STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255252	A. BUILDING _____ B. WING _____	C 03/30/2023

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MS CARE CENTER OF GREENVILLE	1221 EAST UNION STREET GREENVILLE, MS 38703

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F 000	INITIAL COMMENTS The State Agency (SA) conducted two (2) complaint investigations (CI MS#20747 and CI MS#20894) at the facility from 3/28/23 through 3/30/23. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid Services. The SA identified non-compliance and cited F550, F553, F585, F656, and F699 for CI MS# 20747. There were no deficiencies cited for CI MS# 20894 related to sufficient staffing. The census at the time of the survey was 74 with a bed capacity of 90 beds.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(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. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the	F 550		5/12/23

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

Electronically Signed | 04/19/2023

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F 550	Continued From page 1 provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on facility policy review, resident interview, staff interviews, and record reviews, the facility failed to respect a resident's rights, as evidenced by a staff member calling a resident "boy" for one (1) of six (6) residents reviewed. Resident #1 Findings include: Review of facility policy titled, "Resident Rights Policy/F550 Resident Rights/Exercise of Rights," with a revised date of 9/2022, revealed "Facility will ensure the resident has the right to a dignified existence... Facility will treat each resident with respect and dignity... The facility will protect and promote the rights of each resident..." An interview with the Ombudsman on 3/28/23 at	F 550	1.RN Supervisor apologized to Resident #1 and was inserviced on 4/13/23 on Resident Rights and Dignity by Staff Development. 2.All residents who want to be addressed with a title of their choice have the potential to be affected. 3 a Resident Rights policy was reviewed by Administrator with Social Services Designee on 3/31/23 and no revisions were necessary. b The care plans have been updated by careplan nurse on 4/14/23 to reflect how the facility staff will address each resident by name with dignity and	

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F 550	Continued From page 2 08:30 AM, revealed she had been involved with Resident #1 regarding his complaint of being called a "boy" by the Registered Nurse (RN) Supervisor on 2/10/23 and she noted that Resident #1 was very upset by the incident. An observation and interview on 3/28/23 at 06:50 PM, with Resident #1 revealed he was called a "boy" by the RN Supervisor on 2/10/23. Residents #1 revealed he was getting off the second (2nd) floor elevator when the RN Supervisor asked him "Where you going boy?" Resident #1 noted he heard the RN Supervisor but did not respond. Resident #1 then revealed the RN Supervisor expressed "You're on the wrong floor aren't you boy?" Resident #1 stated that he responded after being called a boy the second time and cursed the RN Supervisor. He informed the RN Supervisor that he was a grown man and should be called Mr. or Sir. Resident #1 revealed he was very upset from being called a boy and did not feel as he was being respected by the RN Supervisor. An interview on 3/28/23 at 07:45 PM, with Social Services revealed she spoke with Resident #1 on 2/10/23 regarding the incident where the RN Supervisor called him a boy. She noted Resident #1 was noticeably upset and cursed often in his description of the incident. Social Services revealed Resident #1 was still upset about the incident on 2/12/23, as he continually expressed his feelings about it, and how it bothered him. An interview on 3/28/23 at 07:52 PM, with the RN Supervisor, confirmed he did call Resident #1 a "boy" on 2/10/23. He noted he patted Resident #1 on the shoulder and he said, "You are on the wrong floor boy." He confirmed that Resident #1	F 550	respect to protect and promote their rights. c Inservice on Residents Rights was done for all employees by Staff Development beginning on 4/10/23. d. Employees who are witnessed to fail to use Resident's choice names will receive discipline and be reinserviced immediately as appropriate by the Supervisor and Administrator. 4.Beginning on 4/13/23, the Respect and Dignity Name Audit will be done by interviewing ten (10) residents weekly for eight (8) weeks, then quarterly by the DON and/or designee to ensure Resident choice is being honored. Audit findings of employees using resident choice names will be reported by the Director of Nursing to the Quality Assurance Committee monthly on 5/11/23 for three months then quarterly to ensure continued compliance.	

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F 550	Continued From page 3	F 550		

became furious with him but could not remember everything Resident #1 said. He stated he did remember him expressing that he was a grown man and should not be called a boy. He also revealed that when Resident #1 became as mad as he did, he realized what he had done by calling Resident #1 a "boy". He expressed that he had addressed Resident #1 incorrectly and should have called him Mr.

An interview on 3/29/23 at 05:40 PM, with the Director of Nursing (DON) revealed that the RN Supervisor did report that he called Resident #1 a "boy" on 2/10/23 and confirmed that the RN Supervisor should have treated Resident #1 with dignity and respect by addressing him as Mr. or Sir.

An interview on 3/29/23 at 06:35 PM, with the Former Administrator in Training (AIT) ,that was working at the facility during the time of the incident revealed that she did not feel that Resident #1's Resident Rights were violated because the RN Supervisor did not mean anything by calling Resident #1 a boy. She revealed it was done in a playful manner and was not intended to violate Resident #1.

A telephone interview on 3/30/23 at 11:41 AM, with the Former Interim Administrator, that was working at the facility during the time of the incident confirmed that Resident #1's Resident Rights were violated by the RN Supervisor by calling Resident #1 a "boy" and not Mr. or Sir on 2/10/23.

