STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255142	A. BUILDING _____ B. WING _____	C 04/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OCEAN SPRINGS HEALTH & REHABILITATION CENTER	1199 OCEAN SPRINGS ROAD OCEAN SPRINGS, MS 39564

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted a Compliant Investigation (CI) at the facility for three (3) complaints, CI MS #20710, CI MS #20797, and CI MS #21326 from 4/17/23 through 4/19/23. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid. The SA investigated MS #20710 for verbal abuse and MS #21326 for water not being offered, resident assessment, and medications given per physician orders. There were no deficiencies cited related to these complaints. The SA investigated MS #20797 for verbal abuse and cited F600. The facility had a license for 110 beds, with a census of 100.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and facility	F 600	Responses to the cited deficiencies do	5/13/23

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

Electronically Signed | 05/03/2023

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F 600	Continued From page 1 policy review the facility failed to ensure residents were free from abuse for one (1) of four (4) sampled residents. Resident #1 Findings include: A review of the facility's policy, "Abuse, Neglect, Exploitation & Misappropriation", revised 11/16/22, revealed " ...Policy: It is inherent in the nature and dignity of each resident at the center that he/she be afforded basic human rights, including the right to be free from abuse, neglect, mistreatment ...Employees of the center are charged with a continuing obligation to treat residents so they are free from abuse, neglect, mistreatment ...No employee may at any time commit an act of physical, psychological, or emotional abuse ..." A record review of the facility's "Verification of Investigation" revealed, " ...On 2/18/23 at approximately 4:45 pm, (Proper Name of Resident #1) was upset, wanting a cup of coffee. He approached (Proper Name of Registered Nurse [RN] #1) yelling and asking why he couldn't get a cup of coffee ...(Proper Name of Certified Nurse Aide [CNA] #1) was walking by and approached them and began to talk with them ... (Proper Name of RN #1) while in the dining room heard yelling, went to the lobby area to see (Proper Name of Resident #1) and (Proper Name of CNA #1) exchanging words with each other ...Before (Proper Name of RN #1) could reach them, (Proper Name of CNA #1) and (Proper Name of Resident #1) both had a hold of his cane, neither wanting to let go of it ...(Proper Name of CNA #1) stated ..., "he tried to hit me, he tried to hit me and lost it" ...He tried to hit me with his cane and I tried to take it from him ..."	F 600	not constitute an admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Corrections is prepared solely as a matter of compliance with Federal and State Law. * On 2/18/23, a skin observation was completed by Director of Nursing on Resident #1 with no adverse findings noted. On 2/19/23, Resident #1 was evaluated by Psychiatric Nurse Practitioner for any potential psychosocial needs. The Director of Nursing suspended Proper Name of CNA #1 immediately, pending investigation on 2/18/23 and subsequently discharged Proper Name of CNA #1 from employment on 2/24/23. On 2/18/23, Registered Nurse Supervisor completed interviews of residents with a Brief Interview for Mental Status of 12 or greater with no negative findings noted. The Director of Nursing reported allegation of abuse for Resident #1 to State Agency on 2/18/23 at 9:58pm. *All residents have the potential to be affected by stated deficient practice. Registered Nurse Supervisor to complete three resident interviews to determine if any abuse and/or neglect has occurred weekly for three weeks, then monthly x three months starting on 4/24/23. *Initial in-service on Prevention of Abuse	

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F 600	Continued From page 2 A record review of the handwritten statement signed by RN #1, dated 2/18/23, revealed, " ...I then heard arguing when I got to the lobby the resident and (Proper Name of CNA #1) were arguing ...Next thing I knew, before I could get to them they both had their hands on his cane neither wanting to let go. (Proper Name of CNA #1) lifted him (Resident #1) off the bench with the cane and pulled him across the hallway to doorway of bathroom. I called the police immediately ..." Record review of a handwritten statement dated 2/18/23 from Resident #1 and taken by the Director of Nursing (DON) revealed, " ...Before dinner time, I went to the kitchen and asked for a cup of coffee. The kitchen staff told me they couldn't give any and that they weren't allowed to unless there was staff in the dining room. I got upset and did yell at them. There were 5 people in the dining room with coffee cups in front of them so I don't know why I couldn't have any coffee ...I spoke to a nurse and a CNA that said they would get me some. Then this lady approached me in the lobby, she was a CNA. She told me my mother was a whore. We did have words back and forth. I raised my cane in front of my face and she grabbed it. I wasn't letting go of it. Its my cane. We tussled with the cane across to the other side of the hall. She let go and I got it back. I did tell her "don't' disrespect me, I'm 62 years old" ...She went outside, then the policeman came and talked to me. She didn't hurt me or anything. She just disrespected me ..." On 4/17/23 at 7:49 AM, an interview with RN #1 revealed that on 2/18/23 at 5:06 PM, Resident #1	F 600	and Neglect was initiated on 2/18/23 by the Director of Nursing and completed on 2/24/23. Additional all staff in-service on Prevention of Abuse and Neglect and Strategies for Dealing with Challenging Behaviors began on 4/21/23 by Registered Nurse Educator and was completed on 5/1/23. * Registered Nurse Supervisor to complete three resident interviews to determine if any abuse and/or neglect has occurred weekly for three weeks, then monthly x three months starting on 4/24/23. Findings will be brought to the Quality Assurance Performance Improvement meeting by Administrator on 5/12/23 and and will be continued monthly for three months to determine effectiveness and make necessary changes as indicated.	

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F 600	Continued From page 3	F 600		

was upset initially because the kitchen staff would not provide him with coffee. RN #1 stated she immediately went and got him a cup of coffee and he seemed to calm down. She said she then heard CNA #1 tell Resident #1, "The kitchen does not work for you" and they started arguing with each other. CNA #1 grabbed the resident's cane, and they began struggling over it. RN #1 explained that she brought Resident #1 into the dining room to calm him down. She said she then called 911 because she was scared and it bothered her, and she also notified the DON.

On 4/17/23 at 8:15 AM, an interview with the Director of Nursing (DON) revealed she was aware of the event that occurred on 2/18/23 regarding Resident #1 and CNA #1. She explained that CNA #1 was immediately suspended, pending the investigation. Following the investigation, the CNA was subsequently terminated from employment on 2/24/23 for violation of the facility policy regarding unprofessional conduct. The DON stated that she expected the staff in the facility to not get in any type of verbal altercation with a resident.

On 4/17/23 at 10:08 AM, an interview with RN #2 confirmed that on 2/18/23, she heard CNA #1 and Resident #1 yelling at each other. She explained that Resident #1 was using racial slurs, and CNA #1 yelled at him. She said the incident lasted almost 15 minutes. When the police arrived at the facility, then the resident and CNA #1 calmed down and CNA #1 clocked out.

On 4/18/23 at 12:00 PM, an interview with the Administrator revealed that it was her expectation for staff at the facility not to get into any type of verbal altercation with any resident. She stated it

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F 600	Continued From page 4 is the facility policy to treat all residents with respect and dignity and that Resident #1 may have insulted CNA #1, but staff should not engage in any type of verbal altercation with residents. The Administrator advised that she was notified following the incident, and CNA #1 was immediately suspended pending investigation and was terminated. Record review of the "Admission Record" revealed Resident #1 was admitted by the facility on 1/31/22 and had diagnoses including Type 2 Diabetes Mellitus without Complications and Bipolar Disorder. Record review of the facility's " ...BIMS (Brief Interview for Mental Status) " document, dated 4/6/23, revealed Resident #1 was cognitively intact.	F 600		