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	255229	A. BUILDING _____ B. WING _____	C 01/27/2025

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HOLLY SPRINGS REHABILITATION AND HEALTHCARE CENTER	1315 HIGHWAY 4 EAST HOLLY SPRINGS, MS 38635

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F 000	INITIAL COMMENTS The State Agency (SA) conducted a complaint investigation (CI MS #27279) at the facility on 01/27/25. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid. The SA investigated accidents and cited F656 and F689 at a harm level due to an injury sustained when a resident was improperly transferred. The census at the time of the complaint survey was 86 and they held a license for 120 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 treatment under §483.10(c)(6).	F 656		2/5/25

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

Electronically Signed | 02/14/2025

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F 656	Continued From page 1 (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 staff interviews, record review and facility policy review, the facility failed to implement a comprehensive care plan to provide for two-person assistance with a lift during a transfer in a manner to prevent an injury for one (1) of three (3) sampled residents. Resident #1. Findings Include: Review of the facility policy "Care Plans, Comprehensive Person-Centered" with reviewed date of November 2024 revealed, "A	F 656	1. On 12/5/2024, Certified Nursing Assistant (CNA) number 1 was educated by Administrator regarding the plan of care policy and following care plans regarding how a resident is to be transferred. On 12/5/2024, CNA number 1 was also educated on accessing Kardex in order to view transfer requirements of the residents. On 12/5/2024, CNA number 1 was sent home and placed on the Do Not Return list through agency.	

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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" that was initiated on 07/27/23, revealed that she had an Activities of Daily Living (ADL) self-care performance deficit related to weakness and had interventions in place that included, "Transfer: The resident requires Total by two (2) staff to move between surfaces as necessary. Full Body Lift Extra Large Sling 2 Person Transfers..." During an interview with the Administrator (ADM) on 01/27/25 at 10:10 AM revealed that on 12/05/24, Certified Nursing Assistant (CNA) #1 went into Resident #1's room to help CNA #2 transfer the resident from the wheelchair to her bed. The ADM revealed that CNA #2 was assigned to Resident #1 that day and had asked CNA #1 to help her with the transfer because she required a total lift for all transfers. ADM revealed that CNA #2 left her room to get a Hoyer lift and that when CNA #2 returned to Resident #1's room with the Hoyer Lift, CNA #1 was transferring the resident from the wheelchair to her bed without a lift. CNA #1 stated that he was told by another CNA that the resident could transfer to the bed without a lift. ADM revealed that a short time later, Resident #1 complained of pain, they sent her out to the hospital, and x-rays confirmed that she had fractures to her right leg. Resident #1 was assessed at that time and sent to the Emergency Room (ER) for evaluation. Resident #1 returned to the facility on 12/6/2024 with diagnosis of	F 656	2. On 12/6/2024, an Activities of Daily Living (ADL) care plan audit was conducted by the facility Minimum Data Set Coordinator (MDS) to identify any residents requiring lift transfer that could have been affected by the deficient practice. At the time of the audit, thirty-one of eighty-one were identified with having the potential to be affected. 3. On 12/6/2024, all licensed nurses and CNA's were in-serviced by the Staff Development Coordinator (SDC) on the plan of care policy and following the ADL care plan regarding how residents are required to be transferred. On 12/6/2024, both license nurses and CNA's were in-serviced on where the resident transfer information can be located including the CNA Kardex. 4. Beginning 12/16/2024, the Assistant Director of Nursing (ADON) or nursing supervisor will perform unannounced ADL observation audits on four residents to ensure licensed nurses and CNA's are utilizing the care plan and Kardex information on how a resident is to be transferred three times a week for four weeks, then weekly times four weeks, then monthly times three 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 1/16/2025. The administrator is responsible for monitoring	

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F 656	Continued From page 3 minimally displaced fracture of the distal tibia and fibula. On 01/27/25 at 12:55 PM a phone interview with Assistant Director of Nursing (ADON) revealed that CNA #1 should have looked up Resident #1's plan of care instead of going by what someone else said. The ADON revealed that she hated that it happened, that CNA #1 was great, but he shouldn't have transferred Resident #1 without assistance. She confirmed that CNA #1 did not follow Resident #1's care plan when he allowed her to stand and pivot to transfer from her wheelchair to bed which caused her injury. Record review of Resident #1's X-Ray Final Results completed on 12/05/24 at the hospital revealed, "..Findings: Comminuted, minimally displaced fractures of the distal tibia and fibula ..." Record review of Resident #1's "Admission Record" revealed an admission date of 07/18/22 and that she had diagnoses that included Obesity and Generalized Muscle Weakness. Record review of Resident #1's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 11/07/24 under Section C revealed a Brief Interview for Mental Status (BIMS) score of 12 which indicated that she had moderate cognitive deficits.	F 656	and compliance.	
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	F 689		2/5/25

