STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255109	A. BUILDING _____ B. WING _____	**03/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DIVERSICARE OF SOUTHAVEN	**1730 DORCHESTER DR SOUTHAVEN, MS 38671**

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, staff interview, resident interview, and facility policy review, the facility failed to ensure that one (1) of seven (7) residents reviewed were protected from physical abuse; Resident #1. Review of the facility's Abuse, Neglect and Misappropriation, Exploitation Policy, dated January 2019, revealed: To prohibit and prevent abuse and to ensure reporting and investigation of alleged violations in accordance with Federal and State Laws. Record review revealed an investigation of alleged abuse was conducted by the facility on [DATE] involving Certified Nursing Assistant (CNA) #1 and Resident #1. On [DATE], Resident #1 was asked by Dietary Worker #1 to remove himself from the kitchen where he was getting himself several cartons of milk from the cooler. Resident #1 began to cuss Dietary Worker #1 and used racial slurs towards her. CNA #2 was attempting to calm Resident #1, when CNA #1 overheard the incident that was occurring and approached Resident #1 . Resident #1 began to use racial slurs towards CNA #1. CNA #1 used both hands to push Resident #1 backwards into a chair that was in the hallway. This incident occurred in the hallway in front of other witnesses. Licensed Practical Nurse (LPN) #1 asked CNA #1 to leave the building and she notified the Administrator and Director of Nursing (DON) of the incident. The facility immediately began an investigation, suspended CNA #1 and reported the incident to the State Agency (SA) and notified the local police department, who arrived at the facility at 3:30 PM. On [DATE]20 at 2:50 PM, an interview with Resident #1 revealed, he recalled the events of [DATE]. Resident #1 stated, I had went to the dietary department to get some milk and a woman (Dietary Worker #1) startled me and said that I wasn't supposed to be back there and it made me mad the tone she used, so I called her the N-word. Resident #1 stated, I feel bad about it now and I shouldn't have but I did. I won't ever say it again because I've realized it will get you killed around here. Resident #1 revealed he got the milk though and was walking up the hall. He stated that he had a chair in the hall that he usually sat down in because he gets out of breath, and he was trying to get to that chair. Resident #1 stated when CNA #1 came around the corner, he was saying you ' re not going to talk to her that way. Resident #1 revealed that he told CNA #1 to mind his business that he was a CNA and this didn't have anything to do with him. Resident #1 stated CNA #1 told him that he was messing with the wrong guy, and that he had better knock this[***]off right now. Resident #1 stated CNA #1 and came at him, shoved him right in the chest, and he fell back into the chair and hit head on the magazine rack, on the wall, on his way down. Resident #1 revealed, when CNA #1 hit him, the nurse (LPN #1) and the CNA (CNA #2) grabbed him and they all made him leave. Resident #1 stated he called the police on CNA #1 and he went to court. Resident #1 revealed CNA #1 was being charged with simple assault. Resident #1 stated, I've lived here eight years and I've never had anything like that ever happen before. He (CNA #1) was in the Army and he's got a temper. They checked me out, I mean I'm okay now, but I was shocked that he did what he did. On [DATE]20 at 12:45 PM, during an interview with Licensed Practical Nurse (LPN) #1, she stated that she was in her office and overheard two male voices yelling and loud tones. LPN #1 revealed she stepped out of her office and observed an altercation that was occurring at the doorway of her office. LPN #1 confirmed that she saw CNA #1 and Resident #1 both standing facing each other and CNA #1 took both hands with his palms opened and shoved Resident #1 backwards into the chair that was in the hallway. LPN #1 confirmed CNA #2 was grabbing at CNA #1 trying to remove him from the situation. LPN #1 stated she looked at CNA #1 and told him he had to leave. LPN #1 stated CNA #1 was yelling, Ya'll let him call people the N word. LPN #1 revealed she remembered telling CNA #1 that he couldn't put his hands on a resident. LPN #1 confirmed she assessed Resident #1 for injuries and did not