STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255289	A. BUILDING _____ B. WING _____	C 08/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER CHASE VILLAGE	5090 GAUTIER VANCLEAVE ROAD GAUTIER, MS 39553

(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 investigation survey, MS #16148, from 8/19/2019 through 8/20/2019. During the survey, it was determined the facility was not in compliance with Medicare and Medicaid requirements of participation. The SA substantiated MS #16148 for verbal abuse with the following citations related to the complaint F600, F608, and 609. The facility had a current census of 51 and the facility is licensed for 60 beds.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interviews, record review, facility investigation review, and facility policy review, the facility failed to prevent verbal and/or mental abuse for one (1) of four (4) residents reviewed for abuse, Resident #1.	F 600	1. Policy and procedure on abuse was followed on 8/12/2019 when Administrator and Director of Nursing were notified of incident that happened on Friday, 8/9/2019. Mississippi State Department of Health State Agency (MSDH SA)hotline	9/3/19

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

Electronically Signed | 09/11/2019

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F 600	Continued From page 1 Findings include: Review of the facility policy, "Abuse and Neglect Reporting and Intervention Policy and Procedure", undated, revealed the resident has a right to be free from abuse-verbal, sexual, physical, mental, corporal punishment and/or involuntary seclusion, as well as exploitation. The resident will not be subjected to abuse by anyone. Review of an outside-source complaint, dated 8/13/19, revealed Resident #1 had been harassed by a staff member, Certified Nursing Assistant (CNA) #2, who threatened to have sex with the resident's husband and threatened to beat the resident up. During an interview on 8/19/19 at 9:45 AM, Resident #1 responded "yes", when asked if staff had ever been ugly to her, and had a tear in her right eye. Resident #1 denied any other incidents. Resident #1 did not respond, when asked the staff's name, but stated "no", when asked if the staff was still working with her. Resident #1 did not allege any specific event had occurred. The facility admitted Resident #1 on 8/30/18, with diagnoses of Hemiplegia, Hypertension (High Blood Pressure) and Type II Diabetes. The Quarterly Minimum Data Set (MDS) with the Assessment Reference Date (ARD) of 5/24/19, indicated Resident #1 had a Brief Interview for Mental Status (BIMS) score of 8, which indicated Resident #1 had moderate cognitive impairment. During an interview on 8/19/19 at 9:48 AM, Resident #1's husband stated that he came to visit his wife on 8/9/19, and she reported that CNA #2 was mean to her. He stated he reported	F 600	was notified on 8/12/2019 at 8:00am and again at 10:00am with voice messages. The State Attorney General's office was notified on 8/12/2019 by the Administrator at 10:00am.The Local State Ombudsman was notified on 8/12/2019 by the Administrator at 9:30am. Certified Nursing Assistant (CNA) #2 was suspended pending investigation beginning 8/12/2019, with termination notice given on 8/19/2019, related to alleged abuse. Licensed Clinical Social Worker for psychotherapy evaluated Resident #1 regarding abuse on 8/12/2019 with follow-up appointment to evaluate again by 9/12/2019. Licensed Clinical Social Worker reported elder seemed happy and stated no issues with facility or care of facility. Resident #1 was checked on daily by the Administrator and Director of Nursing beginning 8/12/2019 and continued until 8/26/2019 to ensure resident safety and comfort. Resident #1 to be checked on during Well-Being Audits to ensure resident safety and comfort with care. 2. All residents at River Chase Village have the potential to be affected by the facility failing to prevent verbal or mental abuse. A Well-Being Audit began on 8/15/2019 with completion on 8/21/2019 by the Administrator and Director of Nursing to identify any residents having the potential to be affected by the facility failing to prevent verbal or mental abuse. This audit was completed by speaking/evaluating	

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F 600	Continued From page 2	F 600		

this to the nurse, who told the RN Supervisor. He stated his wife stated that CNA #2 was "real mean". Resident #1's husband stated that CNA #2 had told his wife that she would get in her (wife's) bed with him (Resident #1's husband) that night. Resident #1's husband stated that he came to visit on 8/10/19, and stated that he confronted CNA #2, and told her not to pick on his sick wife and was banned from the facility until after the investigation.

