STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255339	A. BUILDING _____ B. WING _____	**03/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CHOCTAW RESIDENTIAL CENTER	**135 RESIDENTIAL CENTER RD CHOCTAW, MS 39350**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and facility policy review, the facility failed to ensure Resident #8 was protected from physical abuse, for one (1) of seven (7) residents reviewed for Abuse. Findings include: Review of the facility's Abuse Policy, undated, revealed, all residents will be free from physical, mental and/or verbal abuse. Preventing resident abuse is a primary concern for this facility. It is our goal to achieve and maintain an abuse free environment. Record review of an incident submitted to the State Agency (SA) revealed, on 03/04/2020, an allegation of abuse occurred, involving Certified Nursing Assistant (CNA) #1 and Resident #8. Resident #8 reported to staff that CNA #1 was mean to her, rough with her when she gave her a bath, and made statements to her such as You can do it yourself. On 03/12/2020 at 9:25 AM, an interview with Resident #8, revealed, she remembered the morning she reported the incident to her nurse. Resident #8 stated, CNA #1 (proper name) has always been rougher than the other ones, but that day she was horrible mean. I have [MEDICAL CONDITION] real bad in my hands and she knows it. She was unusually rough and pulling on my hands a lot. I was crying in pain and she kept saying, You ain't hurtin', it's all a show and you don't hurt that bad. Then she just kept grabbing them and pulling on them. Review of the facility ' s Face Sheet for Resident #8, revealed, she was admitted by the facility on 07/05/2012 with [DIAGNOSES REDACTED]. The most recent Brief Interview for Mental Status (BIMS), revealed a BIMS score of 14, which indicated Resident #8 had full cognitive ability. On 03/12/2020 at 9:35 AM, during an interview with Resident #9, Resident #8's roommate, she stated, She has been rough with my roommate, but not me. I have my curtain pulled, but I can hear my roommate asking her to stop pulling on her and she was screaming and crying out. I know she told a nurse that day she was rough. I ain't seen that aide since then. A review of the facility ' s Face Sheet for Resident #9, revealed, she was admitted by the facility on 02/24/2012 with [DIAGNOSES REDACTED]. Review of Resident #9 ' s most recent BIMS revealed, she had a score of 15, which indicated cognitively intact. During an interview, on 03/12/2020 at 12:05 PM, LPN #1 stated, she went in the room to give Resident #8 her medicine and she was crying. LPN #1 stated, she asked Resident #8 what was wrong, and she said, Don't let CNA #1 (proper name) come back in here. She's mean and rough with me. Don't tell her because I don't want her to come back in here. LPN #1 stated she then went to RN #1, and she and the Director of Nursing (DON) went to get CNA #1 to send her home. On 03/12/2020 at 12:50 PM, during an interview with RN #1, she stated, Resident #8 asked to speak to her after CNA #1 was walked out and we started the investigation. RN #1 stated, when she went to Resident #8 ' s room, she started to cry again and told her CNA #1 was mean to her and hurt her, when she gave her a bath. RN #1 revealed, Resident #8 stated her hands hurt her a lot and CNA #1 would make statements like You can do this yourself. RN #1 stated Resident #8 ' s roommate was interviewed separately and told her the same things. During an interview with the Administrator, on 03/12/2020 at 11:05 AM, she revealed the conclusion of the investigation for CNA #1 was that she had been rough with Resident #8. The Administrator stated, they attempted to call CNA #1 in to tell her of the findings, and she refused to come back in. The Administrator stated, CNA #1 told them she was through here. On 03/12/2020 at 12:25 PM, during an interview with the DON, she stated they concluded the abuse had occurred, and called CNA #1 for her to come in, to let her go. The DON stated CNA #1 wouldn't come and told them she was through with this place. During a second interview, on 03/12/2020 at 12:45 PM, the DON stated, Resident #8 was crying that morning, and she didn ' t know what had set her off. The DON revealed CNA #1 wasn't on that hallway that day, and Resident #8 couldn't tell her the exact date it occurred, that it was just before this morning. The DON stated CNA #1 smart-mouthed staff, but not the residents. The DON stated Resident #8 never complained about anyone, so they knew it was true. The DON stated Resident #8 ' s roommate was interviewed separately and verified the complaint almost word for word. On 03/12/2020 at 12:55 PM, attempts were made to reach CNA #1 for an interview without success. No return calls were received from CNA #1. A review of CNA #1 ' s timecard, revealed, on 03/04/2020, she clocked in at 6:40 AM and clocked out at 8:32 AM, after the allegation of physical and verbal abuse was made. The time card revealed, on 03/03/2020, CNA #1 clocked in at 6:36 AM, and clocked out at 2:53 PM. A review of the facility ' s CNA group assignments, revealed, CNA #1 was assigned to Resident #8 on 03/03/2020, but was not assigned to Resident #8 on the morning of the allegation (03/04/2020). Record review revealed CNA #1 was immediately suspended on 03/04/2020, and terminated on 03/09/2020, after the abuse allegation was substantiated by the facility. A review of the facility ' s personnel record for CNA #1 revealed, she was hired on 02/11/2019 and received an Abuse in-service upon hire. CNA #1 received additional in-services on Abuse on 10/03/2019, 11/14/2019, 01/09/2020, and 02/06/2020.

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

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