STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255218	A. BUILDING _____ B. WING _____	C 09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TISHOMINGO MANOR	**230 KHAKI STREET IUKA, MS 38852**

(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 complaint investigation CI MS# 19328 and CI MS# 19435 at the facility from 9/7/22 to 9/8/22. The SA substantiated CI MS# 19328 for resident abuse. The SA did not substantiate CI MS# 19345 related to quality of care and treatment. During the investigation , the SA determined that the facility was not in compliance with Medicare and Medicaid regulations for participation and cited regulatory deficiencies at F600 and F609. The facility had a license for 105 beds and a census of 94 at the time of the survey.	F 000		
F 600 SS=E	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 observation, resident and staff interviews, record reviews, and policy review, the facility failed to prevent sexual abuse of Resident #1 for one (1) of five (5) residents reviewed for abuse.	F 600	Certified Nursing Assistant #1 was suspended on May 31, 2022, pending investigation of alleged sexual abuse against Resident #1. Certified Nursing Assistant #1 was terminated on June 2,	10/11/22

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

Electronically Signed | 09/23/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 600	Continued From page 1 Findings include: Review of the facility policy titled, "Incident Investigation & Reporting" with a revision date of 05/18 revealed, "Each resident residing in this facility has the right to be free from any type of abuse including verbal, sexual, mental, physical abuse, neglect, misappropriation of resident property and exploitation." "Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse." On 09/7/22, the State Agency (SA) entered the facility complete an investigation related to MS00019328 regarding a Certified Nurse Aide (CNA) #1 that was witnessed on 05/26/22 touching Resident #1 inappropriately in his private area while performing perineal care. Interview and observation on 09/8/22 at 9:30 AM with Resident #1 revealed he was alert and knew his name and where he was. He was soft-spoken, with clear speech. The interview revealed the resident answered questions with one and two word responses. When asked if he remembered a staff member by the name of CNA #1 he responded "Yes." When asked if a staff member had ever mistreated him or touched him inappropriately while they were cleaning his private area. The resident stated, "Yes," and revealed CNA #1's last name. An interview on 09/7/22 at 11:40 AM with CNA #3 revealed she worked with CNA #1 and that she had a harsh tone when she talked to the residents.	F 600	2022, after the facility substantiated the allegation of sexual abuse against Resident #1. Resident #1 had a weekly body audit on May 30, 2022, by the Medication Nurse on the 7-3 shift with no issues noted. Resident #1 had a complete body audit on May 31, 2022, by the Director of Nursing and Staff Development Nurse with no issues noted. All residents have the potential to be affected by this deficient practice. No other residents have been identified as being affected by this deficient practice. Facility Staff was in-serviced on Resident Abuse/Neglect and Resident Dignity/Respect on May 31, 2022, by the Administrator. All cognitive residents were interviewed on June 1, 2022, by the Regional Supervisor and Social Services regarding any abuse or neglect with no further concerns noted. Facility Staff was in-serviced on September 13, 2022, on Resident Abuse, Elder Justice Act, Incident Investigation and Reporting and Residents Rights by the Director of Nursing and Administrator. A Quality Assurance Meeting was held on September 9, 2022, to discuss findings from survey exit and systematic changes needed to ensure deficient practice will not reoccur to include staff education on Resident Abuse/Neglect and reporting monthly for three months. Beginning September 19, 2022, the Administrator or Director of Nursing will report any concerns regarding F Tag 600	

