STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255296	A. BUILDING _____ B. WING _____	C 01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESOTO HEALTHCARE CENTER	**7805 SOUTHCREST PARKWAY SOUTHAVEN, MS 38671**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted twelve (12) Complaint Investigations (CI MS#23816, CI MS #23586, CI MS#23395, CI MS#23288, CI MS #23322, CI MS#23269, CI MS #23251, CI MS #23200, CI MS #23241, CI MS #23196, CI MS #23197, and CI MS #23198) at the facility from 1/23/24 through 1/30/24. The SA determined the facility was in compliance with the requirements of participation in Medicare and Medicaid. Based on the facility's implementation of corrective actions on 12/30/23-1/2/24, taken prior to survey entrance on 1/23/24, related to CI MS #23816 for Quality of Care/treatment when a resident was transferred improperly resulting in a major injury, this deficient practice was determined to be Past Non-Compliance and the SA cited F656 and F689. The facility was found to be in compliance related to following Complaint Investigations: CI MS#23196, CI MS#23197 Quality Care/Treatment/Responsible Party not notified, CI MS#23198 Quality Care/treatment/Responsible Party not notified, and Administration, CI MS#23200 Resident Abuse, Resident Rights, CI MS#23241 Resident Rights, CI MS#23251 Physical Environment, No proper medical equipment, CI MS#23269 Resident denied visitation/access/Resident Rights, CI MS #23288, CI MS# 23322 Resident safety/Quality of Care/Treatment, CI MS#23395 Resident left wet for extended periods/Neglect/Pressure Sores, CI MS#23586	F 000		

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

Electronically Signed | 02/16/2024

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F 000	Continued From page 1 Assess/Monitor/Transfer/Discharge. The facility had a census of 86 at the time of the survey and held a license for 120 beds.	F 000		
F 656 SS=G	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for	F 656		

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F 656	Continued From page 2 future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review, interview and policy/procedure review, the facility failed to implement the comprehensive person-centered care plan for one (1) of 11 residents sampled, Resident #1. Certified Nurse Aide (CNA) #1, CNA # 2 and CNA #3 failed to follow the Activities of Daily Living (ADL) care plan to use a mechanical lift for Resident #1 and transferred her during the 7:00 AM to 3:00 PM shift on 12/28/23, manually transferring her twice and with the sit to stand lift once. Resident #1 began to display signs of pain on the 3:00 PM to 11:00 PM shift and was given an as needed Acetaminophen. The Nurse Practitioner (NP) ordered in-house X-rays on 12/29/23 due to continued pain. The in-house X-rays were negative for fractures, but it did note that Resident #1 was uncooperative during the X-rays. On 12/30/23, when the resident began guarding her lower right extremity, the NP ordered Resident #1 be sent to the hospital for assessment, evaluation, and X-rays. The X-rays on 12/30/23 revealed a "closed nondisplaced	F 656	Past noncompliance: no plan of correction required.	

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F 656	Continued From page 3	F 656		

fracture of medial condyle of right femur". Resident #1 was fitted with a right knee immobilizer and discharged back to the nursing home on 12/30/23.

Based on the facility's implementation of corrective actions on 12/30/23 - 1/2/24 taken prior to survey entrance on 1/23/24, this deficient practice was determined to be Past Non-Compliance.

Findings include:

Review of the facility's policy "Comprehensive Plan of Care" revised 10/10/2022 revealed, "Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment..."

Record review of the ADL care plan "Date Initiated 12/20/2023" "Revised on "01/25/2024" revealed the "Interventions: Transfer: The resident requires Total Lift with 2 staff assistance for transfers with medium sling. Date Initiated: 12/20/2023 Revision on 01/25/2024".

