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
	MS38BM	A. BUILDING: _____ B. WING _____	C 11/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CARE CENTER OF MARION	6434 A DALE DR MARION, MS 39342

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M 000	Initial Comments The State Agency (SA) conducted Complaint Investigations (CIs), MS #26829, CI MS #26912, and CI MS #27169, at the facility on 11/25/24. During the survey, the SA determined facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements. CI MS #26829 was a Facility Reported Incident (FRI) and CI MS #26912 was a complaint, regarding a resident fall during a mechanical lift transfer and M640 was cited related to these CI's. CI MS #27169 was investigated regarding a resident's plan of care and there were no deficiencies related to the complaint.	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: Level III Based on observation, interviews, record review, facility investigation review, and facility policy reviews the facility failed to ensure a resident was transferred safely while using a mechanical lift when a Certified Nurse Aide (CNA) performed the transfer without assistance and used the incorrect sling size, which caused the resident to fall, resulting in a fracture and head laceration for one (1) of four (4) sampled residents. (Resident #1) Findings include:	M 640	" Resident #1 was sent to the Emergency Room on 10/21/2024 where she received sutures for her forehead and surgery for displaced femoral fracture. Resident #1 returned back to facility per family request. " All Residents have the potential to be affected by the deficient practice. " All Nursing staff were inserviced beginning 11/26/2024 by Administrator, Director of Nursing (DON), and Registered Nurse (RN) supervisor on sling identity and Kardex verification before use, proper	12/21/24

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M 640	Continued From page 1 A review of the facility's policy, "Safe Transfer and Lifting of Residents," revised 08/02/2022, revealed, " ...In order to protect the safety and well-being of staff and residents, and to promote quality care, this facility uses appropriate techniques and devices to lift and move residents... General Guidelines ...6. Enough slings in sizes required by residents should be available at all times... VI. Procedure for transferring resident with full body lift ...c. Ensures proper transfer is followed per care plan ...e. Ensures resident is within weight requirements of lift f. Ensures a 2nd person is assisting..." A record review of Resident #1's "Progress Notes," dated 10/21/2024 at 7:10 AM, revealed the resident was found crying loudly on the floor with a large laceration on the right side of her forehead and a hematoma on her right forearm. CNA #1 stated the resident slid out of the sling during a transfer using a mechanical lift. A record review of Resident #1's "Kardex" revealed the resident required a total lift with two (2) staff and a large sling. The record indicated the resident was non-weight-bearing. A record review of Resident #1's "Investigative Summary-Final Report," dated 10/21/2024, revealed "(Proper name of the CNA) operated lift alone without verifying resident sling size. She used a small sling which contributed to (Proper name of Resident #1) incident ..." A record review of CNA #1's written statement, dated 10/25/2024, revealed that CNA #1 admitted to transferring Resident #1 without assistance. She stated she used the sling already attached to the lift and did not check the Kardex for the	M 640	use of lift, abuse and neglect and following resident care plan. " The RN Supervisors will audit and observe the transfer for 3 residents requiring a total lift to transfer per shift per day for 4 weeks beginning 11/27/2024, then 1 resident per shift per day for 8 weeks. These audits will ensure that the careplan is being followed related to transfer status and proper technique is used during transfers. The audits will be reviewed in the Quality Assessment and Assurance Committee meeting monthly x 3, beginning 12/20/24 to ensure sustained compliance.	

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M 640	Continued From page 2	M 640		

required sling size. She also acknowledged asking another staff member for help, but no one came to help. The witness statement further revealed "I (CNA #1) operated the lift and (Proper name of Resident #1) fell-hit her head."

A record review of the "Fall During Assist" report, dated 10/21/2024, revealed that CNA #1 attempted to transfer Resident #1 using a mechanical lift without the assistance of a second staff member. The report noted that CNA #1 used a medium sling instead of the required large sling, which resulted in the resident sliding out of the sling and falling to the floor. The report documented that the resident sustained a laceration to the right side of the forehead and a hematoma on the right arm and was sent to the emergency room for further evaluation.

A record review of Resident #1's "Emergency Department History and Physical," dated 10/21/2024, revealed the resident sustained a displaced femur fracture and a laceration requiring sutures. She also complained of left hip and knee pain.