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F 600	Continued From page 2 An interview on 09/7/22 at 1:50 PM with CNA #4 revealed that she worked with CNA #1 in the past and considered CNA#1 to have sort of a smart mouth with a bad attitude, and the residents have dementia and deserved to be treated well and not talked to badly. An interview on 09/7/22 at 1:50 PM with Registered Nurse (RN) #1 revealed that in her opinion, CNA #1 was a "bad egg" and had been the whole time she had been here and revealed that her demeanor was rough and stated, she just wasn't a kind person. An interview on 09/7/22 at 2:40 PM with Social Services (SS) #1 revealed that Resident #1 answers in one to two word statements, but if you know him you can understand him, but he usually answers in very few words. She confirmed she was asked by the administrator to go interview the resident and was told to ask him if any staff had touched him inappropriately or had made him feel uncomfortable. She revealed that she was unaware of the situation or what had been alleged, so she just went to the resident's room and asked him if a staff member had ever made him feel uncomfortable or if anyone had ever touched him inappropriately. SS#1 stated CNA #1 and CNA #3 entered the room during her interview with Resident #1 and CNA #1 stood at the foot of the bed and CNA #3 asked if he needed assistance to cut his meat on his lunch tray and he yelled "No." SS#1 stated once the CNAs left the resident's room she asked the resident if anyone made him feel uncomfortable or touched him inappropriately and he gestured to where CNA #1 had been standing. SS#1 stated she confirmed with the resident to make sure he	F 600	in the Department Head Meeting weekly for four weeks then monthly for three months. Beginning September 19, 2022, the Administrator, Director of Nursing or Social Services will interview five cognitive resident weekly for four weeks then monthly for three months to ensure residents are free of any abuse/neglect. Beginning September 23, 2022, the Administrator or Director of Nursing will report any concerns to the Quality Assurance Committee. Beginning October 10, 2022, the Administrator or Director of Nursing will report any concerns to the Quality Assurance Committee and then monthly for three months until substantial compliance is achieved with F Tag 600. The Quality Assurance Committee will revise the corrective action plan as needed until substantial compliance is achieved with F Tag 600.	

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F 600	Continued From page 3	F 600		

meant that CNA #1 had done something to him or touched him inappropriately and he nodded his head yes. SS#1 stated, "I believe he gave me the best answer he could without being verbal."

An interview on 09/7/22 at 3:15 PM with Nurse Aide in Training (NAT) #2 revealed revealed on 05/26/22, she was observing care while in training and it was just her second day at the facility. NAT #2 stated she was standing at the foot of Resident #1's bed while CNA #1 and CNA #5 were giving Resident #1 a sponge bath. NAT #2 stated CNA #1 started wiping the resident's penis roughly and asked the resident "Do you not like it?" NAT #2 stated the resident did not reply and put his hand over his face. NAT#2 revealed that CNA#5 did not say anything to CNA#1, and NAT #2 left the room as soon as the sponge bath was over because she was so uncomfortable. NAT #2 stated CNA#1 and CNA#5 were friends and she was new, so she didn't feel comfortable reporting it, but finally did on 5/31/22 to the Staff Development Nurse.

An interview on 09/8/22 at 9:30 AM with the Staff Development nurse revealed, that NAT#2 came to her office on 05/31/22 and requested to be taken off C Wing duty. She revealed when she inquired about why she wanted to be removed from C Wing duty, the NAT#2 reported that an incident had occurred, and she did not feel comfortable working over there. NAT#2 reported she observed CNA #1 and CNA #5 giving Resident #1 perineal care and CNA #1 slapped around the resident's penis and asked him if he liked it. NAT#2 stated this made her so uncomfortable that she left the room before they were finished with the resident's care. The Staff Development Nurse revealed that Resident #1's

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	255218	A. BUILDING _____ B. WING _____	C 09/08/2022

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F 600	Continued From page 4	F 600		

speech is sometimes difficult to understand due to his cerebrovascular accident (CVA) but he knows what's going on and at times has trouble getting his words out.

An interview on 09/8/22 at 10:50 AM with the Director of Nurses (DON) revealed that CNA #1 was just not a happy bubbly person. She confirmed there had been some complaints about CNA #1 in the past about her attitude. The DON stated she was made aware by the Staff Development Nurse of the incident involving CNA#1 immediately after NAT#2 reported the incident to the Staff Development Nurse. The DON stated NAT #2 retold the story to both her and the Staff Development Nurse and made a hand motion to show how CNA #1 was flinging the resident's penis back and forth.

Interview on 09/8/22 at 11:45 AM, the facility Administrator recalled the incident that occurred with CNA #1 on 05/26/2022 and stated that she suspended CNA #1 pending investigation on 5/31/22 the day she was made aware of it. The Administrator stated she believed CNA #1 did what was reportedly witnessed.. The Administrator stated there had not ever been any allegations of inappropriate touching regarding CNA#1, but there had been complaints of her being disrespectful to some residents.

