STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255301	A. BUILDING _____ B. WING _____	C 04/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON, LLC D/B/A THE CARRINGTON	307 REED RD STARKVILLE, MS 39759

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F 000	INITIAL COMMENTS Initial Comments CI MS #18697- Substantiated On April 7, 2022 the State Agency (SA) conducted an onsite complaint investigation, CI MS #18697, for alleged abuse of a resident when a staff member sent an inappropriate photo to a resident's cell phone that was living in the facility. The SA substantiated the complaint, CI MS #18697, and deficiencies were cited at F600 Scope and Severity (S/S) at a "D" level and F610 (S/S) at a "D" level. The SA determined that the facility was not in substantial compliance for participation in Madicaid and Medicare. The facility held a license for 60 beds on 4/7/2022 and the resident census was 55.	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:	F 600		5/18/22

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

Electronically Signed | 04/28/2022

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F 600	Continued From page 1 F600 S/S=D Based on interviews, observations, facility policy and procedure reviews and record reviews, the facility failed to prevent abuse and neglect when a staff member sent inappropriate pictures to Resident #1's cell phone, for one (1) of five (5) residents reviewed for abuse. Findings Include: Review of the facility policy and procedure titled "Abuse Program" dated revised May 23, 2017, revealed It is the policy of this facility to take all steps necessary to maintain an environment free of abuse, Neglect, exploitation, misappropriation of resident property, and involuntary seclusion. The facility is committed to protecting the residents from abuse by anyone including, but not necessarily limited to facility staff, other residents, consultants, volunteers, sponsors, visitors, and other care givers who provide care and services on behalf of the facility. Abuse means the will infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. It includes abuse facilitated or enabled using technology. Review of the facility policy and procedure titled: "Cellular Telephone Policy" dated Revised August 26, 2016, read: In addition to telephone services, many cell phones or cellular providers offer a host of additional functions and/or services, including test messaging and digital photography. It is not possible to list all the services available. Whether	F 600	I. Address how corrective actions will be accomplished for those residents found to have been affected by the deficient practice. The facility failed to prevent abuse and neglect when a staff member sent an inappropriate picture to Resident #1 cell phone. On March 29, 2022, The Nursing Home Administrator was notified by the facility Social Worker that a report had been made of a staff member sending a sexually explicit picture of his penis to Resident #1 cell phone. An investigation ensued. After interview with Resident #1, and after Resident #1 revealed the picture sent to her, the allegation was substantiated. Staff Member was confronted regarding the allegation, and was terminated on March 29, 2022, for sending inappropriate information to a facility resident. II. Steps taken to identify other residents having the potential to be affected by the same alleged deficient practice. All residents of the facility are at risk for the alleged deficient practice. On March 30, 2022, a sample of other residents with equivalent Brief Interview for Mental Status scores as Resident #1 were interviewed by the facility Social Worker to ensure this deficient practice was not widespread. Based on interview and investigation, this was an isolated case. III. What measures will be put into place	

