STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255347	A. Building B. Wing	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Choctaw Nursing and Rehabilitation Center	311 West Cherry Street Ackerman, MS 39735

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 0656 Level of Harm - Actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21029 Based on interviews, record reviews, policy and procedure reviews, the facility failed to follow the Activity of Daily Living (ADL) care plan for Resident #1's bed mobility, which resulted in a fall with multiple fractures for Resident #1. Resident #1 was one (1) of three (3) Residents reviewed for care plans. The facility policy and procedure dated 2/18/22 and revised date of 1/5/25 titled Comprehensive Care Plans stated: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with residents rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality. Record Review of the facility's investigation documentation revealed the facility had documented that the fall of Resident #1 was caused by Certified Nursing Assistant (CNA) #1 not following the care plan for bed mobility and transfers with a two (2) person assist required for bed mobility and transfers. On 1/29/25 at approximately 7:00 AM the third shift 11 PM- 7 AM CNA #1 was in the facility finishing her care to Resident #1 when the resident rolled off the bed and fell on to the floor during incontinent care. CNA #1 immediately called for help and two additional staff assisted CNA #1 to get Resident #1 up off the floor and back onto the bed. The Registered Nurse (RN) #2 assessed Resident #1 and found that she had pain and injury to her lower extremities. RN #2 called the physician and they had Resident #1 transported to the hospital emergency room (ER) for evaluation and x-rays. The ER found that Resident #1 had fractures to both her legs and they sent resident out to another hospital for surgery. Interview on 3/18/25 at 12:45 PM with Director of Nursing (DON) revealed that the facility conducted a full investigation and obtained a written statement from the attending CNA #1 that was assigned to Resident #1 at the time of the incident on 1/29/25 at approximately 7:00 AM. The CNA #1 admitted that she was alone with Resident #1 delivering incontinent care when Resident #1 fell from her bed on to the floor. DON stated that at the time of the incident on 1/29/25 that the ADL care plan for Resident #1 was for a two (2) person assist with bed mobility and transfers and that CNA #1 did not follow the care plan that was in place for Resident #1 on 1/29/25. (continued on next page)

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

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Interview on 03/18/25 at 2:30 PM with Licensed Practical Nurse (LPN) #1 who completed the care plan revealed that she revised the care plans for the Resident #1 using the Minimum Data Set (MDS) as the basis for the care plans. She stated that Resident #1 was care planned at the time of the incident on 1/29/25 to be a two (2) person assist with bed mobility and that CNA #1 did not follow the care plan that was in place. On 03/18/25 at 5:30 PM, CNA #1 returned the previous phone call that was made to her and stated that never at any time had Resident #1 been a two (2) person assist with any of her ADL's. CNA #1 stated that Resident #1 was able to follow commands and was able to stand and pivot at the time of the incident and that she had rolled her to her right side to complete the incontinent care and that the resident continued to roll over on to the floor. CNA #1 stated that she was very upset that this had occurred and had immediately ran to get help and thought it was just a freak accident and did not in any way mean to injury the resident, nor was she being neglectful. Record review of the face sheet of Resident #1 revealed that she was admitted to the facility on [DATE] and had diagnoses that included, Heart Failure; Wheezing; Dementia; Type 2 Diabetes Mellitus; Major Depression; Hypertension; Gout; Muscle Weakness; among other diagnoses. Record review of the MDS dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 7 which indicated that Resident #1 was severely cognitively impaired. Record review of the CNA's Point Click charting system revealed that Resident 1 had an ADL care sheet that read: Bed Mobility The resident requires LIMITED ASSISTANCE by 2 staff to turn and reposition in bed: The resident requires LIMITED ASSISTANCE by 2 staff to move between surfaces. Record review of the Care Plan for Resident #1 stated: BED MOBILITY: The resident requires LIMITED ASSISTANCE by 2 staff to turn and reposition in bed. Date Initiated: 10/02/2024 Revision on: 01/01/2025. The Care Plan for Resident #1 also read: TRANSFER: The resident requires LIMITED ASSISTANCE by 2 staff to move between surfaces. Date Initiated: 10/02/2024 Revision on: 01/01/2025.