Record review of the facility's incident report dated "01/01/2024" revealed that on 12/28/23, Resident #1 began to complain of pain in the Right Lower Extremity (RLE). She was assessed by nursing with no redness or swelling. Resident #1 was medicated with a standing order of Tylenol 650 MG for pain. On 12/29/23, Resident #1 still exhibited pain to the right knee and the

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Nurse Practitioner ordered a STAT X-ray to be done in the facility. This X-ray was negative for fractures. On 12/30/23, Resident #1 was still complaining of pain in the right knee. The Nurse Practitioner sent her to the Emergency Room for further evaluation and X-rays. The X-rays on 12/30/23 revealed a "closed nondisplaced fracture of medial condyle of right femur". Resident #1 was fitted with a right knee immobilizer and discharged back to the nursing home on 12/30/23. The facility began to conducted an investigation to determine how Resident #1 fracture occurred. Based on interviews with CNA #1, CNA #2 and CNA #3 transferred Resident #1 three (3) times and admitted to not using a Total Lift for those transfers.

Record review on 1/26/24 of Resident #1's Certified Nurse Aide "Standard Task: ADL-Transferring", "Date initiated 10/11/2023" revealed that Resident #1 requires a "Total Lift X2 (times two) Assist."

On 1/29/24 at 12:25 PM, in an interview with the Administrator, revealed that he was notified about Resident #1's X-ray results from the hospital by the Director of Nursing (DON) on 12/30/23. We immediately began an investigation. He stated "No, the Cans did not follow the care plan. Resident #1 requires a total lift for all transfers. There were 3 Cans that admitted to providing a manual transfer and a sit to stand lift on 12/28/23. They were suspended during the investigation and terminated after the investigation completed." He stated "we began in-services immediately after being notified of the fracture. We had an emergency QA (Quality Assurance) meeting. There was a lift inservice and nursing staff had to

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demonstrate use of each lift. We use the Total lift and sit to stand lift. The other in-services were on abuse, neglect, resident rights, following the care plans."

On 1/29/24 at 3:30 PM, interview with the Administrator revealed Resident #1 should be transferred with a total lift and 2 staff members. All three knew this and had been trained on lift use and admitted knowing the resident should have been transferred with a total lift and with 2 staff members. He stated he 3 CNAs did not follow the care plan. That information is on the door of each resident's closet, the kiosk on the wall for CNAs to read the plan of care for each resident and it is on the ADL care plan.

On 1/29/24 at 2:15 PM, interview with the DON she stated that during the investigation, it was revealed that Resident #1 was transferred three times on 12/28/23, twice by manual transfer and once by the sit to stand lift. She stated that Resident #1 required a total lift with the assistance of 2 staff members for transfers. Three CNAs admitted to performing or assisting with transfers on Resident #1 that were not on the residents care plan. CNAs #1 admitted to transferring Resident #1 manually twice and using the sit to stand without any assistance of another staff member once on 12/28/23. CNAs #1 was a new hire. She stated that CNAs #2 told her, during training, that Resident #1 could be transferred by either the sit to stand lift or manually even though her plan of care had to use a total lift. The DON revealed "We immediately began in-servicing staff on abuse, neglect, resident rights, following the plan of care and lifts. We reviewed the plan of care of each resident that require lifts for transfers to make sure the

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plan of care is what their most recent lift assessment has" She stated "No, they did not follow the care plan for Resident #1." She revealed that "each resident that requires lift use has the lift type, number of staff needed, and sling size is on the kiosk where the CNAs' get their care plan for ADL's, it is on the care plan in the medical record and it is also on the closet door of each resident." She also confirmed that the three CNAs' involved had training on lifts and following the care plan in the last 8 months.