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F 600	Continued From page 2 enumerated or not, employees and volunteers are prohibited from using any of these services while at work. Interview on 4/7/2022 at 11:18 P.M. with the ADM, via DON's cell phone, revealed that he first received word on 3/29/2022 at approximately 11:45 A.M., that an obscene photo of a male penis was on the cell phone of resident (Res#1). The resident had told the PT Supervisor, (PTS) that a staff member, Housekeeping Supervisor (HS) had sent the picture of the male penis to her. The ADM stated that when he interviewed Resident #1 with the SW and that she gave them her cell phone and the Facebook profile of the staff member (HS) was posted with the picture of a male penis. ADM stated that he talked to the staff member (HS) on the day of the discovery, 3/29/2022, and he confirmed that he did send a picture to Resident #1 but that it was not a dirty picture it was a picture of a "melted candy bar." The ADM stated that he had confirmed through the Facebook profile of the (HS) that the picture was sent to the resident (Res #1) on 12/30/2021. The ADM stated that he terminated the (HS) on 3/29/2021 for sending inappropriate information to a facility resident. The ADM stated that he felt that the information he obtained was enough to terminate the staff member, (HS) and to establish that the resident (Res #1) had received an inappropriate picture of a male penis on her cell phone from the HS. Interview on 4/7/2022 at 10:50 A.M. with the Director of Nursing (DON) revealed that on 03/29/22 employee Physical Therapy Supervisor (PTS) was told by Resident #1 early that morning that there was a picture of a male penis on her cell phone. The materials of the facility	F 600	or systemic changes made to ensure that the deficient practice will not recur? A directed in-service, by the Nursing Home Administrator was held with all staff present on March 31, 2022, to address the facility policy on Abuse and Neglect, Social Media Policy and The Health Insurance Portability and Accountability Act of 1996. Also discussed in this in-service was employee/resident professional boundaries and reporting procedures. On March 30, 2022, the Nursing Home Administrator held a Quality Assurance & Performance Improvement meeting with the Quality Assurance & Performance Improvement team and the Medical Director to address the issue. The Quality Assurance & Performance Improvement team recommended increasing the frequency of in-services on abuse and neglect to monthly, and to not only include lecture but also role play to ensure staff understanding of the different types of abuse and what each form of abuse looks like. All new hire orientation will include education on abuse and neglect with discussion regarding professional boundaries with residents and their families. Reporting procedures will be discussed with new hires to include direction given to them on “safe place” reporting. .All “new hires” will sign a statement of agreement and understanding regarding the facility abuse policy. The Administrator and Staff Development Nurse will ensure the in-services on abuse and neglect are held	

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F 600	Continued From page 3 investigation were reviewed. The DON stated that to her knowledge the investigation was completed, and all supporting documentation was contained in the investigation. Interview on 4/7/22 at 12:00 noon with the Attorney General's (AG) Investigator, revealed that he came to the facility on 3/31/22 and talked to the family of the resident and talked to the resident (Res #1). AG obtained the cell phone of Res #1 and had possession of the evidence of the "penis picture that was on Res #1's phone". AG confirmed that the staff member (HS) had sent the picture of the penis to Res #1. AG also stated that the staff member (HS) and the resident did not know each other prior to Res #1's admission to the facility. AG stated that he had a warrant for the staff member (HS) and would be going to his home to visit with the staff member and to obtain his cell phone. AG stated that the pictures that were sent to Res #1 was a "cyber-crime", and he was turning over the cell phone of the resident and of the staff member to the AG's cyber-crime unit for review. Interview on 4/7/2022 at 12:45 P.M. with the Physical Therapy Supervisor (PTS) revealed that she had been working with the resident #1 four (4) times each week in the therapy department for several months. PTS had been employed at the facility for approximately 18 years. The PTS stated that Res #1 usually was in the PT department each morning early waiting on her to start therapy at approximately 8:00 A.M. and that on 3/29/2022 she was not there waiting. PTS stated that on 3/29/2022 at 8:00 A.M. Res #1 was not at the department for therapy and that was unusual. The PTS went to the room of Res #1 along with another physical therapist, Doctor of	F 600	on a monthly basis with both lecture and role-play. IV. Monitoring the corrective actions (Quality Assurance Program) to ensure that the alleged deficient practice does not recur. Beginning March 30, 2022, the Quality Assurance & Performance Improvement Committee will audit the staff in-services on abuse and neglect at their monthly meeting for a period of six month, ending September 30, 2022 or until compliance is achieved, to ensure the in-services are adequate and that all staff are being trained. On March 30, 2022, the facility Social Worker began interviewing a sample of five residents each month for six months, ending September 30, 2022, to ensure there are no complaints or grievances regarding inappropriate behavior toward them from staff; her findings will be reported to the Quality Assurance Performance Improvement Committee for a period of six months, beginning on March 30, 2022 and ending on September 30, 2022. On April 19, 2022, the Quality Assurance Committee met with the Medical Director to review the initial findings proposed The Quality Assurance Performance Improvement Committee will make recommendations as needed.	

