STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255217	A. Building B. Wing	06/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Heights Healthcare Center	402 Arnold Avenue Greenville, MS 38701

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. Based on interview, record review, and facility policy review, the facility failed to ensure residents were free from verbal abuse when a registered nurse used profane, intimidating, and demeaning language toward two (2) of 10 residents reviewed for abuse. Resident #1 and Resident #4.Based on corrective actions taken by the facility on 6/3/26, the State Agency determined the deficiency to be Past Non-Compliance, and the facility was in compliance on 6/4/26 prior to survey entrance on 6/15/26. Findings included:Record review of facility policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revealed Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual, or physical abuse and physical or chemical restraint not required to treat the resident's symptoms .Resident #1Record review of facility investigation regarding an allegation of the verbal abuse of Resident #1 revealed on 5/31/2026 at 11:11 PM, Registered Nurse (RN) #1 notified the Administrator (ADM) that RN #2 used profanity toward the resident during medication pass on the 7am-3pm shift. On 6/1/2026 RN #3 stated that Resident #1 asked RN #2 Can I have my medicine, over and over, and she witnessed RN #2 state, Get the f*** away from me. During interview RN #2 denied cursing at the resident. Further interviews revealed that Certified Nursing Assistant (CNA) #1 also heard RN #2 cursing at Resident #1. Based on the investigation the facility corroborated the verbal abuse towards Resident #1.Record review of Statement of Witness-Confidential dated 6/1/26, signed by CNA #1 revealed he witnessed RN #2 tell Resident#1 to Get the f*** away from her cart.Record review of Statement of Witness-Confidential dated 6/2/26, signed by RN #3 revealed that she witnessed RN #2 tell Resident #1 to Get the f*** away from me. Record review of admission Record revealed that the facility admitted Resident #1 on 10/6/2023 with diagnoses including Unspecified Convulsions and Restlessness and Agitation.Record review of the Minimum Data Set Assessment (MDS) with an Assessment Reference Date (ARD) of 3/23/26 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 03 indicating that the resident was severely cognitively impaired.Resident #4 Record review of facility investigation of an allegation of the verbal abuse of Resident #4 revealed on 6/2/2026 at 3:45 PM, during Resident Council meeting, Resident #2 and Resident #3 reported to ADM that they witnessed RN #2 curse at Resident #4 on 5/31/2026 when he asked about his medicine. Resident #3 reported that Resident #4 asked the nurse where the rest of his medicine was and the white nurse stated, N**** this is your medicine. His ugly a** need to leave me alone. Resident #4 stated that he asked the nurse what the medicine was she was giving him, and she told him that she didn't have time to explain and she walked on down the hall; and she said, If you want them come down the hall your d*** self. Resident #2 stated, I was there, I was standing right in front of the nurse's station, and it was that white nurse. We were at the nurse's station, and he asked what pill he was taking. And the nurse said, I don't got no d*** time to explain no medicine to a resident. Based on the investigation the facility corroborated verbal abuse towards Resident #4.Interview with the Administrator on 6/15/26 at 3:00 PM, she verified that based on the facility's investigation they corroborated verbal abuse of Resident #1 and Resident #4 by RN #2. Interview with the Director of Nursing on 6/16/26 at (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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(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	8:00 AM, she stated that RN #3 did not tell her that RN #2 had cursed at the resident. She only told her that she was rude. She stated she did not find out that RN #2 cursed the resident until the next day when the ADM talked to her about the situation.Interview with Resident #4 on 6/16/26 at 9:00 AM, he verified that RN #2 cursed at him during medication administration on 5/31/26 During the day stating that she Did not have d*** time to explain medication to a resident and walked away stating If you want them come down the hall your d*** self.Interview with Resident #3 on 6/16/26 at 9:05 AM, she verified that she was present and heard RN #2 curse at Resident #4 but did not specify what she heard the nurse say. Interview with Resident #2 on 6/16/26 at 9:07 AM, he stated that he was present on 5/31/26 when RN #2 cursed at Resident #4. He stated the only curse word she used was d***. He verified that the nurse said she Did not have d*** time to explain medication to a resident if you want them come down the hall your damn self, and she walked away.Record reviews and follow-up interview with Administrator on 6/16/26 at 9:25 AM, revealed that the facility thoroughly investigation the allegations. An abuse in-service was initiated, and staff were not allowed to work until in-service was attended. The facility reported the abuse to all necessary entities. Facility initiated audits to identify and prevent abuse. Both residents were assessed and monitored for trauma, with no negative outcomes and their care plans were updated. The ADM confirmed that the incident and investigation results were presented to the Quality Assurance Committee on 6/3/26 during which the facility policy was reviewed with no revisions made. State Agency validated this was completed on 6/3/26 and the facility was in compliance on 6/4/26 prior to State Agency entrance on 6/15/26.Record review of admission Record revealed that the facility admitted Resident #2 on 1/23/26 with a diagnosis of Displaced Transverse Fracture of Shaft of Right Tibia.Record review of the MDS with an ARD of 4/28/26 revealed Resident #2 had a BIMS score of 15 indicating that the resident was cognitively intact. Record review of admission Record revealed that the facility admitted Resident #3 on 11/11/24 with a diagnosis of Sickle-Cell Disease. Record review of the MDS with an ARD of 5/25/26 revealed Resident #3 had a BIMS score of 15 indicating that the resident was cognitively intact. Record review of admission Record revealed that the facility admitted Resident #4 on 6/23/22 with a diagnosis of Chronic Obstructive Pulmonary Disease. Record review of the MDS with an ARD of 2/16/26 revealed Resident #4 had a BIMS score of 15 indicating that the resident was cognitively intact.