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
	72TC	A. BUILDING: _____ B. WING _____	C 03/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUNICA COUNTY HEALTH & REHAB, LLC	1024 HIGHWAY 61 SOUTH TUNICA, MS 38676

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M 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 Mississippi Regulations for Minimum Standards for Institutions for the Aged or Infirm. The SA identified non-compliance and cited M 640 for improperly transferring a resident. 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. The census at the time of the survey was 51 with a bed capacity of 60.	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 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	M 640	Past Non-Compliance, No POC needed	3/12/25

Mississippi State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/12/25

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M 640	Continued From page 1 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 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	M 640		

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M 640	Continued From page 2	M 640		

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 residents 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. The Administrator spoke with above mentioned therapy staff and learned that Resident #1 reported that her foot became tangled in the foot rest 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

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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 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) careplan.

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 residents room to evaluated 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

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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 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

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M 640	Continued From page 5 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 careplans were audited for accuracy on 2/10/25. On 2/10/25 the facility began observation of CNA lift operations on 2 resident's 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 careplan 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 a 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	M 640		

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M 640	Continued From page 6 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 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 completion of 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.	M 640		