STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A188	A. BUILDING _____ B. WING _____	C 09/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOLIVAR MEDICAL CENTER LTC	901 E SUNFLOWER RD CLEVELAND, MS 38732

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F 000	INITIAL COMMENTS The State Agency (SA) conducted A Complaint survey for CI MS #17326 and CI MS#18081 at Bolivar Medical Center Long Term Care from 9/29/2021 to 9/30/2021. During the survey, the SA determined that the facility was not in compliance with Medicare and Medicaid regulations for participation. The SA substantiated CI MS 17326 Drug diversion and cited deficiency F 761, and Substantiated CI MS #18081 resident safety and cited F689 and F656. The facility was licensed for 35 beds and had a census of 30 at the time of the survey.	F 000		
F 656	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §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). (iii) Any specialized services or specialized rehabilitative services the nursing facility will	F 656		11/5/21

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

Electronically Signed | 10/18/2021

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F 656	Continued From page 1 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. This REQUIREMENT is not met as evidenced by: F656 S/S D Based on observations, interviews, and record review, the facility failed to follow the care plan for lift transfers for Resident #1 related to a fall while being transferred with the lift. Resident #1 was one 1 of 4 Residents reviewed for lift transfer care plans. Findings include: Record review of the facility policy titled "Nursing Assessment and Interdisciplinary Care Plan" with a revised date of 8/2016 under #2 revealed Long Term Care facility will conduct a comprehensive, accurate, standardized reproducible assessment upon admission and at regular intervals to ensure	F 656	1. Resident #1 was immediately assessed by Director of Nursing (DON) on 09/13/21 at approximately 2:00p.m. DON noted that Resident #1 was on the floor, on her back and head was resting on the footrest of the wheelchair. Resident #1 was alert and oriented. After, DON assessed Resident #1, she was then placed on the bed by the DON, the Registered Nurse Supervisor, and two certified nursing assistants. The resident's attending physician was notified by the DON about the fall and the nurse assessment. The attending physician ordered for Resident #1 to be taken to the Bolivar Medical Center radiology department for x-rays and treatment orders were given for two minor skin tears on the resident's arm.	

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F 656	Continued From page 2 that each resident meet his/her highest practicable level of physical, mental, and psycho-social functioning. An interview on 9/29/21 at 8:45 AM with the Administrator (ADM) revealed that she was made aware of the fall incident immediately and that she reported it to the Attorney General's (AGs) office and to the state within 2 hours of the incident. She revealed that she called the state at 4:10 PM on 9/13/21 and the written report was sent in on 9/16/21. She revealed that the certified nursing assistant (CNA) was interviewed and immediately suspended pending the investigation and terminated on 9/20/21. An interview on 9/29/21 at 10:00 AM with the Director of Nursing (DON) revealed that on 9/13/21 around 2:00 PM that RN #2 called for her assistance to Resident #1's room and when she arrived at the room that she saw Resident #1 was lying on the floor, on her back and her head was resting on the footrest of the wheelchair. She revealed that the lift was close to the door and the wheelchair was close to the bed. She revealed that the first thing she noticed was that the lift sling was still attached to the lift and that the two (2) hooks for the legs were dangling where they had not been hooked on the lift. She revealed that CNA #1 kept saying that she was so sorry that she did not know what happened. She revealed that the resident was assessed and placed on the bed by four people and that she had two skin tears on her right shin, one skin tear on her right shoulder and abrasion on her left side and right temple area. She revealed that the resident was alert and oriented and that her neurological check was normal and that the resident was able to move all extremities, as	F 656	2. All fourteen (14) of the other residents who require lift transfers have the potential to be affected by the failure to carry out the care plan by performing the lifter with two - person assistance. 3.The Administrator (ADM) was immediately informed about Resident#1's fall and the failure of the assigned certified nursing assistant (CNA#1) to ask for assistance in order to perform 2 - person assistance when using the mechanical lifter. The ADM and Director of Nursing (DON) met with the certified nursing assistant (CNA#1) and she stated that she did not ask for assistance to operate the mechanical lifter even though she knew this requires two persons for safety and that was on the CNA assignment sheet to do. CNA#1 was allowed to complete her daily documentation and then was suspended from work. After further investigation, this employee was terminated on 09/20/21. The ADM and DON verified that there was a current, comprehensive, and individualized care plan for Resident#1 and that two-person assistance was listed for transfers for this resident. It was also noted that two-person assistance for transfers with Resident#1 was on the CNA daily assignment sheet. Despite the care plan, the CNA training and the assignment sheet being correct, the CNA#1 decided to try to transfer Resident#1 without asking a second person to assist her and the accident occurred.	

