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F 000	INITIAL COMMENTS Initial Comments: On February 21-23, 2022 the State Agency (SA) conducted an onsite complaint investigation for four (4) complaints, CI MS #17795 related to quality of care, and Responsible Party (RP) not notified timely of the resident's change in condition; CI MS #18294, related to quality of care, injuries of unknown origin, and (RP) not notified timely of the resident's change in condition; CI MS #18471, related to staff to resident alleged abuse; and CI MS #18509 related to infection control preventions not provided for an alleged vaccinated resident that tested positive for Covid. The SA unsubstantiated all four (4) complaints. The complaint investigations generated deficiencies that were cited for failure to report alleged abuse of a resident to all of the appropriate State agencies within two (2) hours of the alleged occurance (F609) and (F565) for failure to resolve resident council group concerns. The SA determined that the facility was not in compliance with the standards for participation in Medicare and Medicaid and deficiencies were cited at F565 with a Scope and Severity (S/S) of "D" and F609 (S/S) of "D." On February 21, 2022 the facility was licensed for 60 beds and the facility census was 44.	F 000		
F 565 SS=D	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take	F 565		5/2/22

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

Electronically Signed | 03/30/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 565	Continued From page 1 reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: F565- S/S=D Based on record reviews, staff interviews, resident interviews, reviews of the resident council meeting minutes, and facility policy and	F 565	On 03/28/22, Activities Director and Social Worker were in-serviced by Administrator on documenting, reporting, and following through with resident concerns from previous resident council meetings. Activities Director was also shown by Administrator on 03/29/22 how	

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F 565	Continued From page 2 procedures reviews, the facility failed to provide evidence of their responses to the resident council concerns and requests for Resident #6. Resident #6 was one (1) of eight (8) residents reviewed for the facility's response to grievances voiced by the resident council. Findings: The facility policy and procedure titled "Grievances - Residents (F-565 & F-585)" dated 03/93 with revision dates of 02/03; 06/11; 1/12; 12/16; 02/17; 04/17 read: All resident are to be encouraged and assisted (if necessary) in filing grievances to include those with respect to care and treatment, the behavior of staff and other resident's and other concerns regarding their facility stay, in the event that they have a need to make a concern known. Minutes of each Resident Council Meeting are recorded and made available to each member of the council, and a copy is maintained by the Administrator. Future meetings will indicate progress made on each suggestion/recommendation, and/or the reason (s) for rejection if changes suggested cannot be implemented. The Social Worker of Social Service Designee has been appointed by the Administrator to work with the Resident Council in obtaining services that assist the residents in voting, marriage, divorce, executing legal documents (i.e., wills, etc.), acquiring and disposing of property, choosing to practice a religion, etc., and to receive grievances and recommendations by residents, or any group or individual designated by the resident and his/her representative. These grievances shall be directed to the appropriate Department Head and/or Administrator for investigation and	F 565	to properly fill out "Old Business" and "New Business" on resident council forms including importance of making copies to give to each Department Head to resolve concerns timely and ensure staff are made aware of resident concerns. Money being stolen from resident was handled and reported to State, Attorney General, and Police by previous Administrator and previous Director of Nursing. State came to investigate the abuse allegation during Covid-19 Focused Emergency Preparedness Survey 03/08/21-03/16/21. Resident #6's bed was replaced by the Maintenance Director on 02/23/22 and new wheelchair was ordered on 02/23/22 by Administrator and Director of Nursing. On 02/24/22, Administrator informed every Department Head of resident concerns from Jan-2021 to March-2022. Beginning 02/25/22, residents' concerns in dietary department were addressed by Dietary Manager through in-services with dietary staff on "Meal of the Month" and meal preferences per residents' requests. Residents received "Meal of the Month" on 03/17/22 and 03/18/22. Menus are posted in front lobby area and cafeteria daily. Meal choices are also offered via Dietary Manager on a routine basis to make certain likes and dislikes are being honored. Beginning 02/24/22, Administrator in-serviced nursing staff on resident complaints concerning nursing department not knocking before entering, leaving trays in rooms, not allowing residents enough time to eat meals, noises in hallways, beds not being made, and not getting baths. Beginning 03/21/22,	