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F 689	Continued From page 4 §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, staff and resident interviews, record review and facility policy review, the facility failed to provide two-person assistance during a transfer for a dependent resident in a manner to prevent an injury for one (1) of three (3) sampled residents. Resident #1. Findings Include: Review of the facility policy titled, "Safe Patient Handling and Moving Protocol" with reviewed date of 06/10/2024, revealed "The Quality Assurance (QA) Committee will ensure implementation of this policy to identify, assess, and develop strategies to control risk of injury to residents and nursing staff associated with the lifting, transferring, repositioning or movement of a resident." Under the "Transfer and Bed Mobility/Positioning Technique Training" topic, , "...It is important to remember that each resident is different; transfer techniques and bed mobility/positioning may need to be modified for the particular resident to meet their individual needs. Please verify level of assistance required prior to initiating transfer..." An interview on 01/27/25 at 10:10 AM with the Administrator (ADM), revealed that on 12/05/24, Certified Nursing Assistant (CNA) #1 went into Resident #1's room to help CNA #2 transfer Resident #1 from the wheelchair to her bed. ADM revealed that CNA #2 was assigned to Resident #1 that day and had asked CNA #1 to help her with	F 689	1. On 12/5/2024, Certified Nursing Assistant (CNA) number 1 was educated by Administrator regarding the plan of care policy and following care plans regarding how a resident is to be transferred. On 12/5/2024, CNA number 1 was also educated on accessing Kardex in order to view transfer requirements of the residents. On 12/5/2024, CNA number 1 was sent home and placed on the Do Not Return list through agency. 2. On 12/6/2024, an Activities of Daily Living (ADL) care plan audit was conducted by the facility Minimum Data Set Coordinator (MDS) to identify any residents requiring lift transfer that could have been affected by the deficient practice. At the time of the audit, thirty-one of eighty-one were identified with having the potential to be affected. 3. On 12/6/2024, all licensed nurses and CNA's were in-serviced by the Staff Development Coordinator (SDC) on the plan of care policy and following the ADL care plan regarding how residents are required to be transferred. On 12/6/2024, both license nurses and CNA's were in-serviced on where the resident transfer information can be located including the CNA Kardex.	

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F 689	Continued From page 5 the transfer because the resident required a total lift for all transfers. CNA #2 left the room to get a Hoyer lift and when CNA #2 returned to Resident #1's room with the Hoyer Lift, CNA #1 was already transferring her from the wheelchair to her bed without a lift. ADM revealed that a short time later, Resident #1 complained of pain, they sent her out to the hospital, and x-rays confirmed that she had fractures to her right leg. An observation and interview on 01/27/25 at 10:20 AM with Resident #1 revealed her lying in bed in her room and she had a brace on her right leg. She revealed that a few weeks ago, she hurt her leg while getting into bed from her wheelchair. Resident #1 revealed that she was sitting in her wheelchair to the left side of her bed when the aide came in to help her. She stated that the aide let the bed down low, he placed his hand under her right arm, and she held onto the bed rail with her other hand. Resident #1 confirmed that the aide helped her to stand up and she hit her right leg on the bed, and she stated, "I couldn't make another move." Resident #1 revealed that another aide came in with the lift during this time and they got her into the bed. The resident stated that soon after the transfer, her leg started hurting, and she told the nurse. She revealed that the nurse came and checked her out, they sent her to the hospital and after doing x-rays, found that she had a broken leg. A phone interview on 01/27/25 at 12:55 PM with Assistant Director of Nursing (ADON), revealed that she worked on 12/05/24, the date that Resident #1 was hurt during a transfer. ADON revealed that CNA #2 was assigned to Resident #1	F 689	4. Beginning 12/16/2024, the Assistant Director of Nursing (ADON) or nursing supervisor will perform unannounced ADL observation audits on four residents to ensure licensed nurses and CNA's are utilizing the care plan and Kardex information on how a resident is to be transferred three times a week for four weeks, then weekly times four weeks, then monthly times three 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 1/16/2025. The administrator is responsible for monitoring and compliance.	

