STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255219	A. Building B. Wing	06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Walk Healthcare Center	570 North Solomon Street Greenville, MS 38703

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 for two (2) of three (3) residents reviewed for abuse. Residents #1 and #2 Findings include: Review of the facility policy titled Resident Rights, with no revision date, revealed under Policy Interpretation and Implementation: 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include: the resident's right to: .c. be free from abuse . An observation and interview on 6/27/25 at 8:40 AM with Resident #1 revealed she had asked a Certified Nurse Assistant (CNA) to notify her nurse that she needed pain medication. Resident #1 stated that RN #1 came into her room and yelled at her, saying she was always asking for pain medicine and would get it when RN #1 was ready. Resident #1 stated the nurse often spoke ugly to her and others and that she had never reported it, believing other residents had not either. She said RN #1 would often say, You better be good today or else. Resident #1 confirmed another nurse did provide her medication without a significant delay and stated she was relieved that someone finally witnessed this and that the nurse no longer worked at the facility. An interview on 6/27/25 at 8:50 AM with the Administrator in Training (AIT) revealed that the Corporate Nurse had overheard RN #1 yelling at Resident #1 from the Minimum Data Set (MDS) nurse's office, which was near the resident's room. The AIT stated the Corporate Nurse heard RN #1 say, You gonna learn today, after the resident requested pain medication. The AIT confirmed RN #1 was suspended pending investigation and subsequently terminated based on witness statements. She acknowledged that Resident #1 did receive her medication in a timely manner from another nurse. An interview on 6/27/25 at 9:00 AM with the Director of Nursing (DON) confirmed that the Corporate Nurse was in the MDS office and had texted her to come listen to RN #1 after overhearing her speak inappropriately to Resident #1. The DON verified that RN #1 was suspended, another nurse administered the medication, and RN #1 was terminated after the investigation. An interview on 6/27/25 at 9:15 AM with the Corporate Nurse confirmed she heard RN #1 say, I can give you your med whenever I get ready, it's not time, in a mean tone. She stated she immediately texted the DON, hoping she could arrive in time to witness the exchange. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255219	A. Building B. Wing	06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Walk Healthcare Center	570 North Solomon Street Greenville, MS 38703

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	Record review of the Corporate Nurse's signed witness statement dated 6/23/25 revealed, I was sitting in MDS office with door closed, heard [RN #1's name] speaking loud, rude, 'We not gonna do this today. I always give you your pain medicine, but today you gonna learn. I will give it to you when I get ready.' I opened the door and saw [RN #1's name]. An interview on 6/27/25 at 12:20 PM with the MDS Nurse confirmed she had been present with the Corporate Nurse on the day RN #1 spoke inappropriately to Resident #1. She stated that Resident #1 had called out for pain medication and began yelling, and RN #1 yelled back, You're in pain, you gonna stay in pain. You gonna be nasty to me, I'll be nasty to you. Record review of the MDS Nurse's signed witness statement dated 6/23/25 read, .I heard yelling in the hall. One of the residents was complaining of pain and the nurse told her that since she was being nasty, she was going to be nasty too and that she's going to stay in pain. Record review of an Employee Counseling Form dated 6/23/25 revealed RN #1 was suspended pending investigation and on 6/24/25 confirmed RN #1 was terminated following the completion of the investigation. Record review of Resident #1's admission Record revealed the facility admitted the resident on 4/6/23 with medical diagnoses including pain. Record review of Resident #1's Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 6/6/25 revealed a Brief Interview for Mental Status (BIMS) score of 13, indicating the resident was cognitively intact. Resident #2 A phone interview on 6/27/25 at 11:30 AM with Resident #2's representative confirmed she had recently contacted the DON after overhearing a nurse speak disrespectfully to her mother. She stated Resident #2 had called after using the call light without a response, soiled herself, and needed cleaning. Her brother contacted the facility, and while she remained on the phone, she overheard a nurse enter and say, I heard you calling, but you can just sit in it. The representative reported the incident to the facility but did not feel it was resolved. Record review of the facility's grievance log for June 2025 revealed a grievance dated 6/6/25 documenting the representative's complaint per our interview on 6/27/25 at 11:30 AM and indicated it was marked as resolved. An interview with the DON on 6/27/25 at 11:45 AM confirmed that Resident #2's representative reported the incident. Record review of Resident #2's admission Record revealed the facility admitted the resident on 12/28/24 with medical diagnoses that included Need for Assistance with Personal Care.