STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255283	A. BUILDING _____ B. WING _____	C 07/22/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VAIDEN COMMUNITY LIVING CENTER	868 MULBERRY STREET VAIDEN, MS 39176

(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, MS #16930 at the facility on 07/23/2020. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid. The SA substantiated the complaint for Abuse and Neglect and cited F600 and F609. The census at the time of the survey was 46, with a bed capacity of 60.	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 staff interview, resident interview, record review, and policy and procedure review, the facility failed to ensure Resident #1 was free from abuse and neglect, for one (1) of five (5) residents reviewed. Findings include:	F 600	1. Allegation of abuse was reported immediately by the Administrator to the Mississippi State Department of Health on 7/20/20 when reported to Administrator. Certified Nursing Assistant #1 was suspended immediately pending investigation and terminated on 7/20/20.	8/14/20

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

Electronically Signed | 08/11/2020

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F 600	Continued From page 1 Review of the facility's "Abuse and/or Neglect Prevention Plan Policy", dated 02/18/2009, revealed: "The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion." The policy revealed the definition of Verbal Abuse as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. A review of the facility's Accident/Incident (A/I) Report, dated 07/17/2020, completed by Licensed Practical Nurse (LPN) #1, revealed, upon making rounds, she entered Resident #1's room and noted the resident was upset. The A/I Report revealed, Resident #1 reported to LPN #1 that Certified Nursing Assistant (CNA) #1 had been rude to her. Resident #1 reported she was transferring herself to the commode by without assistance, and CNA #1 stated to her, "That's why your ass is always on the floor." On 07/23/2020 at 8:40 AM, an interview with the Administrator, revealed, she was notified of an incident that occurred between CNA #1 and Resident #1 on 07/20/2020 at approximately 12:00 noon. The Administrator stated the incident occurred on 07/17/2020, early AM, and was reported to her by the Director of Nursing (DON). The Administrator stated the employee (CNA #1) was called on 07/20/2020 and admitted to saying the word "ass" to Resident #1 and was very apologetic. The Administrator stated CNA #1's employment was terminated at that time and the incident was reported to State officials. The Administrator stated all employees had been	F 600	Resident #1 was assessed immediately on 7/20/20 by the Director of Nursing and Social Worker for any physical or emotional distress with no negative outcomes found. The facility will correct the alleged deficiency by ensuring Resident #1 is safe from abuse as evidenced by no physical or emotional distress x three days monitored by Social Worker, ensuring Resident #1 feels safe in facility and educating Resident # 1 on actions taken by facility to ensure alleged deficient practice does not reoccur. 2.All residents have the potential to be affected by the alleged deficient practice. Thirteen residents able to be interviewed as evidenced by a BIMS score of 12 or above were questioned on 7/20/20 by the Administrator to ensure safety from abuse/neglect and to ensure all allegations were investigated and reported immediately. No negative findings were found. The facility will act to protect residents in similar situations by following abuse policy and prevention plan and ensuring current and newly hired staff are educated on abuse and neglect prevention plan monthly and more often as needed and understand it. Education will also include what is considered abuse and timely reporting of any abuse/neglect or suspected abuse and neglect. The Social Worker will complete weekly visits with at least five residents beginning 7/20/20 to ensure no further concerns are noted x four weeks and longer thereafter if problems are identified. If concerns are expressed, Social Worker will immediately	

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F 600	Continued From page 2 recently in-serviced on reporting abuse and neglect. The Administrator stated the staff was aware that the incident should have been reported within two (2) hours of occurrence but did not report it timely. On 07/23/2020 at 9:00 AM, an interview with Resident #1, revealed she had asked CNA #1 to take her to the bathroom this past Friday morning (07/17/2020). Resident #1 stated CNA #1 was busy at the time and came back a few minutes later. Resident #1 stated she was trying to take herself to the bathroom when CNA #1 came in and he said to her, "That's why your ass keeps falling because you won't wait for help." Resident #1 stated she told CNA #1 it was ok, that he didn't have to help her, and that she could get someone else. Resident #1 revealed CNA #1 stated, "Oh no, I'm going to help you." Resident #1 stated he (CNA #1) had never acted like that before. Resident #1 stated it hurt her feelings because he talked to her like that. Resident #1 stated, "I don't know what was wrong with him, he's never done me like that." Resident #1 reported CNA #1 did not return to her room after this incident. On 07/23/2020 at 9:30 AM, during an interview with the Director of Nursing (DON), she stated that she was notified of the incident between Resident #1 and CNA #1 on 07/20/2020. The DON stated she was on vacation and was notified upon her return to work on the 20th of July. The DON stated she and the Social Worker interviewed Resident #1. The DON revealed Resident #1 reported that she had asked CNA#1 to help her to the bathroom. The DON stated Resident #1 reported that CNA #1 stated he was busy at the time. and told her he would come back. Resident #1 stated that she tried to take	F 600	notify Administrator and/or Director of Nursing for a full investigation. 3.Staff inserviced by Director of Nursing on 7/20/20 regarding abuse and neglect prevention plan and immediately reporting abuse or suspected abuse to direct supervisor who will then report to Administrator or Director of Nursing. All allegations of abuse and neglect or suspected abuse will be thoroughly investigated by Administrator and/or Director of Nursing. The Director of Nursing will educate current and new staff on abuse and neglect monthly and as needed. Education will include how to identify abuse and how and when to report if abuse is known or suspected. Body audits will be completed on all residents weekly by Registered Nurse or Licensed Practical Nurse beginning 7/20/20. 4.New staff hired will be educated in orientation regarding abuse/neglect policy and prevention plan and reporting abuse or suspected abuse immediately. The Director of Nursing will educate current and new staff on abuse and neglect monthly and as needed. Education will include how to identify abuse and how and when to report if abuse is known or suspected. Social Worker will interview residents weekly x four weeks and as needed thereafter to assess and ensure residents are safe from abuse/neglect and will report the findings to the Quality Assurance and Performance Improvement Committee monthly and as	

