STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255227	A. BUILDING _____ B. WING _____	C 06/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLUMBIA REHABILITATION AND HEALTHCARE CENTER	1506 NORTH MAIN STREET COLUMBIA, MS 39429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted a Complaint Investigation (CI),MS #21746 at the facility for Quality of Care related to staffing and incontinence care and Resident Abuse and Resident Rights related to dignity. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid and cited F 550. At the time of the survey the facility was licensed for 80 beds had a census of 70 residents.	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 provision of services under the State plan for all residents regardless of payment source.	F 550		8/7/23

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

Electronically Signed | 07/06/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255227	A. BUILDING _____ B. WING _____	C 06/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLUMBIA REHABILITATION AND HEALTHCARE CENTER	1506 NORTH MAIN STREET COLUMBIA, MS 39429

(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 550	Continued From page 1 §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 observations, interviews, record review, and facility document review, the facility failed to protect the right of each resident to be treated with respect and dignity for one (1) resident of four (4) sampled residents, Resident #1. Findings include: Record review of the facility document titled "Statement of Resident Rights," (undated) revealed, "You ...the resident, do not give up any rights when you enter a nursing facility. The facility must encourage and assist you to fully exercise your rights ...If anyone ...violates your dignity, you have the right to file a complaint ...You have a right to ...be treated with courtesy, consideration, and respect ..." On 6/16/23 at 11:10 AM, during an interview with the Administrator, he stated that a copy of	F 550	Preparation and submission of this plan of correction by The Columbia Rehabilitation and Healthcare Center does not constitute and admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely pursuant to the requirement under the state and federal laws. 1. On 6/02/2023 at approximately 10 AM Resident #1 voiced a complaint against Certified Nursing Assistant (CNA) #1 alleging that CNA #1 had acted with rudeness and discourtesy. Resident#1 was protected by the immediate removal of CNA #1 from the work area and suspended her pending investigation. Life satisfaction rounds for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255227	A. BUILDING _____ B. WING _____	C 06/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLUMBIA REHABILITATION AND HEALTHCARE CENTER	1506 NORTH MAIN STREET COLUMBIA, MS 39429

(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 550	Continued From page 2 "Statement of Resident Rights" was included in all admission packets and provided to each resident admitted by the facility. Record review of the facility's investigation dated 6/02/23, revealed an interview with Resident #1 by the Administrator in which Resident #1 stated that CNA #1 had been "disrespectful" during care and "had a tone and attitude that was unnecessary". The facility's investigation concluded that CNA #1 "will not return to facility due to customer service." Record review of the Daily Staffing Sheet for "B Wing" dated 6/02/23, revealed that on the date of the incident, CNA #1 was assigned to seven (7) rooms, including that of Resident #1 for the 7AM-7PM shift. The sheet also documented the removal/replacement of CNA #1 with the "Shower Team" CNA. Record review of the Timeclock Record for CNA #1 for 5/25/23 through 6/07/23, revealed she clocked in at 6:40 AM on 6/02/23, and clocked out at 10:36 AM. Record review of the Admission Record for Resident #1 revealed they were admitted by the facility on 5/19/23 and had diagnoses of Malignant Neoplasm of the Breast (Left Breast Cancer), Atrial Fibrillation and End State Renal Disease. Record review of the Admission Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 5/26/23, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated no cognitive impairment. Further MDS review revealed that Resident #1	F 550	all other residents with a Brief Interview for Mental Status (BIMS) of 13 or higher in the care of CNA #1 were interviewed for complaints of rudeness and or discourtesy on 6/02/2023. No complaints were voiced. 2. All residents are at risk for the deficient practice. 3. All staff were in-serviced on Resident Right's, Customer Service, and The Vulnerable Adult Act on 6/02/2023 by Risk Manager. Also a mandatory staff meeting was held on 6/21/2023 at 1:30 PM, presented by Administrator. Topics included: The Vulnerable Adult Act, Customer Service, and the Residents Rights. CNA #1 was terminated 6/08/2023. Along with the education piece to prevent reoccurrence, Nexion Neighbor Rounds conducted daily, will be modified to include: Resident's feedback on Customer Service and courtesy beginning 6/07/2023. 4. The facility will monitor the progress of the monitoring modifications by bringing the results of the Nexion Neighbor Rounds to daily Stand Up Meetings beginning 7/03/23 and ongoing, to discuss any findings. All results will be taken to Quality Assurance/ Quality Assurance and Performance Improvement, (QA/QAPI), for four weeks with the completion date of 8/07/2023. A final QA/QAPI meeting will be held on 8/07/2023 to review progress and conclude our monitoring process. 5. Corrective action will be completed by:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255227	A. BUILDING _____ B. WING _____	C 06/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLUMBIA REHABILITATION AND HEALTHCARE CENTER	1506 NORTH MAIN STREET COLUMBIA, MS 39429

(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 550	Continued From page 3	F 550		

required limited assistance of one-person physical assistance for surface-to-surface transfers and extensive assistance of one-person physical assistance for toilet use and personal hygiene.

