STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255346	A. Building B. Wing	01/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Singing River Skilled Nursing Facility	2809 Denny Avenue Pascagoula, MS 39581

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 41306 Based on observation, interviews, record review, and facility policy review, the facility failed to ensure Resident #1's right to be free from physical abuse from a staff member for one (1) of four (4) sampled residents. Resident #1 Resident #1 was physically abused on 12/17/24 when the Campus Police Officer (CPO) #1 hit the resident with his own shoe, pushed the resident to the floor, and attempted to use a taser improperly. (4) nurses observed the abuse and failed to intervene, allowing the abuse to escalate. This resulted in Resident #1 receiving a hematoma. The facility's failure to protect Resident #1 from abuse caused physical harm, including a hematoma requiring an emergency room evaluation. Additionally, the facility's failure to intervene placed other residents at risk for similar abuse. The situation was determined to be an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) that began on 12/17/24. The State Agency (SA) notified the Administrator of the IJ and SQC on 1/10/25 at 12:30 PM and provided an IJ Template. Based on the facility's implementation of corrective actions on 12/18/24, the SA determined the IJ and SQC to be Past-Non-Compliance (PNC) and the IJ was removed on 12/19/24 prior to the SA's entrance on 1/9/25. Findings include: A review of the facility policy titled Abuse or Neglect of a Vulnerable Adult or Child, with an effective date of 8/2024, revealed: .Definitions .Abuse - the commission of a willful act, or the willful omission of the performance of a duty, which act or omission contributes, tends to contribute to, or results in the infliction of physical pain, injury, or mental anguish on or to a vulnerable person .Vulnerable person - A person .whose ability to perform normal activities of daily living or to provide for their own care or protection from abuse .is impaired .The term vulnerable person also include all residents or patients, regardless of age, in a care facility . Record review of the Patient Information revealed the facility admitted Resident #1 on 12/10/24 with diagnoses that included Acute Congestive Heart Failure. (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A record review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date of 12/16/24 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 6, indicating severe cognitive impairment. A record review of the Incident Report for Event 12/17/2024 revealed that Resident #1 was awakened by a Certified Nurse Assistant (CNA) to change his brief and soiled clothing. When awakened, the Resident became aggressive with staff. It was reported that he had not slept well in several days and was agitated that someone woke him. The campus police became aggressive with the resident; staff did not intervene, and campus police aggressively handled the resident, causing him to fall and sustain a head injury (large hematoma/knot to right forehead). The campus police attempted to tase residents twice (unsuccessfully). A second officer then responded to the unit to assist, spoke in Spanish with him, and then transferred him to the Emergency Department for an evaluation. The resident returned to the skilled unit in no apparent distress with examination by providers and continued to be negative. The campus police officer was immediately suspended and then terminated. A record review of the Case Report, dated 12/17/24, completed by the Campus Police Officer (CPO) #1, revealed a Narrative text of .At approximately 0400 (4:00 AM) I was contacted by staff member .in reference to an unruly patient .I asked (Proper Name of Resident) several times to put his clothing on and (Proper Name) openly refused. When I attempted to assist (Proper Name) with putting his clothes on he became aggressive and actively resistant. Do (due) to the height difference I used open hand techniques to assist (Proper Name) back in the chair. Due to (Proper name)'s resistance he fell on to the floor and hit his head . he passively resisted for approximately 30 minutes while the staff tried to coax him to get into the wheelchair. (Proper Name) refused to get in the chair after I told him he would be tased and probably fall again. I tased (Proper Name) twice and he still did not comply . A record review of the Employee Coaching/Corrective Action Report, dated 12/19/24, revealed a Summary of Behavior/Incident/Issue indicated .On 12/17/24 (Proper Name of CPO #1) responded to a call .where assistance was requested with a patient who was reported to be combative. It was reported that (Proper Name) used excessive force, physically shoving pt (patient) to fall and hit his head on the floor. Additionally, it was reported that (Proper Name) used her taser during the interaction with the pt . On 1/9/25 at 10:15 AM, during an observation of the recorded surveillance footage from the event that occurred on 12/17/24 revealed that at 3:45 AM, staff entered Resident #1's room. At 4:03 AM, CPO #1 entered the skilled nursing unit. At 4:04 AM, CPO #1 kicked shoes at Resident #1 and shoved the resident, causing them to fall. At 4:36 AM, Officer #1 unholstered a taser and attempted to use it on Resident #1 twice, while staff were present and failed to intervene. At 4:42 AM, Officer #2 arrived and calmed Resident #1. The resident was then transported to the Emergency Department (ED). A record review of the ED visit, with an encounter date of 12/17/24, revealed a History of Present Illness (HPI) of .campus police tazed him twice . (continued on next page)