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F 689	Continued From page 6	F 689		

that day and had asked CNA #1 to help her transfer Resident #1 using the total lift. ADON revealed that CNA #1 told CNA #2 that another aide had told him that Resident #1 could pivot to transfer. ADON revealed that CNA #2 left her room to get the total lift because she wasn't going to transfer her that way. ADON revealed that when CNA #2 returned with the lift, CNA #1 was transferring Resident #1 into the bed. ADON confirmed that the floor nurse reported a little later that Resident #1 complained of pain to her right leg. ADON stated that she went to the resident's room and assessed her and found that her right leg was a little shorter than the other leg and that her right foot was turned outward. ADON revealed that she notified the Nurse Practitioner (NP) who ordered to send her out to the hospital. The ADON confirmed that both of the CNAs were from a staffing agency and that CNA #1 has not been back to work at the facility again because of the incident.

Record review of the facility investigation revealed that on 12/05/2024, CNA #2 was assigned to Resident #1. CNA #2 requested assistance from CNA #1 to put Resident #1 back in bed. CNA #2 had brought the full body lift into the room to use for the transfer as she stated she was told during walking rounds at the beginning of her shift that Resident #1 was a lift transfer. CNA #1 stated to CNA #2 that he was told by another CNA the previous week that Resident #1 could stand and pivot for a transfer. CNA #1 stated at that point Resident #1 had scooted to the edge of the chair and he began to transfer Resident #1. Both CNA #1 and CNA #2 stated Resident #1 wasn't able to pivot and her foot dragged on the ground as CNA

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#1 continued to transfer Resident #1 to the bed. After being placed on the bed, Resident #1 complained of right leg pain. Resident #1 was assessed at that time and sent to the Emergency Room for evaluation. Resident #1 returned to the facility on 12/6/2024 with diagnosis of minimally displaced fracture of the distal tibia and fibula. Review of Resident #1's care plan revealed that Resident #1 was care planned for 2 persons assist with full body lift for transfers.

Record review of CNA #1's written statement revealed, "I (proper name) (CNA #1) went to transfer (proper name) Resident #1 stand by pivot. I was told by a CNA in report the day of Nov 26, 2024 that's how (proper name) Resident #1 transferred so on Dec 5 about 3:15 I went to help her back to bed using the same stand and pivot not knowing she was supposed to be transferred using the hoyer so in the process of transferring (proper name) Resident #1 her ankle turned or something and I think she broke some bone in her leg." This statement was signed by CNA #1.

The State Agency (SA) attempted to contact CNA #1 and CNA #2 for an interview but was unsuccessful.

Record review of CNA #2's written statement revealed, "I ask (proper name) CNA #1 to help me transfer (proper name) Resident #1 to her bed. I took the lift into the room. He stated he can transfer her with the lift. He said a staff stated, she can be pivot. As he lifted her up, she went down on the bed and I noticed that her leg (right) was behind her. We place her on the bed correctly and the nurse walk in. And he told me what he did.

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And then the DON (Director of Nursing) walk in and he told her what happen." This statement was signed by CNA #2 on 12/05/24 at 4:30 PM.

Record review of Resident #1's "Progress Note" dated 12/05/24 at 15:29 (3:29 PM) revealed, "Called to room per other staff members. Resident lying in bed c/o (complain of) leg pain from transfer from w/c (wheelchair) to bed. Right leg noted painful to touch and leaning to the right. NP (Nurse Practitioner) notified ..."

Record review of Resident #1's "Progress Note" dated 12/05/24 at 15:30 (3:30 PM) revealed, "Floor nurse came to my office at this time and stated that the resident was having c/o (complaint/of) that her leg was broke. Floor nurse stated she started having this c/o leg pain after she was transferred assistance x (times) 2 aid to her bed ...Upon arrival to the room ...the RLE (right lower extremity) was noted to have bruising to the shin, eversion of R (right) foot and the limb presented shorter than the LLE (left lower extremity). Resident did have c/o pain during assessment. (Proper Name) (Nurse Practitioner) was notified at this time ... Order was given to transfer the resident out related to possible fracture."

Record review of Resident #1's "Progress Note" dated 12/05/24 at 16:37 (4:37 PM) revealed that "Resident transported to (proper name) Emergency Room r/t (related to) pain in right leg, by ambulance..."

Record review of Resident #1's X-Ray Final Results completed on 12/05/24 at the hospital revealed, "...Findings: Comminuted, minimally

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F 689	Continued From page 9 displaced fractures of the distal tibia and fibula..." Record review of Resident #1's "Admission Record" revealed an admission date of 07/18/22 and that she had diagnoses that included Obesity and Generalized Muscle Weakness. Record review of Resident #1's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 11/07/24 under Section C revealed a Brief Interview for Mental Status (BIMS) score of 12 which indicated that she had moderate cognitive deficits.	F 689		