On 2/1/24 at 9:10 AM, interview with CNAs #1 revealed that she was assigned to Resident #1 on 12/28/23. She stated that when in training and orientation "A CNAs (name of CNAs #2) was training me and she told me that even though Resident #1 is supposed to be a total lift with 2 people, she can transfer with help manually or use the sit to stand lift. On her first transfer on 12/28/23, from the bed to the shower chair, (name of CNAs #2) helped me do a manual transfer. We were on each side of her. The bed was lowered down to the level of the shower chair. In the shower room, I transferred her from the shower chair to her wheelchair using a sit to stand lift with (Name of CNAs #3). Before my shift was over, I transferred her by myself manually back to bed. She stated you can find the plan of care on the kiosk. That would have how to each resident is transferred. It is also on each resident's closet. It has the lift, number of staff to do the transfer and the sling size. It is in the ADL care plan too. I knew she was a total lift with 2 people, but I had been told by another CNAs that Resident #1 can manually transfer so that is what I did." She revealed "Yes, I had lift training during orientation. I had care plan training during orientation also."

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Interview with CNAs #2 on 1/29/24 at 2:30 PM revealed, "When I was training CNAs #1, we did a manual lift on Resident #1 together. We were putting her in the shower chair from her wheelchair that time." She revealed that it is on resident closet doors, the kiosk and in the ADL care plan on how each resident is transferred.

Interview with CNAs #3 on 1/29/24 at 2:40 PM revealed "Resident #1 was not my resident that day. I was only helping CNAs #1 with her. (Name of CNAs #1) asked me to help her put Resident #1 on the shower chair. I said to (name of CNAs #1) that Resident #1 is supposed to be on a total lift for transfers. On her closet, it said total lift. We proceeded to manually transfer Resident #1. I got on 1 side of the bed and (name of CNAs #1) got on the other side of the bed. We went 1,2,3 and put Resident #1 on the shower chair manually. No, she didn't stand on her feet. We lifted her, nothing touched the floor after that (name of CNAs #1) took Resident #1 to the shower room. Yes, how to transfer a resident is on the closet door. It is also on the ADL's care plan. Yes, I was trained on lifts. I know it takes 2 people to use a lift."

Record review of Resident #1's "Admission Record" revealed she was admitted to the facility 1/2/2020 with diagnoses including Muscle Weakness generalized, other lack of coordination, unspecified dementia, Morbid Obesity, and Need for Assistance with Personal Care.

Record review of Resident #1's MDS dated 1/2/24 revealed she had a "Brief Interview for Mental Status (BIMS)" of "03" meaning she is

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F 656	Continued From page 8 unable to make daily decisions for herself. Validation of Past non-compliance The State Agency (SA) validated through interviews, record review of Progress Notes, Medical Doctor orders and Emergency Room documentation, on 12/29/23, Resident #1 was assessed with no injuries noted after complaints of pain to her right knee. The NP ordered a STAT X-ray with no fractures noted. The resident was sent to the Emergency Room (ER) on 12/30/23 by the NP related to continued complaints of pain in the right knee. X-rays at the ER revealed a closed nondisplaced fracture of medial condyle of right femur. She returned to the facility on 12/30/23 with a knee immobilizer on her right knee. The SA validated by interviews and record review the Director of Nurses began her investigation on 12/30/23 when notified of the fracture. She obtained written statements from staff in the facility beginning on 12/28/23 when Resident #1 began complaining of pain. There were three (3) Certified Nurse Aides (CNAs) that admitted to performing 3 inappropriate transfers of Resident #1 on 12/28/23. The 3 CNAs' were suspended 12/29/23 pending investigation completion and then terminated on 1/3/24. The SA validated from record review and interviews, the Resident Representative (RR) was notified on 12/30/2023 and the State Agency (SA) was notified on 12/30/2023. The Attorney General office was notified when the CNAs' admitted to the inappropriate transfers.	F 656		

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F 656	Continued From page 9 All CNAs' and nurses were in serviced starting 12/30/23 on following the individual care plan related to lift use, the facility policies on Lift Use, Abuse and Neglect, and 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. All nursing new hires will be in-serviced upon hire. The SA validated through interviews that all residents care plans, lift instructions, and the resident cards located on individual resident closet doors were audited to ensure correct and consistent information. Sampled residents care plans, lift instructions, resident cards located on individual resident closet doors were audited by the SA 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 1/2/24 to discuss the incident regarding 3 CNAs' failing to use the correct lift technique for Resident #1. The SA was able to validate the actions the facility took after the incident, beginning 12/30/23 and prior to SA entrance for survey on 1/23/24, involving Resident #1 and CNAs #1, CNAs #2 and CNAs #3 through record review, interviews, and observations.	F 656		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F 689		