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Physical Therapy (DPT). When they got to Res #1's room she was still in bed and was clearly upset and angry. Res #1 told them that she hated the staff at the facility and was upset that two (2) of the CNA's had gotten her cell phone and were trying to block her "dick pictures" that she had on her phone. Res #1 told them that CNA#2 and CNA #3 had tried to block her phone and were trying to erase her "dick pictures" from her phone that had been sent to her by a staff member (HS) Housekeeping Supervisor. Res #1 told both PT's that the Housekeeping Supervisor had sent her a picture of his penis. The PTs stated that Res #1 was clearly and visibly upset, and she was cussing and saying, "I hate those mother fuckers and bitches." Res #1 was refusing to go to therapy and that was very unusual. PTS stated that she went to stand up and reported the incident to the Social Worker (SW) on 3/29/2022 at approximately 10:45 A.M. The PTS stated that she felt that the information given to her by Res #1 was clearly inappropriate and was abuse of a resident. PTS stated that she had never been given any information like this before from Res #1. She stated that this was the first time that she had seen Res #1 cussing and acting angry like she was on the morning of 3/29/2022. PTS stated that she believed that Res #1 was telling the truth on 3/29/2022.

Interview on 4/7/2022 at 1:00 P.M. with the Doctor of Physical Therapy, DPT stated that on 3/29/2022 at approximately 8:30 A.M. she and the PTS went to the room of Res #1 to see why she was not at therapy on 3/29/2022. Upon entering the room and asking why she was still in the bed and not at therapy, Res #1 replied: "I hate all those mother fuckers and bitches." They want to block my phone and get my "dick pictures" from

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my phone. Res #1 was cussing and was visibly upset and in a foul mood. She refused to go to physical therapy on 3/29/2022. Res #1 said that staff member (HS) had sent her a "dick pic" to send to another staff member, a girl (CNA #1). Res #1 stated that she did not want the staff member to get fired and that he had sent the "dick pic" to her phone so she could send it on to another staff member. Res #1 stated that CNA #2 had tried to block her phone and that she wanted her "dick pics." The DPT stated that the PTS had reported the incident to the Social Worker (SW) at the Stand-Up meeting on 3/29/2022 10:45 A.M. . The DPT stated that she had never seen or heard Res #1 angry like she was on 3/29/2022. DPT stated that she had no knowledge of Res #1 being involved in any inappropriate behaviors prior to 3/29/2022. No resident had ever reported anything inappropriate prior to 3/29/2022.

Interview on 4/7/2022 at 1:40 P.M. with the Social Worker (SW) revealed that she was told by the PTS that Res #1 had told her that she had a picture of a male penis on her phone that was sent to her by the Housekeeping Supervisor (HS). SW immediately went to talk to the resident by herself to see what had transpired. Res #1 was upset and was cussing that there were two (2) Certified Nursing Assistants (CNA's) CNA #2, and CNA #3, that were trying to block her phone and she had "dick pics" on her phone from (HS). SW was given the cell phone of Res #1 and she scrolled through her social media account with the permission of Res #1 and found a post from (HS) dated 12/30/2021 that contained a photo of a male penis. Res #1 did not want to get HS in trouble, and she was upset that he may get fired. SW confirmed that the photo was posted on

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12/30/2021 from the Facebook private message account of the HS to the resident (Res #1). (SW) provided the surveyor with a viewing of a copy of the posting from HS dated 12/30/2021 that had HS name and profile attached to a photo of a male penis. SW reported the findings from her interview with Res #1 to the facility administrator (ADM) and they both together returned to interview Res #1. SW stated that Res #1 told them both that she had received the photo on 12/30/2021 of the male penis from the HS to send to another employee (CNA #1). SW confirmed that the CNA #1 had worked at the facility but that she "had left the facility's employment on 12/3/2020. SW stated that back in 2018 Res #1 had posted a picture of a female vagina and that it was immediately taken down. SW stated that she has not had any reports of inappropriate social media postings from or to Res #1 since 2018.

