STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	47CI	A. BUILDING: _____ B. WING _____	C 10/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY SPRINGS REHABILITATION AND HEALTHCAR	1315 HIGHWAY 4 EAST HOLLY SPRINGS, MS 38635

(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) COMPLETE DATE
M 000	Initial Comments *** After review on 12/9/20 the MS Regulation M505 was revised and moved to M500 for the resident's right to be free of abuse/neglect. The State Agency (SA) conducted a complaint investigation MS00017072, MS00016852, MS00016826, MS00016904, MS00016696, MS00016897, MS00016782, MS00016561, MS00016549 and MS00017158 at the facility beginning on 10/05/20 through 10/13/20. During the survey, the SA determined that the the facility was not in compliance with Mississippi Regulations for Minimum Standards for Institutions for Aged or Infirm. The SA substantiated MS00016696 and cited M 500 related to Resident Rights at a level III. The other complaints were unsubstaintiated. Census at time of the survey was 114 with a bed capacity of 120.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem	M 500		12/10/20

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M 500	Continued From page 1 rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend	M 500		

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M 500	Continued From page 2	M 500		

changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal;

6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law;

7. is free from mental and physical abuse;
8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint;
9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract;

10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs;

11. is not required to perform services for the

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M 500	Continued From page 3	M 500		

facility that are not included for therapeutic purposes in his plan of care;

12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record);

13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record);

14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record);

15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and

16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in

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M 500	Continued From page 4 the fullest exercise of these rights. This Statute is not met as evidenced by: Level III- Isolated Based on record review, interview, and facility policy review, the facility failed to protect a resident's right to be free from abuse or neglect as evidenced by Resident #1 sustained a fall with a fracture that was not immediately reported by a Certified Nursing Assistant (CNA) and also the CNA failed to utilize the appropriate number of staff to turn and re-position the resident during the Activity of Daily Living (ADL) care that allowed the resident to fall from the bed sustaining, an injury, for one (1) of 16 residents reviewed for neglect. Findings Include: Review of the facility policy titled, "Abuse Prohibition Policy," dated 12/12/19, stated, "Any employee who becomes aware of an allegation of abuse, neglect or misappropriation of resident property, shall report the incident to the Abuse Coordinator immediately. Failure to do so will result in disciplinary action, up to and including termination." Record review of the Facility Reported Incident (FRI) stated that the facility investigation revealed on 02/15/20, Resident #1 was being cared for by CNA#1 and that a bed bath was being given when the resident rolled out of bed. The investigation revealed that CNA#1 stated that she attempted to catch the resident but she was unsuccessful and the resident rolled onto the floor and that she picked the resident up and placed her back into the bed. The FRI revealed that the	M 500	1. On 3/2/2020, CNA # 1 was terminated. All Certified Nursing Assistants (CNA), Registered Nurses (RN), and Licensed Practical Nurses (LPN)were in-serviced on 2/28/2020 regarding following care plans/Kardex and reporting falls immediately by the Director of Nursing (DON). 2. Resident ADL care plans were reviewed by Administrator to identify all residents that require two persons assist with activities of daily living (ADL's). Thirty four (34) residents were identified as needing two persons assist with ADL's. 3. On 10/19/2020, all CNA's, LPN's, and RN's were in-serviced by Staff Development Coordinator on reporting falls immediately and following care plan/Kardex when providing care. RN Supervisor or LPN Unit Manager will perform ADL care audits three times a week for four weeks then weekly times four weeks to ensure care plan/Kardex is being followed. 4. Beginning 12/7/2020, RN Supervisor or LPN Unit Manager will perform ADL care audits three times a week for four weeks then weekly times four weeks to ensure care plan/Kardex is being followed. Administrator or DON will bring results of ADL audit to Quality Assurance/Performance Improvement Committee for review and recommendation monthly for two months.	

