STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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M 000	Initial Comments The State Agency (SA) conducted a complaint survey at the facility from 5/31/22 through 6/2/22, for MS00018429 related to pressure ulcer care and treatment, and for facility reported incidents MS00018101 related to drug diversion and MS00018859 related to reported verbal abuse of a resident, and a Focused Infection Control Survey. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in the Aged and Infirmed. The SA substantiated the facility reported incident for verbal abuse and the facility reported incident for misappropriation and drug diversion and cited M500. The SA did not substantiate the complaint for resident care for pressure ulcers. The facility had a census of 58 and held a license for 66 beds.	M 000		
M 500 SS=D	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;	M 500		6/29/22

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M 500	Continued From page 1 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his 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	M 500		

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M 500	Continued From page 2 and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 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	M 500		

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M 500	Continued From page 3 purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other 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.	M 500		

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M 500	Continued From page 4 This Statute is not met as evidenced by: Based on observations, staff and resident interviews, record review and facility policy review the facility failed to prevent verbal abuse of a resident as evidenced by an employee calling a resident a profane name for one (1) of seven (7) residents reviewed. Resident # 5. Findings Include: Review of the facility policy titled, "Freedom from Abuse, Neglect, and /or Exploitation Prevention Plan" "Staff Screening" with no revision date revealed under "policy" " The facility has a zero-tolerance policy for abuse, involuntary seclusion, neglect, and misappropriation of resident property. The facility will attempt to identify and will investigate any reported violation or allegation of abuse." Review of the facility policy titled, "Resident Rights " with a revision date of 11/28/2016 revealed under (a) (1) "A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident." Review of the facility policy titled, "Freedom from Abuse, Neglect, and /or Exploitation Prevention Plan" "Staff Training" with a revision date of 8/23/2017 revealed under "policy" "The facility will provide mandatory training to new and existing employees during orientation and annually including the necessary forms with complete instruction to assist employees with their obligation to report suspected crimes under the	M 500	Resident reported incident of abuse to Administrator on 5/18/22 at 2:42pm in a care plan meeting. Administrator initiated investigation and reported allegation to Mississippi Department of Health and Attorney General office. Resident was immediately assessed for any injury or emotional distress with none found. Nursing Assistant #3 was immediately suspended from work pending investigation. Nursing Assistant #3 was terminated on 5/18/22. All residents have the potential to be affected. Facility staff in serviced on Abuse/Neglect and Misappropriation Policy and Procedure and Prevention Plan on 6/3/22 by Director of Nursing. Staff will be in serviced on Abuse/Neglect and Misappropriation upon hire, annually and as needed. Administrator will make walking rounds weekly x4 weeks and will interview 5 residents beginning on 6/1/22 to ensure compliance. The facility will report alleged allegations of Abuse/Neglect and Misappropriation to the appropriate state agencies within 2 hours of incident. Allegations of Abuse/Neglect and Misappropriation will immediately be reported to the Administrator who will initiate an investigation. The administrator will report findings to the Quality Assurance Performance Improvement Committee monthly beginning 6/23/22 x 2	

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M 500	Continued From page 5 Federal Elder Justice Act as well as related to policies on abuse prohibition practices." An interview on 6/1/22 at 10:15 AM with Resident # 5 revealed that NA # 3 had provided care for him for him at least the last 6 months. He revealed that NA # 3 had always been a "smartass" and we had never really got along, so I wasn't hurt by what he said. He revealed he debated on even reporting the incident. He revealed he cannot think of what happened to lead up to NA # 3 calling him an ugly word or what the word was. The resident asked that the State Agency (SA) give him some time to think and maybe he can remember the details. Resident #5 revealed that he asked the Director of Nurses (DON) not to fire him, but just to give him a slap on the hand. He confirmed that he had never been injured by NA # 3 or been neglected. He confirmed that NA # 3 came back to his room the morning of the incident, stuck his head in my room door and stated, "I apologize" then shut the door and left. He revealed he did not give me a chance to respond to the apology. An interview on 6/1/22 at 10:50 AM with CNA # 2 revealed she had not witnessed or had any complaints from residents about staff being rough or talking ugly to them. She revealed that NA # 3 was a good worker and would help you do anything. She revealed she never heard him talk ugly to residents. She stated, "He just sort of talked cocky, so you had to just know how to take him." An interview on 6/1/22 at 3:00 PM with Resident #5 revealed he remembered what happened on	M 500	months and as needed thereafter.	