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F 656	Continued From page 3 good as she had been able to before the fall. She revealed that she asked CNA #1 why she did not hook the last two (2) hooks and CNA #1 told her that she thought she had. She revealed that after the incident and the resident was assessed, that CNA #1 was called to the ADM office and interviewed, and CNA #1 was told that she was being suspended until the investigation was completed. She revealed that CNA #1 was very apologetic and said that she knew that she should have had another person to help her but that she thought that she could do it because the resident was wet. She revealed that CNA #1 completed her charting and then left the facility and later called in and was terminated because she did not follow the policy. She revealed that the MD was notified about the fall and that he ordered Resident #1 to be taken to radiology for x-rays and treatment orders for the skin tears. She revealed that the skin tears and abrasions were minor and that they did not require any sutures. An interview on 9/29/21 at 10:20 AM with Resident #1 with a Brief Interview for Mental Status (BIMS) score of 15 revealed that they use the lift to transfer her and that it used to be scary but now that she has done it a couple times that she is no longer scared. She was unable to recall how many staff members are present during the lift transfer and was unable to recall a fall. She revealed that this place is a good organization. An interview on 9/29/21 at 10:30 AM with Registered Nurse (RN) #1 revealed that she was in the hallway and responded to Resident #1's room due to a loud noise and when she arrived at the room, that Resident #1 was on the floor, and she asked CNA #1 what happened, and she told	F 656	The care plans for all other fourteen (14) residents requiring lift transfers were checked by the DON and Minimum Data Set Nurse (MDS)on October 14, 2021 and they all had current, comprehensive, and individualized care plans and included the need for lift transfers with two - person assistance. Additionally, two - person assistance for lift transfers was included in the daily CNA assignment sheet for each resident requiring lift transfers. ADM, DON and MDS Nurse determined that additional steps were needed to make sure that each resident's care plan for two - person transfer lifts was implemented. There was also a need for the certified nursing assistants to work more closely together to ensure that all lift transfers are performed properly. Our new process will include assigning "transfer partners" for the CNA's to work together to ensure that two - person assistance for lift transfers is done. We will also require the CNA's to place their initials on the CNA assignment sheet each shift to acknowledge that they know and understand their assignments which are reflective of the residents' care plans. As of 10/25/21, all current and new employees will be oriented to the new process of receiving and acknowledging daily care assignments. All current and new employees will be trained and required to sign off on the training with their signatures on mechanical lift safety and the requirement for two - person assistance. STAFF TRAINING: Training by the DON began on 10/14/21 to educate the nurses	

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F 656	Continued From page 4	F 656		

her that it was just an accident. She revealed Resident #1 was assessed and her neurological status was checked and that she was alert and oriented and that with the help of three other people that they placed Resident #1 on the bed. She revealed that Resident #1 did have a couple skin tears and abrasions but that they were minor and that she had no broken bones. She revealed that the sling was connected to the lift but that she could not remember if the hooks were hooked.

An interview on 9/29/21 at 11:45 AM with the DON revealed that she looked for the training on the lift for CNA #1 and she confirmed that she could not find one. She revealed that CNA #1 did have orientation and the competency for this was done. She revealed that new CNAs are placed on the floor with another CNA for a couple shifts to be trained and this includes training on the lift.

An interview on 9/29/21 at 11:55 AM with the ADM confirmed that all CNAs are placed with another CNA for several shifts to be trained and this includes the lift.

A phone interview on 9/29/21 at 1:10 PM with CNA #1 revealed that she and RN #2 got Resident #1 up the morning of 9/13/21 and left the sling under the resident. She revealed that around two o'clock the resident was wet and needed changing, she looked down the hall, did not see anyone to help her and that she just wanted to get the resident changed because she was wet. She attempted to transfer the resident alone, the resident began to slide and that she tried to get the wheelchair under her but could not so the resident slid to the floor. She confirmed that she did not wait for help and that she knew

and CNA's on the new process for ensuring that the care plans for lift transfers are implemented, as follows:

a. At the beginning of each shift, the Nursing Supervisor will assign "transfer partners" so the CNA's will work more closely together and this will be documented on the daily CNA assignment sheet.

b. The Nursing Supervisor will go over the daily CNA assignment sheet during the beginning shift briefing and will inform the CNA's of the assigned transfer partners for their shift.

c. Each CNA will place their initials on the CNA assignment sheet for each shift, that they are aware and understand their assignments, which will be reflective of the residents' care plans.

d. The DON, MDS Nurse and/or Nursing Supervisor will make rounds during each shift to ensure that the transfer partners are working together to carry out the care plans for two - person assistance for all lift transfers.

e. Failure to comply with the new requirements will result in disciplinary action.

