STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255095	A. BUILDING _____ B. WING _____	**03/13/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CARE CENTER OF LAUREL	**935 WEST DR LAUREL, MS 39440**

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 0609 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and facility policy review, the facility failed to report an allegation of Quality of Care/Supervision, related to an incident which resulted in a resident sustaining major injuries, within the two (2) hour required timeframe for one (1) of six (6) residents reviewed, Resident #1. On 02/15/2020, Resident #1 was being transported to an appointment in the facility's van by Driver #1. Resident #1 fell from her wheelchair due to Driver #1's failure to ensure proper shoulder seat belt usage, which resulted in the resident sustaining bilateral femur fractures. The facility's Administrative staff was notified immediately, however it was not reported to the required State agencies until 02/17/2020. Driver #1 was suspended from work pending investigation on 02/15/2020, and employment was terminated 02/18/2020. The failure of the facility to notify the appropriate State agencies in a timely manner of an allegation of Quality of Care related to Supervision, and to ensure proper measures had been addressed, placed Resident #1 and other residents at risk for serious injury, harm, impairment or death. Based on the facility's implementation of an Immediate Jeopardy (IJ) Removal Plan and corrective actions on 02/15/2020, the SA determined the IJ and Substandard Quality of Care (SQC) was Past Non-Compliance (PNC) and the IJ was removed as of 02/18/2020, prior to the State Agency (SA) entrance on 03/11/2020. The SA notified the facility's Administrator of the PNC IJ and SQC on 03/11/2020 at 2:33 PM. Findings include: A review of the facility's Incident Investigation and Reporting policy, dated 05/2018, revealed: The facility administrator shall ensure that any incident involving an allegation or suspicion of abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported not later than two (2) hours after the allegation is made to local law enforcement and the State Agency. If the events of the allegation involve abuse or result in serious bodily injury to the State Survey Agency and the Adult Protective Services where state law provides for jurisdiction in long-term care facilities in accordance with state law. Review of the facility's Elder Justice Act: Policy and Procedure for Reporting Suspected Crimes Under the Federal Elder Justice Act policy, dated 08/2013, revealed, if the reportable event results in serious bodily injury, the staff member shall report the suspicion immediately, but not later than two (2) hours after forming the suspicion. Review of the facility's Resident Incident Report, dated 02/15/2020 at 10:20 AM, revealed, Driver #1 reported he and Resident #1 were on their way to [MEDICAL TREATMENT], when a car pulled out in front of them and the resident came out of her wheelchair. Resident #1 was sent to a local hospital. The report documented the Physician and Resident #1's family member was notified. The report further documented the facility staff was educated on van safety and proper seat belt use while securing residents' in the van. A review of Resident #1's Departmental Notes, dated 02/15/2020 at 3:09 PM, Licensed Practical Nurse (LPN) #1 documented, at 10:25 AM, Driver #1 reported to her that while transporting Resident #1 to [MEDICAL TREATMENT], she had come out of her wheelchair when he slammed on brakes, after a car pulled out in front of them. LPN #1 documented Driver #1 reported Resident #1 complained of head pain and bilateral leg pain, and he was instructed by [MEDICAL TREATMENT] staff to take Resident #1 to the hospital. LPN #1 documented the Responsible Party (RP), Medical Doctor (MD), Administrator, Director of Nursing (DON), and Registered Nurse (RN) Supervisor were made aware of the incident. Review of the MFCU Crimes Web Submission document, generated by the Attorney General's (AG) office, revealed the facility reported the incident involving Resident #1 on 02/17/2020 at 11:02 AM. A review of the Administrator's typed statement, undated, on the facility letterhead, revealed, on 02/17/2020 at approximately 10:00 AM, the Mississippi State Department of Health (MSDH) was notified via the