

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/04/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255332	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/13/2025
NAME OF PROVIDER OR SUPPLIER HOLMES COUNTY LONG TERM CARE CENTER - DURANT			STREET ADDRESS, CITY, STATE, ZIP CODE 15481 BOWLING GREEN ROAD DURANT, MS 39063		
(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 On 01/13/25 the State Agency (SA) conducted two (2) onsite complaint investigations (CI MS #26999 and CI MS #27249). CI MS #26999 was investigated related to accidents. The facility was found to be in compliance with the requirements for participation in Medicare and Medicaid but deficiencies were cited for failure to implement the care plans at F656 and failure to prevent accidents hazards at F689. Based on the facility's implementation of corrective actions taken prior to survey entrance, this deficient practice was determined to be Past Non-Compliance as of 11/11/24. CI MS #27249 was investigated related to infection control was investigated and the facility was found to be in compliance with the requirements for participation in Medicare and Medicaid and no deficiencies were cited for CI MS #27249.	F 000			
F 656 SS=G	The facility was licensed for 80 beds and the census was 74 at the time of the survey. 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	F 656			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

02/04/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 656	Continued From page 1 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 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 interviews, facility policy review, and record reviews, the facility failed to implement the care plan for a two (2) person assist with the use of a full body mechanical lift for all transfers of Resident #4. Resident #4 sustained a head injury and received medical treatment at the Emergency	F 656	Past noncompliance: no plan of correction required.		

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F 656	Continued From page 2 Room (ER) as a result of the misuse of the full body mechanical lift. Resident #4 was one (1) of four (4) sampled residents in the facility identified as dependent upon the full body mechanical lift with two (2) persons assistance for transfers. Based on the facility's implementation of corrective actions on 11/06/24 through 11/11/24, the State Agency (SA) determined the deficiency to be Past Non-Compliance. Findings include: Record review of the facility policy titled, "Care Plans-Comprehensive," revised 10/2016 revealed, "2. The comprehensive care plan is based on a thorough assessment that includes ... a. Incorporate identified problem areas: b. Incorporate risk factors associated with identified problems ... f. Identify the professional services that are responsible for each element of care." Record review of Resident #4's care plan with a revision date of 08/24/21 titled, "Focus: I require assistance with Activity of Daily Living (ADL) related to generalized muscle weakness, lack of coordination, impaired balance, abnormalities of gait and mobilities. Interventions: Transfer use total lift. Requires extensive assist times (x) two (2)." The record review of the Emergency Room (ER) report dated 11/06/2024 read: "Chief Complaint Patient presents with Head Injury. 71 year old female presents to the emergency department via (by) EMS (Emergency Management Services) from nursing home with head laceration from Hoyer lift. Interventions include local anesthesia and 6 staples."	F 656			

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F 656	Continued From page 3 An interview with the facility Administrator (ADM) on 01/13/25 at 12:30 PM revealed that on 11/06/2024 at approximately 6:00 AM CNA #1 used the full body mechanical lift to transfer Resident #4 from her bed to the wheelchair without obtaining or requesting assistance from a second staff member. The facility policy nor the resident's care plan was followed by CNA #1 which caused a head laceration to Resident #4. The facility policy and procedure for using the full body mechanical lift was to utilize two staff to assist and operate the full body mechanical lift. The ADM provided documentation of the investigation and provided documentation of the lift policies. On 1/13/25 at 12:50 PM, interview with the Director of Nursing (DON) stated that Resident #4 was care planned for two (2) person assistance with mechanical lift with all transfers and confirmed that CNA #1 did not follow the care plan for Resident #4 when she transferred the resident without a second person to assist. On 1/13/25 at 2:10 PM, in an interview with the Staff Development Nurse Licensed Practical Nurse (LPN) #4 confirmed that Resident #4 was care planned for two (2) persons assistance with the use of full body mechanical lifts for all transfers. Interview with DON on 1/13/25 at 3:00 P.M. she confirmed that Resident #4 received a head injury and had to be sent to the ER for medical treatment as a result of the inappropriate use of the full body mechanical lift by CNA #1. Attempted several times to reach CNA #1 by	F 656			