4. Quality Assurance Performance Improvement (QAPI): The new process for ensuring that the care plans are followed by the nurses and CNA's for all mechanical lift transfers will be monitored: the Floor Nurse or Nurse Supervisor will check the daily CNA assignment sheet each day beginning on 10/14/21, to ensure all care plans are being implemented correctly. A Care plan for

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F 656	Continued From page 5 that she should have had two people for the transfer with the lift, but she thought she could do it without any problem and just wanted to get the wet clothes off Resident #1. She revealed that she thought she had hooked all the hooks but discovered that she did not once the resident slid to the floor. She confirmed that she knew to make certain that all the hooks were hooked before transferring but that she thought she had them hooked. She revealed that she just wanted to tell the truth and do the right thing. She confirmed that she has been a CNA for 18 years and she knows what to do. She confirmed that she worked with other CNAs for a couple shifts when hired and that they went over the use of the lift and that they used the lift several times during the orientating period. She revealed that after the incident that the DON and ADM talked to her and told her that they had to report the incident to the state and that she would have to go home until they completed the investigation. She revealed that she was called back in last Monday and was terminated. An interview on 9/29/21 at 1:45 PM with RN #1 revealed that they always use 2 people when transferring with the lift and that they make certain that all the hooks are hooked to the lift before lifting the resident. She revealed that all new CNAs are assigned with other CNAs for at least for 3 shifts for orientation and that includes the use of the lift. Record review of the facility Post Fall Huddle with a date of 9/13/21 and a time of 1410 for Resident #1 revealed under injury revealed minor skin tears times three and abrasion times two and under recommendation revealed proper use of hoyer lift with 2 staff members per protocol.	F 656	Mechanical Lift Assist Audit will be conducted two times weekly for one month starting 10/25/21 and then will be done weekly thereafter and will continue for three months. Any noted problems will be addressed immediately. Audit findings will be reported by the DON to the QAPI Committee at least quarterly beginning at the next QAPI on 11/3/21 meeting and by the ADM to the Bolivar Medical Center Quality Council quarterly at the next meeting on 11/4/21 and recommendations will be made as needed to ensure full compliance with the requirements.	

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F 656	Continued From page 6	F 656		

Record review of the care plan for Resident #1 revealed a care plan for at risk for falls related to unsteady gait, poor coordination, and generalized weakness and ADL selfcare performances deficit related to generalized weakness, SOB, and Atrial Fib with an intervention for mechanical lift times two people for all transfers.

Record review of the MDS dated 7/10/21 on Resident #1 revealed under section C a BIMS summary score of 15 and under section G under B how resident moves between surfaces including to or from bed, chair, wheelchair, standing position marked # three for two-person physical assist.

Record review of the facility CNA intervention/task for Resident #1 revealed under ADL-Transferring a #2 that is toilet use: support provided and a #3 for two-person physical assist and initials VB at 14:59 for 9/13/21.

Record review of the x-ray reports on 9/13/21 for Resident #1 revealed left and right femur, bilateral pelvis, left and right tibula and fibula, right and left humerus, and left and right shoulder were all negative for dislocation and fracture and the CT of the head was with no acute intracranial abnormality.

Record review of the face sheet for Resident #1 revealed an admission date of 11/7/17 with diagnoses of weakness, HTN, Vertebra Compression fracture, and Atrial Fibrillation.

Record review of the physician orders for Resident #1 revealed and order on 9/14/21 to clean abrasion to the left side, to skin tears to the

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F 656	Continued From page 7	F 656		

right shin, and skin tear to right shoulder with normal saline, pat dry with 4 x 4 gauze, apply triple antibiotic ointment and cover with clean dry dressing daily and PRN until healed.

Record review of the investigation for Resident #1 revealed the divided leg sling was used during the transfer and this sling was reviewed by therapy and determined it was appropriate for use with transfers and the Invacare manual has this sling listed as one of the slings appropriate for use with the Invacare 600 lift.

Record review of the facility email from HR on 9/29/21 revealed a clock in time of 6:49 AM and clock out time of 16:39 on 9/13/21 for CNA #1.

Record review of the facility September CNA schedule revealed Velma Byas was listed to work on 9/13/21 for 7/3 shift.

