

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

PRINTED: 05/05/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/04/2025
NAME OF PROVIDER OR SUPPLIER TUNICA COUNTY HEALTH & REHAB, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1024 HIGHWAY 61 SOUTH TUNICA, MS 38676		
(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 The State Agency (SA) conducted a complaint investigation (CI MS# 27912) at the facility on 3/4/25. During the survey, the SA determined that the facility was in compliance with the requirements of participation in Medicare and Medicaid Services. The SA identified past non-compliance and cited F656 for failure to implement a care plan and F689 for using the wrong lift during transfer leading to an injury. Based on the facility's implementation of corrective actions on 2/12/25 taken prior to survey entrance, this deficient practice was determined to be Past Non-Compliance and the facility was in compliance as of 02/13/25.	F 000	Past noncompliance: no plan of correction required.		
F 656 SS=G	The census at the time of the survey was 51 with a bed capacity of 60. 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	F 656			

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

TITLE

(X6) DATE

Electronically Signed

03/12/2025

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 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 staff and resident interview, record review and facility policy review, the facility failed to implement a person-centered care plan regarding the use of a total lift for one (1) of three (3) resident care plans reviewed. (Resident #1) On 2/5/25 Resident #1, who required a total mechanical lift for all transfers, was manually transferred by a Certified Nursing Assistant (CNA). The resident sustained a right tibia fracture.	F 656	Past noncompliance: no plan of correction required.		

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F 656	Continued From page 2 Findings Include Review of the facility policy titled, "Care Plans, Comprehensive Person-Centered" with a revision date of 03/2022 revealed under, "Policy...A 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..." Review of the facility policy titled, "Lifting Machine, Using a Portable" with a revision date of 08/2022 revealed under "Preparation...review the resident's care plan to assess for any special needs of the resident..." Record review of Resident #1 care plans revealed an ADL (Activities of Daily Living) care plan, date initiated 8/28/24, with an intervention of...resident usually requires total care assist times two (2) staff with transfers. Staff to assist with all transfers using the Vander (Total) lift with a medium sling and 2 staff members assist. On 3/4/25 at 12:30 PM, an interview with the Director of Nursing (DON) and the Administrator (ADM) they verified that they were notified of the Resident #1's complaint of pain and swelling to the right knee. They both confirmed that their investigation revealed that CNA #2 transferred the resident from the geri-chair to the bed by herself using a stand-pivot transfer instead of following the care plan and using a total lift with 2 staff members. Resident #1 was sent to the hospital on 2/7/25 at 10:02 AM for a Computed Tomography (CT) scan. The facility followed up on the CT results and noted that the resident had	F 656			

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F 656	Continued From page 3 a right tibia fracture. The facility had an emergency quality assurance (QA) meeting with the physician, ADM, DON, Infection Control Nurse in attendance. Root Cause Analysis (RCA) was that the CNA did not follow the residents care plan for transfers. The facility initiated inservices with all nurses and CNA's on 2/7/25 to include abuse, neglect, use of mechanical lifts and following the care plan, as well as skills check off on the use of lifts for CNAs. Lift assessments were performed on all residents and the care plan was updated with any changes beginning 2/7/25. The lift assessments and care plans were audited for accuracy on 2/10/25. On 2/10/25 the facility began observation of CNA lift operations on 2 residents a day for five (5) days a week for 3 weeks. The facility will continue observation of CNA lift operations on two (2) residents daily 2 days a week for 3 additional weeks. Findings will be taken to the QA monthly meeting times 2 months starting 3/7/25. The resident returned to the facility on 2/10/25 and her care plan was updated to include interventions related to the fracture. On 3/4/25 at 11:39 AM, a telephone interview with Certified Nurse Assistant (CNA) #2 confirmed that on the evening of 2/5/25 she used stand and pivot method to transfer Resident #1 back to bed from the geri-chair by herself. She admitted that the resident complained of her feet hurting after she got her in bed, but did not complain of her knee hurting. She verified that she knew that the resident was supposed to be transferred using a total lift. She stated that she knew that the resident's transfer status is on her care plan and admitted that it was important to follow the care plan to prevent resident injury. She then confirmed that she did not follow the residents	F 656			

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F 656	Continued From page 4 care plan for transfers. An interview with Resident #1 on 3/4/25 at 10:00 AM she confirmed that a girl picked her up and put her back to bed one evening. She stated that when she did that, her legs got tangled up in the leg rest and she was injured. She stated she did not remember who the girl was or exactly what day it happened. Resident #1 stated that she is currently wearing a brace on her leg and having to take pain medication. On 3/4/25 at 1:00 PM, during a follow-up interview with the ADM confirmed that failure to transfer any resident according to their care plan could lead to a resident's injury. She stated that care plans provide the staff with the information they need to care for them. She stated that it was her expectation that the CNA would have followed the care plan and transferred the resident using a total lift with 2 staff. Record review of Resident #1's "CT Knee Right Without Contrast" results dated 2/7/25 revealed an acute, impacted fracture of the proximal tibia with large lipohemarthrosis (collection of blood and fat in a joint, usually caused by a fracture). Record review of Resident #1's Admission Record revealed the facility admitted the resident on 10/11/17 with diagnoses that included Epilepsy, Polyneuropathy, and Dementia. Record review of Resident #1's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/6/25 revealed a Brief Interview for Mental Status (BIMS) score of 13, which indicated that the resident was cognitively intact.	F 656			

