MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	47CI	A. BUILDING: _____ B. WING _____	C 09/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY SPRINGS REHABILITATION AND HEALTHCAR	1315 HIGHWAY 4 EAST HOLLY SPRINGS, MS 38635

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M 000	Initial Comments The State Agency (SA) conducted a Complaint Investigation (CI #26037) at the facility on 09/09/24. During the survey, the SA determined the facility was not in compliance with the Minimum Standards of Operation for Institutions for the Aged or Infirm, state licensure requirements. The SA investigated CI #26037 related to resident abuse, incontinent care, and a fall, and cited M640. The facility held a license for 120 beds at the time of the survey, and the facility census was 78.	M 000		
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: Based on interviews, record review and facility policy review the facility failed to provide two-person assistance with incontinent care for a dependent resident in a manner to prevent a fall for one (1) of three (3) sampled residents. Resident #1. Findings Include: Review of the facility policy titled, "Fall Prevention Program" with reviewed date of 06/10/2024 revealed, "All residents will be assessed for the risk for falls at the time of admission, on a quarterly basis, and upon significant change in condition thereafter. Based on the results of this	M 640	1. On 7/22/2024, a one-on-one in-service was conducted by the Staff Development Coordinator (SDC) with Certified Nursing Assistant (CNA) number 1 regarding the plan of care policy and following care plans regarding the amount of assistance required that is denoted on the Activities of Daily Living (ADL) care plan. On 9/18/24, the Staff Development Coordinator (SDC) re-in serviced CNA number 1 regarding the implementation of care regarding the amount of assistance required on the ADL care plan.	10/17/24

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M 640	Continued From page 1 assessment, specific interventions will be implemented to minimize falls, avoid repeat falls and minimize falls resulting in significant injury." Record review of Resident #1's "Incident Report" dated 07/21/24 at 14:42 revealed, "Was notified by Certified Nursing Assistant (CNA Proper Name) that Resident (proper name) was on the floor. CNA (proper name) stated as she was changing her, Resident's (proper name) body was turned to the left. CNA (proper name) was using her hands to hold up the weight of Resident's (proper name) legs as she was getting her brief changed. While changing her, her legs slipped over the side of the bed and Resident (proper name) proceeded to fall on floor. Resident was unable to give description. There were no injuries observed at time of incident." Record review revealed that the resident did not suffer an injury with the fall. An interview with Registered Nurse (RN) Supervisor on 09/09/24 at 11:10 AM, revealed the Assistant Director of Nursing (ADON) reported to her on Monday morning, July 22, 2024, that Resident #1 fell out of the bed the day before. She revealed the ADON reported that (CNA) #1, went into Resident #1's room to change her and she rolled out of the bed. She revealed that Resident #1 had contractures and was supposed to have two-person assistance to prevent any accidents. RN Supervisor revealed that CNA #1 went in by herself to provide care, positioned Resident #1 too close to the edge of the bed and she fell off the bed onto the floor. She confirmed that there should have been two people in the room, one to assist with holding the resident and the other to provide care. RN Supervisor revealed that residents with contractures were supposed to have two- person assistance to prevent falls or	M 640	2. On 9/18/2024, an ADL care plan audit was conducted by the facility Minimum Data Set Coordinator (MDS) to identify residents that required two-person assistance with ADL that could be affected by the deficient practice. At the time of the audit, thirty-six of seventy-six residents were identified with having the potential to be affected. 3. On 9/9/2024, all licensed nurses and CNA□s were in-serviced on the plan of care policy and following the ADL care plan regarding how much assistance a resident needs when providing ADL care. The in-service on 9/9/2024 also included education on where both licensed nurses and CNA□s can locate a residents ADL care plan information. 4. Beginning 9/23/2024, the Assistant Director of Nursing or nursing supervisor will perform unannounced ADL observation audits on four residents to ensure licensed nurses and CNA□s are following the ADL plan of care for required assistance three times a week for four weeks, then weekly times four weeks then monthly times 3 months. The Director of Nursing (DON) or ADON is responsible for bringing the results of the audit to the monthly Quality Assurance/Performance Improvement (QAPI) meeting for four months beginning on 9/27/2024. The administrator is responsible for monitoring	

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M 640	Continued From page 2 injuries. A phone interview with Assistant Director of Nursing (ADON) on 09/09/24 at 11:30 AM revealed that on 07/21/24, CNA #1 was in the room changing Resident #1's brief and doing peri-care, Resident #1 was over too close to the edge of the bed and fell onto the floor. She revealed that Resident #1 was supposed to have two people to assist with her care but CNA #1 went into her room by herself. ADON revealed that she didn't know if CNA #1 was unaware that Resident #1 was a two person assist or if she just got caught up, got busy and forgot. ADON revealed that they educated their staff to look at residents' care plans or ask the nurse to protect the residents and to protect themselves. A phone interview with CNA #1 on 09/09/24 at 12:45 PM, revealed that she was working on 07/21/24 when the accident with Resident #1 happened. She revealed that she was in Resident #1's room by herself changing her brief when she fell out of bed. CNA #1 revealed that she was standing on the right side of the Resident #1's bed and pulled the resident's legs over to the right side against her abdomen for support, she then reached over the resident to the left of the bed to get her clean brief, and Resident #1 fell out of the bed. CNA #1 revealed that she didn't pay attention to the position of Resident #1's upper body and didn't realize that she was positioned near the edge of the bed. CNA #1 revealed that she tried to catch Resident #1 before she hit the floor, and she did prevent her head from hitting the floor. She revealed that she called for help, looked her over, the nurse and ADON, assessed Resident #1 and there were no injuries identified. CNA #1 revealed that she was supposed to have another person in the	M 640	and compliance.	