Record review of the Face Sheet for Resident #1 revealed an admission date of 12/1/21 and diagnoses that included Acquired Absence of

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F 550	Continued From page 4 Limb, Unspecified, and Unspecified Sequelae of Cerebral Infarction. Record review of Section C of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/8/2023, for Resident #1 revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating Resident #1 is cognitively intact.	F 550		
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-	F 553		5/12/23

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F 553	Continued From page 5 (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on facility policy review, record review, resident interview, and staff interviews the facility failed to include a resident in the development of his person-centered Trauma Informed care plan for one (1) of seven (7) residents reviewed for care plans. Resident #1. Findings include: Review of the facility policy titled "F553 Right To Participate In Planning Care," with a revision date of 9/2022, revealed, "The right to participate in the development and implementation of their person-centered plan of care including but not limited to: a. The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions of the person-centered plan of care. b. The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. c. The right to be informed, in advance, of changes to the plan of care." Record review of the "Care Plan" for Resident #1 revealed "Problem Onset: 2/10/2023 Resident stated he has a HX of trauma. Res. reported that he has encountered racism as a child and	F 553	1.Resident #1 care plan for trauma has been redone with resident participation by Social Services on 4/14/23. 2.All residents with care plans have the potential to be affected . 3 a Comprehensive Care Plan Policy review was reviewed by Administrator with Social Services Designee on 3/31/23 and no revisions were necessary. b. A Disciplinary Action was done for the Social Service Director on 4/11/23 by the Administrator on failure to have resident participate on Trauma Informed care planning. c. Care Plan Nurse audited care plan invitations on 4/14/23 and 4/17/23 and will audit weekly beginning on 4/24/23 with the care plan meetings to ensure Residents and Resident Representatives are invited. 4.The Care Plan Audit was done for all residents on 4/14/23 and 4/17/23, then will be done for ten (10) residents per week beginning on 4/24/23 for eight (8) weeks, then quarterly to ensure residents are involved. All residents and Responsible	

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F 553	Continued From page 6 witnessed a Caucasian murder an African American which took an emotional effect on him. Certain words trigger flash backs. Example "boy" ... Social to visit as needed. Engage in activities of choice. Speak with a Mental health Therapist to verbalize my feelings. Consult Psych as needed." An interview on 3/28/23 at 06:50 PM, with Resident #1 revealed he had not been spoken to by Social Services about a Trauma Informed care plan to show how they were going to help him work this through the incident. An interview on 3/28/23 at 07:45 PM, with Social Services revealed she did develop a Trauma Informed care plan for Resident #1 confirmed that she did not give him the opportunity to participate in the development of the care plan and confirmed that she did not inform him in advance of changes to his care plan. An interview on 3/29/23 at 06:35 PM, with the Former Administrator in Training (AIT) that was working at the facility during the time of the incident did not confirm that Resident #1 should have been allowed to be involved in the development of his Trauma Informed care plan. She noted that Resident #1 agreed to his full care plan on 2/14/23, with no complaints, when reviewed with him by the Care Plan Nurse and Social Services even though he was noted by Social Services to not have been involved in the development of it on 2/10/23. A telephone interview on 3/30/23 at 11:00 AM, with Social Services revealed she did not go to Resident #1's room with the Care Plan Nurse to discuss and review the Trauma Informed care	F 553	Representatives will be invited to care plan meeting by Social Services at least a week prior and provide signature sheet they sign, and date of signature. Audit findings will be reported on the last Quality Assurance meeting of the month on 5/11/23 by the Social Worker monthly for three months, then quarterly to ensure continued compliance.	

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F 553	Continued From page 7 plan and had only signed the staff sheet attached to Resident #1's care plan after the Care Plan Nurse informed her she had a care plan meeting with Resident #1. She noted she was not aware of the level of explanation Resident #1 was given regarding his Trauma Informed care plan. A telephone interview on 3/30/23 at 11:41 AM, with Former Interim Administrator, that was working at the facility during the time of the incident, confirmed Resident #1 should have been allowed to participate in the development of his Trauma Informed care plan, to enable him to have an adequate person-centered plan of care. An interview on 3/30/23 at 01:20 PM, with the Care Plan Nurse revealed she was not aware of the development of the Trauma Informed Care Plan for Resident #1 until she was preparing to have her care plan meeting on 2/14/23 with Resident #1. Record review of the Face Sheet for Resident #1 revealed an admission date of 12/1/21 and diagnoses that included Benign Prostatic Hyperplasia Without Lower Urinary Tract, Acquired Absence of Limb, Unspecified, and Unspecified Sequelae of Cerebral Infarction. Record review of Section C of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/8/2023, for Resident #1 revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating Resident #1 is cognitively intact.	F 553		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4)	F 585		5/12/23

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§483.10(j) Grievances.
§483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.

§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.

§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right

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to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance,

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F 585	Continued From page 10 and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Cross Reference F699 Based on facility policy review, resident interview, facility staff interviews, and record review, the facility failed to resolve a grievance for a resident, for one (1) of six (6) residents reviewed for an unresolved grievance. Resident #1 Findings include: Review of the facility policy titled, "F585 Grievances," with a revision date of 9/2022, revealed " The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. ... The facility will make information on how to file a grievance or complaint available to the resident." Record review of the "Grievance/Complaint" dated 2/13/2023, for Resident #1, revealed "Date of Grievance/Complaint 2/10/23 ... Explanation/Nature of Complaint: Res.	F 585	1.Resident #1 participated and completed an updated grievance process on 4/14/23 with the Social Service Designee in a attempt to resolve the grievance on 2/10/23. Grievance was resolved on 4/14/23. 2.All residents that file a grievance have the potential to be affected. 3 a Grievance Policy was reviewed by the Administrator with Social Services Designee on 3/31/23 with no revisions necessary. b A psychiatric services contract has been signed on 4/12/23 and will be available to address the psychological/trauma needs of the residents. d Grievance Policy and Procedures inservices was done on 4/11/23 by Staff Development nurse for employees.	