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F 600	Continued From page 3	F 600		

herself to the bathroom but when CNA #1 came in, he stated to her, "that's why your ass keeps falling, you won't wait for help." The DON stated Resident 1's feelings were hurt because CNA #1 had cursed at her. The DON stated the incident was initially reported to the LPN on duty from 7 PM to 7 AM that morning (07/17/2020), and that the LPN told her she reported it to the oncoming Registered Nurse (RN). The DON stated CNA #1 clocked out at 7:00 AM on 07/17/2020 and did not return to work. The DON stated CNA #1 was called on 07/20/2020 for a verbal statement and admitted to cursing at Resident #1. She stated CNA #1's employment was terminated at that time. The DON stated no one in Administration was notified of the incident until 07/20/2020.

On 07/23/2020 at 9:40 AM, an interview with Registered Nurse (RN) #1 revealed, no one reported an incident to her that occurred between Resident #1 and CNA #1 on 07/17/2020. RN #1 denied any knowledge of the incident.

During an interview, on 07/23/2020 at 10:30 AM, LPN #1 stated Resident #1 reported to her that she was trying to get on the commode and CNA #1 said to her, that's why your ass is always on the floor, you won't wait for anyone to help you. LPN #1 stated she reported the incident to RN #1 and tried to call the DON but couldn't reach her because she was on vacation. LPN #1 stated she had training on abuse and neglect and knew the incident had to be reported within 2 hrs. LPN #1 stated she was getting off work and that was why she reported it to the RN coming on. LPN #1 stated she thought the RN would report it to Administration.

On 07/23/2020 at 1:15 PM, during an interview

needed for review. Social Worker will educate residents on weekly visits regarding how, when and to who they should report abuse or suspected abuse. Any concerns noted during monitoring and visits will be discussed by committee in Quality Assurance and Performance Improvement meeting each month and changes will be modified as needed.

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F 600	Continued From page 4	F 600		

with LPN #2, he stated that he was informed on Monday 07/20/2020 that Resident #1 needed to see him. LPN #2 stated upon entering Resident #1's room, she told him that she needed to tell him about something that happened with one of the CNAs. LPN #2 stated Resident #1 started telling him about CNA #1 cursing her. He stated he told Resident #1 that he needed to get the DON so she could tell her what happened. LPN #2 stated he left the room and reported the incident to the DON and Social Worker and they immediately went to the resident's room.

During an interview, on 07/23/2020 at 1:25 PM, the Social Worker (SW) stated she was with the DON when Resident #1 reported the incident to them which occurred between her and CNA #1. The SW stated she speaks with the residents often about abuse and neglect and encourages them to report any abuse or neglect that occurs.

On 07/23/2020 at 1:50 PM, during an interview with CNA #1, he stated that he saw Resident #1 trying to transfer herself to the bathroom and he said to her, that's why your ass is always falling on the floor, because you won't buzz for help. CNA #1 stated he told Resident #1 that he was sorry for what he had said to her. CNA #1 stated he reported to the nurse on duty what had happened, and she talked to the resident. CNA #1 stated he had been trained on abuse and neglect and understands that cursing at a resident was verbal abuse.

A review of CNA #1's time sheet, revealed, his last day worked was on 07/16/2020 with him clocking out at 6:59 AM on 07/17/2020.

Review of the facility's in-service training related

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F 600	Continued From page 5 to abuse and neglect, revealed, the last in-service CNA #1 attended related to abuse and neglect was on 06/10/2020. Review of CNA #1's Personnel Action Notice, indicated CNA #1 was terminated on 07/20/2020.	F 600		
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 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	F 609		8/14/20