Record review of the facility corrective counseling record dated 9/20/21 and signed by CNA #1 for termination due to the employee did not follow policy and procedure and did not follow the resident's care plan requiring 2 people transfer assist using the mechanical lift.

Record review of the Orientation Training Verification 2021 form dated 5/12/21 with initials VB and signature for Abuse, Neglect, Exploitation.

Record review of the facility long term care daily assignment sheet for 9/13/21 for the seven to three shift revealed CNA #1 was assigned to Resident #1 and that Resident #1, #2, #4, and #5 have listed out of bed (OOB) daily-lift x 2 assists.

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F 689	Continued From page 8	F 689		
F 689	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: F689 S/S D Based on observations, interviews, and record review, the facility failed to protect Resident #1 from a lift accident related to a fall resulting from use of a lift durining a transfer.Resident #1 was one 1 of 4 Residents reviewed for lifts. Finsdings include: Record review of the facility policy titled abuse policy and procedure for the long-term care with a revised date of 3/20/21 revealed under training and C. Neglect is the failure to provide goods and services necessary to avoid physical harm, mental anguish, mental illness, or in the deterioration of a patient's physical or mental condition. Under causes related to physical or mental conditions revealed neglect is deliberate negligence, carelessness, or indifference to a patient's/resident's needs. Record review of the Invacare manual for the Reliant 600 under Lifting the patient Warning: when elevated a few inches off the surface of the	F 689	1. Resident #1 was immediately assessed by Director of Nursing (DON) on 09/13/21 at approximately 2:00p.m. DON noted that Resident #1 was on the floor, on her back and head was resting on the footrest of the wheelchair. Resident #1 was alert and oriented. After, DON assessed Resident #1, she was then placed on the bed by the DON, the Registered Nurse Supervisor, and two certified nursing assistants. The attending physician was notified by the DON about the fall and the nurse assessment. The attending physician ordered that Resident #1 be taken to the Bolivar Medical Center (BMC)radiology department for x-rays and treatment orders were given for two minor skin tears on the resident's arm. 2. All 14 of the other residents who need the use of a mechanical lister for transfers have the potential to be affected by staff not following the resident's care plan and the improper use of the lifter.	11/5/21

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F 689	Continued From page 9 stationary object (wheelchair, commode, or bed) and before moving the patient, check again to make sure that the sling is properly connected to the hooks of the hanger bar. If any attachments are not properly in place, lower the patient back onto the stationary object and correct this problem. Under Introduction: Invacare recommends that two assistants be used for all lifting preparation and transferring procedures; however, our equipment will permit proper operation by one assistant. The use of one assistant is based on the evaluation of the health care professional for each individual case. Under Attaching a sling: place the straps of the sling over the hooks of the hanger bar. Under Detail B reveals the divided leg sling with the commode opening with six straps pictured. Record review of the facility policy on the Hoyer Lift with revised date of 8/2015 under potential indications for use #6 revealed requiring greater than two-person assist for transfer. An interview on 9/29/21 at 8:45 AM with the Administrator (ADM) revealed that she was made aware of the fall incident immediately and that she reported it to the Attorney General's (AGs) office and to the state within 2 hours of the incident. She revealed that she called the state at 4:10 PM on 9/13/21 and the written report was sent in on 9/16/21. She revealed that the certified nursing assistant (CNA) was interviewed and immediately suspended pending the investigation and terminated on 9/20/21. An interview on 9/29/21 at 10:00 AM with the Director of Nursing (DON) revealed that on 9/13/21 around 2:00 PM that RN #2 called for her assistance to Resident #1's room and when she	F 689	3.The DON and Registered Nurse (RN)#1 called a staff huddle on 09/13/21 and reminded the certified nursing assistants and nurses that two - person assistance was always required when using a mechanical lifter. They were also instructed to never use an item such as the unfamiliar sling until they were fully trained. DON and RN#1 then made rounds and observed that the certified nursing assists were utilizing the lifters properly with two - person assistance for the residents that were being transferred. We also determined that more training was needed on the unfamiliar sling in the event we would need to use that style in the future. Additionally, the employee orientation/training packet was reviewed by ADM and DON, to ensure it includes education on Abuse/Neglect training and mechanical lift safety training. All current and new employees will be required to acknowledge receiving education on the orientation/training packet beginning on 10/25/21. STAFF TRAINING: a mandatory staff in-service was completed on 09/14/21 for all of the full time nursing staff, including the licensed practical nurses, the registered nurses and the certified nursing assistants, two physical therapists, one occupational therapist, one social worker and the administrator. The two physical therapists and one occupational therapist provided the training. The two remaining nurses who work part time and who were not present at this meeting, will receive their training on their next scheduled day	

