STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255247	A. Building B. Wing	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rest Haven Health and Rehabilitation	103 Cunningham Drive Ripley, MS 38663

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interview, record review, and facility policy review, the facility failed to ensure a resident's right to be treated with dignity and respect was honored for one (1) of three (3) residents sampled. Resident #1.Findings Include:Review of the facility policy, Resident Rights and Dignity Management, review date 9/2025, under Standard revealed that It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment that maintains or enhances resident's quality of life by recognizing each resident's individuality An interview with Administrator (ADM) on 01/15/26 at 9:25 AM, revealed that Resident #1 came into his office on 12/30/25 at approximately 1:40 PM and reported that Certified Nursing Assistant (CNA) #1 had been rude and disrespectful to her and told her to shut up. Administrator revealed that he watched the video camera footage and confirmed that it was true. He revealed that camera footage revealed that on 12/30/25 at 1:15 PM, Resident #1 was observed yelling down the hall for staff to take her to the restroom and CNA #1 stated they were getting on his nerves with this impatient stuff, and a few words later told her to Shut up. ADM revealed that Resident #1 was impatient and could be impulsive sometimes, but the staff had to understand how to deal with her and treat her with respect. He also agreed that CNA #1 failed to treat Resident #1 with dignity and respect and that was her right. He revealed that he called CNA #1 into the office and suspended him immediately and during the investigation CNA #1 resigned.An observation of video camera footage with ADM on 01/15/26 at 9:35 AM revealed that on 12/30/25 at 1:15 PM, Resident #1 was sitting in her wheelchair asking for help to go to the restroom. A male staff member, who ADM identified as CNA #1, approached Resident #1, spoke to her using a rude tone and told the resident to Shut up and after a few other words from Resident #1, he stated to her again, Hush your mouth. CNA #1 then walked away from Resident #1 and two other staff members assisted her. An interview on 01/15/26 at 10:40 AM with Assistant Director of Nursing (ADON), revealed that Resident #1 was very impulsive and often demanding, wanting what she asked for right then. ADON revealed that Resident #1 would often press her call light and go immediately out into the hall to find someone to help her. ADON revealed that they had issues with her being impatient about going to the bathroom because she was a two-person assist with a lift. She revealed that they could not always stop immediately what they were doing with other residents to attend to her needs and that upset her. ADON revealed that CNA #1 should never have approached Resident #1 with that behavior like he did, that he should have stepped away from the situation and allowed someone else to take over. She also revealed that Resident #1 does know how to push them to anger but they should always treat the resident with dignity and respect regardless because that was her right that should have been honored. An interview on 01/15/26 at 11:00 AM with Resident #1, revealed that on 12/30/25, there was an incident where a CNA failed to treat her with dignity and respect. She revealed that she pressed the call light for (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	someone to come in and help her to the bathroom. Resident #1 revealed that she did not have patience, and when she wanted something, she wanted it right then. She revealed that when she pressed her call light, she wheeled herself out into the hall and asked CNA #1 to take her to the bathroom. Resident #1 revealed that she and CNA #1 had words, and he told her to shut up and she stated, I guess I said something he didn't like. Resident #1 revealed that two other CNAs came in and took her to the restroom after that, and she confirmed that she went straight to ADM office and reported it. She also revealed that CNA #1 was normally kind and stated, I love him to death because he doesn't make me wait. She also revealed that she and CNA #1 always picked on each other and stated, He's a very good aid but he must have been having a bad day. Resident #1 revealed that she felt safe there and she hated that CNA #1 was no longer there.A phone interview on 01/15/26 at 11:45 AM with CNA #1, revealed that he resigned his position at the facility after the verbal altercation he had with Resident #1. He revealed that on 12/30/25, Resident #1 was on one of her [NAME], was upset and yelling out in the hall for someone to take her to the bathroom. He revealed that Resident #1 was not assigned to him that day, but he agreed to assist her to the bathroom when he finished taking care of the resident he was with. CNA #1 revealed that two other CNAs had asked her 15 minutes prior to that time if she needed to go to the bathroom and she declined. He revealed that when he walked up to Resident #1, she was mouthing off and he confirmed that he told her to shut up. He revealed that he got the lift and brought it into her room and she continued mouthing off at him. CNA #1 confirmed that he told her to shut up and to hush her mouth and that it was unprofessional of him to do so. He revealed that he should have walked away and let someone else take over. CNA #1 stated that he was sorry for the way he handled the situation and he should have treated her with respect and dignity and not been rude to her. He revealed that she reported it to the Administrator, and ADM sent him home pending the investigation and he turned in his resignation.Record review of an In-Service on Customer Service, Resident Rights, and Abuse was completed on 08/13/25 and 08/15/25 and CNA #1 attended.Record review of CNA #1's Record of Counseling dated 12/30/25 documented that he was suspended pending investigation of the alleged verbal abuse towards a resident.Record review of Resident #1's admission Record revealed an admission date of 03/13/20 and that she had diagnoses that included Type 2 Diabetes Mellitus and Unspecified Sequelae of Cerebral Infarction.Record review of Resident #1's Quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 12/19/25 under Section C revealed a Brief Interview for Mental Status (BIMS) Score of 15 which indicated that she had no cognitive deficits.