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	On 1/9/25 at 6:20 AM, during an interview with Certified Nurse Assistant (CNA) #1, she confirmed that she had been employed at the facility for three (3) months and attended in-services on abuse, neglect, and vulnerable adult acts upon hire. She stated CNA #2, and a student CNA requested assistance because Resident #1 was being aggressive and hitting CNA #2. She confirmed that upon the arrival of CPO #1, the officer became very aggressive, causing her to fear assisting Resident #1. She stated it was distressing to hear the taser discharge. On 1/9/25 at 6:30 AM, during an interview with Licensed Practical Nurse (LPN) #1, she confirmed that she had been employed at the facility since November 2024 and attended in-services on abuse, neglect, and vulnerable adults acts. LPN #1 stated that on 12/17/24 at approximately 3:45 AM, Resident #1 became confused and combative during care, hitting CNA #2. LPN #2 phoned CPO #1 for assistance. LPN #1 witnessed CPO #1's aggression toward Resident #1, including pushing him to the floor and attempting to use a taser. She expressed fear of CPO #1, which prevented her from intervening. On 1/9/25 at 6:45 AM, during an interview with LPN #2, she stated she called the CPO because she believed the officer's familiarity with the resident might calm him. She described the officer's actions, including pushing Resident #1 to the floor, throwing shoes at him, and attempting to use a taser twice. She confirmed she did not intervene due to fear and reported the incident to the Director of Nursing (DON). On 1/9/25 at 9:20 AM, during an interview with the Nurse Practitioner (NP), she confirmed being informed of the incident in the early hours of 12/17/24. She stated that Resident #1 had been agitated and sleep-deprived for four (4) nights. The NP noted Resident #1's forehead hematoma upon return from the ED and prescribed sleep medications to prevent further agitation. On 1/9/25 at 10:00 AM, during an interview with the Registered Nurse (RN)/Administrator on Call (AOC) #1, she confirmed receiving a call from LPN #2 at 4:45 AM about Resident #1's aggression and the involvement of the Campus Police. She reviewed surveillance footage and stated that CPO#1's actions were inappropriate and aggressive, and staff failed to intervene. On 1/9/25 at 11:00 AM, during an interview with Human Resources, it was confirmed that CPO #1 was hired on 9/30/24 and completed in-services on de-escalation training on 10/13/24. CPO #1 was suspended on 12/17/24 and terminated on 1/3/25 following the investigation. On 1/9/25 at 11:14 AM, during an interview with LPN #3, she described observing CPO #1 pushing Resident #1 to the floor, throwing his shoes, and attempting to use a taser twice. She confirmed the incident was distressing, and fear prevented her from assisting. On 1/9/25 at 11:40 AM, during an interview with LPN #4, she confirmed that she had been employed at the facility for the last three (3) to 4 months and had attended in-services on abuse, neglect, and vulnerable adults. She stated that when CPO #1 entered the unit, the officer was immediately aggressive toward Resident #1. She explained that everything happened quickly, and she became scared and traumatized, feeling as though she might be attacked. She confirmed that fear prevented her from interacting with the officer. On 1/9/25 at 1:00 PM, during an interview with CNA #2, she described providing incontinent care to Resident #1 when he became aggressive and hit her. She stated that CPO #1's actions escalated the situation, and she was too afraid to intervene. (continued on next page)

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	On 1/9/25 at 4:16 PM, during an interview with Resident #1's family member, she confirmed the facility informed her that the resident had been unruly and that the CPO was called to assist with calming him, but instead, she pushed him to the ground and attempted to tase him twice. She also confirmed she was aware of the hematoma he received during the incident. On 1/10/25 at 10:00 AM, during an interview with the Administrator, he confirmed that after reviewing the surveillance videos, his staff should have intervened to assist Resident #1. On 1/10/25 at 11:00 AM, during an interview with the Director of Nursing (DON) she stated that staff failed to intervene during the incident and confirmed immediate corrective actions were implemented. The facility implemented the following corrective actions prior to the State Agency's entrance on 1/9/25: On 12-17-24, resident #1 was sent to the emergency room for evaluation after an incident occurred on the SNF unit involving police officer. Resident #1 returned to the skilled unit on the same day. Upon return, resident #1 was assessed by nurse practitioner for signs and symptoms of distress and for injuries sustained during altercation. Resident #1 denied any pain except for some tenderness to healing ulcers on the lower extremities. On 12/17/24 Social Services conducted interviews with residents with BIMS >/= 13 to determine if they feel safe from abuse at this facility. The police were notified on 12-17-2024 of the incident. The case number that was provided is: 24-8314 The administrator and Director of Nursing (DON) were in -serviced on abuse and neglect on 12-17-2024. These in-services were conducted by Administrative Director and LNFA (Licensed Nursing Facility Administrator) Consultant. On 12/17/24 all SNF staff present during patient incident were interviewed by SNF Admin. The nursing educator provided the following in-services to all SNF nursing staff prior to being allowed to work on the SNF. Abuse and neglect policy, including taking immediate steps to intervene during abusive situations. This was completed on 12-18-2024. Dementia Care, de-escalation, therapeutic communication, nurse responsibility and abuse neglect policies. This in-service was completed on 12-18-2024. The facility conducted an emergency QAPI meeting on 12/17/24. Policies were reviewed with no changes made at this time. Initial monitoring of staff and patients with increased presence on floor. Immediately reviewed previous days incidents to ensure abuse/neglect policy was adhered to and continued daily monitoring of incidents. The Medical Director was notified of patient event on 12/17/2024. (continued on next page)