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F 656	Continued From page 4 telephone to obtain an interview but was unsuccessful. Record review of the facility's investigation revealed a hand-written statement signed by CNA #1 that read: "On October the 6th at 6:00 in the morning, (Resident #4) was to be dressed and ready. I asked the nurse for assistance, her cart was on the hall I walked up front and asked for her assistance, I proceeded to continue to assist (Resident #4) by dressing her and preparing her for transfer to dialysis. By 6:00 AM I weighed her in the bed on the lift, then nurse comes stand in the door across from her cart with her hand on her hip, looking up the hall, I move the lift around the floor to move (Resident #4) to the chair the lift pad swings back and forth and (Resident #4) swings into the side of the door, she hits her head on the corner of the back door. I proceed to put (Resident #4) in the chair then I see she is bleeding I look up the nurse has stepped away I call her, and has to go back up front to get her. I told her what happened and asked why was she bleeding she said she was a dialysis patient, and she was gone send her out. I told her as I was moving the lift she swung into the corner of the door it happened so fast." Record review of the Admission Record of Resident #4 revealed the facility admitted the resident on 02/27/2024 with diagnoses that included Inflammatory Polyps of Colon with intestinal obstruction; End Stage Renal Disease; Type 2 Diabetes; Heart Failure; and Cognitive Communication Deficit. Record review of Resident #4's Minimum Data Set (MDS) Section C, with an Assessment Reference Date (ARD) of 09/20/24, revealed a	F 656			

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F 656	Continued From page 5 Brief Interview for Mental Status (BIMS) score 3, which indicated that Resident #4 was severely cognitively impaired. Record review of the facility in-services after the incident and the investigation records revealed that the facility had acted quickly and had corrected all deficiencies created by the fall of the resident from the improperly used lift. CNA #1 acted alone and had been thoroughly trained as to the procedures for using the lifts. The facility also reviewed their policies with no changes made to the policies and conducted a QA meeting on 11/06/24 as well as conducted a thorough investigation. The State Agency (SA) reviewed the Quality Assurance (QA) meeting, the lift in services that began on 11/06/24 and reviewed the documentation that the facility terminated CNA #1 on 11/11/24. The facility continued to monitor falls, accidents and monitored the lift policy throughout the next eight (8) weeks through their QA program and meetings. The deficient practice had been corrected on 11/11/24 prior to the State Agency (SA) entering the facility on 01/13/2025. The SA validated through interviews, observation, and record reviews that on 11/11/2024 the deficiency was Past Non-Compliance (PNC) and all corrections had been made.	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	F 689			

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F 689	Continued From page 6 supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interviews, facility policy reviews, and record reviews, the facility failed to prevent an injury of a resident by not following the established facility policies and procedures for the use of two (2) person assistance with a full body mechanical lift for all transfers. Resident #4 had to seek medical care at the Emergency Room (ER) for a laceration to her head which required closure with staples. Resident #4 was one (1) of four (4) sampled residents dependent upon full body mechanical lifts for all transfers. Based on the facility's implementation of corrective actions on 11/06/24 through 11/11/24, the State Agency (SA) determined the deficiency to be Past Non-Compliance. Findings Include: Review of the facility policy titled "Modified Lifting Policy for Zero Back Injury (ZBI) Program" dated 1/24/22 revealed, "I acknowledge that if I choose to use a lift without a second person to assist, fail to apply the sling correctly, and fail to use the correct lift specified on the residents care guide I will risk causing injury to that resident. I will be terminated from employment and my actions will be reported to appropriate state agencies as abuse." The policy was signed and dated by Certified Nursing Assistant (CNA) #1 and signed and dated 10/22/24 by the Staff Development Nurse Licensed Practical Nurse (LPN) #4. Review of the "ZBI" In-service Record dated 1/24/2022 signed by CNA #1 and LPN #4 dated	F 689	Past noncompliance: no plan of correction required.		

