

MSDH - Health Facilities Licensure and Certification

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>35KC</b>                | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>01/06/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>MS CARE CENTER OF DEKALB</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>220 WILLOW AVENUE<br/>DE KALB, MS 39328</b> |                                                                                                                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                                           |
| M 000                                                               | Initial Comments<br><br>On 01/06/25 the State Agency (SA) conducted two (2) Complaint Investigation (CI MS #26828 and CI MS #26841). CI MS #26828 was related to accident and hazards. The SA found the facility was in compliance with the Minimum Standards for Institutions for the Aged and Infirm. The SA found that the facility had taken all corrective measures on 10/21/24 and was found to be compliant upon the SA entrance to the facility on 01/06/25. A deficiency was cited at M 640 at Past Non-Compliance (PNC).<br><br>CI MS#26841 was related to alleged neglect. The SA did not substantiate the complaint and no deficiencies were cited.<br><br>The census was 57 and the facility was licensed for 60 beds.                              | M 000                                                                                   |                                                                                                                          |                                                                    |
| M 640                                                               | 45.21.8 Accidents<br><br>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.<br><br>This Statute is not met as evidenced by:<br>Level III<br><br>Based on observations, interviews, facility policy review, and record reviews, the facility failed to prevent an injury to Resident #1 by not following the proper procedures for the use of a full body mechanical lift that required two (2) persons to operate. Resident #1 sustained a fall from the lift, received a hematoma to the back of her head, | M 640                                                                                   | No Plan of Correction required                                                                                           | 1/16/25                                                            |

Mississippi State Department of Health

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

TITLE

(X6) DATE

Electronically Signed

01/17/25

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| M 640                                                               | <p>Continued From page 1</p> <p>three (3) skin tears to her hand, arm and elbow and had to have medical care in the Emergency Room (ER). This was for one (1) of three (3) residents that required a full body mechanical lift for all transfers reviewed.</p> <p>The facility had implemented corrective actions as of 10/21/24, prior to the State Agency (SA) entrance on 1/6/25, therefore the deficiency is determined to be Past Non-Compliance.</p> <p>Findings Include:</p> <p>The facility undated policy titled: "Accidents and Supervision" read: "The resident environment will remain free of accident hazards as is possible. Each resident will receive adequate supervision and assistive devices to prevent accidents."</p> <p>Record review of the Modified Lifting Policy, effective date 1/1/2023 signed by Certified Nursing Assistant (CNA) #1 on 10/16/23 revealed, " ...I understand that whenever I use a lift on a resident, NO EXCEPTION, there MUST be a hands-on assist at all times. This assures that two employees are safety aware, are caring for the resident and the resident's safety and that I am a responsible person, making good sound choices to the best of my ability. I will always ask for assistance when using the lift ...</p> <p>Record review of the facility investigation revealed "Upon investigation, it is stated by CNA1 that resident was up on lift with CNA1 in room, by herself, transferring RESIDENT from recliner to bed. RESIDENT was in the lift seat with all 4 straps attached to the lift and closure pins in place and snapped down, per CNA1 statement. CNA1 stated per statement, RESIDENT just slipped out of the left side of lift sling, hitting</p> | M 640                                                                                   |                                                                                                                          |                                                                    |

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| M 640                                                               | <p>Continued From page 2</p> <p>RESIDENT's head on the floor. Per CNA1 statement, RESIDENT did have a pillow to back in the lift sling ..."</p> <p>Record review of the Emergency Department dated 10/20/24 revealed: Chief Complaint Patient presents with Fall, hematoma on back of head. Patient is an 89-year-old white female that fell at the (name of facility) reportedly out of a chair. Sustaining injury to head, skin tears to left wrist, left elbow, left ankle Patient has severe dementia and Parkinson's Disease. Patients follow commands and stated: "I hate being here." Patient is on Aspirin. Resident had x-rays in the ER of: Computed Tomography (CT) Cervical Spine Without Contrast; CT Head without Contrast with findings including a small scalp hematoma/contusion posteriorly on the left. Resident #1 also underwent x-ray left ankle; x-ray Chest 1 view; x-ray Left Elbow; x-ray Pelvis Routine AP; x-ray Wrist Complete Left. Final impression sprain of left ankle, and acute cervical myofascial strain. Skin tears on the forearm and dorsal (back) of left hand closed with Derma Bond skin adhesive.</p> <p>An interview on 01/06/25 at 9:00 AM, with the Director of Nursing (DON) revealed that on 10/20/24 she received a call at approximately 4:45 PM from the Licensed Practical Nurse (LPN) #1 to report that a resident had fallen and hit her head and was sent out to the ER for evaluation. At that time the reason for the fall had not been determined, so the DON gave instructions to LPN #1 to begin the investigation and to get statements from all staff as to what had occurred. The DON stated that on 10/20/24 at approximately 7:00 PM she received another call that Certified Nursing Assistant (CNA) #1 had confirmed that she had used the full body</p> | M 640                                                                                   |                                                                                                                          |                                                                    |