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F 656	Continued From page 5 The State Agency (SA) validated on 3/4/25, through interview and record review that all corrective actions had been implemented as of 2/12/25, and the facility was in compliance as of 2/13/25, prior to the SA's entrance on 3/4/25.	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 supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff and resident interview, record review and facility policy review the facility failed ensure a resident was free from accident hazards when a resident was transferred from her chair to the bed incorrectly. The resident sustained a right tibia fracture. This was for one (1) of three (3) residents reviewed for accidents. Resident #1 Findings include Review of the facility policy titled, "Safe Lifting and Movement of Residents" with a revision date of 07/2017 revealed under, "Policy Statement...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..." Record review of the facility investigation for the incident involving Resident #1 revealed that at	F 689	Past noncompliance: no plan of correction required.		

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F 689	Continued From page 6 approximately 6:45 PM on 2/5/25 Certified Nurse Assistant (CNA) #2 informed Resident #1's nurse that the resident needed something for pain. The nurse stated that the resident complained of right knee pain. The resident's nurse administered Tylenol 325 mg (milligrams) 2 tablets. At that time the resident had no swelling or redness to her knee and did not report any incidents. On 2/5/25 at 9:20 PM the resident complained of right knee pain and was noted to have moderate swelling. At that time the nurse on duty (Licensed Practical Nurse-(LPN) #2) administered Tylenol and elevated the resident's leg on pillows reporting that the pain was resolved by these interventions. On 2/6/25 at approximately 10:00 AM Occupational Therapy Student (OTS) entered Resident #1's room to perform therapy services, and the resident complained of pain to her right knee. The OTS evaluated the resident's right knee and noted that it was swollen. The OTS reported her findings to Licensed Physical Therapy Assistant (LPTA). LPTA immediately reported the findings to the Director of Nurses (DON). The DON assessed the resident and noted that her right knee was inflamed, warm and tender to the touch. At that time the resident verified that her legs got tangled when the CNA transferred her last evening. The Physician was notified, xrays were ordered and the residents responsible party was notified. The initial xrays were negative and the physician was notified of the results. On the morning of 2/7/25 the Physician assessed the resident's knee and gave new orders for additional medication and a Computed Tomography (CT) scan of the right knee with soft tissue. Resident #1 was transferred to the hospital on 2/7/25 at 10:02 AM. The facility followed up on results of the CT to find that the results revealed a right tibial fracture.	F 689			

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F 689	Continued From page 7 The Administrator spoke with the above mentioned therapy staff and learned that Resident #1 reported that her foot became tangled in the footrest of the reclined chair the evening before (2/5/25) when being transferred from the chair to the bed. The facility continued their investigation which revealed that on the evening of 2/5/25 CNA #2 transferred Resident #1 from the geri-chair to her bed without the use of a lift or assistance from other staff. Record review of a typed statement by the OTS that was dated 2/11/25 verified that around 10:00 AM on 2/6/25 she entered Resident #1's room to perform therapy services, and the resident complained of right knee pain of 10 on a scale of one (1) to 10. Upon evaluation of the resident's right knee the resident had significant swelling that had not been present during therapy on the previous day. The resident informed the OTS that when the CNA transferred her back to bed her leg had gotten caught. An interview with LPN #1 on 3/4/25 at 11:00 AM she stated on 2/5/25 at approximately 6:45 PM CNA #2 informed her that Resident #1 stated that she needed something for pain. She stated upon evaluation Resident #1 complained of right knee pain. She stated that the resident did not have any swelling or injury noted to her right knee and she did not report any incidents at that time. She stated that the resident had gone to therapy and had sat up most of the day, which she did not usually do, so she thought that the increased activity had caused her pain. A telephone interview with CNA #2 on 3/4/25 at 11:39 AM she stated that on the evening of 2/5/25 she transferred Resident #1 back to bed from the	F 689			

