STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CRYSTAL REHABILITATION AND HEALTHCARE CENT	902 SGT JOHN A PITTMAN DRIVE GREENWOOD, MS 38930

(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) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) conducted a complaint investigation CI MS# 22670 at the facility from 9/12/23 through 9/14/23. During the survey, the SA determined that the facility was not in compliance with Mississippi Regulations for Minimum Standards for Institutions for the Aged or Infirm and cited a deficiency at M 500. The census at the time of the survey was 82 with a bed capacity of 110 beds.	M 000		
M 500 SS=D	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his	M 500		10/16/23

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M 500	Continued From page 1	M 500		

medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action;

4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record;

5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal;

6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the

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M 500	Continued From page 2	M 500		

facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law;

7. is free from mental and physical abuse;
8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint;
9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract;

10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs;

11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care;

12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail

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M 500	Continued From page 3 unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Based on staff interviews, resident interview, facility policy review, and record review, the facility failed to ensure residents were free from abuse/neglect, as evidenced by a Certified Nursing Assistant (CNA) not performing needed hygiene care, being rough during care and	M 500	Preparation and Submission of this plan of correction by Crystal Rehabilitation and Healthcare Center does not constitute an admission or agreement by the provider of the truths of the facts alleged or the correctness of the conclusion set forth on	

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M 500	Continued From page 4 cursing around residents, for four (4) of 10 residents that were provided care by CNA #5. Resident #1, Resident #2, Resident #3, and Resident #4. Findings include: Review of the facility policy titled "Abuse Prohibition Policy," with a review date of 3-2023, revealed "INTENT: This protocol was intended to assist in the prevention of abuse, neglect ... Each resident has the right to be free from abuse, mistreatment, neglect ... POLICY: 1. The facility will prohibit neglect, mental or physical abuse..." Record review of the "Investigation Summary" revealed "This is a written investigation summary to follow up on an allegation reported 08/27/2023 ...Resident Statement of Events &/or Timeline of Events: On 08/27/2023, LPN #1 (Formal Name) alleged that she witnessed (Formal Name) CNA #5 being aggressive and rude to (Formal Name) Resident #3 while providing care. LPN #1 also alleged that CNA #5 failed to provide incontinent care to Resident #2 (Formal Name) as directed. CNA #5 has been suspended pending investigation ...LPN #1 alleged an altercation between Resident #1 and CNA #5 ...Upon investigation (Formal Name) CNA #2 alleged that she witnessed CNA #5 use profanity and speak demanding to Resident (Formal Name) #4 ... In conclusion, the center is able to substantiate the allegations of Abuse/Neglect. CNA (Formal Name) #5 employment was terminated ..." An interview on 9/12/23 at 03:09 PM, with CNA #1 revealed on 8/23/23 one (1) of the nurses kept sending for CNA #5 to come and clean Resident #2 because he was constantly having loose stools, that had spilled over his bed, the floor, and	M 500	this statement of deficiencies. The plan of correction is prepared and submitted solely pursuant to the requirements under state and federal laws. The following measures for impacted residents were implemented: Residents #1, #2, #3 and #4 were immediately assessed on 08/27/2023 by Registered Nurse. Assessments revealed no injuries or adverse effects. On 08/27/2023, CNA 5 was called for interview and statement of incident by Director of Nursing. CNA 5 was suspended at this time pending investigation and ultimately terminated on 08/27/2023. 82 residents had the potential to be affected by this deficient practice. On 08/27/2023, Staffing Development Coordinator initiated education for all staff regarding Abuse, Neglect, Resident Rights and Vulnerable Adult Act. On 09/01/2023, Assistant Director of Nursing initiated abuse testing to ensure competency. Beginning 09/29/2023, the facility will conduct a monthly abuse drill for 3 months and then quarterly to ensure staff capability and comprehension. After the incident, beginning 09/01/2023,	

