Communication Form," dated 11/21/19 and completed by the Administrator, revealed: Resident concerned with approach of ADON (RN #1) motivating her to do therapy. Administrator, Director of Rehab (DOR) and ADON (RN #1) meet with resident to talk about concerns with therapy goals and motivation of ADON. Talked with ADON and therapy about approach and different forms of encouragement. Customer contacted for follow up on 11/21/19.

On 12/30/19, at 10:00 AM, during an interview with Resident #1, she stated, "This happened about a month or two ago, I'm not sure of the date, but they (facility) are trying to sweep it under the rug." Resident #1 began to cry and was emotionally upset recalling the event of that day (11/21/19). Resident #1 stated on that day, she really didn't want to get up at all because she had been awake all night with spasms in her legs, but RN #1 told her she needed to get up. Resident #1 stated she allowed CNA #1 and CNA #2 to get her up with the lift, and they placed her in the wheelchair in her room. After about five minutes, 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 stated she asked to be placed back in the bed. Resident #1 revealed CNA #1 and CNA #2 went into the hallway to get the lift, and was stopped by RN #1. Resident #1 stated, "He (RN #1) took the lift back out of the room, and wouldn't let them put me to bed." Resident #1 stated she picked up her cell phone and called her daughter (RP #2). Resident #1 stated while she was telling RP #2 what was

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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 (RP #2), and then came back in the room, gave her phone back, but RP #2 had hung up. Resident #1 stated she had called her daughter because she knew her daughter would stop him from treating her that way. Resident #1 stated RN #1 always had smart comments, but he had never acted like he did that day; and that he was out of control. Resident #1 stated, "Nobody had ever made me feel that way before, 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. He told the staff not to listen to me or my family and to listen to him because he was the boss." Resident #1 stated CNA #1 wanted to put her back to bed. Resident #1 revealed CNA #1 was about to cry because RN #1 wouldn't allow her to put her back to bed. Resident #1 stated the Administrator came to her room the same day the incident occurred, because her daughter (RP #2) had left a message for the Administrator. Resident #1 stated, the Administrator told her that RN #1 didn't mean anything by that (incident) and she needed them to be friends.

During at interview, on 12/30/19 at 1:00 PM, CNA #1 stated around lunchtime (11:30 AM) on 11/21/19, RN #1 had asked us (CNAs) to get Resident #1 up. CNA #1 stated after they got Resident #1 up, the resident began begging to be put back to bed, which was after about five minutes. CNA #1 stated Resident #1 was crying, so they went and got the lift,and RN #1 stopped them. CNA #1 stated RN #1 told them to go on and pass the trays out, he was their boss and they had better do what he said. CNA #1 stated RN #1 stayed in Resident #1's room the whole

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time. CNA #1 stated, RN #1 and Resident #1 could be heard yelling at each other all the way to the nurse's desk. CNA #1 revealed Resident #1 was crying, screaming and cussing at RN #1. CNA #1 became emotional and was crying while recalling the incident. CNA #1 stated, she felt so helpless and was upset that Resident #1 was crying and begging to go back to bed, and RN #1 wouldn't allow them to put her to bed. CNA #1 stated she was fearful of RN#1, but asked him how was that right the way he treated Resident #1. CNA #1 stated RN #1 told her, "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 she was scared. CNA #1 stated since RN #1 came on board, he wanted Resident #1 to get up and sit up. CNA #1 stated Resident #1 was almost falling out of her wheelchair before RN #1 would let them (CNAs) put the resident back to bed. CNA #1 revealed it was about 30-45 minutes later. CNA #1 stated she didn't know what else to do, so after Resident #1 was put back to bed, she went and got the phone numbers for the Ombudsman and the SA. CNA #1 stated she put the phone numbers in Resident #1's phone. CNA #1 confirmed she did not report this incident to anyone, because she was fearful of losing her job. CNA #1 stated, RN #1 kept saying, he was the boss and we better do what he said.

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 (11/21/19). The Administrator stated, "It wasn't an allegation of abuse. I talked to Resident #1, but I didn't write anything down, she wasn't upset. I didn't get a statement from RN#1 because I didn't investigate it as abuse because it

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wasn't, he was just trying to motivate her." The Administrator confirmed she had received a call from the resident's daughter (RP #2), and that RP #2 was concerned, didn't like the way RN #1 had talked to her mother, and was coming up to the facility if she didn't do something about it. The Administrator stated, "I didn't think there was anything to it because she never showed up." The Administrator stated she had never had any allegations or concerns regarding RN #1. The Administrator confirmed she never reported the incident to the State Agency.

On 12/30/19 at 1:10 PM, during an interview, the Director of Nursing (DON) confirmed she was on vacation the week of 11/19/19 through 11/26/19. The DON stated RN #1 was serving as the interim DON while she was away, and she had no knowledge of any complaints or concerns about RN #1, while she was on vacation.

During an interview, on 12/30/19 at 2:15 PM, the Therapy Director stated she had received a text from the Administrator that day (11/21/19) around 4:00 PM, and it state for me to get RN #1 and come to her office. The Therapy Director stated she and RN #1 went to the Administrator's office and was told by the Administrator, she had received a call from Resident #1's daughter (RP #2). The Administrator revealed RP #2 she was upset about an incident that occurred between Resident #1 and RN #1, and she wanted to know if we would go with her to the resident's room to see what was wrong. The Therapy Director stated Resident #1 was crying and upset, and told the Administrator she wouldn't wish on anybody, being in that much pain and being treated that way (incident with RN #1). The Therapy Director stated she was in the room, the entire time the

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Administrator talked Resident #1. The Therapy Director stated Resident #1 was crying and emotional, and she had never seen the resident that emotional and upset before. The Therapy Director stated she thought the Administrator was handling the situation, and didn't know the incident wasn't reported to the State. The Therapy Director stated she thought that was what the Administrator was doing.