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F 689	Continued From page 10 arrived at the room that she saw Resident #1 was lying on the floor, on her back and her head was resting on the footrest of the wheelchair. She revealed that the lift was close to the door and the wheelchair was close to the bed. She revealed that the first thing she noticed was that the lift sling was still attached to the lift and that the two (2) hooks for the legs were dangling where they had not been hooked on the lift. She revealed that CNA #1 kept saying that she was so sorry that she did not know what happened. She revealed that the resident was assessed and placed on the bed by four people and that she had two skin tears on her right shin, one skin tear on her right shoulder and abrasion on her left side and right temple area. She revealed that the resident was alert and oriented and that her neurological check was normal and that the resident was able to move all extremities, as good as she had been able to before the fall. She revealed that she asked CNA #1 why she did not hook the last two (2) hooks and CNA #1 told her that she thought she had. She revealed that after the incident and the resident was assessed, that CNA #1 was called to the ADM office and interviewed, and CNA #1 was told that she was being suspended until the investigation was completed. She revealed that CNA #1 was very apologetic and said that she knew that she should have had another person to help her but that she thought that she could do it because the resident was wet. She revealed that CNA #1 completed her charting and then left the facility and later called in and was terminated because she did not follow the policy. She revealed that the MD was notified about the fall and that he ordered Resident #1 to be taken to radiology for x-rays and treatment orders for the skin tears. She revealed that the skin tears and abrasions	F 689	to work, or by 11/05/21 (whichever comes sooner). A hospital bed, mechanical lifter, and both styles of sling pads were used to demonstrate the proper procedure and the therapists emphasized that this procedure always requires two-person assistance. We also informed staff of the new process being implemented concerning new items or equipment as follows: a. Upon delivery of a new item, whoever receives the item (nurse, social worker, etc.) will take it to the ADM and/or DON. b. In the absence of the ADM or DON, the new item will be placed in the locked medication room and will not be used until approved. c. The ADM and/or DON will evaluate the item, consult with others as needed and then approve the item for use. If the item needs to be checked by the Plant Operations Department, this will be referred to them for evaluation and application of a safety sticker if needed. d. The appropriate safety measures, including staff education of the new item, will be implemented. e All staff were instructed that they are expected to "speak up" if they do not know how to use an item or perform a procedure and they are not to use an item or try to perform a procedure unless they are properly trained to do so. f. All new employees will complete on the job training and will sign off with their signatures that they have been trained on the Abuse and Neglect Policy and proper use of the mechanical lifter, prior to	

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F 689	Continued From page 11 were minor and that they did not require any sutures. An interview on 9/29/21 at 10:20 AM with Resident #1 with a Brief Interview for Mental Status (BIMS) score of 15 revealed that they use the lift to transfer her and that it used to be scary but now that she has done it a couple times that she is no longer scared. She was unable to recall how many staff members are present during the lift transfer and was unable to recall a fall. She revealed that this place is a good organization. An interview on 9/29/21 at 10:30 AM with Registered Nurse (RN) #1 revealed that she was in the hallway and responded to Resident #1's room due to a loud noise and when she arrived at the room, that Resident #1 was on the floor, and she asked CNA #1 what happened, and she told her that it was just an accident. She revealed Resident #1 was assessed and her neurological status was checked and that she was alert and oriented and that with the help of three other people that they placed Resident #1 on the bed. She revealed that Resident #1 did have a couple skin tears and abrasions but that they were minor and that she had no broken bones. She revealed that the sling was connected to the lift but that she could not remember if the hooks were hooked. An interview on 9/29/21 at 11:45 AM with the DON revealed that CNA #1 did have orientation and all new CNAs are placed on the floor with another CNA for a couple of shifts to be trained and this includes training on the lift. An interview on 9/29/21 at 11:55 AM with the ADM confirmed that all CNAs are placed with	F 689	working independently with residents. g. Failure to comply with the requirements will result in disciplinary action. 4. Quality Assurance Performance Improvement (QAPI): The DON, RN#1 and/or RN Supervisor will conduct Mechanical Lift Transfer Audits twice a week beginning 10/25/21 for one month observing nursing staff on mechanical lift safety, then weekly for three additional months. The ADM or DON will conduct an audit twice monthly on new employee orientation/training, beginning on 10/29/21, which includes mechanical lift safety and the Abuse/Neglect Policy. Both audits will be conducted for three months and any noted problems will be addressed immediately. Audit findings will be reported by the DON to the QAPI Committee quarterly beginning at the next meeting on 11/3/21 and by the ADM to the Bolivar Medical Center Quality Council quarterly at the next meeting on 11/4/21 and recommendations will be made as needed to ensure full compliance with the requirements.	