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #1: care plan updated on 12/17/2024. Mississippi Board of Nursing notified on 12/19/2024 at the direction of state agency. Police officer was suspended on 12/17/24 and terminated from Singing River on 1/3/25. The LPN #1, LPN #2, CNA #1 were issued a corrective action with 3-day suspension: The additional will be monitored per staff for continued effectiveness as follows beginning 1/10/25: Abuse/Neglect Policy & Adherence to Care Plan Quality of corrections will be monitored daily by using a minimum of 5 (five) staff interviews per day 5 (five) days a week for 8 (eight) weeks. Quality of correction will also be monitored by observing interventions and interactions with patients 5 (five) days a week for 8 (eight) weeks. Findings will be reported to QAPI (Quality Assurance Performance Improvement). The facility alleges all corrective actions were completed on 12/18/24, and the Immediate Jeopardy was removed on 12/19/24 prior to the State Agency's entrance on 1/9/25. Validation: The SA validated on 1/13/2025, through interview and record review that all corrective actions had been implemented as of 12/18/24, and the facility was in compliance as of 12/19/24, prior to the SA's entrance on 1/9/2025.

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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 0656 Level of Harm - Immediate jeopardy to resident health or safety 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. 41306 Based on interviews, record review, and facility policy review, the facility failed to implement comprehensive care plan interventions for a resident with behaviors for one (1) of four (4) sampled residents. Resident #1 On 12/17/24, when Resident #1 exhibited behaviors, staff failed to implement care plan interventions. Instead, a nurse called the Campus Police Officer (CPO) who physically abused the resident by hitting the resident with their own shoe, pushing the resident to the ground, and attempting to use a taser. The facility's failure to implement the care plan interventions directly resulted in Resident #1, sustaining a hematoma on the head and the need for emergency medical evaluation. Additionally, the facility's failure placed other residents at risk as staff did not follow prescribed actions to manage behaviors and ensure resident safety. The situation was determined to be an Immediate Jeopardy (IJ) that began on 12/17/24. The State Agency (SA) notified the Administrator of the IJ on 1/10/25 at 12:30 PM and provided an IJ Template. Based on the facility's implementation of corrective actions on 12/18/24, the SA determined the IJ to be Past-Non-Compliance (PNC) and the IJ was removed on 12/19/24 prior to the SA's entrance on 1/9/25. Findings include: A review of the facility policy titled SNF (Skilled Nursing Facility) Care Plan Completion, effective date 10/2024, revealed, .Policy .5. The facility will develop a Comprehensive Person-Centered Care Plan for each resident .that includes .b. Services to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . Record review of the Patient Information revealed the facility admitted Resident #1 on 12/10/24 with diagnoses that included Acute Congestive Heart Failure. A record review of the Care Plan revealed Problem: Behaviors: (Proper Name) is slow to respond to questions with a goal of Patient will decrease risk factors of harming themselves or others secondary to their behaviors, with a start date of 12/10/24. A Goal Intervention with a start date of 12/10/24 revealed, Intervene as needed to protect the rights and safety of others; approach in a calm manner; divert attention, remove from situation and take to another location as needed . Another Goal Intervention with a start date of 12/10/24 included interventions details to give one-step directions and allow time to process them before giving more directions decrease sudden or loud noises, ask permission before touching or assisting with dressing task, and if startled, allow to refuse, extra processing time, and return once he has calmed down. (continued on next page)

