STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255217	A. BUILDING _____ B. WING _____	C 04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER HEIGHTS HEALTHCARE CENTER	402 ARNOLD AVENUE GREENVILLE, MS 38701

(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 Complaint Investigations (CI) MS#24643 and CI MS #24497) at the facility on 4/17/24. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid Services. The SA identified non-compliance and cited F656 for failure to follow a residents care plan and F689 for failure to prevent an accident related to CI MS# 24643. There were no deficiencies cited for CI MS #24497 regarding dignity, client services or falls. The census at the time of the survey was 54 with a bed capacity of 60 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	F 656		5/28/24

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

Electronically Signed | 05/03/2024

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F 656	Continued From page 1 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 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 resident and staff interview, record review and facility policy review the facility failed follow the person centered care plan to use a full body lift as indicated, causing a dislocated shoulder for Resident #1. This was for one (1) of four (4) resident care plans reviewed. Findings Include Record review of the facility policy titled, "Care Plans, Comprehensive, Person Centered" with no revision dated revealed "Policy Statement: A	F 656	* Resident #1 did sustain an injury due to this deficient practice. On April 19, 2024 the facility Assistant Director of Nursing and the facility care plan nurse provided additional education to the nursing staff to ensure they are using proper lifting practices. * Only one resident suffered an adverse event from this deficient practice, though all residents with lift orders have the potential to be effected by this deficient	

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F 656	Continued From page 2 comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident ...". Record review of Resident #1's "Care Plan" revealed a care plan dated 3/8/23 "Alteration in ADLS (Activities of Daily Living) r/t (related to) generalized weakness, difficulty walking, impaired mobility secondary to Hx (history) CVA (Cerebral vascular accident) with left sided Hemiplegia, extensive assist x (times) 2 staff with bed mobility and transfer ...Interventions...Transfer using full body mechanical lift with 2 persons assist ..." During an interview on 4/17/24 at 9:10 AM, revealed Resident #1 stated she hurt her shoulder a few weeks ago, but they were using a different kind of lift then. She revealed that she was holding herself up for too long on that lift and that's what hurt her shoulder. During an interview on 4/17/24 at 9:35 AM revealed CNA #1 and CNA #2 both reported Resident #1 "used to be a sit to stand lift but that the resident got to where she could not bear weight, so they changed her to a total lift." During an interview on 4/17/24 at 10:50 AM, with CNA #4 confirmed she did not have access to the resident's care plans. She stated that the care plans should let them know what care the resident needed. During an interview on 4/17/24 at 11:00 AM, with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) revealed that it was discovered during the investigation of Resident	F 656	practice. * The facility Director of Nursing and the Assistant Director of Nursing completed a 100% audit of physician's orders, care plans, and care guides in the facility Match and are consistent. The facility certified nursing assistances and Licensed nursing staff received additional education from the assistant director of nursing on the location of Care guides and following the care plan for safe lifting of residents on April 19 2024. *On May 3, 2024 the Director of Nursing will begin to observe 4 residents with lifting orders 3 times a week for 8 weeks to ensure care plans are being followed. A quality Assurance meeting will be held on May 23 to review F656 and findings from the Director of Nursing monitoring will be discussed for action as indicated. On May 3, 2024 the Assistant director of nursing will begin to monitor 4 residents requiring the use of mechanical lifts 3 times per week for 8 weeks to ensure safe and proper lifting. the Director of Nursing and the Assistant Director of Nursing will bring their findings from monitoring to the Quality Assurance Committee for a period of 3 months or until the issue has been resolved.	

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F 656	Continued From page 3	F 656		

#1's right shoulder dislocation that CNA #5 used a "sit to stand" lift on the resident by herself. The ADON revealed that they changed Resident #1 from a "sit to stand lift" to a "total lift" after this incident because the resident drops her weight by bending her knees and couldn't always hold herself up.

During an interview and record review on 4/17/24 at 11:40 AM, the DON confirmed Resident #1 had a Physician's order for a "Total Lift" to be used since 3/9/2023 and a care plan for the use of a "Total Lift" with a start date of 3/8/23. She stated that care plans are used to direct the care needed for the residents.

During an interview on 4/17/24 at 11:42 AM, with Licensed Practical Nurse (LPN) #1 stated that care plans are important to help guide the care that the resident is supposed to receive.

