STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255097	A. BUILDING _____ B. WING _____	C 05/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE CENTER OF ABERDEEN	505 JACKSON ST ABERDEEN, MS 39730

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Initial Comments CI MS #18224; CI MS #18478; CI MS #18521 and Covid 19 The State Agency (SA) conducted onsite complaint investigations (CI) and a Covid 19 Focused Infection Control Survey on 05/17/2022-05/19/2022 for three (3) complaints, CI MS #18224 alleged abuse of a resident by two (2) staff members while in the bathroom/shower area; CI MS #18478 alleged that there was abuse and/or neglect of resident while riding in a wheel chair on the facility van/bus; and CI MS #18521 alleged abuse and/or neglect of a resident by staff's refusing to deliver quality care to a cognitively impaired resident. The SA unsubstantiated abuse and neglect for all three (3) complaint investigations, and no Substandard Quality of Care was identified. The SA substantiated CI MS #18478 and cited deficiencies at F689 Scope and Severity (S/S) at a "G" level (harm) for failure to supervise a bilateral amputee resident riding in the facility van/bus. The SA determined that the facility was not in substantial compliance with the federal regulations for participation in Medicare and Medicaid. The resident census on 5/17/2022 was 85 and the facility held a license for 120 beds.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		6/20/22

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

Electronically Signed | 06/08/2022

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F 689	Continued From page 1 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: CI MS #18478 Based on facility policy reviews, record reviews, observations, and interviews, the facility failed to supervise and to secure the seat belts to a bilateral amputee resident while riding in the facility van/bus. Resident #1 fell from the unsecured wheelchair and received injuries of fractures to his hand and fractures to three (3) fingers, a head injury requiring three (3) stitches, and a trip via ambulance to the Emergency Room (ER) for treatment of injuries. Resident #1 was one (1) of five (5) residents reviewed for supervision and prevention of accidents hazards. FINDINGS INCLUDE: Review of the facility policy titled "Policies for Company Owned Vehicle", latest review date 4/22; revealed "3. Seatbelts The driver and all passengers in the company/facility owned vehicle must be safely restrained by buckled seat belts, wheelchair floor tie downs and wheelchair harness type seatbelts at all times the vehicle is in use. A qualified individual shall assist patients/residents/clients with seatbelts and wheelchair tie downs and belts, and is responsible for ensuring that all person(s) in the vehicle are safely belted, and remain safely belted until the vehicle reaches its assigned destination." Review of the facility policy titled "Accident Prevention (F-558, F-689, F700)", latest revision	F 689	Resident #1 received medical treatment at Emergency Room and returned to facility on 1/26/22 per facility van. Resident #1 was assessed and care plan updated by Director of Nursing (DON), on January 26, 2022. All Licensed Class "D" facility drivers were in-serviced on facility policy "Company Owned Vehicle Checklist" and "Non-Emergency Transportation for Residents Policy", on January 26, 2022, by DON. All Licensed Class "D" drivers viewed training video "Van Transportation 2020" on Talent LMS website prior to operation of facility vehicle beginning January 26, 2022. All residents who are transported in facility vehicle are at risk for this deficient practice. Beginning June 1, 2022, in the Daily Stand-up Meeting, the Interdisciplinary Team will review all residents being transported on facility vehicle, to ensure safety needs are met by evaluating their physical and mental capabilities All Licensed Class"D" facility drivers will be in-serviced quarterly by Administrator or DON, beginning April 26, 2022, to ensure continued compliance with facility policies titled, "Non-Emergency Transportation for Residents Policy", "Company Owned Vehicle Checklist" and "Vehicle Lift Operations Proficiency Checklist".	

