| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 255097 | A. Building<br>B. Wing | 10/24/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Care Center of Aberdeen | 505 Jackson St<br>Aberdeen, MS 39730 |

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 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45598<br><br>Based on observation, staff, resident and resident family interviews, record review, and facility policy review, the facility failed to ensure a clean environment as evidenced by dirty wheelchairs and strong, offensive odors for three (3) of seven (7) sampled residents reviewed. Resident #6, Resident #7, and Resident #8.<br><br>Findings Include:<br><br>Record review of the facility policy titled, Policy for General Cleaning and Maintenance of Equipment with latest review date of 08/21 revealed, It is the policy of this facility that all resident care equipment will be cleaned and decontaminated after use and will be prepared for reuse by the same or another resident . Equipment is first cleaned of surface soil with soap and water or facility disinfectant .<br><br>Record review of Statement typed on facility letterhead dated 10/24/24 and signed by the Administrator (ADM) revealed that the Facility does not have a policy to include odor free environment. However, the goal of the facility includes: To provide a safe, sanitary and odor free environment for all patients, employees and visitors at the facility.<br><br>An observation and interview on 10/23/24 at 8:40 AM, revealed a strong, pungent odor in Resident #6's room on the 400 hall and a puddle of liquid on the floor in the bathroom at the base of and in front of the commode. The bathroom tile was dark, and the color of the liquid substance was difficult to determine. The wet area on the bathroom floor measured about one and one-half by two feet and had a foul odor. There was also a yellow liquid splattered on the commode seat. Resident #6 was sitting up in a chair in his room and he said that he didn't notice a foul odor and stated, When you stay in here so long, you get used to it.<br><br>An observation on 10/23/24 at 11:15 AM, in Resident #6's room and bathroom revealed a foul odor and a liquid substance on the floor of the bathroom in front of the commode.<br><br>An observation and interview on 10/23/24 at 12:10 PM, in Resident #6's room with the ADM, confirmed the strong, foul odor in the room and bathroom and confirmed the liquid substance on the floor in the bathroom. ADM revealed that the liquid on the floor in the bathroom looked and smelled like urine and she would address that issue. She also agreed that they should provide a clean, odor free environment for the residents because this was their home.<br><br>(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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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An observation and interview on 10/23/24 at 9:12 AM, revealed Resident #8 sitting in her wheelchair in the small dining room on the 400 hall with her husband at her side. Resident #8's husband revealed that she had been at the facility since the end of January of this year and she had Dementia and could no longer take care of herself. He revealed that his only concern with the facility was that he had noticed that her wheelchair was nasty, and he didn't think it had been cleaned since she was admitted to the facility. He revealed that there was junk spilled on it, there was lots of grit, grime, dust, and hair stuck to the wheelchair frame. He stated, It's nasty, and they let it go. Resident #8's husband revealed that he had not mentioned it to anyone, but he shouldn't have to. An observation revealed a grayish brown substance on the wheelchair frame and on the spokes of the two large wheels.<br><br>On 10/23/24 at 10:26 AM, an observation revealed Resident #7 sitting in his wheelchair in the small dining room on the 400-hall. His wheelchair was dirty with white and brown food crumbs in the chair between the cushion and arm rest on both sides and there was a gray and brown substance covering the frame of the wheelchair bilaterally. Resident #7 was alert but was observed as non-verbal.