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F 689	Continued From page 10 The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, policy/procedure review and interview, the facility failed to ensure that each resident receives adequate supervision and assistance devices to prevent accidents for one (1) of 11 residents sampled, Resident #1. During the 7:00 AM to 3:00 PM shift on 12/28/23, Certified Nurse Aide (CNA) #1, CNA #2 and CNA # 3 transferred Resident #1, using a manual transfer twice and the sit to stand lift once. Resident #1 began to display signs of pain on the 3:00 PM to 11:00 PM shift and was given an as needed Acetaminophen. The Nurse Practitioner (NP) ordered in-house X-rays on 12/29/23 due to continued pain. The in-house X-rays were negative for fractures, but it did note that Resident #1 was uncooperative during the X-rays. On 12/30/23, when the resident began guarding her lower right extremity, the NP ordered that Resident #1 be sent to the hospital for assessment, evaluation, and X-rays. The X-rays on 12/30/23 revealed a "closed nondisplaced fracture of medial condyle of right femur". Resident #1 was fitted with a right knee immobilizer and discharged back to the nursing home on 12/30/23. Based on the facility's implementation of corrective actions on 12/30/23 - 1/2/24 taken prior to survey entrance on 1/23/24, this deficient	F 689	Past noncompliance: no plan of correction required.	

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practice was determined to be Past Non-Compliance.

Findings include:

Policy and procedure review of the facility's "Safe Lifting Program" last "revised 9/22/22" revealed the "Policy: It is the policy of this facility to ensure that residents are handled and transferred safely to prevent or minimize risks for injury and provide and promote a safe, secure, and comfortable experience for the residents while keeping the employees safe in accordance with current standards and guidelines ...Compliance Guidelines ...10. Two staff members must be utilized the transferring residents with a mechanical lift ...13. Staff members are expected to maintain compliance with safe handling/transfer practices ...14. Resident lifting and transferring will be performed according to the resident's individual plan of care."

Record review of the facility's incident report dated "01/01/2024" revealed that on 12/28/23, Resident #1 began to complain of pain in the right lower extremity (RLE). She was assessed by nursing with no redness or swelling. Resident #1 was medicated with a standing order of Tylenol 650 MG (milligrams) for pain. On 12/29/23, Resident #1 still exhibited pain to the right knee and the Nurse Practitioner ordered a STAT (immediate) X-ray to be done in the facility. This X-ray was negative for fractures. On 12/30/23, Resident #1 was still complaining of pain in the right knee. The Nurse Practitioner sent her to the Emergency Room for further evaluation and X-rays. The X-rays on 12/30/23 revealed a "closed nondisplaced fracture of medial condyle of right femur". Resident #1 was fitted with a right

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knee immobilizer and discharged back to the nursing home on 12/30/23. The facility began to conduct an investigation to determine how Resident #1's fracture occurred. Based on interviews with CNA #1, CNA #2 and CNA #3 transferred Resident #1 three (3) times and admitted to not using a Total Lift for those transfers.

Record review of the ED (Emergency Department) Provider Notes dated 12/30/23 revealed, "...Examination XR (x-ray) knee right AP and Lateral...Impression fracture of the distal medial right femoral metaphysis likely acute...Clinical Impression: Final diagnoses: Closed non-displaced fracture of medial condyle of right femur..."

Record review of Resident #1's Certified Nurse Aide "Standard Task: ADL-Transferring", "Date initiated 10/11/2023" revealed that Resident #1 requires a "Total Lift X2 (times two) Assist."