Review of the facility investigation, dated 8/13/19, revealed the Housekeeping Supervisor overheard a conversation in the dining room on 8/9/19, between CNA #2 and Resident #1. The CNA was overheard questioning Resident #1 about sex when she goes home with Resident #1's husband. Resident #1 was observed to push her chair back from the table in the dining room and CNA #2 pulled her back to the table and kept questioning Resident #1, when the Housekeeping Supervisor intervened and asked the CNA to leave the resident alone. The investigation revealed a statement received by Resident #1, which revealed, "She would go after my husband", referring to CNA #2, and that CNA #2 was mean to her. The investigation documented that the CNA was suspended during the investigation. Resident #1 was assessed with no injury and no concerns with day to day activity. No other incidents were reported by any resident.

In an interview on 8/19/19 at 12:45 PM, Resident #4 confirmed she overheard CNA #2 being ugly to Resident #1 in the dining room. She stated the CNA said she was going to sleep with Resident #1's husband and it made Resident #1 cry. Resident #4 stated that she didn't tell anyone about the incident. Resident #4's most recent

each resident whom is cognitive privately and confidentially and completing a nurse evaluation for the cognitively impaired residents.

Upon Well-Being Audit review, no other residents were identified for being affected by verbal or mental abuse.

3. All staff at River Chase Village were in-serviced by the Administrator and Director of Nursing on 8/15/2019 regarding abuse and neglect policy and procedure and unusual incidents.

All staff at River Chase Village were in-serviced by the Administrator and Director of Nursing on 8/15/2019 regarding Grievance Process and Resident Rights.

All staff at River Chase Village were in-serviced by the Attorney General's Office on 9/3/2019 regarding reporting and identifying abuse.

All staff at River Chase Village were in-serviced by the Administrator and Director of Nursing on 9/3/2019 regarding updated abuse and neglect policy and procedure and unusual incidents completed on 9/2/2019 by the River Chase Village Nursing consultant for reporting immediately but not later than 2 hours after an allegation is made due to previous policy stating only immediately and within 24 hours.

Certified Nursing Assistant(CNA) #2 was suspended pending investigation beginning 8/12/2019, with termination notice given on 8/19/2019, related to alleged abuse.

A Well-Being Audit began on 8/15/2019

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F 600	Continued From page 3 MDS, with an ARD of 7/15/19, revealed a BIMS score of 15, which indicated no cognitive impairment. Resident #4 denied any other incidents. In an interview on 8/19/19 at 1:15 PM, the Housekeeping Supervisor stated she overheard CNA #2 tell Resident #1 that she would have sex with her husband when she went home. The Housekeeping Supervisor stated this occurred in the dining room toward the end of the 7:00 AM-3:00 PM shift. She stated that she observed Resident #1 push her chair away from the table, but couldn't see if she was upset, because she was behind the resident. She stated that she did not see the resident have any further behavior related to the incident. In an interview on 8/19/2019, the Administrator stated she was made aware of the altercation between CNA #2 and Resident #1's husband, on Saturday 8/10/19, and she told Registered Nurse Supervisor #1 to not let the CNA work with Resident #1 until the investigation was completed. The Administrator stated she found out on Monday, 8/12/19, about the incident that happened in the dining room on Friday, 8/9/2019, when CNA #2 allegedly told the resident she was going to have sex with her husband. She stated CNA #2 was suspended pending the investigation. Review of CNA #2's personnel file revealed she was suspended beginning on 8/11/19, with termination notice given on 8/19/19, related to alleged abuse. In a post-survey interview, on 8/23/19 at 11:42 AM, CNA #2 denied making comments of sleeping with Resident #1's husband.	F 600	with completion on 8/21/2019 by the Administrator and Director of Nursing to ensure all residents were free from verbal or mental abuse with no findings noted. A Well-Being Audit will be completed every 60 days by the Administrator and/or Director of Nursing on all current residents. Any findings will be immediately reported to appropriate agencies. All staff will continue to be trained upon hire and quarterly thereafter regarding abuse and neglect policy and procedure, unusual incidents, grievance procedure and resident rights. 4. The interdisciplinary team to meet weekly and review past Well-Being Audits to ensure all residents concerns and/or issues with care are being identified and resolved. After the initial Well-Being Audit, the Administrator and/or Director of Nursing will continue the audit with all current residents every 60 days to ensure all residents concerns and/or issues with care are being identified and resolved. The findings of the Well-Being Audits are to be reviewed and presented by the Administrator and/or Director of Nursing to the Quality Assessment and Assurance(QAA) team quarterly.	