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F 689	Continued From page 7 10/22/24 revealed: "2 (two) person assist is required both Stand Lift and Total Lift NEVER lift a resident by yourself. You must be assisted by a trained and qualified staff member (the nurse or CNA)." The record review of the Emergency Room (ER) report dated 11/06/2024 read: "Chief Complaint Patient presents with Head Injury. 71 year old female presents to the emergency department via (by) EMS (Emergency Management Services) from nursing home with head laceration from Hoyer lift. Interventions include local anesthesia and 6 staples." On 01/13/25 at 12:30 PM, an interview with the facility Administrator (ADM) revealed that on 11/06/24 at approximately 6:00 AM CNA #1 used the full body mechanical lift to transfer Resident #4 from her bed to the wheelchair without obtaining or requesting assistance from a second staff member. The facility policy was not followed by CNA #1 which caused a head injury to Resident #4. The ADM stated that they suspended CNA #1 immediately after the alleged event on 11/06/24 and began a facility investigation into the incident. ADM provided documentation of the investigation and provided documentation of the lift policies. The facility conducted a thorough investigation of the incident and on 11/11/24 the facility terminated CNA #1 for not following the facility policies and procedures for the use of full body mechanical lift. The ADM stated that Resident #1 was sent out to the local Emergency Room (ER) for treatment of a head injury and several staples were placed in the head of Resident #1 to close the wound and stop the bleeding. The facility immediately in-serviced all staff on the use of mechanical lifts with two (2)	F 689			

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F 689	Continued From page 8 persons and an assessment and review of all residents using lifts was conducted along with a Quality Assurance (QA) meeting. Interview on 1/13/25 at 12:50 PM, with the Director of Nursing (DON) revealed that CNA #1 had not requested assistance from other staff and she used the full body mechanical lift alone which caused Resident #1 to hit her head on the door and caused a head injury to Resident #1. The DON confirmed that CNA #1 was terminated from employment on 11/11/2024 for not using two (2) persons assistance with the mechanical lift and confirmed that the CNA had been in-serviced and trained on the use the full body mechanical lifts. Interview on 1/13/25 at 2:10 PM, with the Staff Development nurse LPN #4 revealed that the staff are trained on the use of two (2) persons to assist with the full body mechanical lifts. She revealed there are no staff that do not know that the facility requires two (2) persons to assist with the mechanical lifts and confirmed that CNA #1 was inserviced on 10/22/24. An interview with DON on 1/13/25 at 3:00 PM, she confirmed that CNA #1's written statement was not consistent with the written statements and verbal statements given by the other staff that were working at the facility on 11/06/24 at 6:00 AM. DON confirmed that CNA #1 was terminated from the facility for not following the facility policy for the use of full body mechanical lifts with two (2) person assistance. An interview by telephone on 01/13/25 at 3:30 PM with LPN #5, revealed that she was working the unit on 11/06/24 along with CNA #1. LPN #5 stated that at no time did CNA #1 request for her	F 689			