Record review of a "Progress Note" for "Lift/transfer evaluation" "Effective Date 12/6/23" revealed "Resident is not able or partially able to assist with transfers from bed to bed."

Review of the Nurse Practitioner's (NP) "Progress Notes: CPT (Amended) with Date of Service (DOS) being 12/29/2023 revealed that Resident #1 was seen by the NP due to "c/o acute RLE (right lower extremity) pain" and "no reported injuries". The NP's "Plan: obtain STAT 2 view x-ray of bilateral hip/pelvis/right knee/continue Tylenol".

Record review of "Progress Notes" dated "12/30/2023 0900" written by a Licensed Practical

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Nurse (LPN)" revealed "NP made aware of Xray results that showed no abnormality to R (right) knee. Res still continues to display s/s of increased pain. NP ordered for res (resident) to be sent to (name of hospital) ER for further eval (evaluation). RP aware."

Record review of "Progress Notes" dated "12/30/2023 11:42" revealed transfer to (local emergency room) for evaluation on leg and thigh pain.

Record review of "Progress Notes" dated "12/30/2023 17:16" revealed a call from the ER reporting Resident #1 has a right distal medial femoral fracture. Resident to return to facility with knee immobilizer this evening.

Record review of "Progress Notes" dated "12/30/2023 18:45" revealed Resident #1 returned from the hospital with a knee immobilizer observed to R knee.

Interview with the Administrator on 1/29/24 at 12:25 PM, revealed he was notified about Resident #1's X-ray results from the hospital by the Director of Nursing (DON) on 12/30/23. "We immediately began an investigation." Resident #1 requires a total lift for all transfers. There were 3 CNA's that admitted to doing a manual transfer and a sit to stand lift on 12/28/23. They were suspended during the investigation and terminated after the was completed." He revealed that the DON contacted the State Agency (SA) and the Attorney General's (AG) office timely. He stated, "We began in-services immediately after being notified of the fracture. We had an emergency QA (Quality Assurance) meeting. There was a lift inservice and nursing

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staff had to demonstrate use of each lift. We use the Total lift and sit to stand lift. The other in-services were on abuse, neglect, resident rights, and following the care plans."

Interview with the Administrator on 1/29/24 at 3:30 PM, regarding the fracture of Resident #1 revealed, "We were unsure of how the fracture happened. It was called in to licensure in the 2-hour time frame. We began investigating the fracture by backtracking who had cared for Resident #1 prior to the fracture and trying to find when she began having pain. The AG office was notified on 1/2/24 when we knew exactly what had happened after the interview, demonstrations and written statements by the three CNAs (CNA #1, CNA #2 and CNA #3). Resident #1 should be transferred with a total life and 2 staff members. All three knew this and had been trained on lift use and admitted knowing the resident should have been transferred with a total lift and with 2 staff members.

Interview with the DON on 1/29/24 at 2:15 PM, she stated that during the investigation, it was revealed that Resident #1 was transferred three times on 12/28/23 twice by manual transfer and once by sit to stand lift. She stated that Resident #1 was a total lift with the assist of 2 staff members. Three CNAs were suspended, then their employment was terminated. All three admitted to performing or assisting with transfers on Resident #1 that were not on the resident's care plan. It was noted that late on 12/28/23 that Resident #1 was displaying signs of pain. A nurse assessed her and saw no signs of redness or swelling on her body. On 12/29/23, Resident #1 was still expressing signs of pain. The Nurse Practitioner (NP) ordered X-rays to be done STAT