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F 565	Continued From page 3 follow-up. The facility policy and procedure titled "Resident Council (F-565)" dated 03/93 with revision dates of 02/03; 01/12; 02/17 read: All residents constitute the governing body of the Resident Council; all meetings are open to each resident residing in the facility. Meetings will be held on a regular basis and not less than quarterly. Staff liaison to the Resident Council will be the Social Services Designee/Social Worker or the Resident Activity Director, as approved by the group. This staff member is responsible for providing assistance and responding to written requests that result from group meetings. Other departmental staff will attend the meeting by invitation only. Meetings will at a minimum address the following: Review of minutes, Old/new Business, Open forum for questions/concerns, staff reports. The facility must consider the views of the group and act promptly upon recommendations regarding issues of resident care and life in the facility. The Grievances-Residents process shall be followed. The grievance report shall reflect the rationale of facility response. In review of the facility's policies and procedures for the facility's responses to Resident Council Meetings, the facility did not follow the guidance outlined in the policies for Resident Council Meetings with responses and action taken for the voiced resident concerns. Record review of the Resident Council Meeting minutes for the past year, January 2021 through December 2021, revealed that the facility had no documented responses to the monthly voiced group concerns as evidenced by : Review of the	F 565	Activities Director gave residents bath cards to inform of bath schedule. Beginning 02/24/22, Administrator met with Housekeeping, Maintenance, and Laundry to discuss and resolve resident complaints concerning lack of deep cleaning being done. Residents informed Administrator on 04/05/22 during resident council meeting that they are satisfied with current activity schedule. Administrator and Director of Nursing met with resident on 04/08/22 who complained of blanket being missing at resident council in September 2021. Resident stated on 04/08/22 to Director of Nursing and Administrator blanket was found and had no other complaints. Forty-four of 44 residents were identified on 02/24/22 by the Administrator as having the potential for lack of follow up concerns during resident council meetings. Administrator reviewed and logged all resident concerns from resident council meeting minutes from January 2021 through March 2022 and gave log of all concerns to each Department Head on 02/24/22. Beginning 02/24/22, staff was in-serviced on resident concerns from log by each department to address complaints per their department. An in-service was begun on 02/24/22 by the Administrator with all staff on policy titled "Resident Council" with a latest revision date of 11/17 to include timely documentation of resident concerns and documentation of follow up on those	

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F 565	Continued From page 4 01/20/1921 Resident Council Meeting minutes revealed that Resident #6 and Resident #7 were two (2) of six (6) residents that attended the Resident Council Meeting in which there were concerns voiced that money had been taken from a resident. The minutes did not identify the resident that had money taken and there was no dollar amount identified in the resident council minutes of January 20, 2021. The minutes also contained dietary requests for eggs, and nursing concerns that the food trays were being left in resident rooms, and housekeeping concerns that deep cleaning was "still" not being done. The January 2021 minutes did not contain responses and follow up actions taken by the facility to resolve the residents' voiced concerns. The facility did not follow their policies and procedures for responding to the voiced concerns from the Resident Council Meeting. The review of the February 23, 2021, Resident Council Meeting minutes did not contain comments and responses to the concerns issued during the January 20, 2021, group meeting. The section of the minutes titled "Old Business" was blank as was the section of the minutes titled "New Business." The February 23, 2021, Resident Council Meeting minutes did document "Housekeeping" rooms not being deep cleaned. Resident #6 and Resident #7 were two (2) of five (5) residents that attended the February 2021 group meeting. The same housekeeping concerns that the residents' rooms were not being deep cleaned were unresolved in group meeting of February 23, 2021, that had also been unresolved during the group meeting of January 20, 2021. Review of the March 24, 2021, Resident Council	F 565	concerns in minutes during resident council meetings. Beginning 02/24/22, an in-service was held with all staff by the Administrator on policy titled "Grievances-Residents," with a latest revision date of 11/17 to include documentation and follow up to resident concerns voiced during resident council meetings. The Quality Assurance Committee, which includes the Administrator, Director of Nursing, Medical Director, and Infection Preventionist, reviewed the findings of interviews, audits, and policies on "Resident Council" and "Grievances" with a revision date of 11/17 on 03/21/22 and 04/05/22 and did not recommend any changes. Beginning 02/24/22, resident council meeting minute audits and grievance audits will be conducted by the Administrator and/or Social Worker weekly for four weeks and monthly for two months to ensure resident council concerns are followed up and resolved timely. Audits will be recorded on the Medical Record Audit form and maintained by the Administrator and/or Social Worker. Beginning 02/24/22, the Medical Record Audit form documentation will also be reviewed weekly during Department Head meetings to ensure that resident concerns are being heard and resolved timely. Beginning 03/21/22, the Quality Assurance Committee will address concerns and/or review findings of the audits monthly for three months. Quality Assurance Committee will make any	