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F 585	Continued From page 11 approached SW stating he needed to talk. SW invited Res. into a private location. (SW office). Res. stated he was on the second floor, about to get off the elevator when (RN Supervisor's Name Removed) stated to him "Boy you on the wrong floor. Boy where are you going?" Res. expressed that he did not like being called a boy because he is a grown man; Summary of the pertinent finding of conclusions: SW spoke with DON (DON's Name Removed) who stated (RN Supervisor's Name Removed) was only joking and did not mean anything by calling Res. a boy. (RN Supervisor's Name Removed) apologized to Res. immediately. However, Res. stated he did not hear (RN Supervisor's Name Removed) apologizing; Corrective Action Taken: DON in serviced (RN Supervisor's Name Removed), informing him that he can not refer to Res. by anything other than their preferred name or Mr. or Mrs. ... ADMINISTRATOR along with AIT and resident had a meeting. Res. informed staff on why he didn't like the word boy. Resident stated he did not like being called a boy d/t racism and witnessing the murder of an African American. Res. stated the word boy makes him have flashbacks. Staff was unaware of the traumatic experience Res. stated he encountered. Res. agreed to have a conversation with (RN Supervisor's Name Removed). (RN Supervisor's Name Removed) apologized again to (Resident #1's Name Removed) and they were able to shake hands; Date and discussion with resident of the findings: 2/10/23; Is this matter resolved?: Yes; Was a copy of written findings requested? No; Was a copy of written findings provided? No; Is further action necessary? No ... 2/12/23-Res. informed SW that he does not desire d/c and that he had another plan. SW asked Res. did he need any assistance Res. stated "Its my personal	F 585	4.Beginning 4/1/23, the Grievance Log Audit will be done daily as grievances are received by the Social Services Designee and reviewed and approved by the Administrator prior to resolution to ensure every grievance is complete and resolved. Audit findings will be reported to the Quality Assurance Committee on 5/11/23 by the Social Services Designee monthly for three months, then quarterly to ensure continued compliance.	

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business."

Record review of the "Departmental Notes/Social Notes," for Resident #1 revealed "2/13/23 ... Grievance verbalized by this Res. on 2/10/23 is currently being investigated. SW reported Grievance to Local Ombudsman, who was present today and she went and spoke with Res. Res. came back to this SW and stated his advocate told him that this SW was suppose to file a Grievance and that he has to sign it. SW informed Res. that the Grievance had been initiated but it was not complete. Res. requested a copy. SW printed a copy for Res. Res. reviewed the Grievance and stated "This shit ain't right, He called me a boy twice. SW changed Nature of Complaint. Res then stated, "That's some bullshit he did not apologize to me". SW deleted that Thompson had apologized. SW informed Res. that this information was given and put in by this SW and the details of the grievance came from the DON. SW also explained that the Grievance process is not complete until the DON has added how she plans to address issue. Res. then stated "She ain't got shit to do with this". SW informed Res. that the DON is responsible for addressing grievances that are filed towards her staff."

On 3/28/23 at 08:30 AM, during an interview with the Ombudsman revealed she had been involved with Resident #1 regarding his complaint of being called a boy by the Registered Nurse (RN) Supervisor on 2/10/23. She noted that Resident #1 was very upset by the incident, and that he had revealed he did not feel the nursing facility would do anything about it since the RN Supervisor's Supervisor, the Director of Nursing (DON), was his fiancé. She revealed Resident #1 told her being called a boy by a Caucasian male

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was very upsetting, she informed Resident #1 that he can be active in his grievance process. The Ombudsman told Resident #1 that he had the right to see what had been put in writing, by the nursing facility, regarding his grievance being resolved. She noted Resident #1 did meet with the Interim Administrator, and the RN Supervisor, but he informed the Ombudsman that he was still not satisfied with how the incident was being resolved.

An interview on 3/28/23 at 06:50 PM, with Resident #1 revealed he was called a boy by the RN Supervisor on 2/10/23. Resident #1 revealed he was getting off the second (2nd) floor elevator when the RN Supervisor ask him "Where you going boy?" Resident #1 revealed he went to Social Services to talk with her on that same day to get help regarding the incident, was told by Social Services that she would write it down for him but he did not feel anything would be done about it since the DON is the RN Supervisor's fiancé. Resident #1 expressed that he felt the DON should not be involved in the investigation, due to her relationship with the RN Supervisor. He noted he met with the two (2) lady bosses, the Interim Administrator and the Former Administrator in Training (AIT), and the RN Supervisor, on the Monday after the incident happened. Resident #1 discussed the conversation he had with the Ombudsman on 2/13/23, after meeting with the Interim Administrator and the RN Supervisor, about not being satisfied with the results of the meeting. He noted the Ombudsman informed him he could request a copy of his grievance form to see what was written on it. He revealed he went to Social Services, and she provided him with a copy of the grievance report and that Social Services had not

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discussed his grievance with him after he initially reported the incident with her. He shared that he was upset that the grievance report showed the DON was active in the investigation process and he was not satisfied with the information that had been recorded on the grievance report by Social Services. Resident #1 noted that none of the facility staff tried to tell him how the incident was going to be handled.

