STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255185	A. Building B. Wing	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Indianola Rehabilitation and Healthcare Center	401 Highway 82 West Indianola, MS 38751

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 - 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** 21029 Based on observations, interviews, record review and facility policy and procedure review, the facility neglected to provide an environment free from abuse/neglect for Resident #1. Certified Nursing Assistant (CNA) #1 did not report to anyone that Resident #1 hit his head during resident care. This resulted in a serious right eye injury with fractures to his orbital bones which remained untreated and unassessed by the facility staff for several hours after the injuries to Resident #1 were discovered for one (1) of 27 residents reviewed for abuse and neglect. Resident #1 Findings include: Record review of the facility policy and procedure titled Abuse Prohibition Policy, reviewed 5/17/24 revealed . Neglect is defined as the failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, mental anguish, or emotional distress. Neglect includes cases where the facility's indifference or disregard for resident care, comfort, or safety resulted in or could have resulted in physical harm, pain, mental anguish, or emotional distress . Investigation: 1. The facility will thoroughly investigate all alleged violations and take appropriate actions . On 7/30/24 at 11:30 AM, an interview with the Administrator (ADM) and the Director of Nurses (DON) revealed the local police had gone to the emergency room (ER) and completed their police report and talked to the resident at the ER. The Attorney General (AG) had been to the facility on Monday. The ADM stated that the local police had come to the facility to follow up on the situation on 7/29/24 and indicated to her they felt Resident #1 had been hit by someone at the facility. The ADM stated that the incident occurred on 7/27/24 2024, during the 7:00 AM - 3:00 PM shift. The ADM stated she obtained a statement from CNA #1, and he denied hitting the resident. CNA #1 stated that Resident #1 hit his head on the bedside table. The ADM stated the DON was contacted by Licensed Practical Nurse (LPN) #1 that Resident #1's eye was swollen shut and the area around his eye was black prior to leaving for dialysis on 7/24/24 at approximately 11:00 AM. Resident #1 initially told LPN #1 on 7/29/24 at 11:00 AM, that he and CNA #1 were boxing, and he got the black eye. The ADM stated CNA #1 did not report the incident of Resident #1 hitting his head on the bedside table to anyone. The ADM stated the DON was contacted on Saturaday, 7/27/24 at approximately 11:15 AM via telephone but did not come to the facility to investigate the incident on 7/27/24 so there was no incident report or documentation assessing the injuries of Resident #1 for that day. (continued on next page)

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.

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Interview on 7/30/24 at 2:18 PM, with LPN #2 revealed that she was the 3:00 PM - 11:00 PM nurse supervisor for the second shift on 7/27/24. She stated she did not receive a report form the first shift nursing supervisor of any incidents that occurred with Resident #1. LPN #2 stated that at approximately 3:15 PM, LPN #1 told her that something happened between CNA #1 and Resident #1 and that Resident #1 had received a black eye. LPN #1 told LPN #2 that the DON had been contacted and that Resident #1 was going to be sent to the local ER for evaluation after dialysis. LPN #2 stated that at approximately 4:00 PM, Resident #1 returned from dialysis and this was the first time that she had seen Resident #1. His right eye was swollen shut and was dark purple and black with large bruises and a small amount of blood noted to the nose. LPN #2 asked Resident #1 what had happened, and he said, we had a little tussle, Resident #1 did not tell LPN #2 who the CNA was or call the CNA by name. Resident #1 was transported to the local ER by the facility van driver at approximately 4:30 PM. LPN #2 stated that at approximately 8:30 PM on 7/27/24 the facility van driver returned to the facility alone because Resident #1 had been sent via ambulance from the local ER to a hospital in another city for overnight observation and further testing. Interview on 7/30/24 at 3:32 PM, with RN #3 from the local ER revealed that on 7/27/24 at approximately 5:00 PM, she saw Resident #1 in the ER where she was working as the ER nurse. She stated that Resident #1 arrived at the ER alone with a female facility van driver. Resident #1 was noted to have a large swollen dark bruised black eye with blood on his shirt and blood drops on his pants, and both nostrils of his nose contained blood. She stated that Resident #1 told her that he had gotten punched in the eye but did not want to talk about it. RN #3 stated that she immediately called the facility DON, and she stated that an investigation was underway to try to determine what had happened. RN #3 stated that