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F 565	Continued From page 5 Meeting minutes revealed that Resident #6 and Resident #7 were in attendance and that they were two (2) of ten (10) residents that attended the March 24, 2021, group meeting. The March 24, 2021, minutes contained no documentation for "Old Business" and no "Old Business" discussions were documented. There was no evidence documented that the facility had addressed the Resident Council group concerns that were voiced in the February 23, 2021, group meeting. Resident #6 voiced to the Administrator that she would like a new chair during the March 24, 2021, group meeting. The group voiced numerous food concerns and requests during the March group meeting. Review of the April 21, 2021, Resident Council Meeting minutes revealed that Residents #6 and #7 were two (2) of ten (10) residents that attended the April 2021 group meeting. The April 21, 2021, group meeting contained no documentation of the facility's follow-up and/or actions taken to resolve and respond to the previous resident group concerns. There was no response documented to in the minutes of April 21, 2021, concerning Resident #6's request for a new chair that she made in March 2021. Review of the May 24, 2021, Resident Council Meeting minutes revealed that Resident #7 was one (1) of eight (8) residents that attended the group meeting. There were no responses and or resolutions documented in the May 2021 minutes of the facility's action taken to address the previous voiced resident group concerns. The residents voiced in the May 24, 2021, group meeting that the beds were not being made by the Certified Nursing Assistance's (CNA's); and that the residents were not gotten up and out of	F 565	recommendations or changes as needed during monthly meetings until resolved. The corrective action will be completed on 05/02/22.	

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bed before 10:00 A.M.

Review of the June 23, 2021, Resident Council Meeting minutes revealed that Resident #6 and Resident #7 were two (2) of ten (10) residents that attended the group meeting. The residents voiced concerns about the food, not getting baths, noise in the hallways, beds not being made, not enough activities and no social worker. The facility did not document what had been done to address the previous group concerns. The minutes contained previously voiced concerns that were on-going and had been documented each month in the Resident Council Meeting minutes.

Review of the July 12, 2021, Resident Council Meeting minutes revealed that Residents #6 and #7 were two (2) of 12 residents that attended the July group meeting. Previous voiced concerns with food, noise in the hallways, activities, beds not being made and hollering up and down the hall. The same group issues remained unresolved and un-responded to by the facility in the July 12, 2021, group meeting.

Review of the August 25, 2021, Resident Council Meeting minutes revealed that Residents #6 and #7 were two (2) of 14 residents that attended the group meeting in August 2021. Resident #6 reported that she was not gotten up before 10:00 A.M. Some of the ongoing voiced concerns that had been documented in prior group meeting were reported by the group such as: noise in the hallways, food, no weekend activities, want more games, and want more snacks. There were no responses to the group concerns documented in the group minutes for August 2021 and/or for the previous voiced group concerns.

