STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255171	A. BUILDING _____ B. WING _____	C 10/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINONA MANOR HEALTH CARE AND REHABILITATION CENTER	**627 MIDDLETON ROAD WINONA, MS 38967**

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F 000	INITIAL COMMENTS The State Agency (SA) conducted a complaint investigation (CI) MS# 23045 at the facility on 10/18/23. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid Services. The SA identified non-compliance and cited F609 for CI MS# 23045 for Reporting of Alleged Violations.. The census at the time of the survey was 90 with a bed capacity of 119 beds.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her	F 609		11/22/23

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

Electronically Signed | 11/08/2023

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F 609	Continued From page 1 designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, resident interview and facility policy review, the facility failed to complete timely reporting of a resident involved accident in the facility's wheelchair lift van to the State Agency, for one (1) of four (4) residents reviewed for wheelchair transportation safety. Resident #1 Findings Include: Review of the facility policy titled, "Policies and Procedures," with a revision date of 11/16/2022, revealed " ... Employee Obligation ... to report such information immediately, but no later than two (2) hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury ... to other officials in accordance with State law. ... Report the result of all investigations ... to the State Survey Agency, with five (5) working days of the incident." A telephone interview on 10/18/23 at 11:30 AM with the Ombudsman revealed she was not notified by the nursing facility of the incident for Resident #1 regarding his wheelchair tilting over in the wheelchair lift van during transport. Record review of the "Verification of Investigation," facility reported incident form, for	F 609	1. On 10/5/2023 at approximately 10:30 AM, an incident involving resident #1 being transported in facility van occurred. According to the time stamp of the initial telephone report by the nursing facility to the State Agency Complaint Division revealed wireless caller voice message was documented on October 9, 2023 at 11:10 20.8 seconds AM. The Executive Director initiated education on reporting incidents deemed reportable to the State Agency in a timely manner on 10/9/2023. 2. All residents have the potential to be affected. Any issues deemed reportable will be reported to the State Agency. 3. Quality Review was conducted on 10/09/2023 by Executive Director and Director of Clinical Services on reportable incidents over the past 7 days. After review, no incidents in the past 7 days were deemed reportable to the State Agency. The Executive Director and Director of Clinical Services were educated on 11/7/2023 by Regional Director of Clinical Services on the components of reporting to the appropriate State Agency. Education on reporting incidents to the State Agency was initiated on 10/9/2023 by the Executive Director and Regional Director of Clinical Services and will be completed with all van drivers on 10/13/2023. Newly	

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F 609	Continued From page 2 Resident #1, revealed "RESIDENT NAME: (Resident #1's name removed) ... DATE/TIME OF OCCURRENCE: 10/05.23 @ (at) approx. (approximately) 10:30 AM ... PROVIDED DETAILED DESCRIPTION OF EVENT/ALLEGATION: Resident was being transported to appointment on facility van. Resident fell backward in van during transport and hit left shoulder on floor. Seat belt remained intact throughout event. ASSESSMENT OF RESIDENT/DESCRIBE INJURY: No bruising, redness, or skin tears noted to resident post incident. Resident refused to go to Emergency Room (ER) to be evaluated. RESIDENT INTERVIEW SUMMARY: Resident stated that he was secured in wheelchair and when they stopped at red light and went forwards, his wheelchair tipped backward and he hit his left shoulder on the floor. He denied any other injuries or pain and refused to go to the ER to be evaluated. ... FIRST REPORTED BY NAME: (Certified Nurse Aide (CNA)#1 name removed), NAME/TITLE REPORTED TO: (Registered Nurse (RN) #1 (name removed), DATE REPORTED: 10/5/23, TIME REPORTED" 10:35 AM ... STATE AGENCY NOTIFIED: YES, CONTACT NAME: Reporting Line, DATE: 10/5/23, TIME: 10:45 AM ... PRINTED NAME: (Former Director of Nursing (DON) name removed), DATE: 10/05/23." Record review of the time stamp of the initial telephone report by the nursing facility, provided by the SA Complaint Division, revealed "WIRELESS CALLER, Voice Message From: WIRELESS CALLER, 1 (662) 7691195 Oct 9, 2023, 11:10 20.8 sec." Record review of the documentation for the	F 609	hired staff will be educated by the Director of Human Resources on the policies and procedures that govern reporting incidents to the State Agency. 4. A Quality Assurance Improvement (QAPI) meeting was held on 10/19/2023 to ensure that incidents deemed as reported to the appropriate State Agency. The Executive Director and Director of Clinical Services will conduct Quality Monitoring initiating on 11/1/2023 of incident reports from the previous day in daily clinical meeting to determine if they are deemed reportable to the State Agency, 5x/weekly X 4 weeks, then 3x/weekly X 2 weeks, then weekly X 6 weeks. On 11/22/2023 we will conduct a QAPI meeting to review our findings from our Quality Monitoring to ensure our solution is sustained. We will review all findings from our Quality Monitoring on the 15th of each month during the QAPI meeting by the QAPI Committee in the monthly meeting for 6 months to ensure our solutions are sustained. 5. AOC:11/22/2023	