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room with her because Resident #1 required 2-person assistance. CNA #1 revealed that she should have pulled her towards the middle of the bed and made sure her body was not on the edge of the bed. She confirmed that since this incident she has made sure that she had two people in the room with her to prevent any other accidents like this.

Record review of Resident #1's "Admission Record" revealed an admission date of 05/29/24 and had diagnoses that included Unspecified Dementia, Need for Assistance with Personal Care, and Contractures to Right Knee, Left Knee, Right Hand, and Left Hand.

Record review of Resident #1's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 07/09/2024 under Section C revealed that a Brief Interview for Mental Status (BIMS) should not be completed because resident was rarely or never understood.

Level II

Based on interviews, record review and facility policy review the facility failed to provide two-person assistance with incontinent care for a

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M 640	Continued From page 4	M 640		

dependent resident in a manner to prevent a fall for one (1) of three (3) sampled residents. Resident #1.

Findings Include:

Review of the facility policy titled, "Fall Prevention Program" with reviewed date of 06/10/2024 revealed, "All residents will be assessed for the risk for falls at the time of admission, on a quarterly basis, and upon significant change in condition thereafter. Based on the results of this assessment, specific interventions will be implemented to minimize falls, avoid repeat falls and minimize falls resulting in significant injury."

Record review of Resident #1's "Incident Report" dated 07/21/24 at 14:42 revealed, "Was notified by Certified Nursing Assistant (CNA Proper Name) that Resident (proper name) was on the floor. CNA (proper name) stated as she was changing her, Resident's (proper name) body was turned to the left. CNA (proper name) was using her hands to hold up the weight of Resident's (proper name) legs as she was getting her brief changed. While changing her, her legs slipped over the side of the bed and Resident (proper name) proceeded to fall on floor. Resident was unable to give description. There were no injuries observed at time of incident." Record review revealed that the resident did not suffer an injury with the fall.

An interview with Registered Nurse (RN) Supervisor on 09/09/24 at 11:10 AM, revealed the Assistant Director of Nursing (ADON) reported to her on Monday morning, July 22, 2024, that Resident #1 fell out of the bed the day before. She revealed the ADON reported that (CNA) #1, went into Resident #1's room to change her and

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M 640	Continued From page 5	M 640		

she rolled out of the bed. She revealed that Resident #1 had contractures and was supposed to have two-person assistance to prevent any accidents. RN Supervisor revealed that CNA #1 went in by herself to provide care, positioned Resident #1 too close to the edge of the bed and she fell off the bed onto the floor. She confirmed that there should have been two people in the room, one to assist with holding the resident and the other to provide care. RN Supervisor revealed that residents with contractures were supposed to have two- person assistance to prevent falls or injuries.

A phone interview with Assistant Director of Nursing (ADON) on 09/09/24 at 11:30 AM revealed that on 07/21/24, CNA #1 was in the room changing Resident #1's brief and doing peri-care, Resident #1 was over too close to the edge of the bed and fell onto the floor. She revealed that Resident #1 was supposed to have two people to assist with her care but CNA #1 went into her room by herself. ADON revealed that she didn't know if CNA #1 was unaware that Resident #1 was a two person assist or if she just got caught up, got busy and forgot. ADON revealed that they educated their staff to look at residents' care plans or ask the nurse to protect the residents and to protect themselves.

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M 640	Continued From page 6	M 640		

the left of the bed to get her clean brief, and Resident #1 fell out of the bed. CNA #1 revealed that she didn't pay attention to the position of Resident #1's upper body and didn't realize that she was positioned near the edge of the bed. CNA #1 revealed that she tried to catch Resident #1 before she hit the floor, and she did prevent her head from hitting the floor. She revealed that she called for help, looked her over, the nurse and ADON, assessed Resident #1 and there were no injuries identified. CNA #1 revealed that she was supposed to have another person in the room with her because Resident #1 required 2-person assistance. CNA #1 revealed that she should have pulled her towards the middle of the bed and made sure her body was not on the edge of the bed. She confirmed that since this incident she has made sure that she had two people in the room with her to prevent any other accidents like this.

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Record review of Resident #1's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 07/09/2024 under Section C revealed that a Brief Interview for Mental Status (BIMS) should not be completed because resident was rarely or never understood.