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Review of the September 28, 2021, Resident Council Meeting minutes revealed that Residents #6 and #7 were two (2) of ten (10) residents that attended the group meeting in September. The minutes contained voiced concerns about the food, want more activities and board games, CNAs in hallways being loud at night, trays being left in the rooms, and want more snacks. The facility did not document the resolutions to previous voiced group concerns and did not document any responses to the voiced requests of the resident group.

Review of the October 21, 2021, Resident Council Meeting minutes revealed that Residents #6 and #7 were two (2) of ten (10) residents that attended the group meeting. The residents voiced concerns about not having Sunday activities and not having Church services, food trays left in rooms, noise in the hallways, residents requested more board games, and one resident reported a blanket with her name on it was missing. The October 2021 group meeting did not contain documentation of responses to the voiced resident concerns. Previously voiced group concerns were voiced in the October 2021 group meeting with no facility resolutions and responses documented.

Review of the November 3, 2021, Resident Council Meeting minutes revealed that Residents #6 and #7 were two (2) of three (3) residents that attended the group meeting. Residents voiced in the group meeting that there was noise in their hallways at night, food trays were left in the rooms all day, snack cart doesn't come to the rooms on the 200 hall, food concerns, and want more activities on the weekends and want more

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outside of facility activities. There were no facility responses documented in the group minutes for November 3, 2021, and the voiced group concerns were the same as from previous group meetings with no facility response to the resident group.

Review of the November 16, 2021, Resident Council Meeting minutes revealed that Residents #6 and #7 were two (2) of ten (10) residents that attended the group meeting. The group voiced that there was noise in the hallways, not knocking on room doors, food concerns, not enough meat servings with meals, and one (1) resident needed a new chair. The facility did not document in the minutes the facility resolutions and/or responses to the November 16, 2021, voiced group concerns.

Review of December 9, 2021, Resident Council Meeting minutes revealed that Residents #6 and #7 were two of the 17 resident that attended the group meeting. The resident's voiced concerns were Sunday activities, residents ar3e not being allowed enough time to finish their food before the aides take up the trays, residents are not aware of who the new administrator is and they think that she should walk around and introduce herself, food requests, and residents made suggestions of several activities that they would like to see in the facility. There was no facility documented responses to the residents group concerns and requests and no resolutions were documented by the facility for the previously issued group concerns.

In an interview on 2/21/2021 at 2:50 P.M. with the facility administrator, ADM, she confirmed that

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she had been newly licensed as an Administrator (ADM) and had begun her first job as an ADM on 11/2/2021 at the facility.

Interview on 2/21/22 at 4:10 P.M. with the Activities Director (AD) revealed that she had been newly employed as the AD and that she had just completed the BIMS scores on all 44 of the residents in the facility. The AD presented the SA with a copy of the BIMS scores for all 44 residents. The AD stated that they had on Friday 2/18/22 met with the resident council and had elected a new resident council president, (Res #5) a new recording secretary, (Res #6) and had elected a new vice president (Res #7). The AD stated that she had no idea what the prior AD had done in relation to the resident council meeting minutes. The AD stated that she would make sure that all the concerns and requests that the residents had in Resident Council Meeting would be responded to and attempts would be made toward resolution and response. The AD confirmed that Res #6 and Res #7 had no cognitive deficits and were interviewable residents.

Interview on 2/22/22 at 12:00 P.M. with the Dietary Manager (DM) revealed that she had never been given the Resident Council Meeting food concerns and she had never been to a Resident Council Meeting to speak with the residents about their food concerns. The DM stated that the residents did not want her at the Resident Council Meetings. The DM stated that the cooperate office provided the menus to the facility. The DM stated that she was given a tight budget for the food purchases and that it was

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hard to provide quality choices in foods on such a tight budget.