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F 608	Continued From page 4	F 608		
F 608 SS=D	Reporting of Reasonable Suspicion of a Crime CFR(s): 483.12(b)(5)(i)-(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. (i) Annually notifying covered individuals, as defined at section 1150B(a)(3) of the Act, of that individual's obligation to comply with the following reporting requirements. (A) Each covered individual shall report to the State Agency and one or more law enforcement entities for the political subdivision in which the facility is located any reasonable suspicion of a crime against any individual who is a resident of, or is receiving care from, the facility. (B) Each covered individual shall report immediately, but not later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury. (ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. (iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, facility investigation review and facility policy review, the facility failed to report an incident of abuse to the Mississippi State Department of Health State Agency (MSDH SA) and local law enforcement	F 608	1. On 8/12/2019 the Administrator notified the Mississippi State Department of Health State Agency (MSDH) hotline as well as the State Attorney General's office of the abuse of Resident #1.	9/3/19

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F 608	Continued From page 5 within two (2) hours of the incident, per regulation, for one (1) of four (4) residents reviewed for abuse, Resident #1. Findings include: Review of the facility policy, "Unusual Incidents of Patient Mistreatment" revised 11/5/2001, revealed, " ... it is the policy of this facility that any employee having any knowledge of the alleged, suspected, or witnessed abuse must report it directly to their supervisor, and to the Administrator immediately." The facility admitted Resident #1 on 8/30/18, with diagnosis of Hemiplegia, Hypertension (High Blood Pressure) and Type II Diabetes. The Quarterly Minimum Data Set (MDS) with the Assessment Reference Date (ARD) of 5/24/19, indicated Resident #1 had a Brief Interview for Mental Status (BIMS)score of 8, which indicated Resident #1 was moderately cognitively impaired. Review of an outside-source complaint, dated 8/13/19, revealed Resident #1 had been harassed by a staff member, Certified Nursing Assistant (CNA) #2, who made statements of having sex with the resident's husband, and threatened to beat the resident up. Review of the facility investigation, dated 8/9/19, revealed the Housekeeping Supervisor overheard a conversation in the dining room between CNA #2 and Resident #1. CNA #2 was overheard questioning Resident #1 about going home with the resident's husband and having sex. Resident #1 was observed to push her chair back from the table and CNA #2 pulled her back to the table and kept questioning Resident #1. The Housekeeping	F 608	Certified Nursing Assistant (CNA) #2 was suspended pending investigation beginning 8/12/2019, with termination notice given on 8/19/2019, related to alleged abuse. Licensed Clinical Social Worker for psychotherapy evaluated Resident #1 regarding abuse on 8/12/2019 with follow-up appointment to evaluate again by 9/12/2019. Resident #1 was checked on daily beginning 8/12/2019 and to continue periodically to ensure resident safety and comfort. 2. All residents at River Chase Village have the potential to be affected by the facility failing to report an incident of abuse to the Mississippi State Department of Health State Agency (MSDH SA) and local law enforcement within two (2) hours of the incident. 3. All staff at River Chase Village were in-serviced by the Administrator and Director of Nursing on 8/15/2019 regarding reporting abuse and neglect policy and procedure and unusual incidents. All staff at River Chase Village were in-serviced by the Administrator and Director of Nursing on 8/15/2019 regarding Grievance Process and Resident Rights. All staff at River Chase Village were in-serviced by the Attorney General's Office on 9/3/2019 regarding reporting and identifying abuse. All staff at River Chase Village were	

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F 608	Continued From page 6	F 608		

Supervisor intervened and asked the CNA to leave the resident alone. The incident was not reported by the Housekeeping Supervisor until Monday, 8/12/19. There was no documented evidence that the incident was reported to the SA and/or local law enforcement until three (3) days after the incident. The investigation revealed a statement by Resident #1, dated 8/13/19, which included CNA #2 made statements such as "She would go after my husband" and that CNA #2 was mean to her. The investigation documented that the CNA was suspended during the investigation.

In an interview with Resident #1, on 8/19/19 at 9:45 AM, the resident confirmed staff had been ugly to her and a tear was observed in her right eye. She did not name the staff.

In an interview on 8/19/19 at 12:45 PM, Resident #4 confirmed she had overheard Certified Nursing Assistant #2 being ugly to Resident #1 in the dining room. She stated that CNA #2 told the resident that she was going to sleep with Resident #1's husband, which made Resident #1 cry. Resident #4 denied reporting the incident to anyone.