On 6/16/23 at 10:11 AM, a telephone interview with the facility Ombudsman revealed that she had been made aware of a grievance voiced by Resident #1 regarding "disrespectful treatment by a CNA."

On 6/16/23 at 10:51 AM, during a telephone interview, CNA #1 discussed the care she provided for Resident #1 on 6/02/23 and denied any disrespect or resident rights violations. She confirmed she was asked to report to the front office on 6/02/23, "a little after 10:00 AM". She stated she was notified of a complaint regarding her and she was asked to write a statement regarding the interaction between herself and Resident #1, that took place on 6/02/23. She confirmed that she was asked to leave the premises. She confirmed she was not scheduled to return and that she had been notified by the Director of Nurses (DON) that her employment at the facility had been terminated.

On 6/16/23 at 11:20 AM, during an interview with Resident #1, she stated that she recalled the morning of 6/02/23 when CNA #1 was assigned to her care. She stated that CNA #1 "was really rude." Resident #1 stated that she had an episode of diarrhea on the morning of 6/02/23 and engaged her call light for assistance. She stated that CNA #1 was rude when she offered the option of wearing an incontinence brief and stated, "I did not have a problem wearing a diaper (incontinent brief), but the CNA was bossy and

8/07/2023.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255227	A. BUILDING _____ B. WING _____	C 06/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLUMBIA REHABILITATION AND HEALTHCARE CENTER	1506 NORTH MAIN STREET COLUMBIA, MS 39429

(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 550	Continued From page 4	F 550		

rude and told me that she did not intend to keep coming in here to change me." She confirmed that after CNA #1 cleaned her and her wheelchair, she cleaned the bedside commode, and when trying to replace the bucket beneath the seat the CNA "shoved the potty against the wall and tossed the bucket on the floor." Resident #1 stated she had then gone to therapy, where she reported the "rude behavior" to the therapists. She stated that CNA #1 "needs compassion." She reported, "She wasn't abusive toward me." She stated that CNA #1's attitude had caused her concern and stated, "I thought I should report it because I didn't want her taking care of me again. I didn't want her in my room again. I was concerned about how she might be if she got worse."

On 6/16/23 at 12:20 PM, an interview with the Rehabilitation Technician, she revealed that she recalled that she had gone to assist Resident #1 to the therapy department on the morning of 6/02/23 and that Resident #1 had reported to her that CNA #1 had been "rude" during care the same morning. She stated that she had immediately taken Resident #1 to the Rehabilitation Director and asked Resident #1 to repeat her concern.

On 6/16/23 at 12:30 PM, an interview with the Rehabilitation Director revealed that she recalled that on the morning of 6/02/23, the Rehabilitation Technician had brought Resident #1 to her, and that Resident #1 had reported an incident during care provided by CNA #1. She stated, "I immediately called the Registered Nurse (RN) Supervisor, and she came to therapy and she (Resident #1) reported what had happened to the RN Supervisor." She stated that she recalled

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255227	A. BUILDING _____ B. WING _____	C 06/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLUMBIA REHABILITATION AND HEALTHCARE CENTER	1506 NORTH MAIN STREET COLUMBIA, MS 39429

(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 550	Continued From page 5	F 550		

Resident #1 saying that CNA #1 "had been rude and had slammed the potty chair against the wall". She stated that Resident #1 required one-person physical assistance to stand, for surface-to-surface transfers and for other activities of daily living (ADLs), but that she was also able to participate in ADLs.

On 6/16/23 at 12:45 PM, an interview with the RN Supervisor revealed that she recalled that she had supervised "B Hall" on 6/02/23. She stated she became aware of the report by Resident #1 "between 9:30 AM and 10:00 AM," when the Rehabilitation Director summoned her to the Therapy Department. She stated that Resident #1 described the behavior of CNA #1 as "rude" and had "forcefully pushed the bedside potty against the wall" and that she (RN Supervisor) had immediately notified the Risk Manager, Social Worker, and the Staff Development Nurse, because the Administrator and the Director of Nurses (DON) were unavailable at the time.

On 6/16/23 at 1:00 PM, an interview with the Risk Manager revealed she had been made aware of the incident on 6/02/23 at approximately 9:30 AM, by verbal report from the RN Supervisor. She said she immediately assessed and interviewed Resident #1 and was told that CNA #1 had been "rude" and had "tossed the bedside commode pot on the floor out of frustration." She stated she spoke with the Staff Development Nurse shortly after speaking with Resident #1 and made sure that CNA #1 had been removed from the facility to ensure the safety of the residents. She confirmed she had conducted "Life Satisfaction Rounds with residents on B Hall with BIMS of 12 or higher," with no complaints noted. She stated she had conducted "Peer Review" interviews with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255227	A. BUILDING _____ B. WING _____	C 06/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLUMBIA REHABILITATION AND HEALTHCARE CENTER	1506 NORTH MAIN STREET COLUMBIA, MS 39429

(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 550	Continued From page 6	F 550		

staff who had worked with CNA #1 and there were no concerns reported. She confirmed that she had reviewed the personnel file for CNA #1 and there were no disciplinary reports in CNA #1's personnel file.