Interview and observation on 4/7/2022 at 2:10 P.M. with (Res #1) revealed that she was a young female in bed with the covers up around her body to her waist and dressed in street clothes. The television was on and she was alone in her room eating orange sherbet with a spoon. Res #1 had a frown on her face, and he affect was hostile and angry. She told the surveyor that she was not doing well and that she was awaiting a transfer to another facility. Res #1 stated that her sister lived nearby and was her RP but that she wanted to get away from her sister and from the staff at the facility because they "got up in my business" and she wanted to be left alone. Res #1 asked the surveyor to leave her room and angrily verbalized that she did not want to talk. No interview with the resident was obtained on 4/7/2022 per the request of Res #1.

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Record review of the face sheet of Res #1 revealed that she had been admitted to the facility on 08/20/2019. Res #1's date of birth was 4/17/1974. Res #1 had admitting diagnoses that included but were not limited to Acute on chronic combined systolic and diastolic heart failure; Acquired absence of right leg below the knee; Covid 19; Difficulty walking; Chronic respiratory failure hypoxia; Essential Hypertension; Type 2 diabetes mellitus; Morbid (severe) obesity due to excess calories; Cognitive communication deficit; among other diagnoses. The Minimum Data Set (MDS) dated 2/7/2022 Section C. documented a Brief Interview of Mental Status (BIMS) score of 15, which indicated that Res #1 was cognitive.

Interview on 4/7/2022 at 2:45 P.M. with the Responsible Party (RP) sister of Res #1, revealed that she had been sent a picture of a penis from her sister, Res #1 back around the first of the new year in January of 2022. She stated that she asked her sister Res #1 "where in the world did such a dirty picture come from" and why was she sending it to her on her Facebook. Res #1 told RP that a staff member named (HS) had sent it to her to send to another employee. RP told her sister Res #1 to "take down that awful picture" of a male penis and to report it to the DON and ADM. RP stated that her sister told her that she had reported the photo to the facility staff. RP stated that since the facility had been told about the photo that she assumed that the matter had been handled and the (HS) had been fired. The RP stated that her sister did not know the HS prior to her admission to the facility. RP stated that she is highly upset about the events of the photo having been sent to her sister's Facebook by an employee of the facility. RP stated that she

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F 600	Continued From page 8 wants Res #1 moved to another facility because she feels that the safety of her sister is at risk because so many people know about the photo being sent to Res #1. RP stated that she gave the AG permission to take the phone of her sister and trace the source of the photo. RP stated that she hoped that the AG arrests the person or persons that sent the photo to her sister Res #1. RP stated that she and her siblings met with the facility staff last week to discuss the alleged events of 3/29/2022. RP expressed that she was very troubled by the fact that a staff member had sent her sister Res #1 such an inappropriate photo. Interview with ADM on 4/7/2022 at 3:30 P.M. revealed that he did meet with the RP, and he was aware of the request to have Res #1 moved to another facility. He stated that the SW had sent the request for transfer papers to the facility that the family and the Res #1 had requested. ADM stated that he was very shocked that the HS had sent the picture to Res #1. ADM stated that the HS was a very good employee and was well liked by the other staff and residents. ADM stated that he had been told by the HS that he had known Res #1 for years and that they were friends prior to her admission and that the picture was a "joke" between the HS and Res #1. The HS denied that the picture was of a penis. He stated to the ADM that it was of a melted candy bar.	F 600		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F 610		5/18/22