An interview on 3/28/23 at 07:45 PM, with Social Services, revealed she spoke with Resident #1 on 2/10/23 regarding the incident where the RN Supervisor called him a boy and his wanting to be moved to another nursing facility. She revealed she started the grievance process and documented, on the grievance form, as she was provided information by the staff members involved in the investigation. She noted she was informed by the Interim Administrator of the meeting with Resident #1 on 2/13/23 and of the resolution between Resident #1 and the RN Supervisor. She confirmed she resolved the grievance and did not discuss it with Resident #1.

An interview on 3/29/23 at 06:35 PM, with the Former AIT/Administrator confirmed that Resident #1 should have been talked to by Social Services before the grievance was resolved and Resident #1 should have been allowed to fully participate in the grievance process.

A telephone interview on 3/30/23 at 11:41 AM, with Former Interim Administrator/Corporate Nurse, revealed she did not inform Social Services to resolve Resident #1's grievance on 2/13/23. She confirmed that Resident #1 should have been involved in his grievance process/resolution of his grievance, and has had

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F 585	Continued From page 15 an unresolved grievance since 2/10/23. Record review of the Face Sheet for Resident #1 revealed an admission date of 12/1/21 and diagnoses of Benign Prostatic Hyperplasia Without Lower Urinary Tract, Essential (primary) Hypertension, Elevated Blood-Pressure Reading, Without Diagnosis of Hypertension, Other Sleep Disorder Not Due to a Substance or Known Physiological Condition, Acquired Absence of Limb, Unspecified, and Unspecified Sequelae of Cerebral Infarction. Record review of Section C of the Quarterly Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 2/8/2023, for Resident #1 revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating Resident #1 is cognitively intact.	F 585		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required	F 656		5/12/23

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F 656	Continued From page 16 under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on facility policy review, resident interview, staff interviews, and record review, the facility failed to implement a Trauma Informed Care Plan for a resident in need of trauma informed care for one (1) of six (6) residents reviewed for care plans. Resident #1 Findings include:	F 656	1.Comprehensive Care Plan, Trauma Informed Care was implemented for Resident #1 by the Social Worker on 4/14/23 and resident participated, signed, and dated. 2.All residents with trauma have the potential to be affected.	

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F 656	Continued From page 17 Review of the facility policy titled, "656 Develop/Implement Comprehensive Care Plan," with a revised date of September 2022, revealed "The facility will ... implement a comprehensive person-centered care plan for each resident ... that includes measurable objectives and timeframes to meet the resident's ... mental and psychosocial need that are identified in the comprehensive assessment." Record review of the "Care Plan" for Resident #1 revealed "Problem Onset: 2/10/2023 Resident stated he has a HX of trauma. Res. reported that he has encountered racism as a child and witnessed a Caucasian murder an African American which took an emotional effect on him. Certain words trigger flash backs. Example "boy" ... Social to visit as needed. Engage in activities of choice. Speak with a Mental health Therapist to verbalize my feelings. Consult Psych as needed." An interview on 3/28/23 at 06:50 PM, with Resident #1 revealed he had not spoken with anyone regarding a Trauma Informed care plan and wanted help to work through the trauma so he would not get upset again. Resident #1 stated that no staff had come to check on him to see how he was making it since the incident, nor had anyone spoken to him about options to deal with the bad feelings that were brought back to his memory. An interview on 3/28/23 at 07:45 PM, with Social Services confirmed she did not implement the Trauma Informed care plan and had not referred Resident #1 to any mental health services for him to work through his feelings about the trauma. She revealed she had not visited Resident #1 as	F 656	3 a. A Psychiatric Services Contract was signed on 4/12/23 and has scheduled a meeting with Resident #1 on 4/20/23 to assess psychological needs of the recent memory of trauma. b. Social Services Designee was inserviced on 4/14/23 on involvement of the Resident in the Development and Implementation of the Comprehensive Care Plan including Cultural Competent Care per facility policy by Administrator. 4.Beginning on 4/14/23 the Care Plan Audit was started by the Social Worker for all residents initially for Trauma Informed Care and Culturally Competent Care and for 10 residents a week for eight (8) weeks, then quarterly. Audit findings will be reported to the Quality Assurance Committee on 5/11/23 and monthly for three months, then quarterly ongoing to ensure continued compliance.	

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indicated on the Trauma Informed Care Plan and had not worked with the nursing staff to get a physician's order for a referral to a psychiatrist for Resident #1. She revealed she did inform the Activities Director that the activities department will have responsibilities listed to implement in the Trauma Informed Care Plan on 2/10/23.

An interview on 3/29/23 at 02:20 PM, with the Activities Director revealed she was not aware that Resident #1 had a Trauma Informed care plan and had not assessed Resident #1 for additional activities to implement the activities intervention of the Trauma Informed care plan. The Activities Director revealed she did not talk with Social Services regarding a Trauma Informed care plan, that she was not aware of the traumatic incident with Resident #1 being called a boy by the RN Supervisor on 2/10/23, and that Social Services could have possibly spoken with the Assistant Activities Director.

An interview on 3/29/23 at 02:30 PM with the Assistant Activities Director revealed she had not been informed that Resident #1 had a Trauma Informed care plan but did come across it in record review in the electronic health record (EHR) last week when she updated other residents' Activities care plan. She revealed she did not assess Resident #1 for additional options for activities to assist to occupy him related to the incident of him being called a boy by the RN Supervisor on 2/10/23.