In an interview with the Housekeeping Supervisor, on 8/19/19 at 1:15 PM, she stated she overheard CNA #2 tell Resident #1 that she would have sex with her husband when she went home that night. The Housekeeping Supervisor stated she observed Resident #1 push her chair away from the table. The Housekeeping Supervisor stated she could not find anyone on Friday afternoon to report this to, so she waited until Monday morning and reported it to the Administrator. This was three (3) days after the event had occurred.

in-serviced by the Administrator and Director of Nursing on 9/3/2019 regarding updated abuse and neglect policy and procedure and unusual incidents completed on 9/2/2019 by the River Chase Village Nursing consultant for reporting immediately but not later than 2 hours after an allegation is made due to previous policy stating only immediately and within 24 hours.

A Well-Being Audit began on 8/15/2019 with completion on 8/21/2019 by the Administrator and Director of Nursing to ensure all residents were free from verbal or mental abuse with no findings noted.

A Well-Being Audit will be completed every 60 days by the Administrator and/or Director of Nursing on all current residents. Any findings will be immediately reported to appropriate agencies.

All staff will continue to be trained upon hire and quarterly thereafter regarding reporting abuse and neglect policy and procedure, unusual incidents, grievance procedure and resident rights.

4. The interdisciplinary team to meet weekly and review past Well-Being Audits to ensure all residents concerns and/or issues with care are being identified and resolved.

After the initial Well-Being Audit, the Administrator and/or Director of Nursing will continue the audit with all current residents every 60 days to ensure all residents concerns and/or issues with care are being identified and resolved.

The findings of the Well-Being Audits are to be reviewed and presented by the

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F 608	Continued From page 7 In an interview on 8/19/2019, the Administrator stated she found out on Monday morning, 8/12/19, about the incident that happened in the dining room on Friday 8/9/2019. She stated Certified Nursing Assistant #2 was suspended pending the investigation after an incident on Saturday, 8/10/19, between Resident #1's husband and CNA #2. The administrator reported the incident the Mississippi State Department of Health State Agency (MSDH) hotline on 8/12/2019 (three days after then incident) at 8:00 AM, and again at 10:00 AM, and left messages. The Ombudsman and State Attorney General's office were notified of the incident on 8/12/2019.	F 608	Administrator and/or Director of Nursing to the Quality Assessment and Assurance(QAA) team quarterly.	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established	F 609		9/3/19

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F 609	Continued From page 8 procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, facility investigation review, and facility policy review, the facility failed to report an incident of abuse to the Mississippi State Department of Health State Agency and other law enforcement agencies within two (2) hours of the incident, per regulation, for one (1) of four (4) residents reviewed for abuse, Resident #1. Findings include: Review of the facility policy, "Unusual Incidents of Patient Mistreatment" revised 11/5/2001, revealed, " ... it is the policy of this facility that any employee having any knowledge of the alleged, suspected, or witnessed abuse must report it directly to their supervisor, and to the Administrator immediately." Review of an outside-source complaint, dated 8/13/19, revealed Resident #1 had been harassed by a staff member, Certified Nursing Assistant (CNA) #2, who made statements of having sex with the resident's husband, and threatened to beat the resident up. Review of the facility investigation, dated 8/9/19, revealed the Housekeeping Supervisor overheard	F 609	1. On 8/12/2019 the Administrator notified the Mississippi State Department of Health State Agency (MSDH) hotline and the State Attorney General's office regarding abuse incident with Resident #1. Certified Nursing Assistant (CNA) #2 was suspended pending investigation beginning 8/12/2019, with termination notice given on 8/19/2019, related to alleged abuse. Licensed Clinical Social Worker for psychotherapy evaluated Resident #1 regarding abuse on 8/12/2019 with follow-up appointment to evaluate again by 9/12/2019. 2. All residents at River Chase Village have the potential to be affected by the facility failing to report an incident of abuse to the Mississippi State Department of Health State Agency (MSDH SA) and local law enforcement within two (2) hours of the incident. 3. All staff at River Chase Village were in-serviced by the Administrator and Director of Nursing on 8/15/2019	