<br><br>An interview on 10/23/24 at 11:55 AM with the Director of Nursing (DON) revealed that resident wheelchairs were assigned to be cleaned by the Certified Nursing Assistants (CNAs) on the third shift, 10 P - 6 A, on Sunday nights. She revealed that they had a CNA Sunday Assignment sheet posted in a binder at the desk and the aides knew that cleaning the wheelchairs was their responsibility to complete. The DON revealed that they divided up the residents between six CNAs and they were required to clean the wheelchairs of the residents who were assigned to them on that shift. She revealed that they did not have a sign-off sheet and didn't have anything in place to make sure the wheelchairs were cleaned. The DON revealed that if any staff member observed that a wheelchair needed to be cleaned at any time, they should take care of it right then and not wait until the scheduled Sunday night shift for someone else to do. She revealed that they had Sani-clothes also available on the carts and anyone could wipe a wheelchair down if it needed to be cleaned.<br><br>An observation and interview on 10/23/24 at 12:05 PM, with the ADM confirmed that Resident #7 and Resident #8's wheelchairs were dirty and needed to be cleaned. She revealed that they had a place out back where they took the dirty wheelchairs, and pressure washed them. ADM confirmed that the wheelchairs didn't look like they had been cleaned in a while and should have been taken care of and stated, We are going to correct it now and there's nothing else I can say except they are dirty.<br><br>A phone interview on 10/23/24 at 12:35 PM with Complainant revealed that she came to the facility often and visited her dad. She revealed that the room her dad was previously in on the 400 hall had a pungent urine odor and stated, It always smelled like pee. She revealed that they had moved her dad into another room and there was no issue with the odor in his room now. The Complainant revealed that during her visits with her dad, she had witnessed a lot of filthy wheelchairs, and she revealed that the facility still smelled of urine sometimes. The Complainant revealed that the urine odor was bad, and she felt sorry for the residents who could not speak for themselves and stated, They deserve better. The Complainant revealed that she had talked to the staff, reported dirty wheelchairs and the odors and there hadn't been much change. She stated, The wheelchairs are never clean.<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An interview on 10/24/24 at 8:15 AM, with CNA #1, revealed that the aides on the 10 P-6 A shift were responsible for cleaning the wheelchairs. She revealed that if any staff member noticed anything spilled on the wheelchair or noticed that the wheelchairs were dirty any other time, they should clean them right then and not wait on the night shift to do it. CNA #1 revealed that they could use soap and water or use the Sani -Wipes to clean them.<br><br>An interview on 10/24/24 at 8:20 AM, with the DON revealed that they should have noticed the dirty wheelchairs, cleaned them, or at least wiped them down with Sani-Wipes which were readily available. She revealed that each CNA was responsible for the wheelchairs of the residents who were assigned to them on Sunday nights on the 10 P to 6 A shift. The DON confirmed that they had a sheet they were supposed to go by, but they didn't document anything about the cleaning of the wheelchairs. The DON revealed that they knew they had an issue and confirmed that they did not have an effective plan in place to ensure they were being cleaned.<br><br>Record review of the facility CNA Sunday Assignment sheet, revealed that on the 10 PM - 6 AM shift every Sunday night the CNA assignments included .Clean and Disinfect all vital sign equipment and wheelchairs .<br><br>Record review of Resident #6's Admission Record revealed an admitted [DATE] and that he had diagnoses that included Chronic Obstructive Pulmonary Disease, Epilepsy, and Osteoarthritis.<br><br>Record review of Resident #6's MDS with ARD of 09/11/24 under Section C revealed a BIMS Score of 10 which indicated that he had mild cognitive deficits. Section GG revealed that he required supervision or touching assistance with toileting hygiene.<br><br>Record review of Resident #7's Admission Record revealed an admitted [DATE] with diagnoses that included Cerebral Infarction, Hemiplegia and Hemiparesis following Cerebral Infarction, Aphasia, and Dependence on Wheelchair.<br><br>Record review of Resident #7's MDS with ARD of 08/09/24 revealed that the Brief Interview for Mental Status (BIMS) should not be conducted due to resident is rarely or never understood.<br><br>Record review of Resident #8'sAdmission Record revealed an admitted [DATE] and that she had diagnoses that included Unspecified Dementia and Epilepsy.<br><br>Record review of Resident #8's MDS with ARD of 10/09/24 under Section C revealed that a Brief Interview for Mental Status should not be conducted due to resident is rarely or never understood. |