STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46FM	A. BUILDING: _____ B. WING _____	C 02/09/2022

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COLUMBIA REHABILITATION AND HEALTHCARE CEI	1506 NORTH MAIN STREET COLUMBIA, MS 39429

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M 000	Initial Comments The State Agency (SA) conducted three (3) Complaint Investigations, CI MS # 18266, CI MS # 18158 and CI MS # 18167 at the facility from 2/08/22 through 2/09/22. During the survey, the SA determined the facility was not in compliance with the Mississippi Regulations for Minimum Standards for Institutions for Aged or Infirm. CI MS # 18266 was not substantiated related to Residents' Rights concerning the 2021 change of "Smoking Policy" in the facility. CI MS # 18158 and CI MS # 18167 were substantiated related to abuse of a resident by a staff member and the SA cited M500.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his	M 500		2/28/22

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M 500	Continued From page 1 medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal;	M 500		

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M 500	Continued From page 2 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other	M 500		

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M 500	Continued From page 3 residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Based on interviews and record review, the facility failed to ensure a resident was protected from abuse for one (1) of four (4) residents	M 500	* On 9/21/21 alleged abuse was reported towards resident #1, by Licensed Practical Nurse #1. Licensed Practical Nurse #1	

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M 500	Continued From page 4 reviewed for abuse. Resident #1 Record review revealed the facility policy titled "POLICY FOR PROHIBITION OF ABUSE, NEGLECT AND MISAPPROPRIATTION OF PROPERTY" dated 5/01/01, stated "Each resident has the right to be free from abuse, mistreatment, neglect, corporal punishment, involuntary seclusion and financial abuse... The facility will prohibit neglect, mental or physical abuse, including involuntary seclusion and the misappropriation of property or finances of residents.". Review of the Mississippi State Department of Health Complaint Intake revealed the facility reported that on 9/21/21 while getting a resident ready for therapy, resident was not cooperating...Resident became agitated...the nurse grabbed resident's chin..." Record review of the facility investigation revealed a timeline of events as documented and provided by the facility: "TIMELINE 9/21/21 10:00 (AM)-Certified Nursing Assistant (CNA) #1 reported Licensed Practical Nurse (LPN) #1 had allegedly physically abused Resident #1, 10:01 (AM) -LPN #1 wrote statement and was immediately suspended, 10:05 (AM) -"CNA #1 and CNA #2 "were interviewed incident..." On 2/08/22 at 1:15 PM, during an interview with Resident #1, she stated she did not remember the incident. On 2/08/22 at 2:00 PM, an interview with CNA #1 revealed she was working at the facility on 9/21/21 and was assigned to care for Resident #1. She stated after providing morning care for	M 500	was removed from care area to protect resident #1. After giving written statement, Licensed Practical nurse #1 was suspended and escorted from the facility, until investigation was complete. Resident#1 was assessed by Director of Nursing on 9/21/21, with no adverse findings were noted upon assessment. All staff were in-service regarding the Vulnerable Adult Act, Abuse, Resident Safety, and reporting on 9/21/21. Details of the incident were taken to special Quality Assurance meeting on 9/21/21. Life Satisfaction rounds were completed on 9/21/21 with no new findings. * On 9/21/21 all other cognitive residents under the care of Licensed Practical Nurse #1 were interviewed regarding their care by Licensed Practical Nurse #1. No other residents voiced concerns. One hundred percent of staff were notified of incident and in-serviced on 9/21/21 regarding Vulnerable Adult Act, Abuse, Resident Safety, and Reporting. All new hires will continue to be in-serviced on the Vulnerable Adult Act, Abuse, Resident Safety, and Reporting during orientation from 9/21/21 and ongoing. We continued life Satisfaction rounds weekly for four weeks, then monthly for three months, and then quarterly for three quarters with questions related to Abuse and Neglect. * Licensed Practical Nurse #1 was terminated on 9/23/21 and reported to Mississippi Board of Nursing. All staff will continued to be in-service on Vulnerable Adult Act, Abuse, Resident Safety, and Reporting beginning 9/21/21 and ongoing by Administrator. Pertaining to incident one hundred percent of staff were	