Interview and observation on 2/22/22 at 1:30 P.M. with the new resident council president (Res #5) revealed that he had never attended a resident council meeting since he had been in the facility. Res #5 stated that he had been admitted to the facility in May of 2021. Res #5 stated that he had had a stroke and was not able to care for himself alone. Res #5 had good eye contact and was appropriately dressed in season appropriate clothes. Res #5 was pleasant in mood and had good command of language and his affect was pleasant. Res #5 was very interviewable and engaging in conversation. Res #5 stated that he felt that the facility did not let him know what was going on in the facility with things like menu changes and foods that would be served in the dining room. Resident #5 also stated that he had been placed on the Covid isolation unit when he was positive with Covid 19. He stated that when he would ask for information and wanted to know what to expect the facility did not answer his questions and did not communicate with him. Res #5 stated that today (2/22/22) was the first time since his admission to the facility in May of 2021, that he had received a menu for the foods that would be served. Res #5 wanted the daily menu to be posted in an area of the dining room where they have meals that could be reviewed by the residents. Res #5 stated that he used to be a tennis pro and ran tennis camps across the State. Res #5 stated that he liked to go outside and get fresh air, but the facility had not allowed him to go outside and sit on the patio with the group that smokes, because he was not a smoker, he felt that he did not get the same privileges as the smokers. Res #5 gave permission to the SA to

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relay his concerns to the facility.

Record review of Resident #5's Minimum Data Set (MDS) section C dated 02/02/22 revealed that Resident #5 had a Brief Interview of Mental Status (BIMS) score of 15 which indicated that he had no cognitive deficits. Record review of Res #5's face sheet revealed that Resident #5 was admitted to the facility on 05/04/2021 and had a date of birth of 08/29/2957.

Interview and Observation on 2/22/22 at 2:00 P.M. with Res #6 revealed that she was sitting in a wheelchair in her private room alone watching television. Res #6 stated that she had reported in resident council meetings that she needed a new wheelchair because her chair was hard to roll. Res #6 stated that this had been the case for several months and her chair had not been replaced. Res #6 stated that the previous ADM had told her that the facility had no money in the budget to replace her wheelchair. Res #6 stated that her wheelchair was too small and would not roll and that it was very hard to push. Res #6 also had a broken remote control on her automatic bed that was broken, and the bed would not let down and up and the wheels on the bed would not lock. Resident #6 stated that she had reported the broken bed to the facility's Director of Maintenance, and he had told her that he would have to order a part to repair the remote control. Resident #6 stated that her bed had been broken for several weeks. Resident #6 stated that the facility had not resolved her concerns from the resident council meeting. Res #6 gave permission to rely on her concerns to the facility.

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	255314	A. BUILDING _____ B. WING _____	C 02/23/2022

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F 565	Continued From page 12	F 565		

Record review of Res #6's face sheet revealed that Res #6 had been admitted to the facility on 12/24/2014 and had a date of birth of 05/30/1940. Res #6's MDS dated 02/16/2022 contained a BIMS score of 13 indicating that Res #6 had mild cognitive impairment.

Interview on 2/22/22 at 2:15 P.M. with the Director of Maintenance, revealed that he was told, by Res #6 that her bed was broken, and he stated that he would have to order a new part for the remote control. SA asked the Maintenance Director for a copy of the invoice of the part ordered and when would it be repaired. The Maintenance Director confirmed that he had no invoice. He stated that he would have to see if he could order the part.

Interview on 2/22/22 at 2:30 with the DON and ADM revealed that Res #5 had not mentioned any concerns and that they had seen Res #5 out on the patio with the smoking residents several times per day sitting in the fresh air. DON stated that she would talk to Res #5 and find out his concerns. Neither the ADM nor the DON were aware of Res #5's concerns. ADM stated that they started today, 2/22/22, giving the residents a daily menu of the meals to be served. The DON will talk to Res #5. DON stated that she will have Res #6's bed repaired, DON did not know that Res #6's bed was broken. The DON stated that she would have a new wheelchair fitted and ordered for Res #6. The ADM and the DON assured the SA that the concerns of Res #5 and Res #6 would be resolved.