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in house. The results did not show any fractures but did note that the resident was moving during the X-rays. On 12/30/23, the NP then ordered Resident #1 to be sent to the hospital for assessment and treatment because of continued pain. The X-rays from the hospital revealed a distal medial right femoral fracture. She returned to the facility with a knee immobilizer. I began the investigation when I got the X-ray results. During the investigation, we started looking at 12/28/23, the day she began to show signs of pain. The three CNAs involved were (names of CNA #1, CNA #2 and CNA #3). CNA #1 was the CNA assigned to Resident #1 on 12/28/23. CNA #1 admitted to transferring Resident #1 manually twice and using the sit to stand lift without any assistance of another staff member once on 12/28/23. CNA #1 was a new hire. She stated that CNA #2 told her, during training, that Resident #1 could be transferred by either the sit to stand lift or manually even though her plan of care had to use a total lift. CNA #3 admitted to assisting CNA #1 with a manual transfer of Resident #1 on 12/28/23. CNA #2 admitted to assisting CNA #1with a manual transfer of Resident #1 on 12/28/23. All 3 CNA's wrote and signed statements regarding what happened with Resident #1. They were suspended. They did return to the facility to demonstrate to the Quality Assurance (QA) team what had happened with Resident #1's transfers. Once the demonstration was completed, all three were terminated. She stated, "We immediately began in-servicing staff on abuse, neglect, resident rights, following the plan of care and lifts. We did a check-off for staff and in-service on lifts. They were required to demonstrate using each lift. There was an emergency QA meeting. We reviewed the plan of care of each resident that require lifts for

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transfers to make sure the plan of care is what their most recent lift assessment has." She revealed that "each resident that requires lift use has the lift type, number of staff needed, and sling size is on the kiosk where the CNAs get their care plan for ADL's, it is on the care plan in the medical record, and it is also on the closet door of each resident." She confirmed that she notified the State Agency (SA) within 2 hours of getting the X-ray results from the hospital. She stated the Attorney General (AG) office was notified of the incident and the admissions of each CNA. She also confirmed that the three CNAs involved had training on lifts and following the care plan in the last 8 months.

Interview with the Nurse Practitioner on 1/26/24 at 9:45 AM, revealed that she saw Resident #1 on 12/27/23 and there were no issues. She was notified on 12/29/23 that the resident was guarding her right leg and moaning. She ordered STAT X-rays on 12/29/23 of the pelvic area, hips and lower extremities. That set of X-rays were done in the facility and it was noted on the X-rays that the resident was moving frequently during the X-rays. She ordered the resident be sent to the hospital on 12/30/23 when the staff stated she was continuing to display symptoms of pain. "I saw her on 12/29/23 for acute pain in the right lower extremity. She would not let me extend the right lower extremity. I ordered X-rays to be done in house at that time. The results were negative for fracture but did state the resident was moving during the X-rays. On 12/30/23, she was still complaining of pain in the right lower extremity, so I had her sent to the hospital for better X-rays and further assessment. (Name of DON) began an investigation when the hospital X-rays revealed a fracture of the right femur. She

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returned from the hospital with a knee immobilizer on the right leg the same day."

Interview with CNA #1 on 2/1/24 at 9:10 AM revealed that she was assigned to Resident #1 on 12/28/23. She stated that when in training and orientation "(Proper name of CNA #2) was training me and she told me that even though Resident #1 is supposed to be a total lift with 2 people, she can transfer with help manually or use the sit to stand lift. On her first transfer on 12/28/23, from the bed to the shower chair, (name of CNA #2) helped me do a manual transfer. We were on each side of her. The bed was lowered down to the level of the shower chair. In the shower room, I transferred her from the shower chair to her wheelchair using a sit to stand lift with (Proper name of CNA #3). Resident #1 never complained of pain or showed signs of pain. She went to lunch, therapy and the beauty shop that day. Before my shift was over, I transferred her by myself manually back to bed. I lowered her bed to the level of her wheelchair seat and put her on her bed. She rubbed her leg but when I changed her, there was no swelling, bruising or redness noted. I did not ask for help when I did her last transfer. I was suspended when they were doing the investigation and then terminated after the investigation was complete. You can find the plan of care on the kiosk. Those are the computers on the walls on each hall. That would have how each resident is transferred. It is also on each resident's closet. It has the lift, number of staff to do the transfer and the sling size. It is in the ADL care plan too. I knew she was a total lift with 2 people, but I had been told by another CNA that Resident #1 can manually transfer so that is what I did." She revealed, "I had lift training during orientation. I

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had care plan training during orientation also."