telephone hotline of the incident that occurred (02/15/2020) when Driver #1 failed to properly secure Resident #1 in the facility's van, which resulted in bilateral femur fractures. During an interview, on 03/11/2020 at 11:35 AM, the Administrator stated she did not report the incident that occurred on Saturday, 02/15/2020, to anyone until Monday, 02/17/2020. The Administrator revealed she called her Corporate office on 02/15/2020 and was instructed not to call the incident to the MSDH hotline until it was further investigated. The Administrator confirmed she notified the Attorney General's Office (AGO) and the local Police Department on 02/17/2020. The Administrator revealed she should have called the incident in to the appropriate agencies within the two (2) hour timeframe. The facility implemented the following Immediate Jeopardy (IJ) Removal Plan and Corrective Actions on 02/15/2020, prior to the State Agency (SA) entrance on 03/11/2020. In response to the PNC IJ and SQC that was cited at 2:33 PM on 03/11/2020, the facility submitted a brief summary of the event, including the IJ Removal Plan and Corrective Actions taken by the facility to remove the IJ. Description of Incident: On February 15, 2020 at approximately 10:25 AM, Licensed Practical Nurse #1 received a call from van Driver #1 stating that while transporting Resident #1, a car pulled out in front of him and he had to slam on brakes. Resident #1 came out of the chair and fell to the floor of the van, immediately complaining of bilateral leg pain and head pain. Resident #1 was taken to the local emergency department on February 15, 2020 at 10:25 AM and was noted to have bilateral femur fractures. Resident #1 was then transported and admitted to an area trauma hospital for further care on February 15, 2020 at 5:50 PM. Van Driver #1 admitted that he did not buckle Resident #1's seat belt during transport which resulted in the fall to the floor. No other staff was present on the van at the time of the incident. 1. On February 15, 2020, the Facility Administrator suspended Van Driver #1 from his duties pending investigation of this incident. During the investigation, other residents that had been taken to appointments by van Driver #1 were interviewed in relation to wearing seatbelts. Three (3) residents confirmed that van Driver #1 had not used a seatbelt during transport on February 14, 2020. 2. On February 17, 2020, the Facility Administrator notified the Mississippi State Department of Health, two (2) days after the event occurred, and the Mississippi Attorney General's Office at approximately 10:00 AM of the fall with injury, in the transport van when Van Driver #1 failed to buckle Resident #1's seatbelt. Also, on February 17, 2020, the Facility Administrator notified the local police department at approximately 11:00 AM. 3. On February 15, 2020, A Quality Assurance (QA) Meeting was held at approximately 2:45 PM to discuss Abuse and Neglect, Accident/Incident Reporting, as well as safety while driving the facility van. The Facility QA Committee members which consisted of the Facility Administrator, Medical Director, Staff Development Nurse, Infection Control Prevention Officer, Director of Nursing, Assistant Director of Nursing, Housekeeping Supervisor/Approved Van Driver #1, Medical Record Nurse, Case Manager, and Social Service Director, discussed topics of: (a) Abuse and Neglect, (b) Accident/Incident Reporting, (c) safety while driving the facility van, and (d) supervision to prevent accident and incidents. The Facility Action Plan was reviewed and approved by the QA Committee Members. The facility's policies and procedures regarding abuse and neglect and supervision to prevent accidents and incidents were reviewed and accepted with no changes indicated. 4. On February 18, 2020, the Facility Administrator terminated Van Driver #1 due to him not ensuring that residents were properly secured into the van before transportation which resulted in Resident #1 receiving bilateral femur fractures major injuries. 5. On February 15, 2020 an in-service training was initiated by the Director of Nursing (DON) along with the Facility Administrator which included 13 Registered Nurses (RN), 29 Licensed Practical Nurses (LPN), 43 Certified Nursing Assistants

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

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.