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F 565	Continued From page 13 Interview on 2/23/22 at 11:00 A.M. with Resident #6 revealed that the facility had been to her room and had begun to switch the bed out for another bed in the facility that was working properly and that was not occupied. Res #6 stated that she was very much looking forward to her new wheelchair and that the DON had come to talk to her about the ordering of a new wheelchair. Interview on 2/23/22 at 11:15 A.M. with Res #5 revealed that he had been told that he could go outside any time with the group of smokers and/or with the staff. Res #5 stated that the facility had followed up on his requests for menus.	F 565		
F 609 SS=D	Reporting of Alleged Violations 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	F 609		5/2/22

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F 609	Continued From page 14 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: F609 S/S=D Based on record reviews, staff interviews, and policy and procedures reviews, the facility failed to timely report alleged staff to resident abuse within two (2) hours of the alleged occurrence for Resident #1. Resident #1 was one (1) of eight (8) residents reviewed for timely reporting of alleged occurrences of abuse and neglect. Findings: The review of the facility policy and procedure titled: "Incident Investigation & Reporting" (MS only) dated 04/06; latest revision: 05/18; read: Abuse, neglect, misappropriation of resident property and exploitation are crimes and shall be reported to proper authorities as such. The facility administrator shall ensure that any incident involving an allegation or suspicion of abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported not later than 2 hours after allegation is made to local law enforcement and the state agency, if the events	F 609	Resident #1 was assessed by the Director of Nursing on 12/11/21 with no adverse findings noted and has had no adverse affects from failure to report allegation of abuse to appropriate officials timely. Resident #1's Resident Representative and Physician were notified of the abuse allegation on 12/11/21 by the Director of Nursing. Certified Nursing Assistant #1 and #2 last scheduled day worked was 12/09/21. Both Certified Nursing Assistants were placed on immediate suspension during pending investigation results. Certified Nursing Assistant #1 was terminated by the Administrator on 12/15/21 after the investigation was completed. Certified Nursing Assistant #2 resigned on 12/19/21 due to stress from the investigation. Facility Medical Director was notified on 12/11/21 by the Director of Nursing for failure to report allegation of abuse timely to State agencies. Forty-four of 44 residents were identified on 02/24/22 by the Administrator as having the potential for allegations of abuse and/or neglect which would result	

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F 609	Continued From page 15 that cause the allegation involve abuse or result in serious bodily injury to the State Survey Agency and adult protective services. Initial Report must be called in to Mississippi State Department of Health Certification and Licensure. Attorney General Office; Local Law Enforcement. Final Report must be submitted within 72 hours to MSDH Certification and Licensure and Attorney General's Office. In an interview on 2/21/2021 at 2:50 P.M. with the facility Administrator (ADM) stated that she had mailed via US mail the investigation that the facility had conducted concerning the alleged abuse of Resident #1 (Res #1) by a Certified Nursing Assistant (CNA#1). The ADM was not able to provide documentation that the alleged abuse was timely reported immediately after the alleged occurrence on 12/10/2021 at 2:00 A.M. The ADM stated that she mailed the facility's report and investigation of the alleged abuse to the State Agency (SA). The ADM confirmed that she did not fax or email the report to the SA. The ADM confirmed that she did not have any email or fax confirmations of the alleged abuse of Resident #1 that occurred on 12/09/21 or 12/10/21. The ADM verified that her investigation report was mailed to the Survey Agency on 12/15/2021. The ADM stated that CNA #1 and CNA #2 had both been placed out on leave pending the conclusion of the facility investigation. CNA #2 resigned due to the stress of the investigation and CNA #1 was terminated out of an abundance of caution. There was no substantiated abuse or neglect of Resident #1. Interview with the Director of Nursing (DON) on 2/21/2021 at 3:00 P.M. revealed that she received	F 609	in the potential to be affected by this deficient practice. No deficits with reporting allegations of abuse/neglect timely to State agencies were identified by the Administrator on 02/24/22. In-services held on 02/24/22 and 03/30/22 by the Administrator on "Incident Investigation and Reporting," dated 04/2004 with a latest revision date of 05/2018 to include timely notification to appropriate state agencies on allegations of abuse/neglect with all staff. The Quality Assurance Committee, which includes the Administrator, Director of Nursing, Medical Director, and Infection Preventionist, reviewed the policy on "Incident Investigation and Reporting" with a revision date of 05/2018 on 03/21/22 and 04/05/22 and did not recommend any changes. Beginning 02/24/22, incident and grievance report audits will be conducted by the Administrator and Social Worker to investigate all allegations of abuse/neglect to determine need for reporting to appropriate officials in accordance with state law. Complaints and concerns will be recorded on the Medical Records Audit form and maintained by the Administrator and/or Social Worker weekly for four weeks and make needed recommendations. Beginning 02/24/22, Social Worker will interview fifteen residents for any concerns or complaints weekly for two weeks and monthly for two months. Findings from interviews and audits will be discussed in weekly	