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F 610	Continued From page 9 §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §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: F610 S/S=D Based on observation, record review, facility policy and procedure review, and interviews, the facility failed to thoroughly investigate the events of an alleged event of abuse to Resident #1 by a staff member. Resident #1 was one (1) of five (5) residents reviewed for abuse. Review of the facility policy and procedure titled "Abuse Program" dated Revised May 23, 2017, revealed: Investigation: The facility will thoroughly investigate, under the direction of the Administrator or Director of Operations/Director of Clinical Operations the time of any findings of potential abuse or neglect to determine the cause and effect, and provide protection to any alleged victims to prevent harm during the continuance of the investigation. The Administrator of designee	F 610	I. Address how corrective actions will be accomplished for those residents found to have been affected by the deficient practice. The facility failed to thoroughly investigate the allegation of abuse made by Resident #1 by not obtaining written statements from the staff members who reported the allegation. On April 8, 2022, The Nursing Home Administrator thoroughly reviewed the facility policy titled “Abuse Program”, subsection “Investigation”. This policy will be followed through to completion on all forthcoming facility investigations. An investigation was conducted, and the allegation of abuse was substantiated, however the investigation was not completed with staff interviews and written statements.	

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F 610	Continued From page 10 shall report any suspected abuse and neglect outlined in this policy within 2 hours to the Department of Health or Office of Long-term Care as required. Interview on 4/7/2022 at 10:50 A.M. with the Director of Nursing (DON) revealed that an employee Physical Therapy Supervisor (PTS) was told by resident #1 that there was a picture of a male penis on her cell phone. The DON obtained the timeline of the administrator's investigation and the documentation that was completed by the administrator. The materials of the facility investigation were reviewed. The DON stated that to her knowledge the investigation was completed, and all supporting documentation was contained in the investigation. ecord review of the facility investigation revealed that there were no statements from the PTS or the DPT who had initially reported the incident on 03/29/22 to the Social Worker in the morning stand up meeting. There were 69 pages of investigation materials reviewed. The record review contained the name and phone number of the Attorney General's (AG) investigator. There were no lists of resident names that had the use of a cell phone/computer in the facility. There were no lists of residents in the facility that had Facebook accounts. There was no documentation contained in the facility investigation that education had been provided to all the residents concerning the reporting of inappropriate materials sent on the cell phones/computers. There was no documentation in the facility investigation that the residents were educated on the appropriate use of a cell phone/computer in the facility. The facility investigation was not thorough enough to	F 610	II. Steps taken to identify other residents having the potential to be affected by the same alleged deficient practice. All residents of the facility are at risk for the alleged deficient practice. III. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? On April 8, 2022, The Nursing Home Administrator thoroughly reviewed the facility policy titled “Abuse Program”, subsection “Investigation”. This policy will be followed through to completion on all forthcoming facility investigations. All future investigations will include staff and resident interviews to include written statements from each staff member interviewed. IV. Monitoring the corrective actions (Quality Assurance Program) to ensure that the alleged deficient practice does not recur. Beginning May 4, 2022, the Administrator and/or Director of Nursing will report all facility investigations to the Quality Assurance Performance Improvement Committee during our monthly meeting for six months, ending October 4, 2022 or until compliance is achieved, to ensure a thorough investigation is performed. Beginning May 01, 2022, The Administrator will send a copy of all investigations and supporting	