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M 500	Continued From page 5 the resident, she and Nurse Aide (NA) #1 had explained to Resident #1 they were going to assist her to get out of bed and into her wheelchair to go to physical therapy. CNA #1 stated Resident #1 told them she didn't want to get out of bed at that time or go to therapy. CNA #1 said she encouraged the resident, but when Resident #1 continued to refuse to get out of bed she went and reported this to LPN #1 per facility policy and procedure. CNA #1 stated she and LPN #1 went to the room of Resident #1 and LPN #1 encouraged the resident to get up and when the resident continued to refuse the LPN "turned the resident on her side to continue to get her ready to get up". CNA #1 stated Resident #1 "was waving her hand behind her and slapping at the nurse, like to get her to leave her alone". CNA #1 said Resident #1's hand made contact with LPN #1 and "(Resident #1) slapped her (LPN #1)". CNA #1 said when the resident slapped LPN #1, "the nurse grabbed the resident by her throat". CNA #1 stated "I'm not saying she tried to choke her, like squeezed with her hand, but she definitely grabbed her (Resident #1) on her neck and it looked like she was pushing down". The CNA said she was not sure of the intention of LPN #1, she said it may have been a "reaction" but she remembered her training on abuse and neglect and did not wait. CNA #1 stated "I wasn't going to stay there and see anymore; I got out of there. I had to take a second to calm myself down and then went immediately to the DON and reported it". On 2/08/22 at 3:00 PM, an interview with NA #1 revealed "It was me, (the LPN #1) and (CNA #1) and (Resident #1) in the room. (Resident #1) stated she didn't want to get out of the bed. She said she didn't want to get up for therapy. CNA #1 went and got (LPN #1). The resident continued to	M 500	immediately in-service on particular incident upon occurrence on 9/21/21 by Director of Nursing. In-service including details of event, the Vulnerable Adult Act, Abuse, Resident Safety, and Reporting. Resident council was held on 9/24/21 with no complaints of mistreatment or abuse voiced. * All allegations of abuse will be investigated immediately, brought to morning meeting, with results and outcomes carried to monthly Quality Assurance Meeting, beginning October 2021. Daily monitoring by "Nexion Neighbor Rounds Sheet" which is conducted by department mangers daily to ascertain resident concerns, beginning October 2021 and continued daily as part of our morning meeting agenda. The Administrator will be responsible for monitoring and results will be taken to the monthly Quality assurance meeting beginning October 2021 and ongoing.	

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M 500	Continued From page 6	M 500		

decline to get up. "I didn't see (LPN #1) make contact with (Resident #1), but she saw the LPN "go down toward the upper part of the resident's body with her hands"; after that, (CNA #1) told me 'Come on let's get out of here. I'm going to report her', then (CNA #1) told the nurse "I'm going to report you". She stated she knew CNA #1 was going to report the incident and she also made a statement to the DON at 10:05 AM on 9/21/21.

On 2/08/22 at 3:30 PM, an interview with the Director of Nurses (DON) revealed on 9/21/21, CNA #1 reported to her an incident in which Resident #1 had displayed unusual behavior of combativeness. CNA #1 reported to the DON Resident #1 slapped LPN #1 and LPN #1 "grabbed" Resident #1. The DON stated she removed LPN #1 from resident care, interviewed LPN #1 and obtained a written statement, after which she was suspended and left the facility immediately; the DON stated LPN had no further contact with any residents. She said LPN #1 was terminated 9/22/21 following completion of the investigation. The DON stated an investigation began immediately upon the report of CNA #1. The DON stated she had immediately assessed Resident #1 following the report of incident and the resident had no marks or bruises noted.

Record review of LPN #1 statement revealed, "I was asked by CNA to help come get resident up for therapy. When we got in there resident was already agitated. I asked her to get up so we can go tell the therapist that you don't want to come anymore. When I rolled her over to put pad under her, she rolled back and slapped me. I put my hand under her chin to stop her from hitting me".

Record review of "Disciplinary Action Record"

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M 500	Continued From page 7 dated 9/23/21 which listed "Termination as the "SOLUTIONS & CORRECTIVE ACTION TO BE TAKEN" as a result of the 9/21/21 incident, which indicated LPN #1 received disciplinary action for the incident that occurred with Resident #1. Record review of the "Employee Termination Form" revealed LPN #1 was terminated on 9/22/21 with "Last Day worked 9/21/21" due to "Substantiated Resident Abuse and Neglect" and was not eligible for rehire; the form was signed by (Human Resources) on 9/27/21. Record review of "The Mississippi Vulnerable Adults Act" dated 8/2001 was signed by LPN #1 on 11/19/20, which indicated she was trained on hire related to the Vulnerable Adults Act. Record review of "Resident's Rights Acknowledgement" with a revision date of 6/16 stated "I have received, read and agree to follow the enclosed Resident's Rights.", and was signed by LPN #1 which revealed she had received training on Resident Rights. Record review revealed the facility policy titled "Regarding the Reporting of Abuse and Associate Acknowledgement" (with Revision date 11/13) revealed "...Mistreatment or abuse of any nature will not be tolerated". The policy stated "I have read and fully understand my legal responsibilities outlined. I have also read and understand the penalties that may be imposed if I violate the above-mentioned responsibilities" followed by the signature of LPN #1 and dated 11/19/20 which indicated she had been trained on resident abuse.	M 500		