A record review of the "X-ray Femur"," dated 10/21/2024, revealed Resident #1 had an acute displaced, obliquely oriented fracture through the distal femoral shaft.

A record review of the "Discharge Summary," dated 10/25/2024, revealed Resident #1 underwent Open Reduction and Internal Fixation (ORIF) surgery for the femur fracture and was discharged back to the facility with a non-weight-bearing status.

A record review of the "Admission Record" revealed the facility admitted Resident #1 on

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M 640	Continued From page 3 10/20/2022 with diagnoses including Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting the Left Non-Dominant Side. A record review of the Comprehensive Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/01/2024 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of eight (8), which indicated the resident's cognition was moderately impaired. On 11/25/2024 at 8:15 AM, during an observation and interview with Resident #1, she recalled only one person was present during the transfer. She stated she kept telling CNA #1, "Something's not right." She became emotional while recalling the incident, describing she had some pain and a subsequent hospital stay. Resident #1 stated she wanted to stay up in her wheelchair until after lunch and would be assisted back to bed at that time. There was a mechanical lift sling underneath her that had a red trim. On 11/25/2024 at 10:55 AM, during an interview, the Administrator confirmed CNA #1 admitted to transferring the resident alone using the sling already attached to the lift without verifying its size. The fall occurred at the end of the shift as the staff were assisting residents up for the day. On 11/25/2024 at 11:20 AM, during an interview with Resident #1's family member, she explained that the nurse informed her that her sister fell out of the lift and sustained a gash on her forehead, which would not stop bleeding, necessitating emergency medical care. She stated that Resident #1 required four (4) stitches to her forehead and added that hospital tests revealed her sister had a fractured femur requiring surgery, and a plate was subsequently inserted.	M 640		

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M 640	Continued From page 4 On 11/25/2024 at 1:20 PM, during an observation and interview with CNA #2, he confirmed the resident required a large sling for transfers and stated two staff members are always required when using a lift. He reviewed the resident's Kardex and identified the correct sling size for the resident was a large. On 11/25/2024 at 1:25 PM, during an observation of Resident #1 being transferred by facility staff via the mechanical lift from her wheelchair to the bed, three (3) CNAs entered the room to assist with the transfer. It was noted that the resident was sitting in a wheelchair with a red lift pad under her, indicating a medium sling, which was not the correct size. CNA #2 confirmed the sling needed to be replaced with a blue (large) sling. The CNAs were able to remove the medium sling and place the large sling while the resident was in the wheelchair and then transferred her using the correct large sling size. On 11/25/2024 at 1:45 PM, during an interview with CNA #2, he confirmed the wrong size of lift pad was under the resident, indicating that the incorrect lift pad was used earlier that morning during a transfer from bed to wheelchair. He stated he did not assist with the resident's transfer that morning because the transfer occurred on the previous shift. On 11/25/24 at 2:00 PM, during an interview, CNA #3 confirmed Resident #1 had a medium lift pad underneath her while in the wheelchair and stated Resident #1 was already up in her chair when she arrived to work. CNA #3 confirmed a medium sling was incorrect according to the residents Kardex.	M 640		

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M 640	Continued From page 5 During an interview on 11/25/2024 at 3:00 PM, the Administrator stated he was unaware that Resident #1 had been transferred this morning with the wrong size lift pad. He explained that all staff had been educated on proper lift pad identification and the need to check the Kardex before using the lift. He reiterated that sufficient lift pads were available and expected staff to follow policies. He stated that CNA #4 had been assigned to Resident #1 this morning. On 11/25/2024 at 3:40 PM, during an interview with CNA #4, she admitted she was assigned to care for Resident #1 during the night shift last night. She reported transferring Resident #1 using a mechanical lift and a red-trimmed/medium size sling pad. She stated she did not check the Kardex that morning, assuming the resident required a large sling. She also noted that only medium sling pads were available at the time. On 11/26/2024 at 9:30 AM, during a post survey interview, CNA #1 stated that on the morning of 10/21/24, she had asked the nurse for assistance with the mechanical lift transfer of Resident #1, but no one came to help. She admitted not checking the Kardex for the correct sling size and using the sling already attached to the lift.	M 640		