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another CNA for several shifts to be trained and this includes the lift.

A phone interview on 9/29/21 at 1:10 PM with CNA #1 revealed that her and RN #2 got Resident #1 up the morning of 9/13/21 and left the sling under the resident. She revealed that around two o'clock the resident was wet and needed changing and that she looked down the hall and did not see anyone to help her and that she just wanted to get the resident changed because she was wet, so she attempted to transfer the resident alone, and the resident began to slide and that she tried to get the wheelchair under her but could not so the resident slide to the floor. She confirmed that she did not wait for help and that she knew that she should have had two people for the transfer with the lift, but she thought she could do it without any problem and just wanted to get the wet clothes off Resident #1. She revealed that she thought she had hooked all the hooks but discovered that she did not once the resident slide to the floor. She confirmed that she knew to make certain that all the hooks were hooked before transferring but that she thought she had them hooked. She revealed that she just wanted to tell the truth and do the right thing. She confirmed that she has been a CNA for 18 years and she knows what to do. She confirmed that she worked with other CNAs for a couple shifts when hired and that they went over the use of the lift and that they used the lift several times during the orientating period. She revealed that after the incident that the DON and ADM talked to her and told her that they had to report the incident to the state and that she would have to go home until they completed the investigation. She revealed that she was called back in last Monday and was

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terminated.

An interview on 9/29/21 at 1:45 PM with RN #1 revealed that they always use 2 people when transferring with the lift and that they make certain that all the hooks are hooked to the lift before lifting the resident. She revealed that all new CNAs are assigned with other CNAs for at least for 3 shifts for orientation and that includes the use of the lift.

Record review of the facility Post Fall Huddle with a date and time of 1410 for Resident #1 revealed under injury revealed minor skin tears times three and abrasion times two and under recommendation revealed proper use of hoyer lift with 2 staff members per protocol.

Record review of the care plan for Resident #1 revealed a care plan for at risk for falls related to unsteady gait, poor coordination, and generalized weakness and ADL selfcare performances deficit related to generalized weakness, SOB, and Atrial Fib with an intervention for mechanical lift times two people for all transfers.

Record review of the MDS dated 7/10/21 on Resident #1 revealed under section C a BIMS summary score of 15 and under section G under B how resident moves between surfaces including to or from bed, chair, wheelchair, standing position marked # three for two-person physical assist.

Record review of the facility CNA intervention/task for Resident #1 revealed under ADL-Transferring a #2 that is toilet use: support provided and a #3 for two-person physical assist and initials VB at 14:59 for 9/13/21.

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Record review of the x-ray reports on 9/13/21 for Resident #1 revealed left and right femur, bilateral pelvis, left and right tibula and fibula, right and left humerus, and left and right shoulder were all negative for dislocation and fracture and the CT of the head was with no acute intracranial abnormality.

Record review of the face sheet for Resident #1 revealed an admission date of 11/7/17 with diagnoses of weakness, HTN, Vertebra Compression fracture, and Atrial Fibrillation.

Record review of the physician orders for Resident #1 revealed and order on 9/14/21 to clean abrasion to the left side, to skin tears to the right shin, and skin tear to right shoulder with normal saline, pat dry with 4 x 4 gauze, apply triple antibiotic ointment and cover with clean dry dressing daily and PRN until healed.

Record review of the investigation for Resident #1 revealed the divided leg sling was used during the transfer and this sling was reviewed by therapy and determined it was appropriate for use with transfers and the Invacare manual has this sling listed as one of the slings appropriate for use with the Invacare 600 lift.

Record review of the facility email from HR on 9/29/21 revealed a clock in time of 6:49 AM and clock out time of 16:39 on 9/13/21 for CNA #1.

Record review of the facility September CNA schedule revealed Velma Byas was listed to work on 9/13/21 for 7/3 shift.