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M 500	Continued From page 5 CNA told Licensed Practical Nurse (LPN) #2 that the resident, "almost fell out of the bed but that she had caught her before she rolled out of bed." LPN #2 stated that she did not fill out an incident report because it was reported to her that the resident did not fall, but that she had gone in to assess the resident immediately and did not see any bruises or issues at that time. Record review a Nurses Note revealed that on 02/17/20, Resident #1 was complaining of pain to her right upper leg. An x-ray was obtained and revealed no fractures noted. Resident #1 was placed on Baclofen for muscle spasms. Resident #1 complained of pain on several occasions but would take the Baclofen and would be relieved. On 02/27/20, the resident continued to complain of pain and the physician ordered a Computed Tomography (CT) scan. Results of the CT scan revealed an intratrochanteric fracture of the proximal right femur. The facility investigation into the incident revealed that the fracture was reported to the Attorney General's Office (AG) and the State Agency (SA) and in-services on Abuse/ Neglect, Resident Rights and Vulnerable Adults Act were completed by all staff. The FRI revealed that statements were gathered and the statement from CNA #1 was a written statement, "I was giving (proper name) a bed bath and she rolled off the bed after yelling "I'm Falling." I attempted to catch her as quickly as I can but she was already on the floor. After I looked her over, I put her back in the bed then notified her nurse." An interview with LPN #2 on 10/07/20, at 12:15 pm, stated that she was the LPN for Resident #1 on the day of 02/15/20 and that CNA #1 had come to her and said that she had hurt her shoulder giving Resident #1 a bath and I asked her what happened and she told me that she interrupted a fall during her bath and caught	M 500	Administrator is responsible for monitoring and compliance.	

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Resident #1 before she fell and that she had hurt her shoulder. LPN #2 stated that she had asked her if she wanted her to fill out an incident report on her and CNA #1 said no. LPN #2 stated that she asked her again about Resident #1 and she told her that the resident didn't fall out of the bed, that she had caught her. LPN #2 stated that she went to the room and looked in on the resident and assessed her and did not see any bruises or concerns so she did not fill out an incident report because she was told it was not a fall. LPN #2 stated that she had reported it to the oncoming nurse. The nurse stated that later in the next couple of days the staff saw bruises on her right side and groin area, that's when the resident had the x-ray. LPN #2 said she asked the CNA again, are you sure she didn't fall, but she denied she fell. Then when we got the CT scan back on 02/28/20, and it showed a fracture, I asked the CNA again if she had fell that day and she said yeah, I told you she did. I told her no you didn't tell me that, so you better go now and tell the Director of Nursing (DON) the truth and that you lied. The Administrator got a statement from both of us and we were both suspended pending the investigation on 02/28/20, when we knew she had a fracture. LPN #2 stated that she would have completed the incident report but she was told that she didn't have a fall. LPN #2 stated that she did not see CNA #1 anymore after that because the facility suspended CNA #1 and then fired her.

The State Agency (SA) attempted to call CNA #1 on 10/07/20, at 10:50 am, and again at 1:40 pm, and left a voicemail that we needed to speak with her regarding the incident and she did not return the call.

An interview with LPN #1, Staff Development and CNA Instructor, stated that she began working at

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M 500	Continued From page 7	M 500		

the facility in October 2019, and that she works with the CNAs and nurses at the facility to provide training. She reviewed the Kardex, which is the guide that a CNA would use to document and provide care to a resident and the Kardex for Resident #1 indicated that she was a extensive assist by two staff to turn and reposition in bed and required extensive assist for bathing. The Staff Development LPN #1 stated that anything on the resident's care plan and Minimum Data Set (MDS) pulls over to the Kardex and the CNA uses that to know what care the resident needs. She also confirmed that staff are educated and in-serviced to report any falls and injuries immediately to their supervisor and in this incident it was revealed that CNA #1 did not report the fall to anyone immediately and she failed to utilize two (2) staff to assist Resident #1.

Interview with LPN #3 on 10/07/20, at 12:45 pm, stated that she remembered the incident very well and when she came into work on 02/17/20, she stated we were at the nurse's desk and CNA #1 had made the comment that they had a very busy weekend and that Resident #1 had almost fell out of the bed. I had not even asked her, I just remember her saying that and offering up the information but she kept saying she had almost fell. So when I went in to give her meds that morning she was hurting and I had noticed a bruise to her right hip and her right knee was red and I looked back into the nurse's notes to see if an incident report had been made and there wasn't one. The Nurse Practitioner (NP) was here that day so he went in and assessed her and ordered an x-ray and I gave her Tylenol for the pain.

Record review revealed Medical Doctor (MD) order dated 02/17/20, stated, "Get right femur

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and knee x-ray. Give Baclofen for right thigh."
Record review of a physician progress note from the NP dated 02/17/20, stated, "Long term care resident complaints of pain yesterday to right leg, right leg spasm but pt.(patient) wasn't relieved of pain. Pt appears to be dehydrated will give one liter normal saline. Right knee abrasion but staff has no stated fall."