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F 689	Continued From page 8 geri-chair by herself using a stand-pivot transfer. She stated that once the resident was in bed that she complained of her feet hurting. She stated that the resident always complains about her feet but did not complain about her knee hurting so she told the nurse that the resident needed something for pain. She stated that she knew that the resident was a total lift and that she should have used the lift to transfer the resident, stating that she just went in and got the resident in the bed and assumed she was ok. She stated that the resident's transfer status is on the lifts and ADL (Activities of Daily Living) care plan. An interview with the LPTA on 3/4/25 at 12:16 PM he verified that the OTS informed him of Resident #1's complaint of right knee pain along with swelling to the knee. He went to the resident's room to evaluate and noticed that the resident's right knee had significant swelling and was painful to the touch. He stated that the resident told him that while she was being transferred from the chair to the bed the evening before her foot became entangled in the leg rest of the reclined chair. He stated he then notified the DON. LPTA stated that Resident #1 should be transferred with a total lift because she is not physically able to participate in a stand-pivot transfer. He stated that at times therapy may transfer a total lift resident using a slide board or stand-pivot in therapy, as part of therapy, but that the nursing staff continues the total lift until otherwise instructed by therapy. An interview with Resident #1 on 3/4/25 at 10:00 AM she stated that her leg was injured by getting caught in the leg rest of the recliner when the girl picked her up and put her back to bed from the chair in the evening. She stated she did not	F 689			

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F 689	Continued From page 9 remember who the girl was or exactly what day it happened. She stated that the facility provided her with pain medication and did elevate her leg, both helped. Resident #1 stated that she is currently wearing a brace on her leg and having to take pain medication. An interview with the DON and the Administrator (ADM) on 3/4/25 at 12:30 PM they verified that they were notified of the Resident #1's complaint of pain and swelling to the right knee. They both confirmed that their investigation revealed that CNA #2 transferred the resident from the geri-chair to the bed by herself using a stand-pivot transfer instead of following the care plan and using a total lift with 2 staff members. The CNA was suspended on 2/7/25 and subsequently terminated. CNA #2 had not worked since 2/5/25. They verified that the resident representative (RR) and physician were notified on 2/6/25. Initial xray results were received on 2/6/25 at 4:45 PM as negative and the physician was notified. The physician assessed the resident on the morning of 2/7/25 and ordered additional pain medication and a CT scan. Resident #1 was sent to the hospital on 2/7/25 at 10:02 AM for a CT scan. The facility followed up on the CT results and noted that the resident had a right tibia fracture. State Agency (SA) and Attorney General (AG) were notified on 2/7/25. The facility had an emergency quality assurance (QA) meeting with the physician, ADM, DON, Infection Control Nurse in attendance. Root Cause Analysis (RCA) was that the CNA did not follow the residents care plan for transfers. The facility initiated inservices with all nurses and CNA's on 2/7/25 to include abuse, neglect, use of mechanical lifts and following the care plan, as well as skills check off on the use of lifts for	F 689			

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F 689	Continued From page 10 CNAs. Lift assessments were performed on all residents and the care plan was updated with any changes beginning 2/7/25. The lift assessments and care plans were audited for accuracy on 2/10/25. On 2/10/25 the facility began observation of CNA lift operations on 2 residents a day for five (5) days a week for 3 weeks, The facility will continue observation of CNA lift operation on two (2) residents daily 2 days a week for 3 additional weeks. Findings will be taken to the QA monthly meeting times 2 months starting 3/7/25. The resident returned to the facility on 2/10/25 and her care plan was updated to include interventions related to the fracture. During a follow-up interview with the ADM on 3/4/25 at 1:00 PM she verified that failure to transfer the resident appropriately could lead to a resident's injury. Record review of the facilities list of residents that require a lift and what type indicated that Resident #1 required a Vander lift, which is a total lift that requires two person assist. Record review of Resident #1 Progress Note dated 2/5/25 at 6:57 PM by LPN #1 revealed that Resident #1 reports right knee pain, no noted swelling or redness to knee, standing order-administered Tylenol. Record review of Resident #1's "CT Knee Right Without Contrast" results dated 2/7/25 revealed an acute, impacted fracture of the proximal tibia with large lipohemarthrosis (collection of blood and fat in a joint, usually caused by a fracture). Record review of the Disciplinary Action Form for CNA#2 dated 2/7/25 revealed she was	F 689			

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F 689	Continued From page 11 suspended from 2/7/25 until 2/10/25 and terminated from employment on 2/11/25. It was revealed that during the phone call between CNA #2, the ADM and the DON, CNA #2 admitted that she did transfer the resident by herself without the lift, that resident complained of leg pain and she told the nurse on duty that resident needed Tylenol. Following the completion of the investigation it was found that employee wrongfully transferred resident independently without the use of proper mechanical lifting device resulting in right tibial fracture. Record review of Resident #1's Admission Record revealed the facility admitted the resident on 10/11/17 with diagnoses that included Epilepsy, Polyneuropathy, and Dementia. Record review of Resident #1's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/6/25 revealed a Brief Interview for Mental Status (BIMS) score of 13, which indicated that the resident was cognitively intact. The SA validated on 3/4/25, through interview and record review that all corrective actions had been implemented as of 2/12/25, and the facility was in compliance as of 2/13/25, prior to the SA's entrance on 3/4/25.	F 689			