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F 609	Continued From page 9 a conversation in the dining room between CNA #2 and Resident #1. CNA #2 was overheard questioning Resident #1 about going home with the resident's husband and having sex. Resident #1 was observed to push her chair back from the table and CNA #2 pulled her back to the table and kept questioning Resident #1, until the Housekeeping Supervisor intervened. The Housekeeping Supervisor asked the CNA to leave the resident alone. The incident was not reported by the Housekeeping Supervisor until Monday, 8/12/19. The investigation revealed a statement by Resident #1, received 8/13/19, which indicated that CNA #2 made statements such as she was going after the resident's husband and that CNA #2 was mean to her. The investigation documented that the CNA was suspended and later terminated for the allegation of abuse. There was no documented evidence that the incident on 8/9/19, of CNA #2's verbal/mental abuse to Resident #1, was reported to the MSDH SA or other required agencies per regulations until 8/12/19, three (3) days after the incident. In an interview with Resident #1 on 8/19/19 at 9:45 AM confirmed staff had been ugly to her and began to cry. She did not name the staff. In an interview on 8/19/19 at 12:45 PM, Resident #4 confirmed she had overheard Certified Nursing Assistant #2 being ugly to Resident #1 in the dining room. She stated that CNA #2 told the resident that she was going to sleep with Resident #1's husband, which made Resident #1 cry. Resident #4 stated that she did not report this to anyone. In an interview with the Housekeeping	F 609	regarding reporting abuse and neglect policy and procedure and unusual incidents to the required agencies. All staff at River Chase Village were in-serviced by the Attorney General's Office on 9/3/2019 regarding reporting and identifying abuse. All staff at River Chase Village were in-serviced by the Administrator and Director of Nursing on 9/3/2019 regarding updated reporting abuse and neglect policy and procedure and unusual incidents. A Well-Being Audit began on 8/15/2019 with completion on 8/21/2019 by the Administrator and Director of Nursing to ensure all residents were free from verbal or mental abuse with no findings noted. A Well-Being Audit will be completed every 60 days by the Administrator and/or Director of Nursing on all current residents. Any findings will be immediately reported to appropriate agencies. All staff will continue to be trained upon hire and quarterly thereafter regarding reporting abuse and neglect policy and procedure, unusual incidents, grievance procedure and resident rights. 4. The interdisciplinary team to meet weekly and review past Well-Being Audits to ensure all residents concerns and/or issues with care are being identified and resolved. After the initial Well-Being Audit, the Administrator and/or Director of Nursing will continue the audit with all current residents every 60 days to ensure all residents concerns and/or issues with	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255289	A. BUILDING _____ B. WING _____	C 08/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER CHASE VILLAGE	5090 GAUTIER VANCLEAVE ROAD GAUTIER, MS 39553

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F 609	Continued From page 10 Supervisor, on 8/19/19 at 1:15 PM, she stated she overheard Certified Nursing Assistant #2 tell Resident #1 that she would have sex with her husband when she went home. The Housekeeping Supervisor stated she observed Resident #1 push her chair away from the table. The Housekeeping Supervisor stated she could not find anyone on Friday afternoon to report this to, so she waited until Monday morning and reported it to the Administrator. In an interview on 8/19/2019, the Administrator stated she found out on Monday morning, 8/12/19, about the incident that happened in the dining room on Friday 8/9/2019, of CNA #2 telling Resident #1 that she was going to have sex with her husband. She stated Certified Nursing Assistant #2 was suspended after an incident on 8/10/19, with Resident #1's husband, pending an investigation. The Administrator reported the incident to the Mississippi State Department of Health State Agency (MSDH SA) hotline on 8/12/2019, (three days after then incident) at 8:00 AM, and again at 10:00 AM, and left messages. Review of the facility investigation revealed the Ombudsman and State Attorney General were notified of the incident on 8/12/2019. The facility admitted Resident #1 on 8/30/18, with the diagnoses of Hemiplegia, Hypertension (High Blood Pressure) and Type II Diabetes. The Quarterly Minimum Data Set (MDS) with the Assessment Reference Date (ARD) of 5/24/19, indicated Resident #1 had a Brief Interview for Mental Status (BIMS)score of 8, which indicated Resident #1 was moderately cognitively impaired.	F 609	care are being identified and resolved. The findings of the Well-Being Audits are to be reviewed and presented by the Administrator and/or Director of Nursing to the Quality Assessment and Assurance(QAA) team quarterly.	