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21029 Based on policy and procedure reviews, interviews, observations, and record reviews, the facility failed to ensure safety and to prevent an accident of a fall during bed mobility, resulting in multiple fractures to Resident #1. Resident #1 was one (1) of three (3) residents reviewed for accidents and safety. Findings Include: The facility policy and procedure titled Safe Resident Handling/Transfers dated 1/1/22 revised 1/5/25 and signed by the facility Director of Nursing (DON) read: It is the policy of this facility to ensure that residents are handled and transferred safely to prevent or minimize risks for injury and provide and promote a safe, secure and comfortable experience for the resident while keeping the employees safe in accordance with current standards and guidelines. The interdisciplinary team designee will evaluate and assess each resident's individual mobility needs, taking into account other factors as well, such as weight, cognitive status. Staff will be educated on the use of safe handling/transfer practices to include use of mechanical lift devices upon hire, annually and as need arises or changes in equipment occur. Record review of the facility's investigation documentation DATE? revealed the facility had documented that the fall of Resident #1 was caused by Certified Nursing Assistant (CNA) #1 not following the care plan for bed mobility and transfers with a two (2) person assist required for bed mobility and transfers. On 1/29/25 at approximately 7:00 AM the third shift 11 PM- 7 AM CNA #1 was in the facility finishing her care to Resident #1 when the resident rolled off the bed and fell on to the floor during incontinent care. CNA #1 immediately called for help and two additional staff assisted CNA #1 to get Resident #1 up off the floor and back onto the bed. The Registered Nurse (RN) #2 assessed Resident #1 and found that she had pain and injury to her lower extremities. RN #2 called the physician and they had Resident #1 transported to the hospital emergency room (ER) for evaluation and x-rays. The ER found that Resident #1 had fractures to both her legs and they sent resident out to another hospital for surgery. The incident report dated 1/29/2025 07:10 stated: While 1900-0700 CNA was performing incontinence care on resident this morning (approximately 0710, resident rolled off of bed (per CNA report). Bed was not in lowest position, as staff member was at bedside assisting resident. CNA reported that resident rolled onto right side and continued rolling, thus falling off the bed. Resident found lying in floor on her left side in a semi fetal position. Resident's initial complaint is of only bilateral knee pain. No open wounds noted. Some redness surrounding left eye. Slight bruising to bilateral knees. Resident reports not being sure what exactly happened, but states she fell off the bed and was unable to get back into bed. Resident reports bilateral knee pain with palpation/movement. Resident taken to the hospital. Oriented to person Injury Type Bruise 37) Right Knee (front) Bruise 38) Left knee (front). Numerical Level of Pain is 8 on a scale of 1-10. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Record review of the emergency room x-rays dated 01/29/2025 12:35 PM revealed: X-ray Right knew 1 or 2 views History Right Knee Pain and Injury. Findings: There is a comminuted fracture of the distal femur. The fracture extends to the articular surface in the region of the intercondylar space. There is no discoloration. Impression: 1. Comminuted fracture of the distal femur. The x-ray report also read: Left Knee Pain and Injury Findings: There is a comminuted fracture of the distal femur. There is one shaft width posterior displacement of the distal femur fracture fragment. Impression 1. Comminuted fracture of the distal femur. Interview on 3/18/25 at 12:45 PM with the DON revealed that the facility conducted a full investigation and obtained a written statement from CNA #1 that was assigned to Resident #1 at the time of the incident on 1/29/25 at approximately 7:00 AM. CNA #1 admitted that she was alone with Resident #1 delivering care when Resident #1 fell from her bed on to the floor. DON stated that at the time of the incident on 1/29/25 that Resident #1 was assessed for a two (2) person assist with bed mobility and transfers. DON stated that CNA #1 did not follow that assessment and was in the room alone with the resident for bed mobility and the resident slid out of the bed to the floor causing the injury. DON stated that this CNA #1 was a very good and responsible, dependable CNA and she had no prior