she also called the local Police Department, Adult Protective Services, and the State Agency. RN #3 stated that approximately 1 hour after he was seen in the ER his two (2) daughters came to the ER but Resident #1 only stated that he got punched and did not want to talk about it anymore. The local Police Department came to the local ER and talked to Resident #1 at approximately 8:00 PM. Resident #1 was transferred for overnight observation and further testing via ambulance to an out-of-town hospital. RN #3 reported that the local ER had received a call earlier in the day around lunchtime (approximately 12:15 PM) from the on-call Nurse Practitioner (NP) who reported to the ER that she had received a call from the facility DON after Resident #1 had been sent out to dialysis. The DON reported to Nurse Practitioner (NP) that Resident #1 had obtained a black eye and bloody nose sometime during patient care the morning of 7/27/24 at around 8:00 AM. The NP stated that Resident #1 was sent out to dialysis before she was notified at 12:15 PM. The NP instructed the facility staff to bring Resident #1 to the local ER as soon as he returned from dialysis. Resident #1 completed dialysis and arrived at the local ER at approximately 5:00 PM. Interview on 7/30/24 at 3:49 PM, with the Attorney General (AG) Investigator revealed that he was in the process of obtaining a copy of the local Police report. He stated that the local ER had contacted the local Police to come to the ER and complete a Police report. The AG stated that as soon as he received the Police Report and gathered more information, he would make his conclusions as to what had occurred. The AG stated that CNA #1 had denied he hit Resident #1. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Interview on 7/30/24 at 3:57 PM, with LPN #1 revealed she was the facility unit nurse on 7/27/24 for the 7:00 AM - 3:00 PM shift. LPN #1 stated that CNA #2 told her that Resident #1 was cutting up and resisting care. LPN #1 went to Resident #1's room to see what was going on and CNA #1 was giving Resident #1 a bath. CNA #1 told LPN #1 everything was fine and that he had things under control. LPN #1 did not see the Resident's face at that time. At approximately 9:00 AM, LPN #1 saw Resident #1 walking down the hall with his walker. LPN #1 stated He appeared fine. I thought I saw a small blister under his right eye, but he did not have any swelling or bruising at that time. At approximately 10:30 - 10:45 AM, LPN #1 passed by the lobby and saw Resident #1 sitting in a chair waiting for dialysis to come pick him up and at that time his right eye was swollen shut and he had dark purple and black bruising around his right eye with some small amount of blood noted to his nose. LPN #1 asked him what had happened, and he said, we were wrestling, I got hit when we were wrestling. He never called any names as to who had hit him. LPN #1 immediately called the DON, and she told LPN #1 to get a statement from CNA #1 and to get CNA #1 out of the building on suspension until an investigation could be completed. LPN #1 stated that she should have written a nursing note and put information in the medical record of Resident #1 immediately after the incident was reported to her, but she honestly thought that RN Supervisor #1 had completed the paperwork. Interview on 7/30/24 at 4:00 PM, with the daughter of Resident #1 revealed that she had been called by LPN #1 on 7/27/24 at approximately 12:00 PM after her dad had been sent to dialysis. LPN #1 told her that her dad had been injured during care that morning and had received a black eye. Resident #1 told the family that he was horsing around and wrestling with a friend. The daughter stated that after dialysis the facility transported Resident #1 to the local ER. Resident #1 had fractures to his orbital bones around his right eye and bruises on his arm and a bloody nose. The daughter stated that Resident #1 had blood on his clothes at dialysis and at the ER. Resident #1 was transported via ambulance to another out-of-town hospital for further evaluation. Interview, on 7/30/24 at 4:20 PM, with CNA #1 revealed that on 7/27/24 at approximately 8:00 AM, CNA #1 discovered that Resident #1 needed to be cleaned up. CNA #1 attempted to deliver care and Resident #1 resisted and was cussing and swinging his arms about. Resident #1's bedside table was to the left of his bed and the window was to the right of his bed. CNA #1 stated Resident #1 was telling him to go on and leave him alone and that he did not want CNA #1 cleaning him up. Resident #1 was swinging his arms about, and CNA #1 told Resident #1 I am not here to hurt you, and I am here to help you. CNA #1 stated that he did not ask another staff to assist him with Resident #1. He stated that he thought he could handle the situation all by himself. He stated that he had left the door to Resident #1's room open. CNA #1 stated that he had been in-serviced and trained to leave the room when a resident was resisting care and get another staff to come in with him after the resident had calmed down, but he did not do that because Resident #1 calmed down on his own. CNA #1 stated Resident #1 did hit his head on the bedside table where CNA #1 had his basin of bath water sitting, but he stated that he was not hurt and that he was okay. CNA #1 stated that because Resident #1 was not hurt, he continued to deliver care. CNA #1 stated that he did not report to anyone that Resident #1 had hit his head until he gave a written statement to LPN #1 several hours later when Resident #1 was discovered to have a black eye. CNA #1 stated that he did not hit Resident #1 and that he loved his residents and would never hurt anyone. CNA #1 stated that he assumed that Resident #1 had either hit himself in the eye or that he hit his head on the bedside table. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Interview on 7/30/24 at 6:15 PM, with the facility van driver revealed that she was called about noon on 7/27/24, by the DON and asked to come to the facility after dialysis and pick up Resident #1 and take him to the local ER for evaluation and x-rays. The van driver waited with Resident #1 at the ER until the local ER stated they were sending Resident #1 to an out-of-town hospital. The facility van driver stated that Resident #1 had a swollen, bruised right eye and his nose started bleeding at the ER. The facility van driver stated that she did not ask Resident #1 about the incident. Observation and interview on 7/30/24 at 6:30 PM, with Resident #1 revealed that he was sitting alone in a chair in the lobby at the front of the facility. Resident #1 had a large swollen shut black right eye with some thick, white substance noted to the corners of the eye and along the eyelash area. Resident #1 stated that he was not able to open his right eye at this time. Resident #1 stated: I got into a little altercation with a friend. Resident #1 refused to disclose the name of his friend and stated they had worked it all out between them and that everything was okay. Interview on 7/31/24 at 9:30 AM, with CNA #2 revealed she was working on the same unit on 7/27/24 as CNA #1. CNA #2 revealed she heard loud yelling coming from Resident #1's room. The door was opened. I heard CNA #1 tell Resident #1 he was not trying to hurt him, he was trying to give him a bath. Resident #1 told CNA #1 to go on and leave him alone and to get out of his room. CNA #2 stated CNA #1 never asked for any help with Resident #1. CNA #2 stated CNA #1 should have left the room until Resident #1 calmed down and he should have asked someone to help him, but he didn't. An interview on 7/31/24 at 12:16 PM, with the dialysis Facility Administrator (RN #4) revealed that she was working at the dialysis clinic on 7/27/24 when Resident #1 was there for dialysis. She stated that the van driver came into the dialysis clinic and asked the staff to come and help with the man from the nursing home because something was wrong. The private company van driver got Resident #1 off the van, and they brought him into the dialysis clinic with blood on his face and hands and clothes and a swollen black right eye. Resident #1 told the dialysis staff that he had been in a wrestling match with another patient at the facility by the name of (gave the first name of CNA #1). The dialysis nurse called the nursing home and talked to a lady that stated that she was an RN at the facility named (name of RN #2). RN #5 wanted to make sure that the facility knew that Resident #1 had been sent to dialysis with an injury to his right eye and a bloody nose. The dialysis staff called the physician, and he gave instructions to have Resident #1 evaluated and x-rayed at the local ER. Record review of the dialysis clinic notes dated 7/27/24 at 1:33 PM, signed by RN #4 revealed Resident #1 arrived to dialysis today with his right eye swollen shut, a bloody nose, blood on his hands and pants. When questioned what happened, he stated he was wrestling with another patient named (name of CNA #1) at the nursing home. RN #4 contacted the nursing home and spoke with RN #2 who stated the patient was combative with a CNA during his bath prior to dialysis. The dialysis physician was notified via telephone, gave approval to start treatment, hold heparin, and wanted Resident #1 to get an x-ray post-dialysis at the hospital to ensure there are no fractures. This information was communicated to the nursing home and Resident #1's family. Record review of a handwritten statements for LPN#1 revealed there was a verbal exchange between CNA #1 and Resident #1 at approximately 8:00 AM or 9:00 AM on 7/27/24. The statement revealed that at approximately 10:50 AM prior to leaving the facility for dialysis she discovered that Resident #1 had an eye injury. LPN #1 documented in her statement .swelling and bruising was noted . around 10:50 to resident's right eye. DON was notified. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Record review of the local hospital Final Radiology Report dated 7/27/24 at 4:27 PM revealed .Exam: CT Head Without Contrast .Clinical Indication Injury or trauma .Impression: Significant right orbital fracture partially imaged with intraorbital air and severe appearing proptosis . Record review of the local hospital Final Radiology Report dated 7/27/24 at 5:15PM revealed .IMPRESSION: 1. Comminuted and depressed right orbit floor fracture. Comminuted and medially displaced right orbit medial wall fracture. Small amount of intraorbital air. Marked proptosis. Thickened edematous appearance of the right inferior rectus muscle also with some gas immediately adjacent to possibly within the muscle fibers. Tiny bone fragments in close proximity to the right inferior rectus muscle. Cannot definitely exclude an element of intramuscular hemorrhage. However, no significant retrobulbar hemorrhage. 2. Age indeterminate nasal bone fracture. 3. Hemorrhage in the right maxillary sinus. Record review of the local police department Incident Report revealed Event Info: Date Reported: July 27, 2024, Time Reported: 20:01 (8:01 PM) . Date of Occurrence Range: 7/27/24 Time of Occurrence Range: 19:55-20:10 (7:55-8:10 PM Call Type: Assault- Victim was assaulted at (Proper name of nursing home facility) by an employee. Employee was trying to dress the victim when the victim began cussing and acting up. Victim has Dementia. Victim was transported to (local ER) where x-rays showed a fractured orbital. Victim was transported to (another city) to see a specialist. Classification: Completed Class: Vulnerable Person Abuse or Neglect Subclass: Abuse. Name type: Suspect Name (name and address and telephone number of CNA #1). Narrative . (Proper name of daughter) stated she received a call from the facility about 11:13 AM and was informed their father had been assaulted. Instead of the facility sending Resident #1 to the hospital it was stated that he was taken to dialysis with a very bad swollen right eye.Resident #1 stated that CNA #1 an employee at the facility is the person that caused his injury . The staff on duty during the shift had not reported the injury at all. The x-ray of Resident #1's face showed his orbital is fractured . Record review of a handwritten statement by CNA #1 dated July 27, 2024 revealed This morning when I went to bathe (Proper name of Resident #1), he started cursing and swinging. I asked him to stop and let me clean him. But he continued to swinging and curse. I notified the nurse that he was fighting and refusing care. During his outburst he hit his head, and his eye was swollen. I notified the nurse. I had went in several times to clean him, and I even asked (Proper name of CNA #2) to come into the room with me. Record review of the handwritten statement by LPN #1 revealed At approximately 9:00 AM, this nurse (Last name of LPN #1) was called to the resident's room because the resident was being combative and refusing care. Upon entering the resident's room, the resident was noted to be lying in bed on his right side facing the window and the aide was giving the resident a bath. The resident was noted to be calm and did not appear to be in distress. After resident stated that he was alright, this nurse exited the room. There was no bruising or swelling noted at this time. Swelling and bruising was noted around 10:50 to the resident's right eye. DON was notified. Signed by LPN #1 and dated July 28, 2024. Record review of a handwritten statement dated 7/29/24 by LPN #2 revealed, On the evening of 7/27/24 I was working the 3:00p- 11p shift as the supervisor when (Proper name of Resident #1) returned to the facility from dialysis. I ask him . why his eye was swollen, he stated that him and his CNA had a 'little tussle.' I ask him what he meant by a 'little tussle.' He stated that he really did not think that the CNA hit him or did anything to him, he stated, 'I might have hit myself.' . (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Record review of a typed statement by facility Administrator (ADM) dated 7/28/24 at 10:52 AM revealed, (Proper name of CNA #1) informed the Administrator that (Proper name of Resident #1) was refusing care, so he sent for (Proper name of LPN #1) . CNA) #1 stated Resident #1 had risen in the bed, swung, and was fighting, and he hit his head on the over-bed table he had at bedside with the bath water on it. CNA #1 stated Resident #1 never complained of pain or said he was hurt. He finally calmed down and he was able to clean him up, dress him, shave him, and trim his hair with no issues. Resident #1 then walked up front prior to going to dialysis. LPN #1 asked Resident #1 what happened per CNA #1. Resident #1 replied, 'I have been down there fighting and did it to myself.' CNA #1 stated he never closed the door to Resident #1's room for his privacy because the smell was so bad. That is the only thing he did wrong was not providing privacy. Record review of the Minimum Data Set (MDS) dated [DATE], for Resident #1 Section C revealed that Resident #1 had a Brief Interview of Mental Status (BIMS) score of 14 which indicated that Resident #1 was intact cognitively and had no cognitive impairment. Record review of the Admission Record revealed Resident #1 had been admitted to the facility on [DATE] and again on 4/16/23 with diagnoses that included Type 2 Diabetes Mellitus and Heart Failure.