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F 689	Continued From page 9 to assist with the use of a full body mechanical lift to transfer Resident #4. She stated that CNA #1 used the full body mechanical lift with Resident #4 alone and the resident hit her head causing a laceration to the top of her scalp. LPN #5 confirmed that the facility had trained them all on the proper use of lifts and they all had to attend in-services after the incident occurred. An interview on 01/13/25 at 3:35 PM with LPN #6, revealed that CNA #1 came to her and said that Resident #4 had hit her head and was bleeding. LPN #6 went with CNA #1 to Resident #4's room and the resident was alone in the room, sitting up in a wheelchair with blood dripping down her face. LPN #6 stated that she attempted to find the source of the bleeding but because of the large amount of blood, she was unable to locate the source. She immediately called for the ambulance. LPN #6 stated that she was concerned about Resident #4 because there was so much blood coming from the cut to her head. The ambulance came quickly and took Resident #4 to the ER. LPN #6 stated that only the resident, the full body mechanical lift, and CNA #1 were in the room with Resident #4 when she arrived to assess Resident #4. LPN #6 confirmed that CNA #1 had not obtained assistance to use the full body mechanical lift with Resident #4. Surveyor attempted several times to reach CNA #1 by telephone to obtain an interview but was unsuccessful. Record review of the facility's investigation revealed a hand-written statement signed by CNA #1 that read: "On October the 6th at 6:00 in the morning, (Resident #4) was to be dressed and ready. I asked the nurse for assistance, her cart	F 689			

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F 689	Continued From page 10 was on the hall I walked up front and asked for her assistance, I proceeded to continue to assist (Resident #4) by dressing her and preparing her for transfer to dialysis. By 6:00 AM I weighed her in the bed on the lift, then nurse comes stand in the door across from her cart with her hand on her hip, looking up the hall, I move the lift around the floor to move (Resident #4) to the chair the lift pad swings back and forth and (Resident #4) swings into the side of the door, she hits her head on the corner of the back door. I proceed to put (Resident #4) in the chair then I see she is bleeding I look up the nurse has stepped away I call her, and has to go back up front to get her. I told her what happened and asked why was she bleeding she said she was a dialysis patient, and she was gone send her out. I told her as I was moving the lift she swung into the corner of the door it happened so fast." The record review of the hand written statement of CNA #1 contained the date of "October 6th" and the names of the nurses that were called to the room of Resident #4 were not revealed in the statement of CNA #1. The hand written statements of the other staff that were interviewed were not consistent with the hand written statement of CNA #1. The statement of CNA #1 did not name a second person to assist with the use of the full body mechanical lift. CNA #1's statement did indicate that she used the full body mechanical lift alone and an incident occurred that caused a head injury to Resident #4. Record review of the Admission Record of Resident #4 revealed that she was admitted to the facility on 02/27/2024 with diagnosis that included Inflammatory Polyps of Colon with	F 689			

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NAME OF PROVIDER OR SUPPLIER HOLMES COUNTY LONG TERM CARE CENTER - DURANT			STREET ADDRESS, CITY, STATE, ZIP CODE 15481 BOWLING GREEN ROAD DURANT, MS 39063		
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F 689	Continued From page 11 intestinal obstruction; End Stage Renal Disease; Type 2 Diabetes; Heart Failure; and Cognitive Communication Deficit. Record review of Resident #4's Minimum Data Set (MDS) Section C, with an Assessment Reference Date (ARD) of 09/20/24, revealed a Brief Interview for Mental Status (BIMS) score 3, which indicated that Resident #4 was severely cognitively impaired. Record review of the facility in-services after the incident and the investigation records revealed that the facility had corrected all deficiencies created by the fall of the resident from the improperly used lift. CNA #1 acted alone and had been thoroughly trained as to the procedures for using the lifts. The facility also reviewed their policies with no changes made to the policies and conducted a QA meeting on 11/06/24 as well as conducted a thorough investigation. The State Agency (SA) reviewed the Quality Assurance (QA) meeting, the lift in services that began on 11/06/24 and reviewed the documentation that the facility terminated CNA #1 on 11/11/24. The facility continued to monitor falls, accidents and monitored the lift policy throughout the next eight (8) weeks through their QA program and meetings. The deficient practice had been corrected on 11/11/24 prior to the State Agency (SA) entering the facility on 01/13/2025. The SA validated through interviews, observation, and record reviews that on 11/11/2024 the deficiency was Past Non-Compliance (PNC) and all corrections had been made.	F 689			