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F 0609 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) (CNA), seven (7) Housekeeping staff, five (5) Laundry staff, 11 Dietary staff, seven (7) Office Personnel, six (6) contract Therapy Department staff, two (2) Activities staff and one (1) Maintenance Director on the following: Abuse and Neglect, Accident/incident Reporting, seven components to reduce, detect, and prevent Abuse and Neglect, and abuse/crime reporting (Elder Justice Act), and accident and incident prevention. 6. On February 15, 2020, an in-service was initiated by the Facility Administrator for all four (4) van drivers on safety while driving the facility van with return demonstration on buckling resident's seatbelt and securing wheelchairs. A copy of the policies for company owned vehicle operation was reviewed as well and the drivers were given a copy. New drivers that are hired will be trained on the Company Owned Vehicle Driver In-Service Checklist as well as the proper securing and buckling of resident safely in the facility van with return demonstration on fastening/unfastening seatbelts, wheelchair tie downs and shoulder straps. 7. On February 17, 2020, the Administrator contacted our agency personnel provider and informed them that no agency staff will be allowed to work until the in-service training has been conducted identifying and reporting abuse and neglect. Agency personnel will not be allowed to work until these in-services have been conducted by licensed facility staff. 8. On February 15, 2020, the Facility Administrator audited all approved driver's license verification as well as their education/training on how to operate the vehicle which includes fastening/unfastening seatbelts and wheelchair tie downs and shoulder straps. There were no discrepancies during this audit. 9. No staff was allowed to work until in-servicing has been complete on: Abuse and Neglect, Accident/Incident Reporting, seven components to reduce, detect, and prevent abuse and neglect, and abuse/crime reporting (Elder Justice Act), and accident and incident prevention. The facility corrective actions were initiated on February 15, 2020. All activities to remove the IJ was initiated on 02/15/2020 and completed on 02/18/2020 and the facility alleges the IJ was removed on 02/18/2020. The State Agency validated the facility's investigation of the incident and implementation of the IJ Removal Plan/Corrective Action through observation, facility record review and interview. 1. The SA validated through record review and interview that Driver #1 was suspended from his duties on February 15, 2020 and terminated on February 18, 2020. It was validated through record review that three (3) residents confirmed that Driver #1 had not used a seat belt during transport on February 14, 2020. 2. The SA validated through record review the facility notified the Mississippi Department of Health, the Attorney general's Office and the local police Department on February 17, 2020, two (2) days after the incident occurred on February 15, 2020. 3. The SA validated through record review and interview that a Quality Assurance (QA) was held on February 15, 2020 to discuss abuse and neglect, Incident reporting, and incident regarding facility vehicle. The Administrator verified, through interview, that policies and procedures were discussed during the meeting and no changes were issued. 4. The SA validated through record review and interview that Van Driver #1 was terminated on February 18, 2020. 5. The SA validated through record review and interview that staff had been in-serviced on abuse/neglect, accident/incident reporting, seven components to reduce, detect, and prevent abuse and neglect, and abuse/crime reporting (Elder Justice Act) and accident/incident prevention. 6. The SA validated through record review and interview that all four (4) van drivers were in-serviced on van safety with return demonstrations on buckling residents seatbelt and securing wheelchairs. A review of document revealed the drivers were in-serviced on the Company Owned Vehicle Driver Checklist. An observation was made on four (4) wheelchair residents on their arrival to the facility in the facility van. It was observed that all four (4) residents were strapped into the facility van using manufactures recommendations. 7. The SA validated through interview with the Administrator that they contacted the agency personnel provider and informed them that no staff would be allowed to work until they received an in-service training on identifying and reporting abuse and neglect. 8. The SA validated through record review that the driver's licenses were audited, along with proof of education on how to operate a vehicle which included fastening seatbelts and shoulder straps. 9. The SA validated through an interview with the Facility Administrator that no staff would be or had been allowed to work without completing the in-service on abuse/neglect, Accident/Incident reporting, seven components to reduce, detect, and prevent abuse and neglect, abuse/crime reporting (Elder Justice Act) and accident/Incident prevention. The Administrator stated that they had no new employees since the in-service was initiated.