Record review of Resident # 1's Face Sheet revealed that the resident was admitted to the facility on 03/12/10 with medical diagnoses that included: Hemiplegia following Cerebral Vascular Disease affecting the right dominant side, and Dysphagia following unspecified Cerebrovascular Disease, Aphasia following unspecified Cerebrovascular Disease, Contracture of muscle,

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F 600	Continued From page 5 right hand, Unspecified Dementia with behavioral disturbance. Record review of Resident # 1's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/19/22 revealed a Brief Interview for Mental Status (BIMS) score of 09, which indicates the resident is moderately cognitively impaired. The facility had substantiated the sexual abuse of Resident #1 by CNA #1 and terminated CNA #1 while she was out on suspension. CNA#1 was suspended from the facility on 5/31/2022 and was terminated on 6/2/2022. Record review of the Termination Report dated 6/3/22 and signed by the Administrator revealed CNA #1's "Last Day Worked 05/31/2022 Termination Effective Date 06/02/2022 ...Type of Separation ...Dismissal ...Performance ...Violation of Policy ...Misconduct ..." Record review of the EMPLOYEE WARNING REPORT for CNA #1 dated 6/2/22 and signed by the Administrator and DON, revealed, "TYPE OF VIOLATION Resident Abuse ...Violation of Company Policies and Procedures ...Violation of Employee Corporate Compliance & Ethics Code of Conduct ...SUPERVISOR'S/EMPLOYER'S STATEMENT Date of Violation 5/26/22 ...Allegation of sexual abuse directed toward Resident #1045 on 5/26/22 - Based on staff and resident interviews allegation of abuse is substantiated resulting in termination of employment effective 6/2/22 ....PREVIOUS WARNINGS ...5/18/22 Written ...3/8/22 Written ...ACTION TO BE TAKEN ...Dismissal ..."	F 600		
F 609 SS=D	Reporting of Alleged Violations	F 609		10/11/22

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F 609	Continued From page 6 CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §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: Based on resident and staff interviews, record reviews, and policy review, the facility failed to report an allegation of sexual abuse of Resident #1 for one (1) of five (5) residents reviewed for abuse when a Nurse Aid (NA) in training failed to report an incident of abuse timely to the Administrator or appropriate authority.	F 609	Nurse Aide Trainee #2 was educated on reporting any witnessed event or suspicion of a crime or abuse upon hire on May 19, 2022. Nurse Aide Trainee was suspended on June 1, 2022, pending investigation for not reporting an allegation of sexual abuse timely. Nurse	

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F 609	Continued From page 7 Findings include: Review of the facility policy titled, "Incident Investigation & Reporting" with a revision date of 05/18 revealed, "Each resident residing in this facility has the right to be free from any type of abuse including verbal, sexual, mental, physical abuse, neglect, misappropriation of resident property and exploitation... "In the event of any incident involving an allegations or suspicion of mistreatment, exploitation, neglect, abuse, misappropriation or other crime... each occurrence will be reported immediately to the Administrator of the facility." On 09/7/22, the State Agency (SA) entered the facility to investigate a facility reported incident of abuse related to MS00019328 regarding a Certified Nurse Aide (CNA) #1 that was witnessed on 05/26/22 touching Resident #1 inappropriately in his private area while performing perineal care. An interview on 09/7/22 at 3:15 PM with Nurse Aide in Training (NAT) #2 revealed on 05/26/22 she was in training and observing while CNA #1 and CNA #5 were giving Resident #1 a sponge bath. NAT #2 stated she observed CNA #1 wiping the resident's penis roughly and told the resident "Do you not like it?" NAT #2 stated the resident did not say anything but had his hand over his face. NAT #2 revealed CNA #5 did not say anything to CNA #1, nor the resident. NAT #2 stated she left the room as soon as the sponge bath was over because she was so uncomfortable. NAT #2 stated she did not report what she saw immediately beccause she was new, the two CNAs involved were friends, and she thought they would support one another.	F 609	Aide Trainee #2 returned to work on June 6, 2022, following suspension and was placed on a thirty day probationary period. All residents have the potential to be affected by this deficient practice. No other residents have been identified as being affected by this deficient practice. Nurse Aide Trainee #2 was educated on reporting any allegation of abuse to a supervisor immediately on June 1, 2022. Facility Staff was in-serviced on reporting any allegation of abuse immediately to a Supervisor on May 31, 2022, by the Administrator. Facility Staff was in-serviced on Resident Abuse, Elder Justice Act, Incident Investigation and Reporting and Residents Rights on September 13, 2022 by the Director of Nursing and Administrator. A Quality Assurance Meeting was held on September 9, 2022, to discuss findings from survey exit and systematic changes needed to ensure deficient practice will not reoccur to include staff education on Resident Abuse/Neglect and reporting monthly for three months. Beginning September 13, 2022, Facility Staff was in-serviced on reporting any allegation of abuse immediately to a Supervisor and then monthly for three months. Beginning September 19, 2022, the Administrator or Director of Nursing will discuss any concerns regarding F tag 609 in the Department Head Meeting weekly for four weeks then monthly for three months. Beginning September 23,	