Record review of MD order dated 02/27/20 stated, "Start Mobic 15 mg 1 by mouth daily."

Record review of MD order dated 02/28/20 stated, "Add CT scan to right pelvis and right femur related to right leg pain."

Record review of CT of the right hip dated 02/28/20 revealed, "There is an intratrochanteric fracture through the right femur with mild proximal migration of the femoral shaft."

Record review of MD order dated 03/02/20 stated, "Ultram tablet 50 mg give 2 tablets by mouth every six hours as needed for pain."

Record review of MD order dated 03/03/20 stated, "Orthopedic appt (appointment) 03/04/20 for follow up of right femur fracture."

Review of the Medication Administration Record (MAR) revealed that resident complained of pain on 02/17/20, 02/18/20, 02/21/20, 02/22/20, 02/23/20, 02/26/20, 02/27/20, 03/01/20, 03/02/20, 03/03/20, 03/04/20, 03/05/20, 03/06/20, 03/07/20, 03/09/20, 03/10/20, 03/12/20, 03/13/20, 03/14/20, 03/15/20, 03/17/20, 03/19/20, 03/20/20 and 03/23/20 and received either Tylenol 325 mg 2 tablets, or Baclofen 10 mg tablets, or Ultram 50 mg 2 tablets as needed for pain.

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M 500	Continued From page 9 Record review of x-ray dated 02/17/20 "No acute fracture." Record review of the Employee file of CNA #1 revealed that she had signed the Abuse/Neglect Policy on 07/25/18, and again on 01/18/20, and attended a facility wide in-service. An interview with the Administrator on 10/07/20, at 3:00 PM, stated that CNA #1 was aware of the reporting policy and also confirmed that she should have informed her Nurse Supervisor immediately of the incident of the fall but that the CNA failed to do this and she was suspended 02/28/20, when the facility was made aware of the fracture and was terminated on 03/02/20. An Interview with the DON on 10/07/20, at 2:00PM, confirmed that CNA #1 had an Ipad that had the Kardex (care guide) for each resident to inform them of the care and the amount of staff needed to care for each resident and she also confirmed that they have Abuse/Neglect in-services quarterly and sometimes more often, so she was aware that she should have reported the incident immediately to her Nurse Supervisor. The MDS nurse was out of the building during the SA investigation into this incident but the DON verified that the MDS assessment needs are carried over to the Kardex for the care that should be provided for the resident. An Interview with the Medical Director on 10/08/20, at 2:00 pm, confirmed that she was aware of the incident, she had heard about it but the physician group that Resident #1's doctor was with is no longer in the facility. The MD confirmed that the CNA neglected care from the resident by not reporting the fall immediately to her	M 500		

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M 500	Continued From page 10 supervisor like she had been in-serviced and knew to do. Review of the employee file for CNA #1 revealed that she was hired at the facility on 07/25/18, and had a disciplinary action dated 05/09/19, that stated, "resident was left heavily soiled to include the bed linen." Employee received her final termination on 03/02/20, for "Employee did not follow care plan guidelines for 2 person assist with a resident. Employee also moved a resident and put resident back in bed without notifying a nurse to assess patient after a fall." Record review the Admission Record revealed that Resident #1 was admitted to the facility on 08/06/19, with diagnosis of Major Depressive Disorder, Muscle Weakness, Abnormalities of Gait and Mobility, Cognitive Communication Deficit, Parkinson's Disease and Need for Assistance with Personal Care and expired in the facility with hospice services on 04/09/20, that was unrelated to this incident. Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/27/20, revealed a Brief Interview for Mental Status (BIMS) score of 07, indicating severe cognitive impairment and a functional status score of 3/3 for bed mobility indicating that the resident required two person physical assist with moving to and from lying position, turning side to side, and positions body while in bed requires two person physical assist and resident is a 4 for bathing, indicating total dependence from staff.	M 500		
M 505	45.17.3 All rights and responsibilities... All rights and responsibilities specified in paragraph (1) through (16) of Section Rule	M 505		12/10/20

