

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675553	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/02/2024
NAME OF PROVIDER OR SUPPLIER Caraday of Quitman		STREET ADDRESS, CITY, STATE, ZIP CODE 1026 E Goode St Quitman, TX 75783	

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 - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47612</p> <p>Based on observations, interviews and record review the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 5 residents (Resident #1) reviewed for accidents.</p> <p>The facility failed to ensure Resident #1 was properly secured in his wheelchair during transport, in which Resident #1 fell forward onto his hands and knees when CNA A hit the brakes on 08/20/2024.</p> <p>The noncompliance was identified as past noncompliance IJ. The noncompliance began on 08/20/2024 and ended on 08/21/2024. The facility had corrected the noncompliance before the survey began.</p> <p>This failure could place residents at risk for injury/death from a vehicle accident and decreased quality of life.</p> <p>Findings Include:</p> <p>Record review of the face sheet dated 10/02/2024, indicated Resident #1 was an [AGE] year-old male admitted to the facility on [DATE] and discharged from the facility on 08/27/2024, with diagnoses including pneumonia, unspecified organism (pneumonia caused by an organism, that was not specified) left bundle-branch block, unspecified (a heart condition that occurs when the electrical impulse that controls the heartbeat was disrupted), emphysema, unspecified (a progressive chronic lung condition in which the tiny air sacs (alveoli) are damaged or destroyed).</p> <p>Record review of the MDS assessment, dated 08/23/2024, revealed Resident # 1 had a BIMS score of 15, indicating resident #1 was cognitively intact. The MDS indicated Resident #1 required supervision only with bed mobility, and transfers.</p> <p>Record review of the care plan dated 09/03/2024, intervention: indicated Resident #1 was independent to transfer, encourage the resident to participate in exercise, physical activity for strengthening and improved mobility between surfaces. Ensure that the resident was wearing appropriate footwear and describe correct client footwear when ambulating or mobilizing in wheelchair.</p> <p>During an attempted interview on 1/012024 at 10:59 a.m., surveyor place a call to Resident # 1 with no answer and no return call.</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 - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview and observation on 10/01/2024 at 1:48 p.m., the Administrator stated he was trained by the Maintenance Supervisor by watching a video and demonstration of skills. The Administrator demonstrated how to correctly load and secure a resident in a wheelchair into the facility's van for transportation.</p> <p>During an interview and observation on 10/01/2024 at 2:30 p.m. the Maintenance Supervisor stated he was responsible for training new staff who would be doing transportation. The Maintenance Supervisor said he was trained by the corporate office. The Maintenance Supervisor said he watched videos and performed demonstrations to become trained. The Maintenance Supervisor said when he trains a new transportation aide, they watched the required videos and then performed safety demonstrations on securing residents who were in wheelchairs and who ambulate, using the lift, securing loose items, and driving the facility van. The Maintenance Supervisor demonstrated how to correctly load and secure a resident in a wheelchair into the facility's van for transportation.</p> <p>During an interview on 10/01/2024 at 3:02 p.m., CNA A stated she worked for a sister facility for several years but had been helping that facility for a couple of weeks when the incident happened. CNA A stated she picked up Resident #1 from the hospital and was on her way back to the facility. CNA A stated she came over a hill and a truck was stopped in the middle of the road. CNA A stated she hit the brakes and Resident #1 fell out of his wheelchair onto his hands and knees. CNA A stated Resident # 1's wheelchair was locked in, but she did not put the shoulder strap on because she did not think it would reach across him. CNA A stated she was terminated from both facilities for neglect.</p> <p>During an interview on 10/01/2024 at 3:20 p.m., the ADON stated she was notified on 08/20/2024 at 1:53p. m. by CNA A of the incident. The ADON stated she was informed Resident #1 had a scrape on his knee and a skin tear to his finger. The ADON stated following the phone call, she notified the DON and the Administrator of the incident.</p> <p>During an interview on 10/02/2024 at 12:50 p.m., the DON stated she was notified by the ADON of the incident. The DON stated when assessing Resident #1 he stated he was not wearing a seatbelt until after the incident. The DON stated Resident #1 had an abrasion to the right knee, and a bruise and skin tear on left hand.</p> <p>During an interview on 10/02/2024 at 1:25 p.m. the Administrator stated he and the Maintenance Supervisor were the only staff currently doing transportations. The Administrator stated only one resident in a wheelchair should be transported due to the van only being equipped to safely secure one wheelchair. The Administrator stated CNA A was terminated after an investigation was conducted.</p> <p>Record review of a facility's undated policy Vehicle Transportation and Safety of Residents indicated secure down all wheelchairs using the secure strap equipment. Always secure the strap to the frame of the wheelchair not the armrest or wheels. Place seatbelt around all residents including those in wheelchairs</p> <p>The facility's course of action prior to surveyor entrance included:</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of the provider investigation report dated 08/20/2024 indicated Resident #1 was being transported by the facility van from the hospital to the facility when the transportation aide made a sudden stop and Resident # 1 fell out of his wheelchair. The provider investigation report indicated Resident #1 had an abrasion to the right knee, bruise and skin tear on left hand. X-rays were immediately ordered with results of no break, fracture or dislocation to the bruised area. The provider investigation report indicated CNA A was found negligent in her actions when failing to properly secure Resident #1 in his wheelchair and was terminated following the investigation by the facility.</p> <p>Record review of an in-service dated 08/20/2024, topic: Abuse, and Neglect, description: all suspected, alleged, or actual abuse was to be reported immediately to the Abuse Coordinator, who was the Administrator. If for some reason staff are unable to reach the Abuse Coordinator, they are to notify the Director of Nurses. The in-service was signed by 31 employees.</p> <p>Record review of an in-service dated 08/21/2024 indicated the Administrator had been in-serviced on Vehicle Transportation and Safety of Residents, and hands on demonstration.</p> <p>Record review of a QAPI sign in sheet dated 08/22/2024 was signed by:</p> <p>Medical Director</p> <p>Administrator</p> <p>DON</p> <p>ADON</p> <p>Administrative</p> <p>Social Services</p> <p>Dietary Manager</p> <p>Record review of an in-service dated 08/27/2024 indicated the Maintenance Supervisor had been in-serviced on Vehicle Transportation and Safety of Residents, and hands on demonstration.</p> <p>The noncompliance was identified as past noncompliance IJ. The noncompliance began on 08/20/2024 and ended on 08/21/2024. The facility had corrected the noncompliance before the survey began.</p>		