STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255221	A. BUILDING _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HALL HEALTH CARE CENTER	101 MILLS STREET BROOKHAVEN, MS 39601

(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 COVID-19 Focused Infection Control survey and Complaint Investigation (CI), MS #18411, MS #18623, and MS#19450 at the facility from 08/10/22 through 08/11/22. The facility was found to be in compliance with infection control regulations and the Centers for Medicare and Medicaid (CMS) and the Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19 and there were no deficiencies cited related to infection control. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid. MS #18411 was not substantiated for visitation. MS #19450 was not substantiated for quality of care/treatment. MS #18623 was not substantiated for abuse, however F557 was cited as a result of the complaint investigation. The facility held a license for 81 beds, with a census of 69 residents.	F 000		
F 557 SS=D	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and	F 557	Preparation and/or execution of this plan	9/26/22

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

Electronically Signed | 08/31/2022

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F 557	Continued From page 1 interviews, the facility failed to ensure that residents were treated with dignity and respect for one (1) of five (5) sampled residents. Resident #1 Findings include: Record review of the "Facility Investigation", dated 2/09/22 (related to MS# 18623) revealed that on 2/05/22 at 10:55 PM, Certified Nurse Aide (CNA) #1 reported to Licensed Practical Nurse (LPN) #1 an exchange between herself and Resident #1. The CNA stated that when Resident #1 became agitated during care and cursed at her, she cursed at Resident #1 in response. LPN #1 reported the incident to Administration and the facility removed the CNA from duty pending results of an investigation. The facility's investigation concluded that the behavior of CNA #1 was unacceptable, and CNA #1 was terminated. The facility reported CNA's inappropriate behavior to the State Agency (SA), Attorney General's Office (AGO), and the CNA registry. On 8/10/22 at 8:05 PM, an interview with the Administrator revealed that on 2/05/22 at 10:55 PM, an incident that involved Resident #1 and CNA #1 resulted in the failure of CNA #1 to treat the resident with respect and dignity. CNA #1's behavior resulted in the termination of her employment. The Administrator stated that Resident Rights were included in the orientation of all new employees and that the facility provided ongoing education to all staff regarding Resident Rights and the importance of treating residents with respect and dignity. The Administrator stated that the CNA's verbal response constituted failure to treat Resident #1 with dignity. In addition to terminating CNA #1, the Administrator confirmed	F 557	of correction does not constitute an admission or agreement by the provider of the truth or the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of Federal and State Law. This plan of correction constitutes the facilities credible allegation of compliance. *Resident #1 has suffered no lasting effects from this deficient practice. On 02/06/2022, LPN #1 evaluated resident with no s/s of injuries, bruising, discoloration noted. Resident was provided emotional support and reassurance by Nurse and Social Worker. The employee involved was suspended on 02/05/2022, the day the allegation happened. The allegation was reported to the appropriate agencies to include the MS Attorney General's Office and MS State Department of Health. The incident was thoroughly investigated and the employee was ultimately terminated on 02/09/2022 related to Resident Rights. *All residents have the potential to be affected by this deficient practice. *An in-service was provided to all staff on 08/29/2022 by Administrator, regarding F-557- Resident Rights. This in-service included abuse, neglect, respect, dignity, personal property, and the Facility's Abuse Prevention and Reporting policy. An emergency resident council meeting was	