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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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A record review of the Incident Report for Event 12/17/2024 revealed that Resident #1 was awakened by a Certified Nurse Assistant (CNA) to change his brief and soiled clothing. When awakened, the Resident became aggressive with staff. It was reported that he had not slept well in several days and was agitated that someone woke him. The campus police became aggressive with the resident; staff did not intervene, and campus police aggressively handled the resident, causing him to fall and sustain a head injury (large hematoma/knot to right forehead). The campus police attempted to tase residents twice (unsuccessfully). A second officer then responded to the unit to assist, spoke in Spanish with him, and then transferred him to the Emergency Department for an evaluation. The resident returned to the skilled unit in no apparent distress with examination by providers and continued to be negative. The campus police officer was immediately suspended and then terminated. During an interview on 1/9/25 at 6:30 AM, License Practical Nurse (LPN) #1 revealed if they would have followed the care plan interventions, they may not have had the incident with CPO #1. During an interview on 1/9/25 at 6:45 AM, LPN #2 confirmed that she did not follow the care plan interventions related to behaviors for Resident #1, but they did give him something to drink during the event. On 1/9/25 at 10:00 AM, during an interview with Registered Nurse (RN)/Administrator on Call (AOC) #1, she confirmed the staff did not follow the care plan interventions, and the facility expects all staff to follow the Comprehensive Care Plans. On 1/9/24 at 12:40 PM, during an interview with the RN/Minimum Data Set (MDS) Coordinator, she confirmed that she expects all staff to follow the Comprehensive Care Plans' interventions on residents. The care plans are person-centered and address residents' needs and safety. On 1/10/25 at 11:00 AM, during an interview with the Director of Nursing (DON), she revealed the staff on the unit should have followed the care plan interventions for the safety of the residents. She expected all staff to follow the residents' care plans, and the purpose of the care plan is to provide each resident with care based on their individual needs. The facility implemented the following corrective actions prior to the State Agency's entrance on 1/9/25: On 12-17-24, resident #1 was sent to the emergency room for evaluation after an incident occurred on the SNF unit involving police officer. Resident #1 returned to the skilled unit on the same day. Upon return, resident #1 was assessed by nurse practitioner for signs and symptoms of distress and for injuries sustained during altercation. Resident #1 denied any pain except for some tenderness to healing ulcers on the lower extremities. On 12/17/24 Social Services conducted interviews with residents with BIMS >/= 13 to determine if they feel safe from abuse at this facility. The police were notified on 12-17-2024 of the incident. The case number that was provided is: 24-8314 (continued on next page)

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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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The administrator and Director of Nursing (DON) were in -serviced on abuse and neglect on 12-17-2024. These in-services were conducted by Administrative Director and LNFA (Licensed Nursing Facility Administrator) Consultant. On 12/17/24 all SNF staff present during patient incident were interviewed by SNF Admin. The nursing educator provided the following in-services to all SNF nursing staff prior to being allowed to work on the SNF. Abuse and neglect policy, including taking immediate steps to intervene during abusive situations. This was completed on 12-18-2024. Dementia Care, de-escalation, therapeutic communication, nurse responsibility and abuse neglect policies. This in-service was completed on 12-18-2024. The facility conducted an emergency QAPI meeting on 12/17/24. Policies were reviewed with no changes made at this time. Initial monitoring of staff and patients with increased presence on floor. Immediately reviewed previous days incidents to ensure abuse/neglect policy was adhered to and continued daily monitoring of incidents. The Medical Director was notified of patient event on 12/17/2024. Resident #1: care plan updated on 12/17/2024. Mississippi Board of Nursing notified on 12/19/2024 at the direction of state agency. Police officer was suspended on 12/17/24 and terminated from Singing River on 1/3/25. The LPN #1, LPN #2, CNA #1 were issued a corrective action with 3-day suspension: The additional will be monitored per staff for continued effectiveness as follows beginning 1/10/25: Abuse/Neglect Policy & Adherence to Care Plan Quality of corrections will be monitored daily by using a minimum of 5 (five) staff interviews per day 5 (five) days a week for 8 (eight) weeks. Quality of correction will also be monitored by observing interventions and interactions with patients 5 (five) days a week for 8 (eight) weeks. Findings will be reported to QAPI (Quality Assurance Performance Improvement). The facility alleges all corrective actions were completed on 12/18/2024 and the IJ removed on 12/19/24 prior to state agency's entrance on 1/9/25. Validation: (continued on next page)

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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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The SA validated on 1/13/2025, through interview and record review that all corrective actions had been implemented as of 12/18/24, and the facility was in compliance as of 12/19/24, prior to the SA's entrance on 1/9/2025.