An interview on 3/29/23 at 05:40 PM, with the Director of Nursing (DON), revealed she was aware that Social Services developed a Trauma Informed care plan for Resident #1 on 2/10/23 and had not attempted to obtain an order for a

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F 656	Continued From page 19 psychiatrist consult for Resident #1. The DON confirmed Resident #1 should have been referred to psychiatry services due to the level of how upset he was regarding his recent trauma from being called a boy by the RN Supervisor on 2/10/23. An interview on 3/29/23 at 06:35 PM, with the Former AIT/Administrator confirmed that the Trauma Informed care plan should have been implemented for Resident #1. A telephone interview on 3/30/23 at 11:41 AM, with the Former Interim Administrator confirmed that Resident #1's Trauma Informed care plan should have been implemented to assist him to work through his recent trauma and to avoid the possibility of psychosocial harm. Record review of the "Physician Orders List" revealed there was no physician's order for a referral to mental health services for Resident #1. Record review of the Face Sheet for Resident #1 revealed an admission date of 12/1/21 and diagnoses that included Acquired Absence of Limb, Unspecified, and Unspecified Sequelae of Cerebral Infarction. Record review of Section C of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/8/2023, for Resident #1 revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating Resident #1 is cognitively intact.	F 656		
F 699 SS=D	Trauma Informed Care CFR(s): 483.25(m)	F 699		5/12/23

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F 699	Continued From page 20 §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by: Cross reference F585 Based on facility policy review, observations, resident interviews, staff interviews, and record reviews, the facility failed to provide trauma-informed care and failed to complete a trauma-informed care assessment properly for a resident experiencing trauma, as evidenced by a resident's behaviors related to a nursing facility staff member calling him a "boy" for one (1) of six (6) residents reviewed for trauma. Resident #1. Findings include: Review of the facility policy titled, "F699 Trauma Informed Care," with a revision date of September 2022, revealed, "...1. The facility will ensure that residents who are trauma survivors receive culturally-competent, trauma care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. ... Collaboration - There is an emphasis on partnering between residents and/or his or her representative, and all staff and disciplines involved in the resident's care in developing the plan of care. ... Trustworthiness and transparency - Efforts to establish a relationship based on trust, and clean	F 699	1.A Trauma Informed Care Assessment has been completed with Resident #1 by Social Service Designee on 4/14/23. The newly contracted psychological services has an appointment with Resident #1 on April 20, 2023 for psychological needs due to recent trauma. 2.All residents with trauma have the potential to be affected. All residents were screened for trauma on 4/14/23-4/18/23 by Social Services. 3 a. Social Services Designee implemented a comprehensive person-centered Trauma Informed Care Plan for Resident #1 with resident participation on 4/14/23 c On 3/30/23, Resident #1 had a psychological consult by Facility Psychiatrist. d. Social Services Director was inserviced on the development and Implementation of a Trauma Informed and Culturally Competent Care Plan for residents with a history of trauma per facility policy on 4/14/23 by Administrator.	

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F 699	Continued From page 21 and open communication between the staff and the resident. ... 4. Facility will use a multi-pronged approach to identifying a resident's history of trauma as well as his or her cultural preferences. This includes asking the resident about triggers that may be stressors or may prompt recall of a previous traumatic event, as well as screening and assessment tools ... 8. Facility will provide cultural competencies to help staff communicate effectively with residents and their families and help provide care that is appropriate to the culture and the individual. Cultural competence refers to a person's ability to interact effectively with person of cultures different from his/her own." An interview on 3/28/23 at 08:30 AM, with the Ombudsman revealed she had been involved with Resident #1 regarding his complaint of being called a "boy" by the Registered Nurse (RN) Supervisor on 2/10/23. She noted that Resident #1 was very upset by the incident and that he had revealed he did not feel the nursing facility would do anything about it since the RN Supervisor's Supervisor was his fiancé, the Director of Nursing (DON). She revealed Resident #1 told her being called a "boy" by a Caucasian male caused him to have flashbacks of traumatic racial events from his youth and he had witnessed a racially motivated homicide as a child. She noted Resident #1 met with the Interim Administrator, the Former Administrator in Training (AIT)/Administrator (that was working at the facility at the time of the incident), and the RN Supervisor on 2/13/23, but he informed the Ombudsman that he was still not satisfied with how the incident was being resolved. The Ombudsman revealed she met with the Interim Administrator, AIT, who is now the nursing	F 699	e. We will continue to invite all residents and Responsible Representatives to care plan meeting and provide signature sheet for them to sign and date. f. The Trauma Informed Care Screening tool was implemented on 4/14/23 to screen all residents on admission for possible past trauma. g. Trauma Informed Care Assessment Form #PCL-5 with LEC-5 and Criterion A from the National Center for Post Traumatic Stress Disorder will be used for all Residents referred to the Social Service Designee through the admission screening process. All current residents were screened on 4/14/23-4/18/23 and those found to have past trauma with or without triggers now have a trauma informed care plan. 4.Beginning on 4/14/23, Trauma Audit Checklist includes all residents who have a history of trauma with triggers for the trauma are in place as care planned will be audited through this tool. This audit will be done quarterly by Social Services. Audit findings will be reported to the Quality Assurance Committee monthly beginning on 5/11/23 for three months, then quarterly to ensure solutions are sustained.	

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facility's Administrator, the DON, and Social Services (SS), on 2/13/23, immediately after Resident #1's meeting, and was informed, by the Interim Administrator, that the situation had been calmed down, and that Resident #1 was satisfied with the results of the meeting with the Interim Administrator and RN Supervisor.