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| M 640                                                               | <p>Continued From page 3</p> <p>mechanical lift without obtaining assistance from another person. CNA #1 told LPN #1 that she thought she could transfer Resident #1 alone without any assistance. DON told LPN #1 to send CNA #1 home until the investigation could be completed. DON stated that she was surprised that CNA #1 had not followed the policies and procedures of the facility because she had been employed at the facility for several years and had attended numerous in-services on the proper use of the full body mechanical lifts. DON stated that after the investigation was completed and all statements were obtained confirming that CNA #1 had misused the full body mechanical lift by not getting help with the transfer of Resident #1 and had caused injury to her, the facility terminated CNA #1 immediately.</p> <p>Interview by telephone on 01/06/25 at 9:45 AM, with CNA #1 revealed that she used the full body mechanical lift alone and did not seek another staff member to assist her with the transfer of Resident #1. CNA #1 stated that she had worked at the facility for five (5) years and had been educated to use at least two (2) people to assist with the full body mechanical lifts during resident transfers. She stated that as soon as Resident #1 fell from the lift she went and got the two (2) LPN's, LPN #1 and LPN #2 to come assist with resident who was on the floor. The nurses assessed Resident #1 on the floor and found that she had blood on her arm due to some skin tears and her ankle was swollen and there was hematoma found on the back of Resident #1's head. The three (3) assisted to lift Resident #1 with the full body mechanical lift, back to her bed. She stated that she could not remember all the details of the incident because it had happened so long ago in October 2024.</p> | M 640                                                                                   |                                                                                                                          |                                                                    |

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| M 640                                                               | <p>Continued From page 4</p> <p>Interviews on 01/06/25 at 10:30 AM with CNA #2, CNA #3 and CNA #4 all working on the unit with other residents, revealed that they always use the full body mechanical lift with the specified residents. They stated that all the full body mechanical lift residents were housed in rooms next to each other and that it only took them a few minutes with each resident to transfer them with the lift. They stated that the three (3) of them team up and go from room to room assisting with the transfers each morning and when needed. All three CNA 's confirmed that they had been in-serviced numerous times about the use of lifts and that they require two people for transfers.</p> <p>Interview and observation on 01/06/25 at 10:40 AM, with Resident #1 revealed that she was sitting in a chair in her room and answered "yes" when her name was called but was unable to have a conversation due to severe dementia.</p> <p>Interview on 01/06/25 at 10:50 AM, with LPN #3 who is the Staff Development nurse revealed that she had trained all CNAs and had watched them each give return demonstrations of the use of all lifts. LPN #3 stated that CNA #1 had been working at the facility for at least five (5) years and had gone through her CNA training at the facility. LPN #3 stated that CNA #1 had been trained on the facility policy and procedures for all lift usages. She stated that she conducts annual training and the representative from the lift company comes and gives an in-service on the use of full-body mechanical lifts at least once per year. The Staff Development nurse (LPN #3) provided a list that was posted and laminated that was hung on the lifts, that documented which resident had what type of lift and sling size and the residents room number.</p> | M 640                                                                                   |                                                                                                                          |                                                                    |

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| M 640                                                               | <p>Continued From page 5</p> <p>Interview on 01/06/2025 at 11:10 AM, with LPN #1 revealed that on 10/20/24, she was sitting at the nursing station just a few feet away from Resident #1's room and she heard someone yell out "help, please I need help." LPN #1 stated that she was the first one to respond and when she entered the room of Resident #1 there was only one person with Resident #1 and that was CNA #1. Resident #1 was lying on the floor, and she was not moving or speaking, nor did she make any complaints or express pain. LPN #1 immediately began to run her fingers through the hair of Resident #1 and across her head. LPN #1 stated that she found Resident #1 to have approximately a three (3) inch hematoma on the back of her head and a significant amount of blood coming from her arm and a swollen ankle. Resident #1 was assisted to her bed from the floor by the three (3) staff and again she was reassessed after they got her in her bed. LPN #1 stated that the hematoma on Resident #1's head was most concerning, and she obtained an order to have her sent out to the ER for evaluation. The ambulance got to the facility within minutes of contact. LPN #1 stated that the DON instructed her to get statements from all staff working on that hall and to send CNA #1 home after she gave her written statement. LPN #1 stated that she really hated that CNA#1 had not obtained help with the lift. LPN #1 stated that CNA #1 said, "I thought I could do it by myself" when she asked her how the resident fell from the lift. LPN #1 stated that the unit was not short staffed on 10/20/24 and there was plenty of staff available to properly use the full body mechanical lifts for the few residents that required them.</p> <p>An interview on 01/06/25 at 11:50 AM, with Registered Nurse (RN) #1 revealed she received Resident #1 back into the facility from the ER at</p> | M 640                                                                                   |                                                                                                                          |                                                                    |

