STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	45WB	A. BUILDING: _____ B. WING _____	C 01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NICHOLS CENTER	1308 HIGHWAY 51 NORTH MADISON, MS 39110

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M 000	Initial Comments The State Agency (SA) conducted a Complaint Investigation for (CI MS#23773) at the facility from 1/8/24 through 1/10/24. The SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements related to CI MS#23773 for Quality of Care/treatment services and cited M500 and M640. Based on the facility's implementation of corrective actions on 12/21/23 taken prior to survey entrance, on 1/08/24, this deficient practice was determined to be Past Non-Compliance. However, the facility remains out of compliance due to deficiencies cited on the 12/18/2023 survey. The facility had a census of 56 at the time of the survey and held a license for 60 beds.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate;	M 500		1/31/24

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M 500	Continued From page 1 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff	M 500		

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M 500	Continued From page 2	M 500		

and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal;

6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law;

7. is free from mental and physical abuse;
8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint;
9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract;

10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs;

11. is not required to perform services for the facility that are not included for therapeutic

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M 500	Continued From page 3 purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights.	M 500		

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M 500	Continued From page 4 This Statute is not met as evidenced by: Level III Based on staff and resident interviews, record review and facility policy review, the facility failed to protect the resident's right to be free from neglect when a resident was transferred utilizing a total lift without two (2) staff members resulting in the lift overturning and the resident falling to the floor. The resident sustained skin tears and a hematoma to her scalp and required transfer to the emergency department. This was for one (1) of seven (7) residents sampled. Resident #1. Findings include: Policy and procedure review of the facility's "Abuse Program" last revised May 23, 2017, revealed "It is the policy of this facility to take all steps necessary to maintain an environment free of abuse and neglect ...Neglect is the failure of the facility, its employees or services providers to provide good and services necessary to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional stress. Neglect occurs when facility staff fail to monitor and/or supervise the delivery of resident care and services to assure that care is provided as needed by residents. Neglect occurs when a facility fails to provide necessary care for residents ..." Record review of the facility investigation "Reportable Incident Form" dated 12/7/23 revealed that CNA (Certified Nurse Aide) #1 attempted to transfer Resident #1 with the total lift without assistance on 12/6/23 at approximately 5:30 PM. CNA #1 admitted that she was trying to transfer Resident #1 to the bed from her	M 500	Past Non-Comliance, No POC needed.	

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M 500	Continued From page 5	M 500		

wheelchair and did not get assistance from another staff member. The lift fell over when CNA #1 turned toward the bed, and Resident #1 landed on the floor. When the nurses arrived, the lift was removed from the lower legs of Resident #1. It was noted Resident #1 had multiple skin tears which were cleaned and treated. The Medical Director was in the facility and gave the order to send Resident #1 to the hospital for further evaluation and treatment. She returned that night at 10:43 PM with no new orders. CNA #1 was suspended immediately after the incident and her employment terminated.

Record review of the Emergency Room (ER) visit on 12/6/23 of Resident #1 revealed the "Assessment/Plan 1. Hematoma of scalp, 2. Skin Tear, 3. Back Pain" on page five (5) of 27.

Record review of Resident #1 "Minor Med Care Progress Note" dated 12/7/2023, by the Nurse Practitioner revealed "91 y/o (years old) WF (white female) s/p (status post) fall from Hoyer lift in the facility last night with left temple contusion, left elbow skin tear and right medial ankle skin tear. She denies a headache at this time but she does have tenderness to her right ankle and left elbow from the skin tears."

Record review of Resident #1's "Lift/Transfer Evaluation" dated 10/17/23 revealed she was assessed to require "Sling Size: XXL (extra, extra large) Sling. Required Total Lift. Select assistance required: Total lift with 2 assist. Total Lift: sling size: Total lift with X-Large Sling"

Record review of undated Resident #1's "Resident Summary", which is on the kiosk for CNAs use, revealed "Bed Mobility Extensive Assistance 2 person, Lift Total Lift, Sling Size XXL