An observation and interview on 3/28/23 at 06:50 PM, with Resident #1 revealed he was called a "boy" by the RN Supervisor on 2/10/23. Resident revealed he was getting off the second (2nd) floor elevator when the RN Supervisor asked him "Where you going boy?" Resident #1 noted he heard the RN Supervisor but did not respond. Resident #1 then revealed the RN Supervisor expressed "You're on the wrong floor aren't you boy?" Resident noted he responded after being called a "boy" the second (2nd) time, cursed the RN Supervisor as he informed him that he was a grown man, was old enough to be the RN Supervisor's father, and did not appreciate being called a "boy". Resident #1 then revealed being called a "boy" was racist to him and it brought back horrible memories of racism from his childhood and when he was a younger adult. Resident #1 shared information of witnessing a racially motivated homicide when he was a child and was often called a "boy" by Caucasians in the 1960's to be degraded. Resident noted all those feelings came rushing back to him and made him feel that he was back in one of those degrading situations. State Agency (SA) observed Resident #1 became tearful and was angrily cursing when recounting the information of what he experienced when he was younger. Resident revealed he went to Social Services to talk with her on that same day to get help regarding the incident, was told by Social Services that she

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would write it down for him, but he did not feel anything would be done about it since the DON was the RN Supervisor's fiancé. Resident #1 expressed that he felt the DON should not be involved in the investigation, due to her relationship with the RN Supervisor. He noted he met with the two (2) lady bosses, the AIT/, and the RN Supervisor, on the Monday after the incident happened, and the RN Supervisor apologized to him. He shared that he did accept the RN Supervisor's apology, shook his hand, but told the RN Supervisor that he did not believe his apology was sincere. Resident #1 discussed the conversation he had with the Ombudsman on 2/13/23, after meeting with the Interim Administrator, the Former AIT/Administrator, and the RN Supervisor, about not being satisfied with the results of the meeting. He revealed he went to Social Services, and she provided him with a copy of the grievance report and that Social Services had not discussed his grievance with him after he initially reported the incident to her. He shared that he was upset that the grievance report that showed the DON was active in the investigation process, and he was not satisfied with the information that had been recorded on the grievance report by Social Services. Resident #1 also revealed the meeting with the AIT, and RN Supervisor called with him after he had gotten upset and strongly expressed himself verbally, again, in the Social Services office after reading the information on the grievance form. Resident noted there were only Caucasian staff members in the meeting on 2/13/23, and he felt they had gotten together to force him to accept the RN Supervisor's apology. Resident #1 shared that he felt he could no longer trust the lead Caucasian staff and Social Services at the nursing facility. Resident #1 noted that none of the nursing facility

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staff tried to tell him how the incident was going to be handled, or to talk with him to check and see how was managing since it made him very upset. Resident #1 also noted he did not to talk about it anymore with the lead staff in the nursing facility. Resident #1 revealed he was having a harder time sleeping and was stressed with all the thoughts of his past being on his mind, most of his day, and there were no activities offered to help keep his mind occupied. Resident #1 also shared that several employees saw him while he was upset and no one attempted to comfort him, nor appeared to care about him being upset, and he no longer felt he was being protected.

An interview on 3/28/23 at 07:45 PM, with SS revealed she spoke with Resident #1 on 2/10/23 regarding the incident where the RN Supervisor called him a boy and his wanting to be moved to another nursing facility. SS revealed Resident #1 was still upset about the incident on 2/12/23, as he continually expressed his feelings about it, and how it bothered him. SS revealed she did not conduct follow up visits with Resident #1 to see how he was managing after the incident and was not aware he was having issues sleeping or was continually reliving traumatic moments from his past. She revealed she would ask him how he was doing when she saw him moving about the facility, and because he had a BIMS of 15, he could express to her if he had issues related to the incident. She noted she did not link him to any mental health services to assist him to work through the trauma. She revealed she had done a Trauma Informed Care Assessment for Resident #1 but did not review the questions with Resident #1 for the answers entered on the assessment.

An interview on 3/28/23 at 07:52 PM with RN

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Supervisor confirmed he did call Resident #1 a boy on 2/10/23. He revealed he was on the 2nd floor and saw Resident #1 coming off the elevator and Resident #1 is not normally on the 2nd floor. He noted he was being playful with Resident #1, patted Resident #1 on the shoulder, and stated "You are on the wrong floor boy." He confirmed that Resident #1 became furious with him, could not remember everything Resident #1 said, but did remember him expressing that he was a grown man with children older than the RN Supervisor and the RN Supervisor will not call him a boy. He also revealed when Resident #1 became as mad as he did, he realized what he had done by calling Resident #1 a boy, and knew it was wrong, but had said it without thinking about what it could mean to Resident #1. He noted could tell that Resident #1 was still not ready to talk with him by the way Resident #1 responded to each of the attempts by the RN Supervisor to talk to Resident #1. He revealed he was not aware that Resident #1 still had possible anxiety and loss of sleep due to the incident and had not talked to any other nursing staff to see if they had followed up on Resident #1.

An interview on 3/29/23 at 02:20 PM, with the Activities Director revealed she had not assessed Resident #1 for additional activities to assist to occupy his mind and help him work through his trauma. The Activities Director revealed that she was not aware of the incident with Resident #1 being called a boy by the RN Supervisor on 2/10/23.