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M 500	Continued From page 5 his wheelchair. CNA #1 also revealed CNA #5 was exhibiting behaviors of being very frustrated and angrily voicing, "I just cleaned him up." CNA #1 noted she was in the breakroom with CNA #5 and revealed she heard CNA #5 mention that Resident #1 had called on the call light requesting for his brief to be changed, but CNA #5 revealed she told Resident #1 he had to wait until she came back from lunch. CNA #5 revealed she had attended Abuse/Neglect in-services and had been told what suspected abuse/neglect was, and that residents are not to be abused/neglected. An interview on 9/12/23 at 03:21 PM, with CNA #2 revealed CNA #5 appeared to be very upset and appeared to be very frustrated on the evening of 8/26/23. She noted she assisted CNA #5 with incontinent care for Resident #4. CNA #2 revealed she asked CNA #5 to roll Resident #4 over so another pad could be placed under him, when CNA #5 quickly grabbed Resident #4 under his upper back and the bend of his knees, and aggressively snatched him up off the bed, forcing him in a cradled, fetal position, in her arms. CNA #2 revealed the action of CNA #5 alarmed her and she was scared the action could be harmful to Resident #4. She revealed she did ask CNA #5, "What the hell are you doing picking the resident up and being that rough?" She noted she could not recall word for word what CNA #5 said but did remember the first part of her statement was "He need to bring his ugly ass." CNA #2 revealed she had attended Abuse/Neglect in-services and was aware the staff were to keep the residents free from abuse/neglect. An interview on 9/12/23 at 03:48 PM with CNA #4 revealed she helped CNA #5 provide incontinent care on 8/26/23 for Resident #2 who had several loose stools, during the shift and had gotten it on	M 500	the Nursing Home Administrator, Director of Nursing and Social Services Director began audit grievance and incident reports weekly time 4 weeks, biweekly twice a month and monthly x 2 months to ensure compliance. Any negative findings will be submitted to the Quality Assurance and Performance Committee (QAPI). Beginning 09/29/2023, QAPI Committee will review potential trends, patterns and provide recommendations X 4 months.	

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several surfaces in the room and himself each time. She revealed she noticed CNA #5 was very upset and cursing in the room with Resident #2 and Resident #3 saying, "I am sick of this shit. This shit don't make no sense." CNA #4 shared that CNA #5 appeared to be upset and came back into the room with Resident #2 and Resident #3 each time saying, "I am sick of the shit," and both residents were awake. CNA #4 revealed she left CNA #5 in Resident #2's and Resident #3's room to clean up the bowel that had spilled on the floor and Resident #2's wheelchair. CNA #4 noted she was trying to help CNA #5 to not get in trouble, and she knew cursing around the residents was considered mistreatment of the residents. CNA #4 also revealed she had attended in-services on Abuse/Neglect, knew the residents were to be free of abuse/neglect.

An interview on 9/12/23 at 04:04 PM with Licensed Practical Nurse (LPN) #2, revealed she was informed by LPN #1, near the end of 3-11 shift for the CNAs, that CNA #5 had been told two (2) times, by LPN #1, to go back and provide additional incontinent care to Resident #2 and to clean the bowel up off his floor and wheelchair. LPN #2 revealed she went to Resident #2's room and observed him in the wheelchair with bowel running out of one of the leg holes of his brief, onto the wheelchair and the floor. LPN #2 noted she did ask CNA #5 to go back to provide incontinent care and to clean the bowel off the floor and wheelchair for Resident #2, before she ended her shift. She instructed CNA #5 that it was neglectful to leave the bowel on Resident #2, and that it was neglectful to not clean the bowel from his floor and wheelchair. LPN #2 noted CNA #5 revealed she had just checked him at the end of shift rounds, that he was not soiled, that she had been busy all night, and was not going back to

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clean him up. She also noted that CNA #5 clocked out and left the nursing facility. She revealed she had attended Abuse/Neglect in-services and knew the residents had the right to be free of abuse/neglect.