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F 557	Continued From page 2 that the facility reported CNA's inappropriate behavior to the SA, AGO, and the CNA registry. Record review of an educational program entitled "Behavior Management Strategies" was electronically signed by CNA #1, indicating that she had received a copy of the training on 10/13/20. Review of the facility's employee policy, "The Rights & Care of Residents" (undated), revealed "Abide by all the Resident's Rights under federal law given to me upon my hiring. Specific Rights: ...to dignity, respect, and freedom", was electronically signed by CNA #1 on 9/14/20. Review of the facility's policy "Policy and Procedures on Resident's Rights" (undated) stated "The facility shall protect and promote the rights of each resident ...The resident has the right to a dignified existence ..." It was noted that a copy of the policy was signed by CNA #1 on 9/14/20. Record review of the Admission Record for Resident #1 revealed she was admitted by the facility on 7/09/21 with diagnoses that included Diabetes, Psychosis, and Dementia. Record review of the Quarterly Minimum Data Set (MDS) with Assessment Reference date of (ARD) 6/30/22, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 8 out of 15, which indicated moderate cognitive impairment. Further review of the MDS revealed the resident required limited one-person assistance for dressing and was independent or needed supervision for all other Activities of Daily Living.	F 557	held on 08/30/2022 by Activity Director. This meeting was held to educate the council and other involved residents on F-557. Starting 08/29/2022, the facility Social Worker will monitor compliance of F-557 through five individual resident interviews a week for 8 weeks to ensure there are no violations of F-557. On 09/26/2022, the facility Social Worker will monitor on an ongoing basis by visits with residents, reviewing of monthly Resident Council Minutes and in conjunction with the facility morning leadership meetings to help identify and violations with F-557. Starting 08/29/2022, Administrator will monitor for ongoing compliance through review of residents interviews 5 times a week for 8 weeks and then monthly in the facility Quality Assurance and Performance Improvement Committee Meetings. On 08/30/2022, emergency resident council meeting was held to discuss F-557 Resident Rights. F-557 and monitoring plan will be discussed in Quality Assurance and Performance Improvement Meeting for September 2022, October 2022, and November 2022.	

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On 8/11/22 at 11:00 AM, observation and an interview with Resident #1 revealed she was sitting on the edge of her bed in her room with the television on. She appeared neat, clean, and appropriately dressed, alert and oriented, and able to communicate without difficulty. The Resident initially stated she did not recall an incident with staff, then stated "I did have a problem with one nurse's aide. She had a bad attitude." She stated she could not recall what was said. She said the incident had not affected her in a negative way and denied any lingering effects. She stated, "I feel safe here" and denied that any staff had been abusive toward her.

On 8/11/22 at 12:18 PM, a telephone interview with the Responsible Party (RP) for Resident #1 revealed she had forgotten the incident and voiced no complaints related to the resident's care.

On 8/11/22 at 1:19 PM, an interview with the facility's Social Worker, revealed she was involved in the investigation of the incident involving Resident #1. She confirmed the facility investigation determined that CNA #1 failed to treat Resident #1 with respect and dignity at the time of the verbal disagreement. She revealed that both she and the Administrator had visited Resident #1 in her room on multiple occasions following the incident and noted no residual adverse effects. A licensed psychologist had also been notified of the incident and had conducted a psychosocial assessment of Resident #1 following the incident. The psychologist did not verify any resulting negative psychosocial effects. The Social Worker stated that the facility routinely provided staff with in-service training regarding

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the care of residents with dementia and difficult behaviors. She stated Resident #1's care plan was updated on 2/10/22, to include a goals related to the recent incident.

Review of Resident #1's Care Plan revealed that on 2/10/22, the Care Plan was updated to include goals and interventions to ensure that the resident would not have decline in mood and will feel safe from verbal abuse. Interventions included additional social service visits to offer emotional support and the reassurance of safety, staff in-services addressing verbal abuse, the allowance of Resident #1 to talk about her feelings, and to encourage continuation of normal activities and daily routine.

On 8/11/22 at 3:40 PM, an interview with LPN #1 confirmed that on 2/05/22 she was assigned to the care of Resident #1. Stated that CNA #1 came out of Resident #1's room from measuring vital signs and reported a verbal exchange in which CNA #1 responded to the resident's calling her and her mother an offensive name, by responding in kind. She said the CNA #1 was upset and recognized that her response to the resident was not appropriate or acceptable. The LPN said she telephoned the Director of Nursing (DON) and was instructed to send CNA #1 home immediately, pending investigation. The LPN said she completed an incident report which initiated monitoring and assessments of Resident #1 every shift for seventy-two (72) hours. She stated Resident #1 had no adverse reaction or response to the incident. She stated that upon interview of the resident approximately twenty (20) minutes following the report from CNA #1, the resident confirmed calling CNA #1 an offensive name, but denied that the CNA had called her any names.

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F 557	Continued From page 5 The LPN confirmed the facility routinely provided in-service training regarding the care of residents with dementia and those with difficult behaviors. She reported the failure of CNA #1 to respect the rights of the resident to be treated with dignity, resulted in the termination of CNA #1.	F 557		