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the morning of the incident with NA # 3. He revealed that he told NA # 3 to handle his feet a different way and that NA # 3 stated, "What, I am perfect". He revealed he told NA # 3 there was only one perfect man and then NA # 3 stated, "Oh God." He revealed he then told NA # 3, "No, his son" and then NA # 3 called me a "smartass". He confirmed that this did not hurt his feelings, nor did it make him feel nervous or afraid to be around NA # 3.

An attempted call to conduct a phone interview on 6/1/22 at 9:37AM with Nurse Assistant (NA) # 3 revealed no answer with a voice mail left for him to return my call.

Attempted another call to conduct a phone interview to NA # 3 on 6/1/22 at 3:15 PM revealed no answer and left voice mail for him to return my call.

An interview on 6/2/22 at 11:15 AM with the Director of Nurses (DON) revealed she was the DON when the incident happened with NA # 3 and Resident #5. She revealed she was shocked when Resident #5 reported the incident, because it was out of character for NA # 3. She revealed that NA # 3 was a hard worker that always wanted things done right for the residents, was soft spoken and never called in. She revealed that the way Resident # 5 talks, you must know how to take him. She stated, "I don't believe NA # 3 had a mean bone in his body." She revealed that she has had a lot of residents reveal they miss him. She revealed that NA # 3 never had any disciplinary actions toward him, and she hated this happened.

An interview on 6/2/22 at 11:50 AM with the Administrator revealed that she never had any

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complaints on NA # 3 prior to this incident. She revealed NA # 3 was a likeable person, happy go lucky, came in and did his job and was helpful. She revealed she was surprised when resident #5 reported the incident, because it did not sound like something NA # 3 would do. She revealed that Resident #5 told her he would have accepted NA # 3's apology, but he did not give me a chance to respond. She revealed that when she interviewed NA # 3, she asked him "what he was thinking?" and that NA # 3 stated, "I wasn't". She revealed she asked NA # 3 why he did not talk with Resident #5 when he apologized instead of just leaving the room and NA # 3 stated, "I was ashamed."

Record review of the facilities investigation of the employee to resident incident with NA # 3 and Resident #5 on 5/18/22 revealed that the resident reported during a care plan meeting on 5/18/22 at 2:42 PM that NA # 3 used profanity toward him that morning. The resident revealed to the Administrator and the Social Worker that "he did not feel unsafe at any time during or after the event." The investigation revealed that notifications were made on 5/18/22 to: SA at 4:12 PM and the Attorney General's Office at 4:23 PM. The investigation revealed that NA # 3 was placed on suspension on 5/18/22 until the investigation was completed. The investigation revealed that an interview with NA # 3 confirmed that he called the resident an "asshole" on the morning of 5/18/22 and went back and apologized to the resident. The investigation revealed that all interviewable residents were interviewed regarding if any staff members had talked ugly to them or been rough with them and all denied that any staff member had talked ugly or been rough with them. The investigation revealed that all interviewable residents were

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questioned regarding NA # 3 and whether he had ever said anything inappropriate or been rough with them and all replied "No." The conclusion of the investigation revealed that NA # 3 had been trained regarding all types of abuse including verbal and he admitted making the profane comment toward Resident #5. Record review revealed the facility terminated NA # 3 on 5/18/22 due to the facility having no tolerance for verbal abuse toward any/all residents.

Record review of NA # 3's personnel file revealed he was hired at the facility on 9/20/21 and his criminal record check came back clear on 11/2/2020. The review revealed he completed a "Temporary Nurse Aide" training on 9/17/2021 and has not completed a certification course. The review revealed he was terminated from employment on 5/18/22.

Record review of NA # 3's personnel file revealed he signed the "Vulnerable Adults' Prevention Policy" as he read on 09/15/2021.

Record review of the facility in-services revealed NA # 3 attended an in-service on 1/19/22-1/20/22 titled, "Misappropriation of Property/Abuse/Resident Rights.

Record review of the facility "Daily Schedule" revealed that NA # 3 worked 11 PM-7AM on the South Hall and was called off the schedule for 11 PM-7 AM shift on 5/18/22.

Record review of Resident # 5's face sheet revealed an admission date of 9/15/2020 with medical diagnoses that included: Chronic Inflammatory Demyelinating Polyneuritis, Pain Unspecified and Spastic Quadriplegic Cerebral Palsy.

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M 500	Continued From page 9 Record review of Resident #5's most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/16/22 revealed a Brief Interview of Mental Status (BIMS) of 15, which indicated that the resident was cognitively intact.	M 500		