Record review of the facility corrective counseling

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F 689	Continued From page 15 record dated 9/20/21 and signed by CNA #1 for termination due to the employee did not follow policy and procedure and did not follow the resident's care plan requiring 2 people transfer assist using the mechanical lift. Record review of the Orientation Training Verification 2021 form dated 5/12/21 with initials VB and signature for Abuse, Neglect, Exploitation. Record review of the facility long term care daily assignment sheet for 9/13/21 for the seven to three shift revealed CNA #1 was assigned to Resident #1 and that Resident #1, #2, #4, and #5 have listed out of bed (OOB) daily-lift x 2 assists.	F 689		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of	F 761		11/5/21

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F 761	Continued From page 16 the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on interview of staff, and record review the facility failed to prevent the diversion of narcotics due to allowing unauthorized personnel to have access to the keys to the lock box attached to the wall in one (1) of one (1) medication rooms where discontinued narcotics were stored waiting to be destroyed and were cited F761 at a D level. Facility policy review of "Nursing Care Center Pharmacy Policy and Procedure Manual" -2007 PharMerica Corp, page 1 of four (4) section 5.5 (five point five) under "Procedures" number 2 (two) revealed, controlled substances listed in schedules II, III, IV, and V remaining in the nursing care center after the order has been discontinued are retained in the nursing care center in a securely double locked area with restricted access until destroyed as outlined by state regulation. On 09/29/2021 at 2:05 AM an interview with the Administrator (ADM) revealed prior to COVID the Pharmacy Consultant would come monthly and would destroy any discontinued medications. The Pharmacist stopped coming to the facility in April of 2020 and was reviewing resident's records virtual. The lock box that contained discontinued medications was located in the medication room with the key to the lock box on one of the nurse's medication cart key ring. The ADM was not	F 761	1. On November 24, 2020, upon discovery of the missing narcotics, the Administrator (ADM) removed the only key to the locked cabinet in the medication room from the medication cart key ring and it was locked in the DON's office to prevent further unauthorized use. The BMC Pharmacy Director was notified on November 24, 2020 and he removed the remaining narcotics and took them to the BMC Pharmacy. The BMC Pharmacy is located on the first floor of the hospital and the Long Term Care Facility (LTCF) is on the second floor. 2. All residents have the potential to be affected by the failure to properly store and destroy discontinued or expired narcotics, as well as unauthorized access to these medications. 3. Effective November 27, 2020, Long Term Care Facility no longer stores expired/discontinued narcotics in the locked cabinet in the medication room but promptly destroys them with the assistance of the Bolivar Medical Center (BMC) Pharmacy. The locked cabinet inside the medication room was not used since the diversion of narcotics and it was later removed from the medication room	

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F 761	Continued From page 17 knowledgeable of who implemented the lock box to be in the medication room or the key being kept on the nurse's medication cart key ring. The missing medications were noticed by Licensed Practical Nurse (LPN) #2 when she entered the lock box for a resident's medication and noticed the medications in the box did not look the same as the last time she had seen inside the lock box. The ADM confirmed that any of the nurses assigned to the medication carts would have a key to the medication room. The key to the lock box located in the medication room and attached to the wall was in possession of one of the medication cart key rings and that any nurse working that cart would have had access to the discontinued Narcotic box. On 09/29/2021 at 2:20 PM an interview with Registered Nurse (RN) #2 revealed she was unaware there was a lock box on the wall for discontinued medications in the medication room until the incident occurred in November of 2020. She denies knowing of the key to the lock box being kept on the medication cart key ring. She reported the nurses were counting and reconciling the narcotic medications that were in the medication cart lock box at change of shift but were not counting the medication blister-pack cards. Record review of the facility's investigation of the unusual occurrence of missing narcotics in November 2020, dated November 27,2020 revealed, on November 25,2020 at 1:30 PM the ADM was informed by RN #3, Director of Nursing (DON) at that time, that there were narcotics missing from the facility's locked cabinet (medications on hold to be destroyed) inside of the medication room. The narcotics were	F 761	on October 11, 2021 and discarded. Effective October 11, 2021, in addition to completing narcotic drug counts, the medication nurses began counting each narcotic blister package/box/bottle at the beginning of each shift and when keys are rendered to another nurse during the shift. The count is then documented on the narcotic accountability record. This increases the accountability of the narcotic count. A new Narcotic Destruction Policy was developed on October 20, 2021 to reflect the following changes in procedure that were originally implemented during a mandatory staff meeting on November 27, 2020. All licensed personnel will be educated on the Narcotic Destruction Policy beginning on 10/25/21. The policy is as follows: a. No discontinued, expired or deceased resident's narcotics will go in the locked cabinet or anywhere else in the medication room. b. Narcotics that need to be destroyed will be done promptly, no later than 24 hours, and will not be stored in the Facility. The medication nurse will inform the Charge Nurse or Director of Nursing of narcotics to be destroyed. If the narcotics need to be destroyed and it is after hours and the BMC Pharmacy is closed, the medication nurse will temporarily keep the narcotics under double lock in the medication cart until they can be destroyed. c. The medication nurse will contact the BMC Pharmacy and a Pharmacist or	