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 21029 Based on interview, record review and facility policy and procedure review the facility failed to implement the Activities of Daily Living (ADL) care plan when Certified Nursing Assistant (CNA) #1 did not notify the charge nurse supervisor when a resident was resisting care. This failure resulted in Resident #1 receiving fractures to his orbital bones during an altercation with CNA #1 during care for one (1) of 27 residents reviewed. Resident #1. Findings include: Record review of the facility policy titled, Care Plans, Comprehensive-Centered with a reviewed date of January 2023 revealed Policy Statement: A comprehensive, person-centered care plan .is developed and implemented for each resident. Policy Interpretation and Implementation .8. The comprehensive, person-centered care plan will: .g. Incorporate identified problem areas h. Incorporate risk factors associated with identified problems 10. Identifying problem areas and their causes, and developed interventions that are targeted and meaningful to the resident .11 a. When possible, interventions address the underlying sources (s) of the problem area (s), not just addressing only symptoms or triggers . Record review of the care plan with a date initiated of 2/23/24 revealed Focus: I have inappropriate behaviors and at risk for injuries and complications. I yell at staff and resist care .Interventions: Monitor behaviors .Notify charge nurse, supervisor .Notify physician and RR (Resident Representative) .Redirect as needed Interview on 07/30/24 at 11:30 AM, with the Director of Nursing (DON) and the Administrator (ADM) revealed Resident #1 was discovered to have a black eye and a nosebleed on 07/27/24 at approximately 10:40 AM after he had received care from CNA #1 on 07/27/24 at approximately 8:00 AM-9:00 AM. The DON revealed there was no documentation CNA #1 notified the charge nurse supervisor or obtained help from additional staff when Resident #1 resisted care. During an interview on 07/30/24 at 3:57 PM, Licensed Practical Nurse (LPN #1) revealed CNA #1 never reported to anyone that Resident #1 hit his head during patient care earlier that morning on 07/27/24 at approximately 8:00 AM to 9:00 AM. LPN #1 confirmed that CNA #1 did not follow protocol for Residents with behaviors or that were resisting ADL care. LPN #1 stated that CNA #1 should have called for another staff to assist him and walked away and left the room after the resident became resistant to care. LPN #1 stated that CNA #1 never asked for help with Resident #1 after he became resistant to ADL care. LPN #1 stated that Resident #1 received injuries of a swollen black eye and some bleeding to his nose that occurred during ADL care with CNA #1. LPN #1 stated that she should have assessed Resident #1, and she should have documented the events of the incident of Resident #1, but she did not. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Interview on 07/30/24 at 4:20 PM, with CNA #1 revealed that during patient care on 07/27/24 at approximately 8:00 AM Resident #1 became resistant and began yelling and swinging his arms about during bath time. CNA #1 stated that Resident #1 hit the right side of his head on the bedside table that was positioned on the left side of Resident #1's bed. CNA #1 confirmed that he did not report the incident or notify the nurse because Resident #1 was not hurt and did not issue any complaints of pain. CNA #1 confirmed he did not obtain other staff to assist when Resident #1 was resisting care or notify the nurse or nurse supervisor. Interview on 07/31/24 at 11:02 AM, with the Minimum Data Set (MDS) nurse, Registered Nurse (RN) #6 revealed that the ADL care plan was not appropriately followed for Resident #1. RN #6 stated that CNA #1 should have obtained an additional staff member to assist with the ADL care of Resident #1 after he became resistant and should have reported Resident #1 was resisting care to the Charge Nurse/Supervisor. RN #6 stated that all the staff are trained to leave the room and to allow a Resident time to calm down, and to obtain an additional staff member to come and assist with ADL care, when a resident exhibits behaviors. RN #6 stated CNA #1 did not follow protocol and did not implement the care plan for Resident #1.