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F 689	Continued From page 2 11/17 revealed, "Each resident shall receive supervision and assistive devices to prevent accidents." Interview on 05/17/2022 at 1:30 PM, with the Director of Nursing (DON) revealed that Resident #1 was placed on the van/bus by the facility van/bus driver (Driver #1). The DON stated that Driver #1 was no longer driving the facility van/bus but was currently a Nurse Aide (NA) on the 11:00 PM to 7:00 AM night shift at the facility. Driver #1 has not driven the facility van/bus since the incident occurred on 1/26/2022. The DON confirmed that the Resident # 1 was injured from the fall in the van/bus and was transported to the Emergency Room (ER) via ambulance for treatment. The DON and the facility Administrator (ADM) completed an investigation and found no abuse and no neglect of Resident #1. Resident #1 was treated and released from the ER with three (3) stitches to his forehead and a splint applied to his hand due to fractures. The DON confirmed that Resident #1 was a bilateral amputee. DON stated that Resident #1 was a difficult resident and had complained that the seat belt was too tight and that he did not want to wear the seat belt. DON stated that the resident was cognitive and had a Brief Interview for Mental Status (BIMS) score of 15 which confirmed that he was cognitively intact. DON stated that the Driver #1 was the only staff on the bus when Resident #1 fell from his wheelchair. DON stated that Driver #1 called 911 and had the resident transported to the ER via ambulance. DON stated that the resident was a dialysis resident, and he rode the van/bus three (3) times per week to dialysis. DON confirmed that the resident remained in the facility for over a month after the incident of 1/26/2022 and was discharged to his	F 689	Beginning May 23,2022, DON or Charge Nurse will observe resident in facility vehicle with 4-point tie-down on bottom of wheelchair and the upper body secured with chest and waist safety belts prior to leaving the facility Monday-Friday on-going. Beginning June 7, 2022, the Administrator or Director of Nursing will report any concerns from the plan of correction to the Department Head Meeting weekly for four (4) weeks, then monthly for three (3) months and then quarterly until substantial compliance is achieved with F-689.The Quality Assurance Committee will meet beginning June 20, 2022, monthly times three (3) months then quarterly until substantial compliance is achieved with F-689. If problems or concerns are identified with the current corrective action plan, the Quality Assurance Committee will meet immediately and revise the corrective action plan as needed.	

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brother's home, to live with his brother and sister-in-law, in February 2022.

Interview on 05/18/2022 at 9:00 AM, with the van/bus Driver #2 revealed that she had been working at the facility for 18 years and had been the backup driver for over one year. Driver #2 stated that she and all drivers were trained on how to properly secure the seat belts and to supervise the residents riding on the van/bus. (Driver #2) stated that they had regular in-services/training on van/bus safety and on the proper way to secure the seat belts. (Driver #2) stated that the maintenance man had trained them on how to operate the wheelchair lift and how to secure the wheelchairs in the van/bus. Driver #2 stated that she had transported the resident in the facility van/bus on several occasions to dialysis and to other appointments and she had never had any problems with him refusing to wear the seat belts. Driver #2 stated that they had been trained/educated that if a resident was difficult or was having problems that they were to get a second person to ride the van/bus with the driver to ensure safety of the residents.

Interview on 05/18/2022 at 11:00 AM, with the former Social Services Designee (SSD #1) Marketing Director confirmed that she was supervisor of the van/bus drivers when the fall of Resident #1 occurred on 1/26/2022. SSD #1 stated that Driver #1 called her to report that there was a van/bus accident involving Resident #1 falling from his wheelchair out on to the floor of the van/bus. SSD #1 stated that Driver #1 had not called 911 prior to calling her. SSD #1 told Driver #1 to hang up the phone and to call 911 immediately. SSD #1 stated that the accident

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occurred on Chestnut Street (the street that ran in front of the facility) not far from the ER. SSD #1 stated that Driver #1 had told her that Resident #1 was bleeding from a head injury, and she needed help. SSD #1 informed Driver #1 to call 911 and not to move the resident. SSD #1 confirmed that none of the staff from the facility went to the scene of the accident to assist. SSD #1 stated that Resident #1 was a dialysis resident and went to dialysis three (3) times per week. Resident #1 was a demanding resident but was not a problem. Resident #1 was discharged on February 11, 2022 to the home of his brother and did receive injuries of a fracture to his hand and three (3) fingers and had received three (3) stitches to his head from the fall in the facility van/bus.