Interview with CNA #2 on 1/29/24 at 2:30 PM revealed "No, I did not tell CNA #1 to transfer Resident #1 manually during training. I told her she has to use the lift. I was on a different hall that day. Now, when I was training CNA #1, we did a manual lift on Resident #1 together. We were putting her in the shower chair from her wheelchair that time." She was unable to recall the date. She revealed that it is on resident closet doors, the kiosk and in the ADL care plan on how each resident is transferred.

Interview with CNA #3 on 1/29/24 at 2:40 PM, revealed "Resident #1 was not my resident that day. I was only helping CNA #1 with her. (Name of CNA #1) asked me to help her put Resident #1 on the shower chair. I said to (name of CNA #1) that Resident #1 is supposed to be on a total lift for transfers. On her closet, it said total lift. We proceeded to manually transfer Resident #1. I got on 1 side of the bed and (name of CNA #1) got on the other side of the bed. We went 1,2,3 and put Resident #1 on the shower chair manually. No, she didn't stand on her feet. We lifted her, nothing touched the floor after that (name of CNA #1) took Resident #1 to the shower room. How to transfer a resident is on the closet door. It is also on the ADL's care plan. I was trained on lifts. I know it takes 2 people to use a lift."

Record review of Resident #1's "Admission Record" revealed she was admitted to the facility 1/2/2020 with diagnoses including Muscle Weakness generalized, other lack of coordination, unspecified dementia, Morbid Obesity, and Need for Assistance with Personal Care.

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Record review of Resident #1 Minimum Data Set (MDS) dated 9/21/23 "Section G Functional Status" revealed Resident #1 required two person extensive physical assistance with transfers.

Record review of Resident #1's MDS dated 1/2/24 revealed she had a Brief Interview for Mental Status (BIMS) score of "03" meaning she is unable to make daily decisions for herself.

Validation of Past non-compliance

The State Agency (SA) validated through interviews, record review of Progress Notes, Medical Doctor orders and Emergency Room documentation, on 12/29/23, Resident #1 was assessed with no injuries noted after complaints of pain in her right knee. The NP ordered a STAT X-ray with no fractures noted. The resident was sent to the Emergency Room (ER) on 12/30/23 by the NP related to continued complaints of pain in the right knee. X-rays at the ER revealed a closed nondisplaced fracture of medial condyle of right femur. She returned to the facility on 12/30/23 with a knee immobilizer on her right knee.

The SA validated by interviews and record review the Director of Nurses began her investigation on 12/30/23 when notified of the fracture. She obtained written statements from staff in the facility beginning on 12/28/23 when Resident #1 began complaining of pain. There were three (3) Certified Nurse Aides (CNA) that admitted to performing 3 inappropriate transfers of Resident #1 on 12/28/23. The 3 CNAs were suspended 12/29/23 pending investigation completion and

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then terminated on 1/3/24.

The SA validated from record review and interviews, the Resident Representative (RR) was notified on 12/30/2023 and the State Agency (SA) was notified on 12/30/2023. The Attorney General office was notified when the CNA's admitted to the inappropriate transfers.

All CNA's and nurses were in serviced starting 12/30/23 on following the individual care plan related to lift use, the facility policies on Lift Use, Abuse and Neglect, and 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. All nursing new hires will be in-serviced upon hire.

The SA validated through interviews that all residents care plans, lift instructions, and the resident cards located on individual resident closet doors were audited to ensure correct and consistent information. Sampled residents care plans, lift instructions, resident cards located on individual resident closet doors were audited by the SA 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 1/2/24 to discuss the incident regarding 3 CNA's failing to use the correct lift technique for Resident #1.

The SA was able to validate the actions the facility took after the incident, beginning 12/30/23

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