An interview on 3/29/23 at 02:30 PM with the Assistant Activities Director, revealed she did not assess Resident #1 for additional options for activities to assist to occupy him related to trauma

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he experienced due to the incident from 2/10/23 of him being called a boy by the RN Supervisor.

An interview on 3/29/23 at 05:40 PM, with the DON revealed Resident #1 did not have an order to be assessed by psychiatry to be evaluated for possible psychiatric interventions to assist him to work through the trauma. She noted she was not aware that Resident #1 was still upset regarding the incident. She revealed there was skilled monitoring and documentation being done by the nurses after the incident with Resident #1 that happened on 2/10/23 but confirmed there was no specification that the documentation was skilled monitoring related to the incident.

An interview on 3/29/23 at 06:35 PM, with the Former AIT/Administrator revealed she did not agree that the incident should be related to Trauma Informed Care due to Resident #1 not initially expressing that his anger was related to a past trauma, and him only revealing he felt he should be respected by the RN Supervisor related to his age. She noted it was later that Resident #1 started to state that the incident caused him trauma and flashbacks of previous life events.

An interview on 3/30/23 at 10:35 PM, with the Administrator and the DON revealed both noting Resident #1 did not tell them or any staff members that he was still having derogatory feelings related to the incident of being called a boy on 2/10/23. They both confirmed that they did not address Resident #1 specifically about the incident after 2/10/23.

A telephone interview on 3/30/23 at 11:05 AM, with Licensed Practical Nurse (LPN) #1, revealed Resident #1 came to her several times on

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2/12/23 to talk about being upset regarding being called a boy by the RN Supervisor on a previous day.

A telephone interview on 3/30/23 at 11:41 AM, with Former Interim Administrator, revealed she had a meeting on 2/13/23 with Resident #1 and noted that he expressed why being called a boy by the RN Supervisor bothered him so badly. She revealed she did not follow up to ask Resident #1 how he was doing related to the incident. The Former Interim Administrator confirmed that Resident #1 should have received trauma informed care to avoid the possibility of psychosocial harm, and that the facility staff did not provide trauma informed care to Resident #1.

An interview on 3/30/23 at 01:20 PM, with the Care Plan Nurse revealed she was aware that Resident #1 had been called a boy by the RN Supervisor, because Resident #1 had come into her office area two (2) times, on 2/10/23, tearful and talking about the incident.

Record review of the "Departmental Notes" revealed there was no documentation that revealed Resident #1 received skilled monitoring from the nursing staff related to the incident of being called a boy on 2/10/23. The record review did reveal a nurse note from LPN #1, dated 2/12/2023, that revealed "RESIDENT C/O RN SUPERVISOR CALLING HIM A "BOY" THE OTHER DAY. RESIDENT STATED, "I CALLED MY FAMILY AND SHE TOLD ME NOT TO REQUEST TO MOVE, JUST REPORT IT."

Record review of the Incident Log revealed there was no incident report completed for the incident of Resident #1 being called a boy by the RN

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Supervisor on 2/10/23.

Record review of the nursing facility's in-services revealed an in-service for all nursing facility staff dated 10/19/22 titled "Phase 3 training Number 1 and 2 Quality of Care (Trauma Informed Care and Cultural Diversity)."

Record review of the "Physician Orders List" revealed no physician's orders for a referral to mental health services for Resident #1.

Record review of the "Care Plan" for Resident #1 revealed "Problem Onset: 2/10/2023 Resident stated he has a HX of trauma. Res. reported that he has encountered racism as a child and witnessed a Caucasian murder an African American which took an emotional effect on him. Certain words trigger flash backs. Example "boy" ... Social to visit as needed. Engage in activities of choice. Speak with a Mental health Therapist to verbalize my feelings. Consult Psych as needed."

Record review of documentation from the DON, with a Date of Occurrence of 2/10/23, for Resident #1, revealed " ... Details of Incident: On 2/10/23 at approximately 1030 AM (RN Supervisor's Name Removed) RN came to this nurse and (Interim Administrator's Name Removed) Administrator and stated he saw (Resident #1's Name Removed) getting off the elevator and stated "you're on the wrong floor boy". He stated he said this jokingly but could immediately see that (Resident #1's Name Removed) got upset. (RN Supervisor's Name Removed) states he apologized and came to the administrators office to report what happened. As soon as Administrator and DON met with (RN

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Supervisor's Name Removed), (Resident #1's Name Removed) was waiting to meet with this nurse. (Resident #1's Name Removed) was upset stating "that nurse called me a boy, that the same thing as calling me the N word." Resident got irate and said he was calling state and wanted to go to another facility. We discussed it was his right to call state but not to make a decision about going to another facility while he was upset. Encouraged resident that it was not meant in a derogatory way and again apologized. Resident calmed down and left the office. ... Findings: Incident did occur and was investigated and was not found to be racial or derogatory and was just conversation."

