STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255292	A. Building B. Wing	01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy Manor Nursing and Rehabilitation	1935 North Theobold Extension Greenville, MS 38704

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, facility security camera video observations, policy reviews, interviews, and record reviews, the facility failed to ensure Resident #1's right to be free from abuse. Resident #1 was punched in the head, face, and chest with a closed fist at least 10 times and flipped over in his wheelchair on to the hallway floor by Certified Nursing Assistant (CNA) #1. Resident #1 received an injury of broken blood vessels to his right eye and swelling and had to be treated and evaluated by a physician. Resident #1 was one (1) of four (4) residents reviewed for abuse and neglect. Findings Include: Review of the facility policy titled: Resident Abuse last review date 01/24 stated, Conduct detrimental to resident care that results in neglect or abuse of any resident is strictly prohibited .B. Any employee suspected of abuse will be suspended immediately and future employment will be based on the outcome of the investigation. Review of the facility policy titled Employee Corporate Compliance Code of Conduct dated 05/18 and signed by CNA #1 on 1/11/23 revealed, Each resident residing in this facility has the right to be free from any type of abuse including verbal, sexual, mental, physical abuse, neglect, misappropriation of resident property and exploitation . Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. The facility's undated investigation report that was signed by the Director of Nursing (DON) stated, Staff Development, Licensed Practical Nurse (LPN) #2 and DON to building to review camera footage and noted that on 12/24/24 @ 1553 (3:53 PM) Resident #1 approached CNA#1 in hallway and appears to have tapped her on her arm and then made a motion like he was bowing up on her. CNA #1 was not pinned or trapped like she stated and had ample opportunity to step away. She began to hit him with her closed fist multiple times in the face. We counted approximately 10 times, and then proceeded to flip his wheelchair over. Resident #1 was then left lying on the floor and he proceeded to crawl into his room. At 4:06 PM she appeared back in hallway and picked up his belongings and threw them into his room and shut his door. She also picked wheelchair upright and it was left sitting in hallway. At 4:30 PM LPN #1 in hallway and they entered resident's room and got him up off the floor using lift. DON did assess right eye sclera is noted to be red with what appears to be ruptured blood vessels. (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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NAME OF PROVIDER OR SUPPLIER: Legacy Manor Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 1935 North Theobold Extension Greenville, MS 38704	

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Record review of the facility investigation concluded that CNA #1 had abused and neglected Resident #1 on 12/24/24. CNA #1 was terminated on 12/26/24 from the facility for abuse and neglect of Resident #1. Record review of the facility termination form titled Termination Report dated 12/26/24 revealed: (CNA #1) Last Day Worked 12/24/24 Termination Effective Date 12/26/24 Resident Abuse, Violation of Company Policies/Procedure-See Facility Investigation Interview on 01/14/25 at 12:30 PM with the facility Administrator (ADM) revealed that he was not involved in the investigation of the alleged abuse of (Resident #1) that occurred on 12/24/24. ADM stated that he was out of the state for the holidays and the DON and LPN #2 had completed the investigation and they had terminated CNA #1. ADM stated that the facility security video cameras were reviewed by the DON and LPN #2 and they both confirmed that CNA #1 was identified in the video and they both saw in plain view on the video that CNA #1 hit Resident #1 several times in the head, face, and chest with a closed fist. The DON terminated CNA #1 from her employment at the facility upon confirming that CNA #1 had abused and neglected Resident #1 and that she never attempted to remove herself from the encounter and go get help. CNA #1 not only hit Resident #1 with a closed fist, but she grabbed his wheelchair and intentionally flipped the wheelchair over dumping the resident out onto the floor of the hallway and stepped over Resident #1 leaving him unattended and unassessed for over 30 minutes. The ADM stated that the video was hard for him to watch and that the blatant abuse of Resident #1 was sickening. ADM stated that on 12/30/24 the Attorney General's (AG) office had come to the facility, and he too had obtained a copy of the facility video for his investigation. ADM stated that the AG was pursuing charges against CNA #1 for felony abuse and neglect. ADM shared the facility investigation, the facility video, and the phone numbers of the AG with the surveyor and sat down and reviewed and narrated the approximate 45-minute facility security video. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Observation of the facility security camera video on 1/14/2025 at 12:45 PM-1:35 PM along with the interview of the ADM verbally identifying the times of the events, along with the video clock (which verified the time of the event as 3:50 PM on 12/24/24 until 4:30 PM on 12/24/24). The video contained no audio. Observation of the facility video revealed that at approximately 3:55 PM on 12/24/24 Resident #1 approached CNA #1 in the hallway as he rolled up close to her in his wheelchair. Immediately CNA #1 began to punch Resident #1 in the face, head and chest with a closed fist. CNA #1 never attempted to obtain assistance, nor did she attempt to leave the situation and go get help. CNA #1 hit Resident #1 many times with a closed fist and was unable to count the fist punches accurately because they were happening too fast. It appeared to be at least a dozen fist punches (approximately) administered by CNA #1 to Resident #1. CNA #1 had several opportunities to leave away from Resident #1, but she did not attempt to remove herself from the situation. CNA #1 reached down near the front wheels of Resident #1's wheelchair and flipped the chair over dumping Resident #1 on to the floor and on to his back. From approximately 4:05 PM on 12/24/24 until approximately 4:20 PM on 12/24/24 Resident #1 was left lying on the floor in the hallway unassisted and unattended. Resident #1's wheelchair remained turned over on its side and personal clothing items and a seat cushion were scattered about the hallway. Resident #1 moved slowly on the floor of the hallway dragging his limp body across the floor and into his room where he disappeared from the camera view. At approximately 4:30 PM on 12/24/24 (LPN #1) appeared on the hallway and she and CNA #1 went into the room of Resident #1. CNA #1 was pushing the full body lift into the room of Resident #1. CNA #1 went into another resident's room across the hall from Resident #1 and left Resident #1 unattended and unassessed lying in the hallway for approximately 30 minutes. When CNA #1 came out of the other resident room she picked up the wheelchair and threw the cushion and clothing from the hallway into Resident #1's room and then reached in and closed the door to Resident #1's room. CNA #1 did not go into Resident #1's room and never assisted Resident #1. CNA #1 never went to get help/assistance for approximately 30 minutes. CNA #1 was never seen on the video reporting the incident to anyone or seeking assistance for Resident #1. ADM stated that CNA #1 never reported a fall or any incident to anyone. CNA #1 worked second shift (3:00 PM-11:00PM) on 12/24/24 and worked third shift (11:00 PM -7:00 AM) on 12/24/24 and never mentioned the incident with Resident #1 to anyone. CNA #1 did not report the altercation between her and Resident #1 to any staff member or to anyone at the facility for two (2) eight-hour shifts (approximately 16 hours), according to the interview with the ADM on 1/14/25 at 12:30 PM. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Observation of the facility security camera video and interview on 1/14/25 at 1:00 PM with the DON revealed that she was out of town with her family celebrating Christmas Day when at approximately 12:00 noon she was contacted by LPN #2 and told that there was a report of abuse given by another resident (Resident #3). DON stated that she never in a million years would have believed that CNA#1 would have done such a thing as abuse a resident like she did. DON had to drive to the facility from another state to investigate the situation at the facility. She informed LPN #2 to call CNA #1 and suspend her until the investigation could be completed and to get a statement from CNA #1 over the phone as to what had occurred. CNA #1 told them that Resident #1 attacked her first and pinned her up against the wall with his legs and that she had to get him off of her and she slapped Resident #1 with an open hand and then he slid out of his wheelchair. CNA #1 told LPN #2 that she had not abused Resident #1. LPN #2 and DON both arrived at the facility at approximately 4:00 PM and they together viewed the security video cameras and they could not believe their eyes as they both saw CNA #1 repeatedly hitting Resident #1. CNA #1 flipped over the wheelchair dumping Resident #1 out on his back into the hallway floor. DON stated that they identified several times during the encounter when CNA #1 could have left and gone for assistance, but she never did. She also left Resident #1 in the floor unattended and unassessed for over 30 minutes and she never reported the incident to anyone. DON stated that at no time during the encounter was CNA #1 pinned up to the wall by Resident #1. DON stated that the realization of the video clearly confirmed that Resident #1 was abused and neglected by CNA#1. DON stated that the video was not at all consistent with the statement that was given by CNA #1. DON viewed the video with ADM and surveyor and she identified CNA #1 and Resident #1 and she confirmed that CNA #1 was terminated for the abuse and neglect of Resident #1. DON stated that CNA #1 never reported the incident during the 16 hours that she worked on 12/24/24-12/25/24 and that the incident occurred within an hour of her first coming into work that day. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	In an interview on 1/14/25 at 1:40 PM with LPN #2 revealed that she was the on call nurse supervisor on 12/25/24. She stated that CNA #3 called her to report that another resident (Resident #3) reported that on 12/24/24 Resident #1 and CNA #1 had been in an altercation in which CNA #1 hit Resident #1. It was reported that on 12/25/24 at 11:48 AM Resident #1 had a swollen eyed with blood vessels busted in his eye. When LPN #2 asked Resident #1 what had occurred he stated that maybe CNA #1 had stuck her finger in his eye when they were on the floor tussling. LPN#2 then called LPN#1 at 11:59 AM on 12/25/24 and asked her what had occurred on 12/24/24 and how did Resident #1 get a blood shot eye. LPN #1 told LPN #2 that she had no idea how Resident #1 had received a blood shot eye. All that had occurred during the second shift on 12/24/24 was Resident #1 had slid out of his wheelchair on to the