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F 761	Continued From page 18 discovered missing when LPN #2 had to enter the locked cabinet to check if a resident's reordered medication was inside the cabinet. The facility at that time had a process for destroying discontinued medications that included holding the medications until the Pharmacy consultant arrived monthly when the consultant and a nurse would destroy the medications. The Pharmacy consultants began working from home remotely in March of 2020 due to the pandemic and the last date the medications were destroyed was 02/11/2020. The facility changed Pharmacy consultants in August of 2020, and she also worked remotely from her home, due to COVID. It was determined that the medication missing from the locked box were 169 Norco pills. The facility began an investigation that included drug screens, immediately drug screens were performed for the employees on site and the other staff were called to return to the facility and were screened when they arrived. A locksmith was notified and the lock to the medication room was changed. The remaining medications from the locked box were removed and a Pharmacy Technician came to the facility and she and the medication nurse took the medications to the downstairs local hospital Pharmacy and destroyed them. The facility developed a different way to destroy discontinued narcotics as follows: when a medication on the medication cart is expired or discontinued, the medication nurse will contact the local hospital Pharmacy Department and request one of the Pharmacists to come to the facility to assist the medication nurse in destroying the medications. The facility will no longer store discontinued medication but will destroy them promptly. The ADM reported this occurrence to the Complaint Unit/Division of Health Facilities Licensure and Certification, MS	F 761	Pharmacy Technician will come to LTCF and will accompany the nurse to the BMC Pharmacy/or two nurses together will be allowed to take the narcotics to the BMC Pharmacy to be destroyed. d. The required documentation, including the method of destruction, will be completed and signed by the Pharmacist and nurse on the Medication Destruction Log. e. No nurse should ever take narcotics alone to the BMC Pharmacy to be destroyed. f. The medication nurses were already completing narcotic counts, where they counted each pill every shift. In addition to the narcotic pill count, they are now required to count each narcotic blister package/box/bottle at the beginning of each shift and when keys are rendered to another nurse during the shift. The count will be documented on the narcotic accountability record. This will increase the accountability of the narcotic count. The DON began educating the nurses on this safety measure on October 1, 2021. g. Failure to comply with the requirements will result in disciplinary action. 4. Quality Assurance Performance Improvement(QAPI: The new process for destroying narcotics to prevent diversion and unauthorized access to narcotics was submitted to the QAPI Committee for the 4th Quarter 2020 on April 29, 2021. Since that date, there have been 5 times in which we have documentation that narcotics were destroyed and they were	

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F 761	Continued From page 19 State Department of Health, and the Attorney General office. Record review of an E-mail sent on Tuesday, April 6,2021 2:37 PM to the ADM revealed LPN #1 revealed in her confession to the Attorney General's Office she had noticed a key on the medication cart ring that she used it to see if it would open the box, she did open the box and noticed the discontinued medications, a week later she said she used the key and took the narcotic cards for her own personal use. Record review of the investigation in an email to the ADM from the Attorney General's Office revealed the unusual occurrence of missing medications from a locked box at Bolivar Medical Center dated April 14, 202, revealed on April 6, 2021, that the administrator was notified by the Inspector from the Mississippi Office of the Attorney General that during their investigation he had interviewed LPN #1. He reported that LPN #1 failed a polygraph test and that she had admitted that she had stole the narcotic cards (the Norco) from the facility. He stated that LPN #1 had provided him with a signed statement confessing to taking the narcotics from the facility for her own personal use. He also reported that he would be pressing charges against LPN #1. On April 6,2021 LPN #1 was terminated from Bolivar Medical center LTCF. The Director of the local hospital Pharmacy updated the Drug Enforcement Agency. Additionally, LPN #1 was reported to the Mississippi Board of Nursing.	F 761	destroyed according to our plan 100%. We feel that 100% compliance has been achieved but will continue to monitor this process on a quarterly basis beginning October 25, 2021, by conducting audits, for three more months to ensure continued compliance, due to the fact that we added another step of counting the blister packs of narcotics. Any noted problems will be addressed immediately. Audit findings will be reported by the DON to the QAPI Committee at the next meeting on 11/3/21 and by the Administrator to the BMC Quality Council quarterly at the next meeting on 11/4/21 and recommendations will be made as needed to ensure full compliance with the requirements.	