Interview on 05/18/2022 at 12:40 PM, with Driver #1 revealed that on the day of 1/26/2022, she had driven the van/bus approximately six (6) miles from the facility when (Res #1) fell out of his wheelchair. Driver #1 stated that she put on the brakes and that Resident #1 fell to the floor of the van/bus. Driver #1 stated that she had secured the seat belts on Resident #1 prior to leaving the facility, and that he had complained that the seat belts were too tight and he did not want the seat belt on him. Driver #1 secured the seat belt and drove away in the van/bus with the resident. There were no other residents or staff on the van/bus at the time of the incident on 1/26/2022. Driver #1 was transporting the resident to an out-of-town doctor's appointment in another city approximately 30 miles away. Driver #1 stated that she was driving safely and slowly and had softly put on the brakes when the resident fell out of his wheelchair on to the floor. Driver #1 stated that she immediately pulled the van/bus over to

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the side of the road and called 911 and then called the facility office and talked to the facility switchboard operator. Driver #1 stated that the resident was bleeding on his head and that she applied pressure to his head until the ambulance arrived approximately 20 minutes later. The ambulance picked up the resident and transported him to the ER for treatment. Driver #1 stated that she did not use the first aide kit she used napkins to put pressure on the resident's head and to wipe the blood. Driver #1 changed her account of the accident events and stated that she did use bandages from the first aide kit located on the van/bus to the head of the resident. Driver #1 stated that she no longer would drive the facility van/bus. Driver #1 stated that she did not see the resident remove the seat belt "but he must have taken it off" when she was driving the van/bus, causing him to fall to the floor when she put on the brakes. Driver #1 stated that she had secured the seat belt on the resident prior to leaving the facility. (Driver #1) confirmed that no staff from the facility came to the scene of the accident to assist.

Interview on 05/19/2022 at 9:20 A.M. with the facility Medical Director (MD) revealed that he was also the ER physician on 1/26/2022 when the ambulance was called to pick up the resident after he fell in the facility van/bus. MD stated that he treated the resident in the ER on 1/26/22 and placed three (3) stitches to the cut on his head. MD stated that he then x-rayed the resident's hand and fingers and placed a splint on the hand and fingers due to multiple fractures. MD made a consult referral to an orthopedic surgeon for evaluation after release from the ER on 1/26/2022. MD stated that the resident received superficial injuries from the fall in the facility

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van/bus. MD stated that the ambulance picked up resident quickly after the 911 call was placed and that it was not 20 minutes after the 911 call was placed. MD stated that after the call was made to 911 until the time the resident arrived in the ER was no more than 10 minutes. MD stated that the van/bus was pulled over with the injured resident less than a block from the ER.

Record review of the Face Sheet for Resident #1 revealed that he had been admitted to the facility on 12/20/2021 and was discharged from the facility on 02/11/2022. Resident #1 had diagnoses of Acquired absence of right leg above the knee and Acquired absence of left leg above the knee; End Stage renal disease; Type 2 diabetes; Essential Hypertension; Unspecific fracture to right forearm; among other diagnoses.

Record review revealed a facility Accident and Incident Report (A&I) dated 1/28/2022 revealed the resident involved was Resident #1 with documentation of a fall with head injury laceration-superficial, fractures, abrasions in facility vehicle. The facility (A&I) revealed "Elder was being transported by facility van to MD appointment in Tupelo." (Driver #1) stated that she went to apply her brake due to a car turning in front of her, elder slid from his wheelchair (W/C) onto the floor. (Driver #1) called 911 and the ambulance transported him (Res #1) to the ER. (MD) was present in the ER. Computerized Tomography (CT) and x-rays performed. CT negative -xrays revealed fracture to Right index finger and possible fracture to middle finger. Elder was transported back to the facility. Rt (right) (right) arm and hand in splint -3 sutures to forehead.

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F 689	Continued From page 7 Record review of the radiology report x-ray right hand dated 1/26/2022 at 10:59 AM, revealed that Resident #1 had fracture of the proximal phalanx, right fourth finger with probable essentially nondisplaced fractures of the third and fifth finger proximal phalanges. Advanced arteriosclerosis of the visible distal right forearm and hand. The CT Head without contrast report dated 1/26/2022 at 10:58 A.M. revealed that there is evidence of a scalp laceration overlying the frontal scalp.	F 689		