A telephone interview on 9/12/23 at 04:12 PM, with LPN #1 revealed CNA #5 asked her to assist with the care for Resident #3, because he grabs a hold of whoever assisted with his care or held onto the bed rails often during care. LPN #1 noted Resident #3 was turned facing her holding onto the bedrail, and CNA #5 snatched his arms to make Resident #3 release the bed rail as she jerked him towards her to turn him over to face her. She further shared CNA #5 was moving fast with providing Resident #3's care and did not appear to be gentle when she was pulling on him to move him around in the bed. LPN #1 revealed she did not say anything to CNA #5 about being aggressive with moving Resident #3, was not sure if it was abusive behavior towards Resident #3 from CNA #5 but shared that it made her feel uncomfortable. She noted she observed bowel on the floor and on the wheelchair for Resident #2, and asked CNA #5 who was responsible to clean it up. She revealed CNA #5 told her she did not know who was supposed to clean it up, but she was not going to be the one to clean it up. LPN #1 also shared that she did tell LPN #2 about CNA #5's behavior towards Resident #3, and about CNA #5 needing to clean the bowel up from Resident #2's and Resident #3's floor. LPN #1 noted she did attend an Abuse/Neglect in-service but could not remember all what was said in the in-services about abuse. She shared that she did not feel the incident between CNA #5 and Resident #3 was suspected abuse because Resident #2 was not punched by CNA #5.

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M 500	Continued From page 8 An interview on 9/12/23 at 4:20 PM, with Resident #1 revealed he had called over the call system one night for the assistance to have his brief changed because he had a bowel movement. He also revealed his CNA did come to his room that night, told him he had to sit and wait until she came off lunch break, and revealed the CNA never came back to his room to clean him up. He noted he could not remember her name or how long he waited for her. Resident #1 also noted he had to wait to be changed by one of the CNAs that came to work on the next shift. Resident #1 voiced, "Being treated that way made me feel shitty and made me feel bad." An interview on 9/14/23 at 10:10 AM, with the Director of Nursing (DON), confirmed the nurses and the CNAs, including CNA #5, had been in-serviced on the Abuse/Neglect policy and were aware that residents of the nursing facility were to be kept free of abuse and neglect. She confirmed that Resident #1, Resident #2, Resident #3, and Resident #4 were not kept free of abuse/neglect by the nursing facility staff. An interview on 9/14/23 at 10:30 AM, with the Administrator confirmed the nursing facility failed to keep Resident #1, Resident #2, Resident #3, and Resident #4 free from abuse/neglect. The Administrator also confirmed, through facility investigation, the nursing facility was not in compliance with the allegations of abuse/neglect by a CNA on 8/26/23 for Resident #1, Resident #2, Resident #3, and Resident #4. Record review of the nursing facility in-services revealed "Abuse and Neglect," dated 07/12/23; "Abuse Neglect Vulnerable Adult Patient Rights," dated 7/13/23; "Elderly Care Acts/Abuse and Neglect," dated 7/20/23; "Abuse and Neglect,	M 500		

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Reporting Abuse," date 8/9/2023; "Abuse Neglect, Patient Rights," dated 8/11/23; and "Abuse Neglect, Resident Rights," dated 8/28/23.

Record review of the Personnel Record for the CNA#5 revealed the last day worked was 8/26/23, the date of the alleged incident of abuse and neglect and was terminated on 9/1/23.

Record review of the Admission Record for Resident #1 revealed an admission date of 07/08/2023 with diagnoses of Functional Quadriplegia and Unspecified Focal Trauma Brain Injury Without Loss of Consciousness, Sequela.

Record review of a Minimum Data Set (MDS) with an Assessment Reference Date of 9/1/23 with a Brief Interview For Mental Status (BIMS), for Resident #1, revealed a score of 7, indicating Resident #1 is moderately cognitively impaired.

Record review of the Admission Record for Resident #2 revealed an admission date of 03/03/2023 with diagnoses of Hemiplegia and Hemiparesis Following Nontraumatic Intracerebral Hemorrhage Affecting Right Dominant Side, Dysphagia Following Cerebral Infarction, and Aphasia Following Cerebral Infarction.

Record review of Section C of a Minimum Data Set (MDS) Admission Assessment, with an Assessment Reference Date (ARD) of August 28, 2023, for Resident #2, revealed a BIMS score of 99, indicating Resident #2 is severely cognitively impaired.