F 0689 **Level of harm -** Immediate jeopardy **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** Based on record review, interview, and facility policy review the facility failed to provide residents with supervision to prevent accidents, during van transport for one (1) of four (4) residents reviewed for van transport, Resident #1. Resident #1 was being transported to [MEDICAL TREATMENT] when she fell out of her wheelchair onto the floor of the van. Driver #1 failed to secured Resident #1 with the shoulder/seat belt strap. Resident #1 was taken to the local emergency room for evaluation and later transferred to a local trauma hospital for evaluation and treatment. The facility's failure to provide supervision and proper securing of a wheelchair during transport, led to Resident #1 receiving bilateral femur fractures and placed other residents being transported in a situation likely to cause serious harm, injury, impairment or death. Based on the facility's implementation of an Immediate Jeopardy (IJ) Removal Plan and Corrective Actions, as of 02/18/2020, prior to the State Agency (SA) entrance on 03/11/2020, the SA determined the IJ and Substandard Quality of Care (SQC) was Past Non-Compliance (PNC) and the IJ was removed as of 02/18/2020. The SA notified the Administrator of the PNC IJ and SQC on 03/11/2020 at 2:33 PM. Findings include: A review of the facility's Policies for Company Owned Vehicles policy, dated May 2018, revealed, 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 seat belted and remain safely seat belted until the vehicle reaches it's assigned destination. A review of the manufacturer's recommendation revealed to attach lap belt by using intergraded stiffeners to feed belts through openings between seat backs and bottoms and or armrests to ensure proper belt fit around occupant. The manufacturers recommendations also stated to attach a shoulder belt by extending shoulder belt over passengers' shoulder and across upper torso and fasten pin connector onto lap belt. Combination lap/shoulder belts serve as both window-side lap belt and shoulder belt. Ensure belt are adjusted as firmly as possible, but consistent with use comfort. A review of the facility's Resident Incident Report for Resident #1, dated 02/15/2020 at 10:20 AM, revealed Driver #1 reported to Licensed Practical Nurse (LPN) #1, that while transporting Resident #1 to [MEDICAL TREATMENT], she came out of her wheelchair when a car pulled out in from of them. Driver #1 reported Resident #1 complained of pain to her head and both legs. The investigation narrative from the Resident Incident Report, revealed, Resident #1 had a fall on the facility van when she was being transported to [MEDICAL TREATMENT]. The van driver had to slam on brakes to keep from hitting a car that pulled out in front of him. The narrative further revealed Resident #1 tipped from her wheelchair and onto the floor causing injury. Resident #1 was transported to the hospital. Staff was educated on van safety and proper seat belt use while securing resident's into the van. A review of the hand-written statement by LPN #1 revealed, Driver #1 called the facility and reported to her that while transporting Resident #1 to [MEDICAL TREATMENT], a car pulled out in front of him causing him to slam on brakes. Driver #1 reported, when he slammed on brakes, Resident #1 flew out of her wheelchair. LPN #1 documented, Driver #1 stated to her that a good Samaritan stopped and assisted him with getting Resident #1 back into her wheelchair. LPN #1 further documented that Driver #1 told her he continued to transport Resident #1 to [MEDICAL TREATMENT] and the nurse at the [MEDICAL TREATMENT] unit came out and told him to take Resident #1 to the local emergency room . LPN #1 documented Driver #1 stated he took Resident #1 to the emergency room and then contacted the facility to report the incident. LPN #1 documented she called the [MEDICAL TREATMENT] unit, and spoke with the Registered Nurse (RN). The RN told her that she went out to the van to check on Resident #1 herself, and Resident #1's legs were deformed looking, like they were broken. LPN #1 documented the RN told her that she instructed Driver #1 to carry Resident #1 to the emergency room . Record review of the hospital's Final Report of Resident #1's x-rays, dated 02/15/2020, revealed Resident #1 had an acute comminuted [MEDICAL CONDITION] distal femur and an acute [MEDICAL CONDITION] distal femur just superior to the level of the condyles. During an interview, on 03/11/2020 at 9:55 AM, Resident #1 stated on the day of the incident (02/15/2020), she was launched from her wheelchair when Driver #1 slammed on brakes. Resident #1 stated Driver #1 did not fasten her into the van correctly. Resident #1 revealed Driver #1 fastened the wheels of her wheelchair with the clips on the van floor, but he did not put the belt across her shoulders. Resident #1 stated she told Driver #1 that she wanted and needed him to fasten the shoulder seat belt, but he still didn't do it. Resident #1 confirmed she has two broken legs from being launched from her wheelchair. During an interview, on 03/11/2020 at 11:25 AM, Driver #1

