

Mississippi State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/22/2025	
NAME OF PROVIDER OR SUPPLIER THE NICHOLS CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1308 HIGHWAY 51 NORTH P O DRAWER 720, MADISON, Mississippi, 39110			
(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	
M0000	Initial Comments		M0000				
	The State Agency (SA) conducted an onsite facility reported incident investigation for Incident # 2607111 at the facility on 10/22/25. During the survey, SA determined that the facility was not in compliance with the requirements of the Mississippi Regulations for Minimum Standards for Institutions for the Aged or Infirm and cited M640. The census at the time of the survey was 58 with a bed capacity of 60 beds.						
M0640	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 LICENSURE REQUIREMENT is NOT MET as evidenced by: Level III Based on observation, resident and staff interviews, record review, and facility policy review, the facility failed to ensure resident safety during mechanical lift transfers by failing to assess and use the appropriate sling, and by failing to inspect the sling for signs of wear or damage prior to use for one (1) of three (3) residents reviewed for accidents and hazards (Resident #1). Findings include: Review of the facility policy titled "Modified Lifting Policy," last updated 2/3/23, revealed: "Policy: The facility will provide a safe work environment for patient care by providing and requiring the use of safety materials and equipment designed to prevent patient injury."		M0640				

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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M0640	Continued from page 1 Review of the [proper name] lift manufacturer guidelines under "Safety Information" revealed: "Before each patient transfer, the sling must be inspected for signs of damage... that might cause it to fail." Under "Transfer Criteria," it revealed: "Before using the lift, patients must be assessed by the facility's professional nursing staff... to determine which patients are suitable for transfer with the lift, which sling size is appropriate, and the number of staff necessary to transfer each patient..." Record review of the facility investigation revealed that Resident #1 fell approximately three (3) feet to the floor while being lifted with a total lift using a sling. The fall resulted in a skin abrasion to the residents right elbow and an L1 (lumbar) compression fracture. This investigation determined that the resident was not assessed for the use of a lift, an incorrect sling was used, and the lift had not been inspected. During an interview with the Administrator (ADM) on 10/22/25 at 8:16 AM, she confirmed that staff failed to use the correct sling and failed to assess the sling that was used, resulting in Resident #1 falling and sustaining a lumbar fracture with associated skin abrasion. She stated staff are educated to always assess the sling and use the appropriate sling for each resident. She confirmed that monthly audits are conducted on slings; however, the sling used was not on the August 2025 audit list and was not a sling provided by the facility's lift company. She stated, "It must have come from the hospital or something." She confirmed the sling was in poor condition and was immediately removed from use. She stated that all staff involved in the incident were terminated for failing to inspect and use the proper sling during the transfer. She further stated, "If staff had inspected the sling properly, the accident would likely not have occurred." An interview with Resident #1 on 10/22/25 at 9:00 AM confirmed that she fell from the total lift when the straps broke on the sling, causing her to fall to the floor on her buttocks and lower back. She stated she experienced soreness and increased pain and later learned she had a lumbar fracture. The resident stated that prior to the transfer, staff were commenting that the sling was not the correct one, but the nurse told them it would be "okay to use this time." Record review of an orthopedic note dated 10/6/25 revealed: "Patient is status post fall from a Hoyer lift chair. Now with L1 compression fracture."			M0640			

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M0640	Continued from page 2 A phone interview with Certified Nursing Assistant (CNA) #1 on 10/22/25 at 10:14 AM revealed she assisted with the transfer when the sling broke, and Resident #1 fell. She stated she obtained the sling from laundry, and it was the only one available. She stated CNA #2 told her, "We can't use a shower sling for a transfer," and that she then asked Registered Nurse (RN) #1 and Licensed Practical Nurse (LPN) #2 who stated it would be "okay to use this time, but not again because it's technically not the right sling." CNA #1 stated the sling appeared old and faded "like it had been washed a lot." She confirmed that she had been educated and checked off on proper sling use. A phone interview with RN #1 on 10/22/25 at 10:48 AM revealed she did not recognize the sling as a shower sling and did not assess the sling for proper size or condition. She confirmed she should have assessed the resident and sling for appropriateness and stated the resident was a new admission with no lift assessment completed at that time. Record review of a written statement by CNA#2 revealed she told CNA #1, "No, we can't use that sling," and advised her to ask the nurse. She confirmed both nurses said it was "okay this time but not next time." CNA #2 stated that she, RN #1, and CNA #1 attached the sling to the lift, and it broke during the transfer, causing the resident to fall. During an interview with the Staff Development Coordinator on 10/22/25 at 10:55 AM, she stated all residents should be assessed prior to mechanical lift use to ensure proper sling size and that slings should be inspected for wear and tear before each use. She confirmed she observed the sling after the incident and noted it was in poor condition with fraying on the straps. She stated that if a proper sling was unavailable, staff should have waited or sanitized another sling rather than use one not approved for transfer. A phone interview with the Loss Control Representative for the [proper name] lift company on 10/22/25 at 11:00 AM revealed the sling used was not one provided by their company. She inspected the sling and confirmed it was frayed, old in appearance, and manufactured in 2019, and stated it should not have been used. An interview with CNA #3 on 10/22/25 at 11:10 AM revealed she had completed lift skills checkoffs and was trained to inspect slings before use to ensure they were in good condition. She stated she was taught that shower slings are only to be used for bathing, not for			M0640			

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M0640	Continued from page 3 transfers. An interview with RN#2 on 10/22/25 at 11:15 AM revealed that all residents must be assessed for proper equipment, sling size, and sling condition before each transfer. Record review of the mechanical lift skills check-off for CNA #1 dated 8/13/25 and CNA #2 dated 8/14/25 confirmed that both employees were observed for selecting the correct size sling and inspecting it for damage. Record review of the "Admission Record" revealed the facility admitted Resident #1 on 9/3/25 with medical diagnosis that included anxiety disorder. Record review of the Brief Interview for Mental Status (BIMS) dated 9/9/25 revealed a score of 15, indicating the resident was cognitively intact.			M0640			