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M 500	Continued From page 6 sling." Record review of the binder connected to each lift in the facility revealed a "LONG TERM CARE GUIDE" with Resident #1 required the Total Lift for transfers with 2 staff members and an extra extra large sling. On 1/8/24 at 5:00 PM, during an interview with the Administrator on information needed for a facility reported incident regarding Resident #1 falling from a lift and what happened the Administrator stated the Assistant Director of Nursing (ADON) was actually in the facility at the time of the incident working the medication cart. She was Resident #1's assigned nurse that 3-11 shift. CNA #1 was the CNA for Resident #1. CNA #1 attempted to transfer Resident #1 from the wheelchair to bed without getting assistance from another staff member. The CNA turned towards the bed and the lift fell over with Resident #1 in it and she fell onto the floor. CNA #1 admitted she didn't ask for assistance for the Total Lift transfer. She had been recently trained on lift use. She admitted knowing she needed another staff member to assist with the lift but didn't ask anyone. She was suspended that night and terminated after the investigation. He stated, "Thank God (Proper Name) Resident #1 wasn't hurt worse." Interview with Resident #1 at 5:15 PM on 1/8/24, revealed that one (1) CNA had attempted to put her in bed using a lift. She stated she doesn't know what happened, but she and the lift fell over. She landed between the bedside table and the head of her bed. She revealed that she had a bump and bruise on her left temple area and some skin tears.	M 500		

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M 500	Continued From page 7 Interview with the Assistant Director of Nursing (ADON) on 1/8/24 at 5:45 PM, revealed that she was working on the unit as a medication nurse the 3-11 shift on 12/6/23. She stated that when she came into the room, Resident #1 was on the floor with the lift leaning over. Her head was between the bedside table and bed lying on the floor. She stated she did notice the base of the Total Lift was not spread out to prevent the lift from falling over. CNA #1 admitted to not getting another staff member to assist with the transfer of Resident #1 on the Total Lift. The resident had a skin tear to her left inner arm and on her bilateral lower extremities. She was assessed by nursing staff and 911 called for an ambulance to transfer her to the emergency room for further assessment and treatment. Interview with CNA #1 on 1/9/24 at 1:05 PM, revealed that Resident #1 "had been on the light" and wanted in bed. She stated, "She is a total lift." When asked by the State Agency (SA) if she had asked for help, she stated "No. I didn't ask for help. I poked my head out of the door and didn't see anyone, so I tried to lift her alone." She stated, "I walked away from the lift toward the bed and the lift fell over." She stated she was attempting to use the total lift to transfer Resident #1 from her wheelchair to the bed without assistance. She denied being trained in abuse, neglect, resident rights, the vulnerable adults act and on lift use. She stated that the information for lift use and other ADL's are located on the kiosk on the walls of the resident halls. She said she "thinks there is a folder on the lifts too that have each resident's lift information". Review of CNA #1's personnel file revealed she was hired 9/6/2023. She signed a "Lift free facility" form and it was dated for 6/9/2023. When	M 500		

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M 500	Continued From page 8 the SA interviewed CNA #1 on 1/9/24 at 1:05 PM, she stated that her first day at work was 9/6/23 and she must have accidentally switched the numbers of the date. She signed the abuse/neglect policy for the facility on 9/6/23. She completed the facility's "CNAs Skills Check-off" on 11/9/23. This included "Transfer Using Mechanical Lift". She was terminated from employment on 12/7/23. Record review of the "Face Sheet" of Resident #1 revealed that she was admitted to the facility on 11/23/2020 with her diagnosis' including Chronic Respiratory Failure with Hypercapnia, Morbid (severe) Obesity with Alveolar Hypoventilation, Muscle Weakness, and other Abnormalities of Gait and Mobility." Record review of the Minimum Data Set (MDS) of Resident #1 with an Assessment Reference Date (ARD) of 10/17/2023, Section C-Cognitive Patterns Brief Interview for Mental Status (BIMS) score of 15 indicated she is able to make daily decisions. Based on the facility's implementation of corrective actions on 12/7/23, the State Agency (SA) determined the deficiency to be Past Non-Compliance (PNC) and the deficiency was corrected as of 12/7/23, prior to the SA's first entrance on 1/8/24. Validation of Past non-compliance: On 12/6/23 the resident was assessed by the Director of Nursing and transferred immediately to the Emergency Room by ambulance. The Survey agency (SA) validated by record review of the nurses notes and Emergency Room documentation.	M 500		

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M 500	Continued From page 9 The Certified Nursing Assistant involved in the incident was immediately suspended and terminated 12/7/23. This was validated by the SA by reviewing the facility discipline form that revealed the termination of CNA #1. The Resident Representative was notified on 12/6/23 and the Survey Agency and Attorney General's office were notified on 12/7/23. This was validated by the SA from record review and interviews. All CNA's and Nurses were in serviced/retrained starting on 12/7/23 on following the individual care plan related to lift use, the facility policies on Total Lift Use, Abuse and Neglect, Care Plans. This was validated by the SA from sampled staff being interviewed to confirm their attendance, knowledge of the training, observation of lift use and record review of the signed documents of the attendance by the staff. As part of the facility monitoring, inservices will continue on the Total Lift use monthly for CNAs and quarterly for nurses throughout 2024. All nursing new hires will be in-serviced upon hire. All residents care plans, lift instructions, resident summary's (information with access for the CNAs in the Kiosk with guidance for individual lift use), and the binders on all the lifts that contained the individual resident information for specific lift use were audited to ensure correct and consistent information. Sampled residents care plans, lift instructions, resident summary's and binders on the lifts were audited by the Survey Agency to confirm they had consistent and correct information. The SA validated through record review and	M 500		