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F 610	Continued From page 11 completely establish the attempts that were made by the facility to provide protection and safety for all residents in the facility and to prevent the abuse of residents. Interview on 4/7/2022 at 11:18 P.M. with the ADM, via DON's cell phone, revealed that he first received word on 3/29/2022 at approximately 11:45 A.M., that an obscene photo of a male penis was on the cell phone of resident (Res#1). The resident had told the PT Supervisor, (PTS) that a staff member, Housekeeping Supervisor (HS) had sent the picture of the male penis to her. Surveyor asked the ADM if he had a statement of any type from the (PTS) in his investigation. The ADM stated that he did not obtain a written statement or a verbal statement from the PT Supervisor. The ADM stated that he did not have any staff interviews or statements (verbal or written) in his investigation because they were not necessary. ADM stated that when he interviewed the resident #1 with the SW that she gave them her cell phone and the Facebook profile of the staff member (HS) was posted with the picture of a male penis. ADM stated that he talked to the staff member (HS) on the day of the discovery, 3/29/2022, and he confirmed that he did send a picture to resident #1 but that it was not a dirty picture it was a picture of a "melted candy bar." The ADM stated that he had confirmed through the Facebook profile of (HS) that the picture was sent to the resident (Res #1) on 12/30/2021. The ADM stated that he terminated the (HS) on 3/29/2021 for sending inappropriate information to a facility resident. ADM stated that he felt that the information he obtained was enough to terminate the staff member, (HS) and to establish that the resident (Res #1) had received an inappropriate picture of	F 610	documentation to the Director of Clinical Services to ensure all elements of the investigation have been completed for the next six months, ending October 1, 2022 or when compliance is achieved. On April 19, 2022, the Quality Assurance Committee met with the Medical Director to address the findings of this deficient practice, and the plan to correct this deficient practice. The Quality Assurance Performance Improvement Committee will make recommendations as needed.	

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a male penis on her cell phone from the HS.

Interview on 4/7/22 at 12:00 noon with the Attorney General's (AG) Investigator, revealed that he came to the facility on 3/31/22 and talked to the family of the resident and talked to the resident (Res #1). AG obtained the cell phone of Res #1 and had possession of the evidence of the "penis picture that was on Res #1's phone". AG confirmed that the staff member (HS) had sent the picture of the penis to Res #1. AG also stated that the staff member (HS) and the resident did not know each other prior to Res #1's admission to the facility. AG stated that he had a warrant for the staff member (HS) and would be going to his home to visit with the staff member and to obtain his cell phone. AG stated that the pictures that were sent to Res #1 was a "cyber-crime", and he was turning over the cell phone of the resident and of the staff member to the AG's cyber-crime unit for review.

Interview on 4/7/2022 at 12:45 P.M. with the Physical Therapy Supervisor (PTS) revealed that she had been working with the resident #1 four (4) times each week in the therapy department for several months. PTS had been employed at the facility for approximately 18 years. The PTS stated that Res #1 usually was in the PT department each morning early waiting on her to start therapy at approximately 8:00 A.M. and that on 3/29/2022 she was not there waiting. PTS stated that on 3/29/2022 at 8:00 A.M. Res #1 was not at the department for therapy and that was unusual. The PTS went to the room of Res #1 along with another physical therapist, Doctor of Physical Therapy (DPT). When they got to Res #1's room she was still in bed and was clearly upset and angry. Res #1 told them that she

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hated the staff at the facility and was upset that two (2) of the CNA's had gotten her cell phone and were trying to block her "dick pictures" that she had on her phone. Res #1 told them that CNA#2 and CNA #3 had tried to block her phone and were trying to erase her "dick pictures" from her phone that had been sent to her by a staff member (HS)Housekeeping Supervisor. Res #1 told both PT's that the Housekeeping Supervisor had sent her a picture of his penis. The PTs stated that Res #1 was clearly and visibly upset, and she was cussing and saying, "I hate those mother fuckers and bitches." Res #1 was refusing to go to therapy and that was very unusual. PTS stated that she went to stand up and reported the incident to the Social Worker (SW) on 3/29/2022 at approximately 10:45 A.M. The PTS stated that the facility administrator did not interview her or ask her any questions concerning the alleged incident/matter of the pictures on Res #1's cell phone. The administrator had not obtained a written statement from the PTS to date. The PTS stated that she felt that the information given to her by Res #1 was clearly inappropriate and was abuse of a resident. PTS stated that she had never been given any information like this before from Res #1. She stated that this was the first time that she had seen Res #1 cussing and acting angry like she was on the morning of 3/29/2022. PTS stated that she believed that Res #1 was telling the truth on 3/29/2022. PTS stated that she was positive that Res #1 had not known the staff member (HS) prior to her admission to the facility.