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F 609	Continued From page 6 by: Based on staff interview, record review and facility policy review the facility failed to report an allegation of abuse and neglect within the required two (2) hour time frame for Resident #1, for one (1) of five (5) residents reviewed. Findings include: Review of the facility's "Freedom from Abuse, Neglect, and or Exploitation Prevention Plan" policy, dated 11/14/2017, revealed: "Reports must be within 24 hours (if the allegation does not involve abuse or there is not serious bodily injury) after forming your reasonable suspicion. Within 2 hours (if the allegation involves abuse or there is serious bodily injury) after forming your reasonable suspicion." On 07/23/2020 at 8:40 AM, during an interview, the Administrator revealed, she was notified on 07/20/2020 at approximately 12 noon, of an incident that occurred between Certified Nursing Assistant (CNA) #1 and Resident #1. The Administrator stated the incident occurred on 07/17/2020, early AM, and it was reported to her by the Director of Nursing (DON) on 07/20/2020. The Administrator stated CNA #1 was called on 07/20/2020, admitted to saying the word "ass" to the resident, and was very apologetic. The Administrator stated CNA #1's employment was terminated at that time, and the incident was reported to State officials. The Administrator stated all employees had been recently in-serviced on reporting abuse and neglect. The Administrator further stated the staff was aware that the incident should have been reported within two (2) hours of occurrence but did not report it timely.	F 609	1.Allegation of abuse was reported immediately by the Administrator to the Mississippi State Department of Health on 7/20/20 when reported to Administrator. Certified Nursing Assistant #1 was suspended immediately pending investigation and terminated on 7/20/20. Resident #1 was assessed immediately by the Director of Nursing and Social Worker on 7/20/20 for any physical or emotional distress. No negative outcomes were found. The facility will correct the alleged deficiency by ensuring Resident #1 is safe from abuse as evidenced by no physical or emotional distress for three days beginning 7/20/20 monitored by Social Worker, ensuring Resident #1 feels safe in facility and educating Resident #1 on actions taken by facility to ensure alleged deficient practice does not reoccur. 2.All residents have the potential to be affected by deficient practice. Thirteen residents able to be interviewed were questioned on 7/20/20 by the Administrator to ensure safety from abuse/neglect and to ensure all allegations were investigated and reported immediately. No negative findings were found. The facility will act to protect residents in similar situations by following abuse policy and prevention plan and ensuring current and newly hired staff are educated on abuse and neglect prevention plan monthly and more often as needed and understand it. Education will also include what is considered abuse	

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F 609	Continued From page 7 During an interview, on 07/23/2020 at 9:30 AM, the Director of Nursing (DON) stated she was notified of the incident between Resident #1 and CNA #1 on 07/20/2020. The DON stated she was on vacation and was notified upon her return to work on the 20th. The DON stated the incident was initially reported to the Licensed Practical Nurse (LPN) on duty from 7 PM to 7 AM on 07/17/2020 and that the LPN told her she reported it to the oncoming Registered Nurse (RN). The DON stated no one in Administration was notified of the incident until 07/20/2020. On 7/23/20 at 9:40 AM, an interview with RN #1, revealed, no one reported to her an incident between Resident #1 and CNA #1 on 07/17/2020. RN #1 denied any knowledge of the incident. On 07/23/2020 at 10:30 AM, during an interview with LPN #1, she stated that she reported the incident to RN #1 and tried to call the DON but couldn't reach her because she was on vacation. LPN #1 stated she had training on abuse and neglect and knew the incident had to be reported within 2 hrs. LPN #1 stated she was getting off work on 07/17/2020 and that was why she reported it to the RN coming on. LPN #1 stated she thought that the RN would report it to Administration. A review of the facility's in-service documentation, revealed the last in-service related to reporting abuse and neglect within two (2) hours, was conducted on 06/10/2020.	F 609	and timely reporting of any abuse/neglect or suspected abuse and neglect. The Social Worker will complete weekly visits with at least five residents beginning 7/20/20 to ensure no further concerns are noted x four weeks and longer thereafter if problems are identified. If concerns are expressed, social worker will immediately notify Administrator and/or Director of Nursing for a full investigation. 3.Staff inserviced by Director of Nursing on 7/20/20 regarding abuse and neglect prevention plan and immediately reporting abuse or suspected abuse to direct supervisor who will then report to Administrator or Director of Nursing. All allegations of abuse and neglect or suspected abuse will be thoroughly investigated by Administrator and/or Director of Nursing. The Director of Nursing will educate current and new staff on abuse and neglect monthly and as needed. Education will include how to identify abuse and how and when to report if abuse is known or suspected. Body audits will be completed on all residents weekly by Registered Nurse or Licensed Practical Nurse beginning 7/20/20. 4.New staff hired will be educated in orientation regarding abuse/neglect policy and prevention plan and reporting abuse or suspected abuse immediately. The Director of Nursing will educate current and new staff on abuse and neglect monthly and as needed. Education will include how to identify abuse and how and	

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F 609	Continued From page 8	F 609	when to report if abuse is known or suspected. Social Worker will interview residents weekly x four weeks beginning 8/10/20 and as needed thereafter to assess and ensure residents are safe from abuse/neglect and will report the findings to the Quality Assurance and Performance Improvement committee monthly and as needed for review. Social Worker will educate residents on weekly visits regarding how, when and to who they should report abuse or suspected abuse. Any concerns noted during monitoring and visits will be discussed by committee in Quality Assurance and Performance Improvement each month and changes will be modified as needed.	