Record review of the Admission Record for

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M 500	Continued From page 10 Resident #3 revealed an admission date of 05/25/2022 with diagnoses of Unspecified Dementia, Unspecified Severity, With Other Behavioral Disturbance, Other Sequelae of Cerebral Infarction, and Transient Cerebral Ischemic Attack, Unspecified. Record review of Section C of a Quarterly MDS Assessment, with an ARD of August 23, 2023, for Resident #3, revealed a BIMS score of 03, indicating Resident #3 is severely cognitively impaired. Record review of the Admission Record for Resident #4 revealed an admission date of 08/15/2023 with diagnoses of Acute and Chronic Respiratory Failure, Unspecified Whether With Hypoxia or Hypercapnia, Encounter for Attention to Tracheostomy, Dysphagia Following Cerebral Infarction, and Unspecified Sequelae of Cerebral Infarction. Record review of Section C of a 5-Day MDS Assessment, with an ARD of August 22, 2023, for Resident #4, revealed "C0100. Should Brief Interview for Mental Status (C0200-C0500) be Conducted? ... Enter Code: 0; 0. No (resident is rarely/never understood). The record review did not reveal a BIMS score. Level II	M 500		

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Based on staff interviews, resident interview, facility policy review, and record review, the facility failed to ensure residents were free from abuse/neglect, as evidenced by a Certified Nursing Assistant (CNA) not performing needed hygiene care, being rough during care and cursing around residents, for four (4) of 10 residents that were provided care by CNA #5. Resident #1, Resident #2, Resident #3, and Resident #4.

Findings include:

Review of the facility policy titled "Abuse Prohibition Policy," with a review date of 3-2023, revealed "INTENT: This protocol was intended to assist in the prevention of abuse, neglect ... Each resident has the right to be free from abuse, mistreatment, neglect ... POLICY: 1. The facility will prohibit neglect, mental or physical abuse..."

Record review of the "Investigation Summary" revealed "This is a written investigation summary to follow up on an allegation reported 08/27/2023 ...Resident Statement of Events &/or Timeline of Events: On 08/27/2023, LPN #1 (Formal Name) alleged that she witnessed (Formal Name) CNA #5 being aggressive and rude to (Formal Name) Resident #3 while providing care. LPN #1 also alleged that CNA #5 failed to provide incontinent care to Resident #2 (Formal Name) as directed. CNA #5 has been suspended pending investigation ...LPN #1 alleged an altercation between Resident #1 and CNA #5 ...Upon investigation (Formal Name) CNA #2 alleged that she witnessed CNA #5 use profanity and speak demanding to Resident (Formal Name) #4 ... In

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CRYSTAL REHABILITATION AND HEALTHCARE CENT	902 SGT JOHN A PITTMAN DRIVE GREENWOOD, MS 38930

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conclusion, the center is able to substantiate the allegations of Abuse/Neglect. CNA (Formal Name) #5 employment was terminated ..."

An interview on 9/12/23 at 03:09 PM, with CNA #1 revealed on 8/23/23 one (1) of the nurses kept sending for CNA #5 to come and clean Resident #2 because he was constantly having loose stools, that had spilled over his bed, the floor, and his wheelchair. CNA #1 also revealed CNA #5 was exhibiting behaviors of being very frustrated and angrily voicing, "I just cleaned him up." CNA #1 noted she was in the breakroom with CNA #5 and revealed she heard CNA #5 mention that Resident #1 had called on the call light requesting for his brief to be changed, but CNA #5 revealed she told Resident #1 he had to wait until she came back from lunch. CNA #5 revealed she had attended Abuse/Neglect in-services and had been told what suspected abuse/neglect was, and that residents are not to be abused/neglected.