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

On 12/30/19 at 3:55 PM, during an interview, RN #1 stated he was the Assistant Director of Nursing Services (ADNS) at the facility, and oversees 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 to have Resident #1 sit up two (2) hours, three (3) times a week. RN #1 stated he told the resident he was going to be tough on her. RN #1 stated Resident #1 began refusing to get up, so he called RP #1 to let him know. RN #1 stated on 11/21/19, he went to Resident #1's room, and the resident 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 stated, after about five to ten minutes, the CNAs were trying to put

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Resident #1back to bed. RN #1 stated he told the CNAs to go on and he would put Resident #1 back to bed after the trays were passed, and that he would go down to Resident #1's room and handle her. RN#1 stated Resident #1 was crying, yelling and complaining her right hip hurt. RN #1 stated he padded the resident in the wheelchair, and she continued to sit up, until he told the CNAs to put her back to bed. RN #1 revealed Resident #1 did not want to continue to sit up, but stated, "We had made a plan for her to get up three times a week, and I told her I 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."

On 12/31/19 at 9:58 AM, and interview with the Regional Nurse Consultant (RNC) revealed, she received a call from the Minimum Data Set (MDS) Nurse around 9:30 PM, on 12/02/19. The RNC stated the MDS Nurse asked her if anyone had said anything to her RN #1 making a resident cry. The RNC stated she told the MDS Nurse "no". The RNC stated she then called the Administrator, within five minutes, and asked the Administrator if she knew anything about this incident, and the Administrator said, "Yes, I did a grievance." The RNC stated the Administrator told her Resident #1's daughter had called, and reported her mom was upset. The RNC revealed she told the Administrator to go to Resident #1's room the next day, and talk to her. The RNC stated the Administrator called her back, the following day, and told 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, an interview with

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Resident #1's son (RP#1), at the facility (Resident #1's room), and with Resident 1's daughter (RP#2) by phone, revealed, RP #1 stated he was not aware of the full story of what had occurred that day (11/21/19). RP #1 stated he received a phone call from his sister, and she told me that she had left a message for the Administrator. RP #1 stated his sister said that he needed to come up to the facility, to see what was going on, because their mother was her upset about how RN #1 had talked to her. RP #1 stated that he came to the facility, but RN #1 informed him that he and Resident #1 had just had a conversation. RP #1 stated RN #1 made it sound like it wasn't a big deal. Resident #1 stated to the RP #1, while he was in the room, on 12/31/19 at 10:30 AM, she had called her daughter (RP #2) because she didn't want to upset him (RP #1). Resident #1 stated she knew RP #2 would take care of RN #1. RP #2 confirmed by phone, she was upset about how RN #1 had talked to her mother (Resident #1). RP #2 stated she left a message with the receptionist for the Administrator to call her, but that the Administrator never called her back.

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

On 12/31/19 at 3:45 PM, an interview with Resident #1's Primary Physician (Physician #1), revealed she was not aware of the incident, and had heard nothing about it.

On 01/02/20 at 2:40 PM, during an interview with the MDS Nurse, she stated the staff knew the

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incident had been reported to the Administrator. The MDS Nurse stated the CNAs were upset that 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 revealed they didn't see anything being done about it (incident), so she called her Corporate person, and she then called the Regional Nurse Consultant.

During an interview, on 01/02/20 at 2:00 PM, the Receptionist stated that she had taken the phone call that day (11/21/19), around 11:30 AM, from Resident #1's daughter (RP #2). The Receptionist confirmed RP #2 wanted to speak with the Administrator right away. The Receptionist revealed RP #2 told her she was upset, because she didn't like how RN #1 had talked to her mother (Resident #1). The Receptionist stated RP#2 stated she wanted somebody to take care of it. The Receptionist stated she told the Administrator right away, RP #2 had called and was upset. The Receptionist confirmed she didn't know if the situation was handled 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 RN #1's personnel file, revealed he

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was hired on 09/23/19, and had no prior disciplines or any corrective actions in his employee file. RN #1 was allowed to work and was not suspended, until the SA made the Administrator aware of an allegation of verbal and mental abuse involving RN #1, on 12/30/19 at 1:10 PM.

Review of an In-service Attendance record, dated 11/07/19, with a topic of "Abuse, Neglect, Misappropriation, Exploitation Policy", revealed RN #1 signed as being in attendance for this in-service.

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 the MDS Quarterly Assessment, with an Assessment Reference Date (ARD) of 11/25/19, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) of 15, which indicated intact cognitive skills for daily decision making.

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

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

3. The Assistant Director of Nursing (ADNS)/RN#1 was suspended pending an investigation on December 30, 2019 by the DNS.

4. The Mississippi State Board of Nursing was notified on December 31, 2019 related to the ADNS's abuse and neglect.

5. Medical Director was notified by the Director of Clinical Education on December 30, 2019 at 4:30 PM.

6. 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.

7. Resident #1's responsible party was notified by

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the Administrator on December 30, 2019 at 6:00 PM of the abuse allegation and the request for psychological services to evaluate Resident #1.

8. 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.

9. The Administrator reported the allegation of abuse to the Attorney General's office on December 30, 2019 at 4:24 PM.

10. The Administrator was suspended by the Vice President of Operations pending an investigation on December 31, 2019 at 1:30 PM.

11. The local Police Department was notified 2:45 PM on December 31, 2019.

12. 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.

13. No employee will work until education is completed.

14. The Administrator was educated on

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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.

15. 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 facility alleges that the Immediate Jeopardy is 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 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

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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 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

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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, 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.

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F 610	Continued From page 55 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.	F 610		