

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255169	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/24/2025
NAME OF PROVIDER OR SUPPLIER Adams County Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 587 John R Junkin Drive Natchez, MS 39120	

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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>41680</p> <p>Based on observation, interviews, record review and facility policy review, the facility failed to investigate or determine root causes for Resident #38 for three (3) of seven (7) falls. (1/12/25, 2/13/25, and 2/25/25)</p> <p>Findings included:</p> <p>A review of the facility's Responsibility for Accident/Incident Reports Policy, dated 07/2016, revealed, It is the policy of this facility for all Incident and Accidents involving resident's to be investigated immediately upon knowledge of the incident. Procedure. Staff are to be trained how to investigate and document assessment of possible causes for the accident/incident. They are to obtain written statements from staff on duty and an possible witnesses to the incident. They are to document on the proper forms .</p> <p>A record review of the Admission Record revealed the facility initially admitted Resident #38 on 01/09/25 with diagnoses including Cardiac Arrest.</p> <p>A record review of the Comprehensive Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/7/25, revealed Resident #38 had a Brief Interview for Mental Status (BIMS) score of 12, which indicates moderate cognitive impairment.</p> <p>A record review of the Progress Notes, for Resident #38, dated 1/12/2025 at 9:26 AM, revealed, .This nurse was called to resident room by unit CNA (Certified Nurse Aide) R/T (related to) witnessed fall without injury. CNA stated 'resident slid to the floor and sat down when trying to get on the stand lift . The author was LPN #4.</p> <p>A record review of the Progress Notes, for Resident #38, dated 2/13/25 at 11:18 AM, revealed, .This nurse was called to Therapy, when entering the room noted resident laying on the floor on her left side . immediately started c/o (complaining of) being dizzy .Resident left the facility at approx (approximately) 10:10 AM .Nurse called report to (Proper Name of Acute Care Hospital_ .</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A record review of the Progress Notes, for Resident #38, dated 2/25/25 at 15:30 (3:30 PM), revealed, This nurse was called to residents room by CNA upon entering the room resident was sitting on bed. Noted knot to left side of forehead noted bleeding . Another note dated 2/25/25 at 14:14 (2:14 PM) revealed, This nurse assisted floor nurse .with sending resident to ER (emergency room) DT (due to) unwitnessed fall with head injury .</p> <p>A record review of the medical record for Resident #38 revealed there was no facility fall investigation (Fall Evaluation Tool) completed related to the falls that occurred on 1/12/25, 2/13/25, and 2/25/25. There was a Fall Evaluation Tool, for falls that occurred on 1/17/2025, 1/25/25, 1/28/25, and 2/27/25.</p> <p>On 04/21/25 at 10:11 AM, during an observation and interview with Resident #38, she was sitting in her wheelchair at the bedside. Resident #38 stated that she had fallen three (3) different times.</p> <p>On 04/23/25 at 10:55 AM, during an interview with the facility's Director of Nursing (DON), she explained that an investigation should be completed each time a resident falls, even when a resident experiences more than one fall in the same day. The DON stated that each incident should be reviewed separately to determine the cause and to implement interventions to prevent recurrence.</p> <p>On 04/24/25 at 10:17 AM, during a follow up interview with the DON, she stated she was not aware that Resident #38 had experienced a fall on 01/12/25. She acknowledged there should have been an incident report completed for that fall, explaining that incident reports help identify the circumstances of a fall and guide the implementation of preventive interventions. The DON stated she was also unaware of the fall that occurred on 02/13/25. She confirmed she had knowledge of the fall on 02/25/25 but admitted she failed to complete the incident report, stating she became sidetracked and forgot. She confirmed that all falls should be documented and investigated.</p>