Interview on 4/7/2022 at 1:00 P.M. with the Doctor of Physical Therapy, DPT stated that on 3/29/2022 at approximately 8:30 A.M. she and the

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PTS went to the room of Res #1 to see why she was not at therapy on 3/29/2022. Upon entering the room and asking why she was still in the bed and not at therapy, Res #1 replied: "I hate all those mother fuckers and bitches." They want to block my phone and get my "dick pictures" from my phone. Res #1 was cussing and was visibly upset and in a foul mood. She refused to go to physical therapy on 3/29/2022. Res #1 said that staff member (HS) had sent her a "dick pic" to send to another staff member, a girl (CNA #1). Res #1 stated that she did not want the staff member to get fired and that he had sent the "dick pic" to her phone so she could send it on to another staff member. Res #1 stated that CNA #2 had tried to block her phone and that she wanted her "dick pics." The DPT stated that the PTS had reported the incident to the Social Worker (SW) at the Stand-Up meeting on 3/29/2022 10:45 A.M. . The DPT stated that to date no one from the facility had asked her for a statement of the events that occurred on 3/29/2022, and she had not given a written report of the events of 3/29/2022 with Res #1. DPT stated that she had never seen or heard Res #1 angry like she was on 3/29/2022. DPT stated that she had no knowledge of Res #1 being involved in any inappropriate behaviors prior to 3/29/2022. No resident had ever reported anything inappropriate prior to 3/29/2022.

Interview on 4/7/2022 at 1:40 P.M. with the Social Worker (SW) revealed that she was told by the PTS that Res #1 had told her that she had a picture of a male penis on her phone that was sent to her by the Housekeeping Supervisor (HS). SW immediately went to talk to the resident by herself to see what had transpired. Res #1 was upset and was cussing that there were two (2)

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Certified Nursing Assistants (CNA's) CNA #2, and CNA #3, that were trying to block her phone and she had "dick pics" on her phone from (HS). SW was given the cell phone of Res #1 and she scrolled through her social media account with the permission of Res #1 and found a post from (HS) dated 12/30/2021 that contained a photo of a male penis. Res #1 did not want to get HS in trouble, and she was upset that he may get fired. SW confirmed that the photo was posted on 12/30/2021 from the Facebook private message account of the HS to the resident (Res #1). (SW) provided the surveyor with a viewing of a copy of the posting from HS dated 12/30/2021 that had HS name and profile attached to a photo of a male penis. SW reported the findings from her interview with Res #1 to the facility administrator (ADM) and they both together returned to interview Res #1. SW stated that Res #1 told them both that she had received the photo on 12/30/2021 of the male penis from the HS to send to another employee (CNA #1). SW confirmed that the CNA #1 had worked at the facility but that she "had left the facility's employment on 12/3/2020. SW stated that back in 2018 Res #1 had posted a picture of a female vagina and that it was immediately taken down. SW stated that she has not had any reports of inappropriate social media postings from or to Res #1 since 2018.

Record review of the personnel files of (CNA #1) revealed that she terminated her employment with the facility on 12/03/2020. No other negative findings were found in the personnel records of (CNA#1). Reviewed the personnel file of HS and there were no negative findings in his personnel record. The record review of the facility's investigation revealed that there were no

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statements from the two (2) CNA's that Res #1 had named that were blocking her phone. There were no statements in the facility's investigation from (CNA #2) or (CNA #3). The record review revealed that the facility had not obtained statements from any staff members or from Res #1 to answer the questions of how the photos came about or how the HS and Res #1 had become so familiar with each other. The facility investigation did not establish if Res #1 and HS had known each other prior to the admission of Res #1 to the facility on 08/20/2019. The facility investigation did not establish which residents in the facility used cell phones and computers. The facility investigation did not include any statements from cognitive residents and other staff members concerning inappropriate events of conduct at the facility. There were no in-services or education of residents after the events of alleged abuse on 3/29/2022 took place. The facility did not report the alleged abuse to the MSDH office within two (2) hours of occurrence as outlined in the regulations and the facility policy and procedure. The timeline submitted by the ADM documented that he received the report of the alleged abuse at 11:45 A.M. on 3/29/2022 and that he placed the staff member (HS) on investigative leave at 12:15 P.M. on 3/29/2022. The timeline submitted by the ADM documented that the local police department was notified at 1:30 P.M. on 3/29/2022 and that the MSDH office was notified by phone on 3/29/2022 at 3:45 P.M.