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M 500	Continued From page 10 interview that the facility held a Quality Assurance and Performance Improvement meeting on 12/7/23 to discuss the incident with the fall from the Total Lift. On 12/7/23, the Administrator, DON and ADON began monitoring resident halls daily reminding CNAs and nurses of the requirement of always having two staff members when using the Total Lift. The SA was able to validate the actions the facility took after the incident involving Resident #1 and CNA #1 through record review, interviews and observations.	M 500		
M 640	45.21.8 Accidents Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies. This Statute is not met as evidenced by: Level III Based on record review, interview and facility policy/procedure review, the facility failed to ensure an environment that is free from accident hazards and provide the necessary supervision to prevent injury for one (1) of seven (7) sampled residents, Resident #1. Findings include: Policy and procedure review of the facility's "Total Lift Vanderlift II", last "Updated 2/3/2023" revealed	M 640	Past Non-Compliance, No POC needed.	2/2/24

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M 640	Continued From page 11	M 640		

the "Responsibility: All Licensed Nursing Personnel and All Other Staff Providing Care to Resident or Lifting. Two people are required to operate the Total Lift."

Record review of the facility investigation "Reportable Incident Form" dated 12/7/23 revealed that CNA (Certified Nurse Aide) #1 attempted to transfer Resident #1 with the total lift without assistance on 12/6/23 at approximately 5:30 PM. CNA #1 admitted that she was trying to transfer Resident #1 to the bed from her wheelchair and did not get assistance from another staff member. The lift fell over when CNA #1 turned toward the bed, and Resident #1 landed on the floor. When the nurses arrived, the lift was removed from the lower legs of Resident #1. It was noted Resident #1 had multiple skin tears which were cleaned and treated. The Medical Director was in the facility and gave the order to send Resident #1 to the hospital for further evaluation and treatment. She returned that night at 10:43 PM with no new orders. CNA #1 was suspended immediately after the incident and her employment terminated.

Record review of Resident #1's the Emergency Room (ER) visit on 12/6/23 revealed the "Assessment/Plan 1. Hematoma of scalp, 2. Skin Tear, 3. Back Pain" on page five (5) of 27.

Record review of Resident #1 "Minor Med Care Progress Note" dated 12/7/2023, by the Nurse Practitioner revealed "91 y/o (years old) WF (white female) s/p (status post) fall from Hoyer lift in the facility last night with left temple contusion left elbow skin tear and right medial ankle skin tear. She denies a headache at this time but she does have tenderness to her right ankle and left elbow from the skin tears."

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M 640	Continued From page 12 Record review of Resident #1's "Lift/Transfer Evaluation" dated 10/17/23 revealed she was assessed to require an XXL (extra extra large) Sling with the Total lift with the assistance of 2 staff members. Record review of undated Resident #1's "Resident Summary", which is on the kiosk for CNA use, revealed "Bed Mobility Extensive Assistance 2 person, Lift Total Lift, Sling Size XXL sling." Record review of the binder connected to each lift in the facility revealed a "LONG TERM CARE GUIDE" with Resident #1 required the Total Lift with 2 person assistance and the XXL sling. Interview with the Administrator on 1/8/24 at 5:00 PM, reviewing information needed for a facility reported incident regarding Resident #1 falling from a lift and what happened the Administrator stated the Assistant Director of Nursing (ADON) was actually in the facility at the time of the incident working the medication cart. She was Resident #1's assigned nurse that 3-11 shift. CNA #1 was the CNA for Resident #1. CNA #1 attempted to transfer Resident #1 from the wheelchair to bed without getting assistance from another staff member. The CNA turned towards the bed and the lift fell over with Resident #1 in it and she fell onto the floor. CNA #1 admitted she didn't ask for assistance for the Total Lift transfer. She had been recently trained on lift use. She admitted knowing she needed another staff member to assist with the lift but didn't ask anyone. She was suspended that night and terminated after the investigation. He stated, "Thank God (Proper Name) Resident #1 wasn't hurt worse."	M 640		