During an interview on 4/17/24 at 11:45 AM, with the Director of Clinical Services confirmed that the care plan is put into place to guide the staff on what type of care the resident needs.

During an interview on 4/17/24 at 12:00 PM, the Administrator stated "staff must not be looking at the resident's care plans like they are supposed too.

Record review of Resident #1's "Face Sheet" revealed the resident was admitted to the facility on 3/8/23 with medical diagnoses that included Hemiplegia following Cerebral Infarction affecting left nondominant side.

Record review of the facility's "Report of Investigation" for Resident #1's incident revealed

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F 656	Continued From page 4 that on 3/21/24 the resident was left in a "sit to stand" lift too long without assistance, which resulted in an injury of a dislocated right shoulder. The report indicated Certified Nursing Assistant (CNA) #5 "provided care to resident by herself." Record review of Resident #1's "Radiology Interpretation: x-ray report dated 3/25/24 revealed " ...Significant Findings: Right Shoulder X-Ray ...Findings:There is anterior shoulder dislocation ..."	F 656		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. 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 observation, resident and staff interview, record review and facility policy review the facility failed to prevent an accident that resulted in an injury, as evidenced by a staff member using a lift the physician had not ordered for one (1) of four (4) residents reviewed that required a lift. Resident #1 Findings Include Review of the facility policy titled, "Modified Lifting Policy" with no revision dated revealed " ...Policy Interpretation and Implementation ...3. Staff will follow the documented lifting protocol deemed	F 689	* The facility did use a lift that was not ordered by the physician for resident #1. All licensed nursing staff and certified nursing assistance received additional education on April 19, 2024 to ensure the correct lifting device is used per physician orders. * One resident was affected by this deficient practice. All residents that require the use of a manual lift have the potential to be affected by this deficient practice.	5/28/24

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F 689	Continued From page 5 appropriate for each resident. This information is documented in the resident's chart and on the Resident Care Sheet. This information should be referred to prior to lifting/transferring or assisting each resident ..." An interview and observation on 4/17/24 at 9:10 AM, revealed Resident #1 lying in bed with a total lift sling underneath her. She revealed they now use a lift that lifts her up out of the bed and sits her in her wheelchair. She stated she hurt her shoulder a few weeks ago, but they were using a different kind of lift then. She stated that she was holding herself up for too long on that lift and that's what hurt her shoulder. She admits she feels better now and likes this lift better. Record review of the facility's "Report of Investigation" for Resident #1's incident revealed that on 3/21/24 the resident was left in a "sit to stand" lift too long without assistance, which resulted in an injury of a dislocated right shoulder. The report indicated Certified Nursing Assistant (CNA) #5, an agency CNA, "provided care to resident by herself." Record review of Resident #1's "Radiology Interpretation: x-ray report dated 3/25/24 revealed " ...Significant Findings: Right Shoulder X-Ray ...Findings: There is anterior shoulder dislocation ..." Record review of the witness statement dated 3/26/24 from CNA #5 revealed she had put Resident #1 in the bed on Wednesday or Thursday around 6:30 PM and the resident stated that the lift was hurting and then complained the next day with her shoulder hurting so she told the nurse.	F 689	* The facility Director of Nursing and the assistant director of nursing conducted a 100% audit on April 19, 2024 to ensure physician orders for lifts are followed. All licensed nurses and certified nursing assistance received additional education from the facility Assistant director of Nursing to ensure that the correct lift listed on residents care plans are being followed. *On May 3,2024 The Director of Nursing will observe 4 residents 3 times per week for 8 weeks to ensure the correct lift is used per residents Care Plan. On May 3, 2024 the Assistant Director of Nursing will observe 4 residents 3 times per week with lifting orders for 8 weeks to ensure that the correct lift is properly used. The Director of nursing will present her findings to the quality assurance committee on May 23,2024 and for the next 3 moths for review and further action as indicated for 3 months or until issue is resolved.	

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Record review of Resident #1's "Departmental Notes" dated 3/26/24 at 3:58 AM, revealed the resident returned to the facility from the ER (emergency room) and report from the ER nurse revealed that the resident had a dislocated shoulder, was given local anesthesia and shoulder put back in place.

Record review of Resident #1's "Physicians Orders" revealed an order dated 3/9/23 "Transfer using full body mechanical lift with 2 persons assist."