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F 609	Continued From page 8 NAT#2 stated she finally did report the incident on 5/31/22 to the Staff Development Nurse. The NAT #2 stated she had been in-serviced regarding reporting abuse right away and was aware that this was an example of abuse. Record review revealed that NAT #2 received and signed, "Reporting Requirements of the Vulnerable Adult Act," dated 05/19/22 and acknowledged that she understood to report abuse/neglect immediately to her supervisor. Record review revealed that on 06/01/22 NAT #2 was given a "Verbal Warning, suspension for three days and 30 days probation," for failure to report to her supervisor timely after she witnessed abuse on 05/26/22. Record review revealed that she reported the abuse on 05/31/22 to the Staff Development Nurse. An interview on 09/8/22 at 9:30 AM with the Staff Development nurse confirmed that NAT #2 came to her office on 05/31/22 and requested to be taken off C Wing duty because of an incident that occurred that made her uncomfortable. The Staff Development Nurse stated NAT #2 revealed to her she witnessed CNA #1 slapping around the resident's penis and asking if he liked it during perineal care on 05/26/22. An interview on 09/8/22 at 10:50 AM with the Director of Nurses (DON) revealed she was made aware of the incident involving Resident #1 and CNA #1 and CNA #5 when the Staff Development Nurse came and got her immediately after NAT #2 reported to the Staff Development Nurse. She stated at that time that NAT #2 retold the story to both her and the Staff Development Nurse and made a hand motion to show how CNA #1 was flinging the resident's	F 609	2022, the Administrator or Director of Nursing will report any concerns to the Quality Assurance Committee. Beginning October 10, 2022, the Administrator or Director of Nursing will report any concerns to the Quality Assurance Committee and then monthly for three months until substantial compliance is achieved with F Tag 609. The Quality Assurance Committee will revise the corrective action plan as needed until substantial compliance is achieved with F Tag 609.	

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F 609	Continued From page 9	F 609		

penis back and forth.

An interview on 09/8/22 at 11:45 AM with the facility Administrator confirmed she was told about the incident and suspended CNA #1 pending investigation on 5/31/22, the day she was made aware of it. The Administrator revealed she thinks that CNA #1 did what was reported. The Administrator confirmed that through the facility's investigation of the abuse, the resident confirmed the occurrance and no further residents reported abuse.

Record review of Resident # 1's face sheet revealed that the resident was admitted to the facility on 03/12/10 with medical diagnoses that included: Hemiplegia following cerebral vascular disease affecting the right dominant side, aphasia following unspecified cerebrovascular disease, contracture of muscle, right hand, unspecified dementia with behavioral disturbance.

Record review of Resident # 1's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/19/22 revealed a Brief Interview for Mental Status (BIMS) of 09, which indicates the resident is moderately cognitively impaired.

A review of the facility's investigation revealed the facility substantiated the sexual abuse of Resident #1 by CNA #1 and terminated CNA #1 while she was out on suspension. CNA#1 was suspended from the facility on 5/31/2022 and was terminated on 6/2/2022. CNA #1 and CNA #5 both denied the allegations, however, CNA #5 was reprimanded and inserviced on identifying and reporting abuse.