Interview on 4/7/2022 at 2:00 P.M. with (CNA #2) revealed that he had worked at the facility for approximately one and a half years. CNA #2 stated that he worked in the housekeeping/laundry department with (HS) as his supervisor. He stated that the HS had hired

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him at the facility and that recently in 12/2021 he had become a CNA at the facility. CNA #2 stated that he had not attempted to block Res #1 and he had not had a discussion with Res #1 about her cell phone. CNA #2 stated that he had not worked the night of 3/28/2022 as Res #1 had told the SW. He stated that he was off from work on 3/28/2022. CNA #2 stated that he had no knowledge that Res #1 had inappropriate photos on her phone. Res #1 had asked CNA #2 to be Facebook friends, but he had never accepted her friend requests. CNA #2 stated that he had not been interviewed by the facility about the alleged abuse of 3/29/2022 between Res #1 and the HS. CNA #2 stated that he found it hard to believe that HS had sent an inappropriate photo to Res #1. He felt that the HS was a very supportive and fare supervisor and that he had never witnessed any inappropriate behaviors between HS and any staff or residents. CNA #2 stated that they had regular in-services and training on abuse and neglect. CNA #2 stated that any inappropriate exchanges between staff members and residents of any type would be an example of abuse.

Interview and observation on 4/7/2022 at 2:10 P.M. with (Res #1) revealed that she was a young female in bed with the covers up around her body to her waist and dressed in street clothes. The television was on and she was alone in her room eating orange sherbet with a spoon. Res #1 had a frown on her face, and he affect was hostile and angry. She told the surveyor that she was not doing well and that she was awaiting a transfer to another facility. Res #1 stated that her sister lived in Starkville and was her RP but that she wanted to get away from her sister and from the staff at the facility because they "got up in my business" and she wanted to be left alone. Res #1 asked

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the surveyor to leave her room and angrily verbalized that she did not want to talk. No interview with the resident was obtained on 4/7/2022 per the request of Res #1.

Record review of the face sheet of Res #1 revealed that she had been admitted to the facility on 08/20/2019. Res #1's date of birth was 4/17/1974. Res #1 had admitting diagnoses that included but were not limited to Acute on chronic combined systolic and diastolic heart failure; Acquired absence of right leg below the knee; Covid 19; Difficulty walking; Chronic respiratory failure hypoxia; Essential Hypertension; Type 2 diabetes mellitus; Morbid (severe) obesity due to excess calories; Cognitive communication deficit; among other diagnoses. The Minimum Data Set (MDS) dated 2/7/2022 Section C. documented a Brief Interview of Mental Status (BIMS) score of 15, which indicated that Res #1 was cognitive.

Interview with ADM on 4/7/2022 at 3:30 P.M. revealed that he did meet with the RP, and he was aware of the request to have Res #1 moved to another facility. He stated that the SW had sent the request for transfer papers to the facility that the family and the Res #1 had requested. ADM stated that he was very shocked that the HS had sent the picture to Res #1. ADM stated that the HS was a very good employee and was well liked by the other staff and residents. ADM stated that he felt that Res #1 had asked the HS to send her the photo. ADM stated that he had been told by the HS that he had known Res #1 for years and that they were friends prior to her admission and that the picture was a "joke" between the HS and Res #1. The HS denied that the picture was of a penis. He stated to the ADM that it was of a melted candy bar.

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