An interview on 9/12/23 at 03:21 PM, with CNA #2 revealed CNA #5 appeared to be very upset and appeared to be very frustrated on the evening of 8/26/23. She noted she assisted CNA #5 with incontinent care for Resident #4. CNA #2 revealed she asked CNA #5 to roll Resident #4 over so another pad could be placed under him, when CNA #5 quickly grabbed Resident #4 under his upper back and the bend of his knees, and aggressively snatched him up off the bed, forcing him in a cradled, fetal position, in her arms. CNA #2 revealed the action of CNA #5 alarmed her and she was scared the action could be harmful to Resident #4. She revealed she did ask CNA #5, "What the hell are you doing picking the resident up and being that rough?" She noted she could not recall word for word what CNA #5 said but did remember the first part of her statement

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was "He need to bring his ugly ass." CNA #2 revealed she had attended Abuse/Neglect in-services and was aware the staff were to keep the residents free from abuse/neglect.

An interview on 9/12/23 at 03:48 PM with CNA #4 revealed she helped CNA #5 provide incontinent care on 8/26/23 for Resident #2 who had several loose stools, during the shift and had gotten it on several surfaces in the room and himself each time. She revealed she noticed CNA #5 was very upset and cursing in the room with Resident #2 and Resident #3 saying, "I am sick of this shit. This shit don't make no sense." CNA #4 shared that CNA #5 appeared to be upset and came back into the room with Resident #2 and Resident #3 each time saying, "I am sick of the shit," and both residents were awake. CNA #4 revealed she left CNA #5 in Resident #2's and Resident #3's room to clean up the bowel that had spilled on the floor and Resident #2's wheelchair. CNA #4 noted she was trying to help CNA #5 to not get in trouble, and she knew cursing around the residents was considered mistreatment of the residents. CNA #4 also revealed she had attended in-services on Abuse/Neglect, knew the residents were to be free of abuse/neglect.

An interview on 9/12/23 at 04:04 PM with Licensed Practical Nurse (LPN) #2, revealed she was informed by LPN #1, near the end of 3-11 shift for the CNAs, that CNA #5 had been told two (2) times, by LPN #1, to go back and provide additional incontinent care to Resident #2 and to clean the bowel up off his floor and wheelchair. LPN #2 revealed she went to Resident #2's room and observed him in the wheelchair with bowel running out of one of the leg holes of his brief, onto the wheelchair and the floor. LPN #2 noted she did ask CNA #5 to go back to provide

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incontinent care and to clean the bowel off the floor and wheelchair for Resident #2, before she ended her shift. She instructed CNA #5 that it was neglectful to leave the bowel on Resident #2, and that it was neglectful to not clean the bowel from his floor and wheelchair. LPN #2 noted CNA #5 revealed she had just checked him at the end of shift rounds, that he was not soiled, that she had been busy all night, and was not going back to clean him up. She also noted that CNA #5 clocked out and left the nursing facility. She revealed she had attended Abuse/Neglect in-services and knew the residents had the right to be free of abuse/neglect.

A telephone interview on 9/12/23 at 04:12 PM, with LPN #1 revealed CNA #5 asked her to assist with the care for Resident #3, because he grabs a hold of whoever assisted with his care or held onto the bed rails often during care. LPN #1 noted Resident #3 was turned facing her holding onto the bedrail, and CNA #5 snatched his arms to make Resident #3 release the bed rail as she jerked him towards her to turn him over to face her. She further shared CNA #5 was moving fast with providing Resident #3's care and did not appear to be gentle when she was pulling on him to move him around in the bed. LPN #1 revealed she did not say anything to CNA #5 about being aggressive with moving Resident #3, was not sure if it was abusive behavior towards Resident #3 from CNA #5 but shared that it made her feel uncomfortable. She noted she observed bowel on the floor and on the wheelchair for Resident #2, and asked CNA #5 who was responsible to clean it up. She revealed CNA #5 told her she did not know who was supposed to clean it up, but she was not going to be the one to clean it up. LPN #1 also shared that she did tell LPN #2 about CNA #5's behavior towards Resident #3, and about

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CNA #5 needing to clean the bowel up from Resident #2's and Resident #3's floor. LPN #1 noted she did attend an Abuse/Neglect in-service but could not remember all what was said in the in-services about abuse. She shared that she did not feel the incident between CNA #5 and Resident #3 was suspected abuse because Resident #2 was not punched by CNA #5.

