STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255227	A. BUILDING _____ B. WING _____	C 02/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLUMBIA REHABILITATION AND HEALTHCARE CENTER	1506 NORTH MAIN STREET COLUMBIA, MS 39429

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F 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 requirements of participation in Medicare and Medicaid. 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 F600. The census at the time of the survey was 77, and the facility held a license for 108 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 and record review, the facility failed to ensure a resident was protected	F 600	* On 9/21/21 alleged abuse was reported towards resident #1, by Licensed Practical	2/28/22

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

Electronically Signed | 03/03/2022

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F 600	Continued From page 1 from abuse for one (1) of four (4) residents 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	F 600	Nurse #1. Licensed Practical Nurse #1 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	

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F 600	Continued From page 2 9/21/21 and was assigned to care for Resident #1. She stated after providing morning care for 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)	F 600	by Administrator. Pertaining to incident one hundred percent of staff were 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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F 600	Continued From page 3	F 600		

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 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

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F 600	Continued From page 4	F 600		

my hand under her chin to stop her from hitting me".

Record review of "Disciplinary Action Record" 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

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F 600	Continued From page 5 indicated she had been trained on resident abuse.	F 600		