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) stated he and Resident #1 were going up 16th Ave to the [MEDICAL TREATMENT] clinic. Driver #1 stated a car came out of the car wash in front of him and he hit his brakes. He stated Resident #1 came out of the wheelchair onto the floor of the van. Driver #1 stated a man stopped and helped him pick Resident #1 up and put her back in the wheelchair and he took Resident #1 on to [MEDICAL TREATMENT]. Driver #1 stated the [MEDICAL TREATMENT] nurse told him to take Resident #1 on to the local emergency room . Driver #1 stated he called the facility and told what had happened after he got her to the emergency room . Driver #1 stated he had the bottom of the wheelchair strapped to the floor of the van. Driver #1 further stated that he did not have Resident #1 buckled down into the chair. He confirmed that he did not have the shoulder strap/seat belt on Resident #1 during the transport. A review of the facility's Company Owned Vehicle Driver In-Service Checklist, dated 06/18/2019, revealed Driver #1 was in-serviced on Patient/Passenger Safety and Special Equipment , and demonstrated how to safely and adequately perform each of the following functions: 1) properly securing a patient/passenger in the vehicle with seatbelts, 2) properly securing a wheelchair in the vehicle, and 3) properly securing the wheelchair occupant with safety and/or shoulder harness belts. Review of the facility's Vehicle lift Operations Proficiency Checklist for Driver #1, dated 06/18/2019, revealed he was in-serviced and demonstrated how to safely secure resident/transport chair as per manufacturer's instructions. During an interview, on 3/11/2020 at 11:35 AM, the Administrator stated Driver #1 should have stopped the van and called an ambulance to come assist with Resident #1, once he realized she had fallen out of the wheelchair. The Administrator stated Driver #1 should have never picked Resident #1 up from the floor and certainly should have not carried her on to [MEDICAL TREATMENT]. The Administrator confirmed Driver #1 should have strapped the shoulder seat belt on Resident #1. She stated Driver #1 told her that he did not have the shoulder seat belt fastened on Resident #1, just the chair to the bottom of the van. She stated Resident #1 was not secured in the wheelchair without the shoulder strap, and so she went forward out of the chair. The Administrator revealed that by the shoulder seat belt not being secured on Resident #1, allowed the resident to fall from the wheelchair, and assisted with Resident #1 receiving bilateral femur fractures. A review of the facility's, Termination Report, dated 02/18/2020, revealed Driver #1 was terminated from employment on 02/18/2020 for acts of dangerous or destructive nature including carelessness. The document further revealed, Driver #1's last day of employment was 02/15/2020. The facility implemented the following Immediate Jeopardy (IJ) Removal Plan/Corrective Actions prior to the State Agency (SA) entrance on 03/11/2020. In response to the PNC IJ and SQC cited at 2:33 PM on 03/11/2020, the facility submitted a brief summary of the event, including an IJ Removal Plan and Corrective Actions, taken by the facility, to remove the Immediate Jeopardy (IJ): Description of Incident: On February 15, 2020 at approximately 10:25 AM, Licensed Practical Nurse #1 received a call from van Driver #1 stating that while transporting Resident #1, a car pulled out in front of him and he had to slam on brakes. Resident #1 came out of the chair and fell to the floor of the van, immediately complaining of bilateral leg pain and head pain. Resident #1 was taken to the local emergency department on February 15, 2020 at 10:25 AM and was noted to have bilateral femur fractures. Resident #1 was then transported and admitted to an area trauma hospital for further care on February 15, 2020 at 5:50 PM. Van Driver #1 admitted that he did not buckle Resident #1's seat belt during transport which resulted in the fall to the floor. No other staff was present on the van at the time of the incident. 1. On February 15, 2020, the Facility Administrator suspended Van Driver #1 from his duties pending investigation of this incident. During the investigation, other residents that had been taken to appointments by van Driver #1 were interviewed in relation to wearing seatbelts. Three (3) residents confirmed that van Driver #1 had not used a seatbelt during transport on February 14, 2020. 2. On February 17, 2020, the Facility Administrator notified the Mississippi State Department of Health, two (2) days after the event occurred, and the Mississippi Attorney General's Office at approximately 10:00 AM of the fall with injury, in the transport van when Van Driver #1 failed to buckle Resident #1's seatbelt. Also, on February 17, 2020, the Facility Administrator notified the local police department at approximately 11:00 AM. 3. On February 15, 2020, A Quality Assurance (QA) Meeting was held at approximately 2:45 PM to discuss Abuse and Neglect, Accident/Incident Reporting, as well as safety while driving the facility van. The Facility QA Committee members which consisted of the Facility Administrator, Medical Director, Staff Development Nurse, Infection Control Prevention Officer, Director of Nursing, Assistant Director of Nursing, Housekeeping Supervisor/Approved Van Driver #1, Medical Record Nurse, Case Manager, and Social Service Director, discussed topics of: (a) Abuse and Neglect, (b) Accident/Incident Reporting, (c) safety while driving the facility van, and (d) supervision to prevent accident and incidents. The Facility Action Plan was reviewed and approved by the QA Committee Members. The facility's policies and procedures regarding abuse and neglect and supervision to prevent accidents and incidents were reviewed and accepted with no changes indicated. 4. On February 18, 2020, the Facility Administrator terminated Van Driver #1 due to him not ensuring that residents were properly secured into the van before transportation which resulted in Resident #1 receiving bilateral femur fractures major injuries. 