floor and was assessed by LPN #1 and Resident #1 was found to have had no injuries. LPN #1 had no knowledge of any incidents/accident with Resident #1 on 12/24/24. LPN #2 stated that she received a call from CNA #1 at approximately 12:11 PM on 12/25/24 in which CNA #1 said she had something to report to LPN #2. CNA #1 stated that Resident #1 had attacked her, and he had hit her and pinned her up against the wall. CNA #1 told LPN#2 that she hit Resident #1 with an open hand to get him off of her and that she did not report the incident to LPN #1 and did not seek assistance from anyone. LPN #2 stated that she then went back and watched the security video to see what had happened. LPN #2 and the DON viewed the video together on 12/25/25 and they both were in disbelief at the abuse that they saw on the video to Resident #1 from CNA #1. LPN #2 stated that she and the DON slowed the video down while viewing and counted 10 times that CNA #1 hit Resident #1 with a closed fist. CNA #1 purposefully flipped Resident #1 over in his wheelchair, dumping him onto the floor of the hallway and then walked away leaving Resident #1 on the floor unattended and unassessed. LPN #2 stated that never did she view on the video that Resident #1 had pinned CNA #1 up against the wall. The video did not show the encounter with Resident #1 that CNA #1 had explained. LPN #2 stated that she interviewed Resident #1 on 12/25/24 and he was unable to remember how he received the broken blood vessels to his right eye. LPN #2 called the local Police department at 1:22 PM to come and complete a police report of the incident because it was determined that alleged abuse had occurred. LPN #2 stated that after viewing the facility security video it was determined that CNA #1 had abused and neglected Resident #1 and she was terminated from the facility. LPN #2 stated that she and the DON were so upset by the abuse that they viewed on the video that they both cried. LPN #2 stated that no one, no matter what had happened, deserved what CNA #1 did to Resident #1. LPN #2 stated that CNA #1 had several opportunities to leave and go get help, but she did not, she continued to hit Resident #1 and flipped him over in his wheelchair. An interview on 1/14/25 at 2:00 PM with the AG Investigator, revealed that he came to the facility on [DATE] and obtained copies of the Police Report, the facility video, and copies of Resident #1's records. He stated that he was taking the case to the District Attorney and was asking for felony charges to be placed against CNA #1 for abuse and neglect of Resident #1. The AG stated that he was convinced that the District Attorney would allow him to arrest CNA #1 for abuse and neglect of Resident #1. He stated that the video alone was enough evidence to put CNA #1 in jail. Interview and observation on 1/24/25 at 3:00 PM with Resident #1 revealed an obese male sitting in a wheelchair in his private room, alone. Resident #1 mumbled and made statements that were not relevant to the subjects and appeared to not be cognitive of his surroundings as he rambled and stated that no one had ever hurt him there and that he had not gotten into an altercation with anyone. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Interview and observation on 1/24/25 at 3:10 PM with Resident #3 revealed that he remembered the altercation between Resident #1 and CNA #1 that occurred on Christmas Eve. Resident #3 stated that everyday Resident #1 cusses and turns over furniture and causes problems. He also makes sexual comments to the staff and He metals in things that do not belong to him. Interview on 1/14/25 at 3:30 PM with LPN #1 revealed that she was the second shift (3:00 PM-11:00 PM) nurse on 12/24/24. She stated that she was making rounds and giving out medications at approximately 4:30 PM on 12/24/24 when she found Resident #1 lying on the floor of his room. She stated that CNA #1 was coming past with the full body lift, and she asked CNA #1 to help her put Resident #1 back in his bed with the full body mechanical lift. LPN#1 had assessed the resident on the floor and had determined he was not injured and he told her he fell out of his chair. LPN #1 re-assessed Resident #1 again when he was lifted to his bed and he voiced that he was not injured and issued no complaints and gave no information as to how he fell other than he slipped out of his wheelchair. LPN #1 stated that CNA #1 never reported that she had knowledge of Resident #1 falling or that there had been an incident. LPN #1 was busy during that period giving out medications and making rounds and she never heard any disturbances and was unaware that there had been an incident between Resident #1 and CNA #1. Resident #1 has behaviors, and he regularly acts out and gets loud and turns over furniture and makes demands to go home. He is cognitively impaired, and he has sundowners. Interview on 1/14/25 at 4:10 PM with CNA #2, revealed that on 12/24/24 she was the other CNA on that unit along with CNA #1 and LPN #1. She stated that she never heard any disturbances on 12/24/24 between CNA #1 and Resident #1 and that no one had reported to her that Resident #1 had been found on the floor. Record review of Resident #1's Minimum Data Set (MDS) Section C dated 11/12/24 revealed a Brief Interview for Mental Status (BIMS) score of 7 which indicated that Resident #1 was severely cognitively impaired. Record review of Resident #1's Admission Record documented that Resident #1 had been admitted to the facility on [DATE] and had diagnoses which included Alcohol Abuse with Alcohol Induced Mood Disorder; Psychoactive Substance Abuse with Withdrawal; Dementia with Behaviors; and Cognitive Communication Deficit.