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M 505	Continued From page 11 45.17.2, as they pertain to (1) a resident adjudicated incompetent in accordance with State law, (2) a resident who is found by his physician or nurse practitioner/physician assistant to be medically incapable of understanding these rights, or (3) a resident who exhibits a communication barrier, devolve to and shall be exercised by the resident's guardian, next of kin, sponsoring agencies, or representative payee (except when the facility is representative payee). This Statute is not met as evidenced by: Based on record review, interview, and facility policy review, the facility failed to prevent neglect in the facility as evidenced by Resident #1 sustained a fall with a fracture that was not immediately reported by a Certified Nursing Assistant (CNA) and also the CNA failed to utilize the appropriate number of staff to turn and re-position the resident during the Activity of Daily Living (ADL) care that allowed the resident to fall from the bed sustaining, an injury, for one (1) of 16 residents reviewed for neglect. Review of the facility policy titled, "Abuse Prohibition Policy," dated 12/12/19, stated, "Any employee who becomes aware of an allegation of abuse, neglect or misappropriation of resident property, shall report the incident to the Abuse Coordinator immediately. Failure to do so will result in disciplinary action, up to and including termination." Record review of the Facility Reported Incident (FRI) stated that the facility investigation revealed on 02/15/20, Resident #1 was being cared for by CNA#1 and that a bed bath was being given when the resident rolled out of bed. The investigation revealed that CNA#1 stated that she attempted to catch the resident but she was	M 505	The creation and submission of this plan of correction does not constitute an admission by the provider of any conclusion set forth in the statement of deficiencies or any violation of regulations. Plan of correction to meet state and federal guidelines. 1. On 3/2/2020, CNA # 1 was terminated. All certified nursing assistants(CNA's), Registered Nurses(RN's), and Licensed Practical Nurses(LPN's) were in-serviced on 2/28/2020 regarding following care plan/Kardex and reporting falls immediately by the Director of Nursing(DON). 2. Resident Activities of Daily Living(ADL) care plans were reviewed by Administrator to identify all residents that require two persons assist with ADL's on 3/3/2020. Thirty four(34) of one hundred and fourteen(114) residents were identified. 3. On 10/19/2020, all CNA's, LPN's, and RN's were in-serviced by Staff Development Coordinator on reporting falls immediately and following care	

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M 505	Continued From page 12 unsuccessful and the resident rolled onto the floor and that she picked the resident up and placed her back into the bed. The FRI revealed that the CNA told Licensed Practical Nurse (LPN) #2 that the resident, "almost fell out of the bed but that she had caught her before she rolled out of bed." LPN #2 stated that she did not fill out an incident report because it was reported to her that the resident did not fall, but that she had gone in to assess the resident immediately and did not see any bruises or issues at that time. Record review (of what) revealed that on 02/17/20, Resident #1 was complaining of pain to her right upper leg. An x-ray was obtained and revealed no fractures noted. Resident #1 was placed on Baclofen for muscle spasms. Resident #1 complained of pain on several occasions but would take the Baclofen and would be relieved. On 02/27/20, the resident continued to complain of pain and the physician ordered a Computed Tomography (CT) scan. Results of the CT scan revealed an intratrochanteric fracture of the proximal right femur. The facility investigation into the incident revealed that the fracture was reported to the Attorney General's Office (AG) and the State Agency (SA) and in-services on Abuse/ Neglect, Resident Rights and Vulnerable Adults Act were completed by all staff. The FRI revealed that statements were gathered and the statement from CNA #1 was a written statement, "I was giving (proper name) a bed bath and she rolled off the bed after yelling "I'm Falling." I attempted to catch her as quickly as I can but she was already on the floor. After I looked her over, I put her back in the bed then notified her nurse." An interview with LPN #2 on 10/07/20, at 12:15 pm, stated that she was the LPN for Resident #1 on the day of 02/15/20 and that CNA #1 had come to her and said that she had hurt her	M 505	plan/Kardex. 4. Beginning 12/7/2020, RN Supervisor or LPN Unit Manager will perform ADL care audits three times a week for four weeks then weekly times 4 weeks to ensure care plan/Kardex is being followed. Administrator or Director of Nursing(DON) will review audit results weekly. Administrator or DON will bring results of ADL audit to Quality Assurance/Performance Improvement Committee for review and recommendation monthly for two months. Administrator is responsible for monitoring and compliance.	