5. On February 15, 2020 an in-service training was initiated by the Director of Nursing (DON) along with the Facility Administrator which included 13 Registered Nurses (RN), 29 Licensed Practical Nurses (LPN), 43 Certified Nursing Assistants (CNA), seven (7) Housekeeping staff, five (5) Laundry staff, 11 Dietary staff, seven (7) Office Personnel, six (6) contract Therapy Department staff, two (2) Activities staff and one (1) Maintenance Director on the following: Abuse and Neglect, Accident/incident Reporting, seven components to reduce, detect, and prevent Abuse and Neglect, and abuse/crime reporting (Elder Justice Act), and accident and incident prevention. 6. On February 15, 2020, an in-service was initiated by the Facility Administrator for all four (4) van drivers on safety while driving the facility van with return demonstration on buckling resident's seatbelt and securing wheelchairs. A copy of the policies for company owned vehicle operation was reviewed as well and the drivers were given a copy. New drivers that are hired will be trained on the Company Owned Vehicle Driver In-Service Checklist as well as the proper securing and buckling of resident safely in the facility van with return demonstration on fastening/unfastening seatbelts, wheelchair tie downs and shoulder straps. 7. On February 17, 2020, the Administrator contacted our agency personnel provider and informed them that no agency staff will be allowed to work until the in-service training has been conducted identifying and reporting abuse and neglect. Agency personnel will not be allowed to work until these in-services have been conducted by licensed facility staff. 8. On February 15, 2020, the Facility Administrator audited all approved driver's license verification as well as their education/training on how to operate the vehicle which includes fastening/unfastening seatbelts and wheelchair tie downs and shoulder straps. There were no discrepancies during this audit. 9. No staff was allowed to work until in-servicing has been complete on: Abuse and Neglect, Accident/Incident Reporting, seven components to reduce, detect, and prevent abuse and neglect, and abuse/crime reporting (Elder Justice Act), and accident and incident prevention. The facility corrective actions were initiated on February 15, 2020. All activities to remove the IJ was initiated on 02/15/2020 and completed on 02/18/2020 and the facility alleges the IJ was removed on 02/18/2020. The State Agency validated the facility's investigation of the incident and implementation of the IJ Removal Plan/Corrective Action through observation, facility record review and interview. 1. The SA validated through record review and interview that Driver #1 was suspended from his duties on February 15, 2020 and terminated on February 18, 2020. It was validated through record review that three (3) residents confirmed that Driver #1 had not used a seat belt during transport on February 14, 2020. 2. The SA validated through record review the facility notified the Mississippi Department of Health, the Attorney general's Office and the local police Department on February 17, 2020, two (2) days after the incident occurred on February 15, 2020. 3. The SA validated through record review and interview that a Quality Assurance (QA) was held on February 15, 2020 to discuss abuse and neglect, Incident reporting, and incident regarding facility vehicle. The Administrator verified, through interview, that policies and procedures were discussed during the meeting and no changes were issued. 4. The SA validated through record review and interview that Van Driver #1 was terminated on February 18, 2020. 5. The SA validated through record review and interview that staff had been in-serviced on abuse/neglect, accident/incident reporting, seven components to reduce, detect, and prevent abuse and neglect, and abuse/crime reporting (Elder Justice Act) and accident/incident prevention. 6. The SA validated through record review and interview that all four (4) van drivers were in-serviced on van safety with return demonstrations on buckling residents seatbelt and securing wheelchairs. A review of document revealed the drivers were in-serviced on the Company Owned Vehicle Driver Checklist. An observation was made on four (4) wheelchair residents on their arrival to the facility in the facility van. It was observed that all four (4) residents were strapped into the facility van using manufactures recommendations. 7. The SA validated through interview with the Administrator that they contacted the agency personnel provider and informed them that no staff would be allowed to work until they received an in-service training on identifying and reporting abuse and neglect. 8. The SA validated through record review that the driver's licenses were audited, along with proof of education on how to operate a vehicle which included fastening seatbelts and shoulder straps. 9. The SA validated through an interview with the Facility Administrator that no staff would be or had been allowed to work without completing the

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 3) in-service on abuse/neglect, Accident/Incident reporting, seven components to reduce, detect, and prevent abuse and neglect, abuse/crime reporting (Elder Justice Act) and accident/Incident prevention. The Administrator stated that they had no new employees since the in-service was initiated.