incidents and there had been no issues with her delivery of care prior to or until 1/29/25. DON stated that CNA #1 gave a written statement that she was alone delivering care to Resident #1 and that she had not used the required two (2) person assist for bed mobility. DON provided the written statement of CNA #1 and DON confirmed that she called the agency and told them that CNA #1 was not to be allowed to return to work at the facility due to her not following the care needed for Resident #1 and that she had fallen and had received fractures as a result. DON confirmed that CNA #1 was informed that she would not be allowed to work at the facility any longer. On 3/18/25 at 1:40 PM surveyor placed a telephone call to CNA #1 and left a message on her voicemail to please return the call. Interview on 03/18/25 at 3:00 PM with CNA #2 revealed that she was working the same shift as CNA #1 on 1/29/25 and confirmed that she had assisted CNA #1 and RN #2 to get Resident #1 off the floor and placed her back in bed after the fall. She stated that all she remembered was that the resident was on the floor and that she assisted the nurse and the other CNA to place Resident #1 back in the bed. She stated that Resident #1 was voicing pain while the three (3) were placing her back in bed for an assessment. On 03/18/25 at 3:00 PM a telephone call was placed to RN #2 and there was no voicemail available. Continued to try and reach RN#2 and was unable to reach her for an interview. Interview on 03/18/25 at 3:05 PM with Licensed Practical Nurse (LPN) #2 revealed that she was the nurse trainer for all CNA's and had been the trainer for the past two (2) years. She confirmed that CNA #1 had been trained and educated that Resident #1 was a two (2) person assist with bed mobility. LPN #2 stated that when CNA #1 was hired through the agency as a contract worker for the facility that CNA #1 spent her first week at the local affiliate hospital completing a one (1) week orientation prior to coming to the floor of the nursing home. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview and observation with Resident #1 on 03/18/25 at 3:15 PM revealed that she was a large framed obese female that was lying in her bed with the bed lowered to the lowest position. Resident was asked if she was in any pain and she stated No. Resident was pleasant but was severely cognitively impaired and she was a poor historian. Her facial expressions were relaxed and happy. She stated yes to the question that the staff were good to her and met her needs to her satisfaction. On 03/18/25 at 5:30 PM, CNA #1 returned the previous phone call that was made to her. CNA #1 stated that never at any time had Resident #1 been a two (2) person assist with any of her incontinent care in the bed. CNA #1 stated that she began working as a full time contract CNA at the facility in March of 2024. CNA #1 stated that she was devastated when Resident #1 rolled out of the bed and that it was very upsetting to her. CNA #1 stated that the facility staff told her that she was responsible for the injuries and fractures of Resident #1 and that upset her greatly because she always went the extra mile for all her residents and that she loved her work at the facility. CNA #1 stated that she had talked to the facility Administrator (ADM) and that she told her that she was loosing her job. CNA stated that Resident #1 was able to follow commands and was able to stand and pivot prior to 1/29/25. CNA #1 confirmed that she was delivering care to Resident #1 alone and that Resident #1 rolled out of the bed and on to the floor when she turned her to her right side to clean her during incontinent care. Record review of the CNA's Point Click charting system revealed that Resident #1 had a care that read: Bed Mobility The resident requires LIMITED ASSISTANCE by 2 staff to turn and reposition in bed. Transferring: The resident requires LIMITED ASSISTANCE by 2 staff to move between surfaces. Record review of the facility nursing notes dated 01/29/2025 14:00 and signed by the DON read: Received phone call from ER nurse who reports that resident had fractured both of her femurs and they are attempting to find an ortho doctor/hospital to accept. Daughter (name) notified via (name of RN #2). Record review of the face sheet of Resident #1 revealed that she was admitted to the facility on [DATE] with diagnoses that included, Heart Failure; Wheezing; Dementia; Type 2 Diabetes Mellitus; Major Depression; Hypertension; Gout; Muscle Weakness; among other diagnoses. Record review of the the Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 7 which indicated that she was severely cognitively impaired.