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F 609	Continued From page 16 the call from the third shift nurse, Licensed Practical Nurse (LPN) #1, sometime after midnight on Saturday 12/11/2021 reporting that CNA #2 told her that she witnessed CNA #1 curse and grab the wrist of Resident #1 and say "F****r, I am stronger than you are. You can't hurt me." The DON stated that she came to the facility on the first shift on Saturday 12/11/2021 and at approximately 10:30 A.M. the DON began the assessments of all of the residents in the facility. The DON completed the accident and incident report for resident #1 on 12/11/2021. The DON called the ADM, and she called the local police department to report alleged abuse of resident #1 by the CNA #1. The DON stated that she called the "hotline" at Mississippi State Department of Health (MSDH) at approximately 11:00 A.M. on 12/11/2021 to report the alleged abuse. The DON confirmed that she was not able to provide documentation that the alleged abuse was timely reported immediately after the occurrence on 12/10/2021 at 2:00 A.M. The DON stated that she had looked through her personal cell phone and was not able to locate the date and time that she called the alleged abuse of resident #1 into the State agencies. There was no record of the notification of the SA with in two (2) hours of the alleged occurrence of abuse. The DON confirmed that the incident of alleged abuse occurred during the third shift on 12/09/2022-12/10/2022. The DON confirmed that the facility did not substantiate any abuse or neglect of Res #1. The SA attempted to interview and observe Resident #1 during the investigation of 2/21/22-2/23/22. No observations and/or interviews were made since resident #1 was in the hospital for complications with Covid 19.	F 609	stand-up meetings with Quality Improvement Committee. Beginning 03/21/22, the Quality Assurance Committee will address concerns identified from the audits and interviews completed by the Administrator and/or Social Worker monthly for three months and make any recommendations or changes needed until resolved. The corrective action will be completed on 05/02/22.	

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F 609	Continued From page 17 The record review of Resident #1's Minimum Data Set (MDS) section C-Cognitive Patterns dated 02/04/2022 revealed that Res #1 had a Brief Interview of Mental Status (BIMS) score of 5 which indicated he had severe cognitive deficits. Review of Resident #1's face sheet revealed that he had a documented diagnoses that included but were not limited to Cognitive Communication Deficit; Personal History of Traumatic Brain Injury; Anxiety Disorder; Restlessness and Agitation; Impulsiveness; Anorexia; among other diagnoses. The SA confirmed that the first notification the facility made to the SA of the alleged occurrence was on 1/6/2022 via US mail. The SA had no record of the facility reporting the alleged abuse in a timely manner within two (2) hours of occurrence that took place on 12/09/2021 during the third shift. The facility did not timely report the incident of alleged abuse of Resident #1 by CNA #1.	F 609		