Record review of the Trauma Informed Care Assessments, dated 2/13/23 and 3/29/23, for Resident #1 revealed " ... For each event check one or more of the boxes to the right to indicate that: (a) it happened to you personally; (b) you witnessed it happen to someone else; (c) you learned about it happening to a close family member or close friend; (d) you were exposed to is as part of your job (for example, paramedic, police, military, or other first responder); (e) you're not sure if it fits; or (f) it doesn't apply to you. Be sure to consider your entire life (growing up as well as adulthood) as you go through the list of events. ... 2/13/23 ... Event: 2. Fire and explosion ... Doesn't Apply; ... 3/29/23 ... Event: Fire and explosion ... Witnessed it; ... 2/13/23 ... Event: Life-threatening illness or injury ... Doesn't apply; ... 3/29/23 ... Event: Life-threatening illness or injury ... Happened to me (COVID); ... 2/13/23 ... Briefly describe the worst even (for example, what happened, who was involved, etc.) ... (document revealed no response); ... 3/29/23 ... Briefly describe the worst event (for example,

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what happened, who was involved, etc.): Witnessed a homicide as a child-Res. stated he witnessed a white man murder a black woman; ... 2/13/23 ... How many times altogether have you experienced a similar event as stressful or nearly as stressful as the worst event?: Just once; ... 3/29/23 ... How many times altogether have you experienced a similar event as stressful or nearly as stressful as the worst event?: More than once (please specify or estimate the total number of times you have had this experience ___): lived on street, on drugs; ... Keeping your worst event in mine, please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month. ... 2/13/23 ... 1. Repeated, disturbing, and unwanted memories of the stressful experience? ... 1-A little bit; ... 3/29/23 ... 1. Repeated, disturbing, and unwanted memories of the stressful experience? ... 3-Quite a bit; ... 2/13/23 ... 3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)? ... 0-Not at all; ... 3/29/23 ... 3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)? ... 1-A little bit; ... 2/13/23 ... 4. Feeling very upset when something reminded you of the stressful experience?: ... 0-Not at all; ... 3/29/23 ... 4. Feeling very upset when something reminded you of the stressful experience? ... 1-A little bit; ... 2/13/23 ... 5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)? ... 0-Not at all; ... 3/29/23 ... 5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart

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pounding, trouble breathing, sweating)? ... 1-A little bit; ... 2/13/23 ... 6. Avoiding memories, thoughts, or feelings related to the stressful experience? ... 0-Not at all; ... 3/29/23 ... 6. Avoiding memories, thoughts, or feelings related to the stressful experience? ... 3-Quite a bit; ... 2/13/23 ... 7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)? ... 0-Not at all; ... 3/29/23 ... 7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)? ... 2-Moderately; ... 2/13/23 ... 11. Having strong negative feelings such as dear, horror, anger, guilt, or shame? ... 0-Not at all; ... 3/29/23 ... 11. Having strong negative feelings such as dear, horror, anger, guilt, or shame? ... 1-A little bit; ... 2/13/23 ... 12. Loss of interest in activities that you used to enjoy? ... 0-Not at all; ... 3/29/23 ... 12. Loss of interest in activities that you used to enjoy. ... 1-A little bit; ... 2/13/23 ... 13. Feeling distant or cut off form other people? ... 0-Not at all; ... 3/29/23 ... 13. Feeling distant or cut off from other people? ... 1-A little bit; ... 2/13/23 ... 15. Irritable behavior, angry outbursts, or acting aggressively? ... 0-Not at all; ... 3/29/23 ... 15. Irritable behavior, angry outbursts, or acting aggressively? ... 3-Quite a bit; ... 2/13/23 ... 17. Being "super alert" or watchful or on guard? ... Not at all; ... 3/29/23 ... 17. Being "super alert" or watchful or on guard? ... 4-Extremely; ... 2/13/23 ... 18. Feeling jumpy or easily startled? ... 0-Not at all; ... 3/29/23 ... 18. Feeling jumpy or easily startled? ... 1-A little bit; ... 2/13/23 ... 19. Having difficulty concentrating? ... 0-Not at all; ... 3/29/23 ... 19. Having difficulty concentrating? ... 1-A little bit; ... 20. Trouble falling or staying asleep? ... 0-Not at all; ... 3/29/23 ... 20. Trouble

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falling or staying asleep? ... 3-Quite a bit."

Record review of the "Life Experience Assessment," dated 12/1/21, for Resident #1, revealed "If you have had a troubling event in your lifetime or if you witnessed something that is troubling to you, please complete the areas below. ... Disturbing memories, dreams, thoughts, or images of a stressful experience? 1-Not at all; ... Do you struggle to find meaning, anger to God, giving up on your faith, or questioning lifetime beliefs? ... 1-Not at all; ... Suddenly acting or feeling as if the stressful situation were happening again? ... 1-Not at all; ... Feeling very upset when something reminds you of the stressful experience: ... 1-Not at all; ... do you fee fearfulness, anxiety, loneliness, helplessness but can't explain why? ... 1-Not at all; ... Do you feel apathy, isolation, have difficulty trusting, have thoughts of self-injury aggression because of a stressful situation? ... 1-Not at all."

Record review of documentation from the meeting for Resident #1, with no date and no staff signature, revealed " On February 13, 2023 (Interim Administrator's Name Removed), Administrator, and (Former AIT/Administrator's Name removed), RN met with (Resident #1's Name Removed) on incident that occurred on February 10/ 2023. (Resident #1's Name Removed) expressed how he felt about the nurse calling him a "boy". (Resident #1's Name Removed) stated this incident brought up old memories from his past where he witnessed a black lady being shot and how his whole hometown was prejudiced. The nurse was called down to meet with us with the permission from the resident. The resident stated his concerns with the statement of being called "boy" to the

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F 699	Continued From page 33 nurse." Record review of the Face Sheet for Resident #1 revealed an admission date of 12/1/21 and diagnoses that included Acquired Absence of Limb, Unspecified, and Unspecified Sequelae of Cerebral Infarction. Record review of Section C of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/8/2023, for Resident #1 revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating Resident #1 is cognitively intact.	F 699		