see any, and that she told the witnesses to write a statement of what they saw. LPN #1 stated she called the Administrator and the DON. LPN #1 revealed she heard Resident #1 talking to the police on his cell phone. During an interview, on [DATE]20 at 2:15 PM, CNA #3 stated she was in the hallway and heard CNA #1 and Resident #1 getting loud. CNA #3 stated when she began to walk towards them, she observed CNA #1 shove Resident #1 into the chair. CNA #3 stated she could not hear everything that was said, but she did hear CNA #1 tell Resident #1, Come at me now, after he had shoved Resident #1 into the chair. On 03/04/2020 at 11:15 AM, during an interview with Dietary Worker #1, she confirmed that she had returned to the dietary department and observed Resident #1 in the milk cooler, with his foot propping the door open. Dietary Worker #1 stated she told Resident #1, he was not supposed to be in there. Dietary Worker #1 stated before she could say anything else, Resident #1 started cussing her and called me a [REDACTED]. Dietary Worker #1 stated, she guessed that she was shocked, that she stood there a second, and Resident #1 came on by her and walked up the hallway. Dietary Worker #1 stated CNA #1 and CNA #2 were at the time clock, and CNA #2 was trying to get him to calm down. Dietary Worker #1 revealed she heard CNA #1 say, You're not going to talk to her like that. You messing with the wrong one now. Dietary Worker #1 stated she was walking up the hallway looking for someone to report the incident to, when she saw CNA #1 shove Resident #1 backwards into a chair. Dietary Worker #1 revealed CNA #2 was behind CNA #1 and grabbed him by the arm and pulled him back. Dietary Worker #1 stated she heard one of the nurses tell CNA #1 that he had to leave. Dietary Worker #1 stated she heard CNA #1 say, Ya'll just let him talk anyway he wants, and he called me a [REDACTED]. During an interview, on 03/04/2020 at 12:15 PM, CNA #2 stated she was in the hallway by the time clock when she saw Resident #1 getting the milk, and Dietary Worker #1 told him that he wasn't supposed to be in there. CNA #2 stated Resident #1 started cussing Dietary Worker #1 and called her a [REDACTED]. CNA #2 confirmed that she was trying to calm Resident #1 when CNA #1 overheard the conversation and came back down the hallway towards Resident #1. CNA #2 stated CNA #1 and told Resident #1, Don't talk to her like that, and Resident #1 called CNA #1 a [REDACTED]. CNA #2 stated that CNA #1 put his arm up and Resident #1 fell back into the chair. On 03/04/2020 at 12:30 PM, CNA #1 was interviewed by phone. CNA #1 stated that he was by the front desk and was leaving when he overheard Resident #1 yelling and cussing. CNA #1 stated he went to try to calm Resident #1 down. CNA #1 stated, It happened in just an instant, he stood up, and I put my arm up and he stumbled back into the chair. The nurse told me to leave so I did. CNA #1 stated he never cussed or threatened Resident #1. CNA #1 stated he only put his arm up to stop Resident #1 from coming at him, and Resident #1 fell back in the chair. On 03/04/2020 at 1:30 PM, during an interview with the DON, she confirmed that she had just put a psychosocial evaluation in for Resident #1 on 02/21/2020, the day before the incident occurred. The DON stated, We could see his behaviors escalating and if he doesn't get what he wants, then he acts out. The DON confirmed the doctor visited and made medication changes. The DON stated CNA #1 was a great CNA, he was always at work, and never had any issues with him. The DON stated that she just hated it so bad that this happened between CNA #1 and Resident #1. Record review revealed CNA #1 was immediately suspended, and was terminated on [DATE]20 after the abuse allegation was substantiated by the facility. A review of CNA #1's personnel records, revealed, CNA #1 was hired by the facility on 04/24/2017 as a CNA. CNA #1 received an in-service, Survey Readiness, on 0[DATE], which included training on Abuse Reporting. CNA #1 was in attendance on 10/07/2019, which covered the topic of Abuse. Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The most recent Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 01/29/2020,

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.

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F 0600 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated Resident #1 was cognitively intact.