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| M 640                                                               | <p>Continued From page 6</p> <p>approximately 8:00 PM on 10/20/24. She stated that Resident #1 had three (3) skin tears that had been closed with "Derma Bond" (surgical glue) in the ER and had been wrapped with a bandage. RN #1 stated that there was plenty of staff working on 10/20/24 and there were no shortages of staff on that day.</p> <p>The interview on 01/06/25 at 7:00 PM, with LPN #2 revealed that she was the second nurse on the unit on 10/20/24 and had arrived in the room of Resident #1. She stated that she assisted in the assessment of Resident #1 after she fell from the lift and stated that CNA #1 had not properly used the full body lift while transferring Resident #1. Resident #1 fell from the lift to the floor and had to be sent out to the ER for evaluation because of her injuries. CNA #1 stated that she thought she could use the lift alone and she had not asked for assistance. LPN #2 stated that Resident #1 had a large hematoma to the back of her head that was the main concern for sending her out to the ER, and she also had blood on her arm from three (3) rather significant skin tears that would not stop bleeding. Resident #1 also had a swollen ankle.</p> <p>Record review of the facility's investigation report signed by the facility DON and dated 10/21/2024 read: "At this time, it is the decision of DON, Assistant Director of Nursing (ADON), and Administrator that CNA #1 is liable for her actions and therefore terminated for Violation of Facility Rules and Lifting Immobile Resident without Proper Assistance leading to Resident Neglect/Abuse and Substandard Care. Nurses were also in serviced on mechanical lift incidents being reportable, immediately and having to be fully investigated."</p> | M 640                                                                                   |                                                                                                                          |                                                                    |

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>35KC</b>                | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>01/06/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>MS CARE CENTER OF DEKALB</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>220 WILLOW AVENUE<br/>DE KALB, MS 39328</b> |                                                                                                                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                                           |
| M 640                                                               | <p>Continued From page 7</p> <p>Record review of the handwritten statement of CNA #1 signed and dated 10/20/24 revealed, "I did not ask for assist from a CNA or nurse when using the total lift when transfer a resident." Signed by CNA #1 dated 10/20/24 at 9:15 PM.</p> <p>Record review of the Admission Record of Resident #1 documented that she was admitted to the facility on 12/21/2023 with diagnoses that included, Parkinsonism; Mood Disorder; Dementia; Depression; Osteoarthritis; and Muscle Weakness.</p> <p>Record Review of Resident #1's Minimum Data Set (MDS) Section C: Cognitive Patterns dated 11/27/24 revealed a Brief Interview for Mental Status should not be conducted because the resident is rarely/never understood and cognitive skills for daily decision making were severely impaired.</p> <p>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 she admitted that she knew better 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 Quality Assurance (QA) meeting on Monday 10/21/24 as well as conducted a thorough investigation. The State Agency (SA) reviewed the QA meeting held on 10/21/24, the lift in services that began on 10/20/24 and reviewed the documentation that the facility terminated CNA #1 on 10/21/24. The facility continues to monitor fall and accidents throughout the next eight (8) weeks through their QA program and meetings. The deficient practice had been</p> | M 640                                                                                   |                                                                                                                          |                                                                    |

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>35KC</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>01/06/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>MS CARE CENTER OF DEKALB</b> |                                                                                                                                                                       |                                                                          | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>220 WILLOW AVENUE</b><br><b>DE KALB, MS 39328</b>                            |                          |                                                                    |
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| M 640                                                               | Continued From page 8<br><br>corrected on 10/21/24 prior to the State Agency<br>(SA) entering the facility on 01/06/2025 and<br>determined to be Past Non-Compliance. | M 640                                                                    |                                                                                                                          |                          |                                                                    |