An interview and observation on 4/17/24 at 9:35 AM, revealed CNA #1 and CNA #2 used a total lift to get Resident #1 out of bed and into her wheelchair. Both CNAs revealed that the resident used to be a "sit to stand" lift but that the resident "got to where she could not bear weight, so they changed her to a total lift." CNA #1 stated that the lift change was not long ago. CNA #2 stated that when residents are admitted that therapy decides what type of lift the resident needs and then the nurses tell the CNA's. Both CNAs stated that they were not aware of any care guide that they can look at that tells them what kind of lift to use for the resident. CNA #2 stated that they just know if the residents are weight bearing or not and that helps us to know what kind of lift they need. CNA #1 stated they also have colored dots on their room number that indicate what kind of lift they need. This observation revealed that Resident #1 did not have a colored dot by her room number.

An interview on 4/17/24 at 10:15 AM, with Registered Nurse (RN) #1 stated that the residents should have a care plan for lift transfers

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and that it should confirm rather they are a total or a stand-up lift. She confirmed that the dots that are on the resident's door indicates whether they are independent (green), sit to stand (yellow) or full body lift (red). RN #1 revealed that it lets the nurse aides know which lift to use and that they should use two people with both lift transfers.

An interview on 4/17/24 at 10:30 AM, with CNA #3 stated that Resident #1 was not always able to hold her weight up on the "Sit to Stand" lift so they recently changed her to a "Total Lift".

An interview on 4/17/24 at 10:50 AM, with CNA #4 confirmed that the colored dots on the resident's room doors let the CNA's know what type of lift to use on the resident. She confirmed that Resident #1 did not have a colored dot on her door. She stated if she did not have a dot then she would just have to ask the nurse what kind of lift to use. She confirmed she was not aware of any care guide that indicated what type of lift the residents use.

An interview on 4/27/24 at 11:00 AM, with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) revealed that it was discovered during the investigation of Resident #1's right shoulder dislocation that CNA #5 used a "sit to stand" lift on the resident by herself. The DON stated that an X-ray revealed the resident's right shoulder was dislocated. The ADON revealed that they immediately started an investigation that began with interviewing Resident #1. She stated that the resident told her that she had to hold herself up too long on that lift and that was when her shoulder started hurting. The DON stated that CNA #5 admitted that she used the "Sit to Stand" lift without any other staff

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help. The ADON revealed that they changed Resident #1 from a "sit to stand" lift to a "total" lift after this incident because the resident drops her weight by bending her knees and couldn't always hold herself up. They both revealed that the CNA's have a care guide at the nurse's station that tells them what kind of lift to use, but the residents also have colored dots on their room numbers that indicate what kind also.

An interview on 4/17/24 at 11:20 AM, with the Administrator stated that he knew that CNA #5 had used a "Sit to Stand" lift without any help and she was not supposed to do that, so she is on my "no hire" list.

An interview and record review on 4/17/24 at 11: 40 AM with the DON confirmed that Resident #1 had an order for a "Total Lift" to be used since 3/9/2023. The DON stated, "so she (CNA) #5 did not even use the correct lift". She stated that she thought the resident had an order for a "Sit to Stand" but confirmed that she did not. She stated that the use of the wrong lift was against their policy and not following physicians' orders, which could have led to the residents dislocated shoulder. She stated that they put the colored dots in place to indicate the type of lift a little while back but admits that the staff need to be educated on the use of their care guide.

An interview and record review on 4/17/24 at 11:50 AM, with CNA #1 revealed she had never seen the care guide form before that indicated a number system that told what type of lift the resident supposed to use. She stated she did not know that Resident #1 was supposed to have been using a total lift because they had always used a "sit to stand" with her until this incident

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F 689	Continued From page 9 happened. An interview on 4/17/24 at 12:00 PM, with the Administrator revealed he was not aware that CNA #5 had used the wrong lift and stated that staff must not be looking at the resident's care guides like they are supposed too. Record review of Resident #1's "Daily Care Guide" revealed the resident needed "Total Dependence" for transfer. Record review of Resident #1's "Face Sheet" revealed the resident was admitted to the facility on 3/8/23 with medical diagnoses that included Hemiplegia following Cerebral Infarction affecting left nondominant side.	F 689		