STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255217	A. BUILDING _____ B. WING _____	07/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER HEIGHTS HEALTHCARE CENTER	402 ARNOLD AVENUE GREENVILLE, MS 38701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted a complaint survey investigating CI MS #16508, CI MS #16525, and CI MS #16815 on 7/27/2020. Concerns identified in the complaint were related to possible abuse and neglect of Resident #1 and physical concerns of the facility's environment. These concerns were not substantiated and no deficiencies were cited for CI MS #16508 and CI MS #16815. CI MS #16525 was substantiated for verbal abuse and F600 was cited. During the survey the SA detrmined the facility was not in substantial compliance with requirements for partcipation in Medicare and medicaid. The facilty had a census of 48.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interviews. record reviews	F 600	Preparation and/or execution of this plan	9/11/20

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

Electronically Signed | 09/03/2020

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F 600	Continued From page 1 and policy review, the facility failed to ensure that one (1) out of four (4) residents was not verbally abused, Resident #1. Findings include: Review of the facility's "Abuse Prevention Program" policy, revised December 2016, revealed our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusions, verbal , mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. A review of the facility's investigation report, dated 12/30/19, revealed that a family member reported to the Administrator that while visiting a love one, she witnessed Certified Nursing Assistant (CNA #1) cursing and yelling at another resident, who was determined to be Resident #1. CNA #1 and Resident #1 was arguing in which she heard CNA #1 stated "(F**k) you with your pissy ass". The Administrator interviewed Resident #1, but she denied allegations. Resident #1 was encouraged to discuss what happened, but continued to state she could handle it on her own. Staff members were interviewed and corroborated that CNA #1 had the verbal altercation with Resident #1 to include yelling and cursing. Staff members were quickly interviewed and stated CNA #3 intervened and stated CNA #1 continued to walk away yelling and cursing. CNA#1 was suspended and escorted by Human Resources out of the facility. On 7/27/20 at 11:22 AM, an interview with Resident #1 revealed, when the State Agency	F 600	of correction does not constitute admission or agreement by the provider of the truth or the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of Federal and State Law. This plan of correction constitutes the facilities credible allegation of compliance. Resident #1 suffered no lasting adverse physical, emotional, or psychological effects from this deficient practice. Certified Nursing Assistant # 1, was immediately suspended and as escorted from the building 12/30/19 by the Human Resources. Resident was visited by Social Services and by the Director of Nursing 12/30/19 to ensure resident was not upset, uncomfortable, or afraid. Certified Nursing Assistant # 1 was terminated on 01/03/20 All residents of the facility are at risk from this deficient practice. Staff are educated on hire by Human Resources, annually by the Director of Nursing, and as needed by the Administrator on Abuse, Neglect, and Exploitation of residents per facility policy. A facility wide in-service was initiated 9/3/2020, on Abuse, Neglect, and Exploitation by the Director of Clinical Services and the Director of Nursing Services, with completion of this in-service on 9/4/2020. Beginning on 9/3/2020, Social Services will interview	

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F 600	Continued From page 2 (SA) surveyor asked Resident #1 about the incident, she stated the incident happened a long time ago, however immediately when CNA #1's name was mentioned, she knew exactly who CNA #1 was. Resident #1 stated she cursed me out. When asked what happened Resident #1 stated we was talking in the dining room and I said something to her but did not remember what and she called me a (B**ch). Resident #1 stated one of the nurse's heard her cursing and came in. Resident #1 stated they got her out of here. When asked if this had happened before and she stated "no maim", no one here has ever talked to me like that, everyone is good to me and my roommate. On 7/27/20 at 11:50 AM, an interview with CNA #2 revealed at 6:00 PM she was coming down the hall and heard shouting and cursing and it was coming from CNA #1 saying better get that (B**ch). CNA #2 stated CNA #3 told her (CNA #1) not to let these residents get under your skin like this and if you feel this way you should clock out and go home. CNA #2 said she went to check on Resident #1 and she said CNA #1 got an attitude because she and another staff member were talking about another staff member, and CNA #2 told them not to because she wasn't here to defend herself. On 7/27/20 at 1:00 PM, an interview with Resident #2 revealed staff takes good care of her, stated it takes awhile sometimes to come and change her, but they do. Resident #2 stated she has never seen anyone being abused. On 7/27/20 at 1:20 PM, an interview with Resident #3 stated he has never seen anyone	F 600	five random residents two times a week for four weeks, then once a week for four weeks to ensure there has been no verbal abuse. Beginning on 9/3/2020, the Administrator will interview five random residents weekly for four weeks, then every two weeks to ensure there has been no verbal abuse. The Administrator is responsible for on-going monitoring and compliance. Beginning 9/4/2020, the Administrator will report any adverse findings to the Quality Assurance Committee for review and recommendations.	

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F 600	Continued From page 3	F 600		

being abused.

On 7/27/20 at 2:00 PM, an interview with Resident #4 revealed staff was very good to him, and he hasn't had any one talk to him rude or seen anyone being abused.

On 7/27/20 at 2:45 PM, an interview with CNA #3 revealed around 6:15 PM when he came up on the incident that he heard CNA #1 and Resident #1 arguing. CNA #3 stated he didn't know what it was about. CNA #3 said he told CNA #1 she was not allowed to get in an altercation with the residents. CNA #3 stated he heard curse words from both of them and didn't really know what the curse words were. CNA #3 said he tried to move CNA #1 out in the hall. CNA #3 said when he did get CNA #1 to the hallway she was still yelling and cursing.

On 7/27/20 at 3:15 PM, a telephone interview with Visitor #1 revealed she was visiting her aunt and heard very loud yelling and cursing from someone. Visitor #1 stated she did not remember at this time exactly what was said because that happened back in last year. Visitor #1 stated she did know that the young lady (CNA #1) was using some choice words that should not have been used. Visitor #1 stated the young man was trying to calm her down, but she was still yelling and cursing. Visitor #1 stated she went and reported the incident to the Social Worker.

On 7/27/20 3:30 PM, an interview with the Administrator and Director of Nursing (DON) revealed they were not working at the facility at that time. The Administrator stated that review of the investigation did reveal that CNA #1 was suspended immediately on 12/30/19 and was

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F 600	Continued From page 4 terminated on 1/3/20. Review of CNA #1's Personnel File revealed no previous disciplinary actions and she had only been employed a month at the facility. Review of the Face Sheet revealed the facility admitted Resident #1, on 3/14/19, with diagnoses which included Diabetes Mellitus, Diabetic Neuropathy and Hypertension. Review of Resident #1's Minimum Data Sheets (MDS), with an Assessment Reference Date (ARD) of 06/16/2020, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated Resident #1 was cognitively intact.	F 600		