An interview on 9/12/23 at 4:20 PM, with Resident #1 revealed he had called over the call system one night for the assistance to have his brief changed because he had a bowel movement. He also revealed his CNA did come to his room that night, told him he had to sit and wait until she came off lunch break, and revealed the CNA never came back to his room to clean him up. He noted he could not remember her name or how long he waited for her. Resident #1 also noted he had to wait to be changed by one of the CNAs that came to work on the next shift. Resident #1 voiced, "Being treated that way made me feel shitty and made me feel bad."

An interview on 9/14/23 at 10:10 AM, with the Director of Nursing (DON), confirmed the nurses and the CNAs, including CNA #5, had been in-serviced on the Abuse/Neglect policy and were aware that residents of the nursing facility were to be kept free of abuse and neglect. She confirmed that Resident #1, Resident #2, Resident #3, and Resident #4 were not kept free of abuse/neglect by the nursing facility staff.

An interview on 9/14/23 at 10:30 AM, with the Administrator confirmed the nursing facility failed to keep Resident #1, Resident #2, Resident #3, and Resident #4 free from abuse/neglect. The Administrator also confirmed, through facility investigation, the nursing facility was not in

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compliance with the allegations of abuse/neglect by a CNA on 8/26/23 for Resident #1, Resident #2, Resident #3, and Resident #4.

Record review of the nursing facility in-services revealed "Abuse and Neglect," dated 07/12/23; "Abuse Neglect Vulnerable Adult Patient Rights," dated 7/13/23; "Elderly Care Acts/Abuse and Neglect," dated 7/20/23; "Abuse and Neglect, Reporting Abuse," date 8/9/2023; "Abuse Neglect, Patient Rights," dated 8/11/23; and "Abuse Neglect, Resident Rights," dated 8/28/23.

Record review of the Personnel Record for the CNA#5 revealed the last day worked was 8/26/23, the date of the alleged incident of abuse and neglect and was terminated on 9/1/23.

Record review of the Admission Record for Resident #1 revealed an admission date of 07/08/2023 with diagnoses of Functional Quadriplegia and Unspecified Focal Trauma Brain Injury Without Loss of Consciousness, Sequela.

Record review of a Minimum Data Set (MDS) with an Assessment Reference Date of 9/1/23 with a Brief Interview For Mental Status (BIMS), for Resident #1, revealed a score of 7, indicating Resident #1 is moderately cognitively impaired.

Record review of the Admission Record for Resident #2 revealed an admission date of 03/03/2023 with diagnoses of Hemiplegia and Hemiparesis Following Nontraumatic Intracerebral Hemorrhage Affecting Right Dominant Side, Dysphagia Following Cerebral Infarction, and Aphasia Following Cerebral Infarction.

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M 500	Continued From page 17 Record review of Section C of a Minimum Data Set (MDS) Admission Assessment, with an Assessment Reference Date (ARD) of August 28, 2023, for Resident #2, revealed a BIMS score of 99, indicating Resident #2 is severely cognitively impaired. Record review of the Admission Record for Resident #3 revealed an admission date of 05/25/2022 with diagnoses of Unspecified Dementia, Unspecified Severity, With Other Behavioral Disturbance, Other Sequelae of Cerebral Infarction, and Transient Cerebral Ischemic Attack, Unspecified. Record review of Section C of a Quarterly MDS Assessment, with an ARD of August 23, 2023, for Resident #3, revealed a BIMS score of 03, indicating Resident #3 is severely cognitively impaired. Record review of the Admission Record for Resident #4 revealed an admission date of 08/15/2023 with diagnoses of Acute and Chronic Respiratory Failure, Unspecified Whether With Hypoxia or Hypercapnia, Encounter for Attention to Tracheostomy, Dysphagia Following Cerebral Infarction, and Unspecified Sequelae of Cerebral Infarction. Record review of Section C of a 5-Day MDS Assessment, with an ARD of August 22, 2023, for Resident #4, revealed "C0100. Should Brief Interview for Mental Status (C0200-C0500) be Conducted? ... Enter Code: 0; 0. No (resident is rarely/never understood). The record review did not reveal a BIMS score.	M 500		