On 6/16/23 at 1:20 PM, an interview with the Social Worker revealed she had been made aware of the incident on 6/02/23 "around 9:30 AM" by verbal report from the RN Supervisor and had conducted an interview with Resident #1 who reported that CNA #1 had been "gruff with her" during care that morning. The Social Worker stated that the resident preferred that CNA #1 not provide care for her anymore and said that CNA #1 made her feel "uncomfortable."

On 6/16/23 at 1:50 PM, an interview with the Staff Development Nurse revealed she had been made aware of the incident on 6/02/23 at approximately 9:30 AM by verbal report from the RN Supervisor and had immediately summoned CNA #1 to her office and at 10:18 AM on 5/02/23, conducted an interview with CNA #1, obtained a written statement, and notified the CNA that she was suspended pending investigation and needed to leave the premises.

On 6/16/23 at 2:10 PM, an interview with Licensed Practical Nurse (LPN) #1 revealed he stated he recalled being assigned as the primary care nurse for residents "on the 200 Hall", which included Resident #1, on 6/02/23. He stated that he was made aware of the incident on at approximately 10:30 AM on 6/02/23, by the facility Risk Manager. He confirmed that the facility provided mandatory in-service training on Resident Rights on 6/02/23.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255227	A. BUILDING _____ B. WING _____	C 06/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLUMBIA REHABILITATION AND HEALTHCARE CENTER	1506 NORTH MAIN STREET COLUMBIA, MS 39429

(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 550	Continued From page 7	F 550		

On 6/16/23 at 4:00 PM, an interview with the Director of Nurses (DON) revealed she was made aware of the incident on 6/02/23 "shortly after 9:30 AM." She stated that she was familiar with Resident #1 and her care. She stated that Resident #1 had not displayed any behavior of making false accusations. She stated that she considered Resident #1 a reliable witness. She stated that following completion of the Facility Investigation, CNA #1 was issued a notice of termination due to "Unsatisfactory Performance." She stated that Resident #1 had alleged that CNA #1 was "rude" and "made her uncomfortable" and that was not in line with facility standards or Resident Rights. She stated that the facility conducted a mandatory in-service for all staff, including contract staff, on Resident Rights on 6/02/23 and that no staff were allowed to provide care without completion of the in-service.

On 6/16/23 at 4:15 PM an interview with CNA #2 revealed that she confirmed that the facility provided mandatory In-Service training on Resident Rights on 6/02/23. She stated that the facility provided In-Service training on Resident Rights monthly and as needed. Regarding Resident Rights, she stated that she had received training from the facility that residents were to be "treated with courteously and respect" at all times.

On 6/16/23 at 4:25 PM, an interview with CNA #3 revealed that she confirmed that the facility provided mandatory In-Service training on Resident Rights on 6/02/23. She stated that the facility provided In-Service training on Resident Rights monthly and as needed. Regarding Resident Rights, she stated that she had received training from the facility that residents were to be "treated with courteously and respect" at all times.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255227	A. BUILDING _____ B. WING _____	C 06/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLUMBIA REHABILITATION AND HEALTHCARE CENTER	1506 NORTH MAIN STREET COLUMBIA, MS 39429

(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 550	Continued From page 8	F 550		

She confirmed that the facility provided mandatory In-Service training on Resident Rights on 6/02/23.

On 6/16/23 at 4:50 PM, an interview with the Administrator revealed he had been made aware of the incident on 6/02/23, between 9:30 AM and 10:00 AM. He stated that he was the Abuse Prevention Officer at the facility and had interviewed Resident #1 on 6/02/23, and that the resident denied abuse but reported that CNA #1 was "rude," and he confirmed that the resident said CNA #1 had made her uncomfortable. He stated that Resident #1 stated she felt safe at the facility but did not want CNA #1 to provide care for her anymore. He confirmed that CNA #1 had been suspended on 6/02/23 and terminated on 6/03/23 and had not worked at the facility following the report of Resident #1. He confirmed the complaint was reported to State Agency (SA) and other appropriate agencies on 6/02/23, with conclusion of the Facility Investigation reported on 6/04/23, in accordance with reporting requirements. He stated that the facility conducted a mandatory In-Service for all staff, including contract staff, on Resident Rights on 6/02/23, and that no staff were allowed to provide care without completion of the in-service. He confirmed that the facility Quality Assurance and Performance Improvement (QAPI) Committee had not met since the incident, but that the incident had been placed on the agenda for the next QAPI Committee meeting.