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M 640	Continued From page 13 On 1/8/24 at 5:15 PM, an interview with Resident #1 revealed her saying that one Certified Nurse Aide (CNA) had attempted to put her in bed using a lift. She stated she doesn't know what happened, but she and the lift fell over. She landed between the bedside table and the head of her bed. She revealed that she had a bump and bruise on her left temple area and some skin tears. On 1/8/24 at 5:45 PM an interview with the ADON revealed that she was working on the unit as a medication nurse on the 3-11 shift on 12/6/23. She stated that when she came into the room, Resident #1 was on the floor with the lift leaning over. Her head was between the bedside table and bed lying on the floor. She stated she did notice the base of the Total Lift was not spread out to prevent the lift from falling over. CNA #1 admitted to not getting another staff member to assist with the transfer of Resident #1 on the Total Lift. The resident had a skin tear to her left inner arm and on her bilateral lower extremities. She was assessed by nursing staff and 911 called for an ambulance to transfer her to the emergency room for further assessment and treatment. On 1/9/24 at 1:05 PM an interview with CNA #1 revealed that Resident #1 "had been on the light" and wanted in bed. "She is a total lift." When asked by the State Agency (SA) if she had asked for help, she stated "No. I didn't ask for help. I poked my head out of the door and didn't see anyone, so I tried to lift her alone." She stated, "I walked away from the lift toward the bed and the lift fell over." She stated she was attempting to use the total lift to transfer Resident #1 from her wheelchair to the bed without assist. She denied	M 640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	45WB	A. BUILDING: _____ B. WING _____	C 01/10/2024

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M 640	Continued From page 14	M 640		

being trained in abuse, neglect, resident rights, the vulnerable act and on lift use.

Record review of CNA #1's personnel file revealed she was hired 9/6/2023. She signed a "Lift free facility" form and it was dated for 6/9/2023. When the State Agency (SA) interviewed CNA #1 on 1/9/24 at 1:05 PM, she stated that her first day at work was 9/6/23 and she must have accidentally switched the numbers. She signed the abuse/neglect policy for the facility on 9/6/23. She completed the facility's "CNAs Skills Check-off" on 11/9/23. This included "Transfer Using Mechanical Lift". She was terminated from employment on 12/7/23.

Record review of the "Face Sheet" of Resident #1 revealed that she admitted to the facility on 11/23/2020 with her diagnosis' including Chronic respiratory failure with hypercapnia, Morbid (severe) obesity with alveolar hypoventilation, Muscle weakness, other abnormalities of gait and mobility.

Review of the "Minimum Data Set (MDS)-Version 3.0" of Resident #1 with an Assessment Reference Date (ARD) of "10/17/2023", "Section C-Cognitive Patterns Brief Interview for Mental Status (BIMS)" of "15". She is able to make daily decisions.

Based on the facility's implementation of corrective actions on 12/7/23, the State Agency (SA) determined the deficiency to be Past Non-Compliance (PNC) and the deficiency was corrected as of 12/7/23, prior to the SA's first entrance on 1/8/24.

Validation of Past non-compliance:

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M 640	Continued From page 15 On 12/6/23 the resident was assessed by the Director of Nursing and transferred immediately to the Emergency Room by ambulance. The Survey agency (SA) validated by record review of the nurses notes and Emergency Room documentation. The Certified Nursing Assistant involved in the incident was immediately suspended and terminated 12/7/23. This was validated by the SA by reviewing the facility discipline form that revealed the termination of CNA #1. The Resident Representative was notified on 12/6/23 and the Survey Agency and Attorney General's office were notified on 12/7/23. This was validated by the SA from record review and interviews. All CNA's and Nurses were in serviced/retrained starting on 12/7/23 on following the individual care plan related to lift use, the facility policies on Total Lift Use, Abuse and Neglect, Care Plans. This was validated by the SA from sampled staff being interviewed to confirm their attendance, knowledge of the training, observation of lift use and record review of the signed documents of the attendance by the staff. As part of the facility monitoring, inservices will continue on the Total Lift use monthly for CNAs and quarterly for nurses throughout 2024. All nursing new hires will be in-serviced upon hire. All residents care plans, lift instructions, resident summary's (information with access for the CNAs in the Kiosk with guidance for individual lift use), and the binders on all the lifts that contained the individual resident information for specific lift use were audited to ensure correct and consistent information. Sampled residents care plans, lift	M 640		

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M 640	Continued From page 16 instructions, resident summary's and binders on the lifts were audited by the Survey Agency to confirm they had consistent and correct information. The SA validated through record review and interview that the facility held a Quality Assurance and Performance Improvement meeting on 12/7/23 to discuss the incident with the fall from the Total Lift. On 12/7/23, the Administrator, Director of Nursing and ADON began monitoring resident halls daily reminding CNAs and nurses of the requirement of always having two staff members when using the Total Lift. The SA was able to validate the actions the facility took after the incident involving Resident #1 and CNA #1 through record review, interviews and observations.	M 640		