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incident revealed "DON and NP (Nurse Practitioner)/MD (Medical Director) aware and resident is his own RP (Responsible Party). MD gave orders to continue with transportation and upon return to center can follow up at the ER for an X-Ray."

An interview on 10/18/23 at 12:38 PM with CNA #1 revealed she immediately called and reported the incident of Resident #1's wheelchair tilting over during transport.

An interview on 10/18/23 at 2:09 PM with Resident #1 revealed he was sitting in the wheelchair during transport on 10/5/23, when the driver pulled off from the red light and his chair flipped over, causing him to bump his left shoulder and the left side of his head.

An interview on 10/18/23 at 3:01 PM with RN #1 revealed she did receive the initial report and witness statement from CNA #1 of the incident with Resident #1' wheelchair tilting over in the wheelchair van during a transport to an appointment, on 10/5/23 before 10:30 AM, and immediately returned to a meeting with the Administrator, the Former DON, the MD, and his NP, and informed them of the incident.

A telephone interview on 10/18/23 at 04:22 PM with the Former DON, revealed she called the report in to the State Agency (SA) hotline on 10/5/23 shortly after she was informed of the information by the RN #1 on the same day. She revealed she was not aware of why the SA reported her call recorded on 10/9/23 at 11:10 AM. She revealed she emailed her report a couple of days later and did not include findings because there were none. She noted she did not

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have to add a conclusion because she did not prove something went wrong. She shared she was not late calling in the initial report and was not late sending the written report.

A telephone interview on 10/18/23 at 05:07 PM with the SA Complaint Division confirmed the initial report time of 10/9/23 at 11:10 AM from the Former DON at the nursing facility. SA was allowed to listen to the initial recorded report, from the Former DON, that warranted the SA Complaint Division to need to call back for clarification of what the incident entailed, and emailed SA a copy of the time stamp for the recording of the initial report from the Former DON at the nursing facility. The SA Complaint Division also verified the Former DON's personal cell phone number that was recorded as the number the incident was called in from, provided 10/11/23 at 02:20 PM as the first submission for the final/completed written investigation, and provided 10/15/23 at 09:22 PM for a resubmission of the final/completed written investigation.

An interview on 10/18/23 at 05:20 PM with the Administrator revealed the Former DON was the one responsible, at the time of the incident, for reporting facility incidents to the SA Complaint Division, and confirmed that the Former DON did not follow the federal regulations for timely reporting of a resident involved incident in a timely manner.

Record review of the Admission Record for Resident #1 revealed an admission date of 07/15/2022.

Record review of Section C of the Quarterly

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F 609	Continued From page 5 Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 09/18/2023, for Resident #1, revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating Resident #1 is cognitively intact.	F 609		