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M 505	Continued From page 13 shoulder giving Resident #1 a bath and I asked her what happened and she told me that she interrupted a fall during her bath and caught Resident #1 before she fell and that she had hurt her shoulder. LPN #2 stated that she had asked her if she wanted her to fill out an incident report on her and CNA #1 said no. LPN #2 stated that she asked her again about Resident #1 and she told her that the resident didn't fall out of the bed, that she had caught her. LPN #2 stated that she went to the room and looked in on the resident and assessed her and did not see any bruises or concerns so she did not fill out an incident report because she was told it was not a fall. LPN #2 stated that she had reported it to the oncoming nurse. The nurse stated that later in the next couple of days the staff saw bruises on her right side and groin area, that's when the resident had the x-ray. LPN #2 said she asked the CNA again, are you sure she didn't fall, but she denied she fell. Then when we got the CT scan back on 02/28/20, and it showed a fracture, I asked the CNA again if she had fell that day and she said yeah, I told you she did. I told her no you didn't tell me that, so you better go now and tell the Director of Nursing (DON) the truth and that you lied. The Administrator got a statement from both of us and we were both suspended pending the investigation on 02/28/20, when we knew she had a fracture. LPN #2 stated that she would have completed the incident report but she was told that she didn't have a fall. LPN #2 stated that she did not see CNA #1 anymore after that because the facility suspended CNA #1 and then fired her. The State Agency (SA) attempted to call CNA #1 on 10/07/20, at 10:50 am, and again at 1:40 pm, and left a voicemail that we needed to speak with her regarding the incident and she did not return the call.	M 505		

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M 505	Continued From page 14 An interview with LPN #1, Staff Development and CNA Instructor, stated that she began working at the facility in October 2019, and that she works with the CNAs and nurses at the facility to provide training. She reviewed the Kardex, which is the guide that a CNA would use to document and provide care to a resident and the Kardex for Resident #1 indicated that she was a extensive assist by two staff to turn and reposition in bed and required extensive assist for bathing. The Staff Development LPN #1 stated that anything on the resident's care plan and Minimum Data Set (MDS) pulls over to the Kardex and the CNA uses that to know what care the resident needs. She also confirmed that staff are educated and in-serviced to report any falls and injuries immediately to their supervisor and in this incident it was revealed that CNA #1 did not report the fall to anyone immediately and she failed to utilize two (2) staff to assist Resident #1. Interview with LPN #3 on 10/07/20, at 12:45 pm, stated that she remembered the incident very well and when she came into work on 02/17/20, she stated we were at the nurse's desk and CNA #1 had made the comment that they had a very busy weekend and that Resident #1 had almost fell out of the bed. I had not even asked her, I just remember her saying that and offering up the information but she kept saying she had almost fell. So when I went in to give her meds that morning she was hurting and I had noticed a bruise to her right hip and her right knee was red and I looked back into the nurse's notes to see if an incident report had been made and there wasn't one. The Nurse Practitioner (NP) was here that day so he went in and assessed her and ordered an x-ray and I gave her Tylenol for the pain.	M 505		

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M 505	Continued From page 15 Record review revealed Medical Doctor (MD) order dated 02/17/20, stated, "Get right femur and knee x-ray. Give Baclofen for right thigh." Record review of a physician progress note from the NP dated 02/17/20, stated, "Long term care resident complaints of pain yesterday to right leg, right leg spasm but pt.(patient) wasn't relieved of pain. Pt appears to be dehydrated will give one liter normal saline. Right knee abrasion but staff has no stated fall." Record review of MD order dated 02/27/20 stated, "Start Mobic 15 mg 1 by mouth daily." Record review of MD order dated 02/28/20 stated, "Add CT scan to right pelvis and right femur related to right leg pain." Record review of CT of the right hip dated 02/28/20 revealed, "There is an intratrochanteric fracture through the right femur with mild proximal migration of the femoral shaft." Record review of MD order dated 03/02/20 stated, "Ultram tablet 50 mg give 2 tablets by mouth every six hours as needed for pain." Record review of MD order dated 03/03/20 stated, "Orthopedic appt (appointment) 03/04/20 for follow up of right femur fracture." Review of the Medication Administration Record (MAR) revealed that resident complained of pain on 02/17/20, 02/18/20, 02/21/20, 02/22/20, 02/23/20, 02/26/20, 02/27/20, 03/01/20, 03/02/20, 03/03/20, 03/04/20, 03/05/20, 03/06/20, 03/07/20, 03/09/20, 03/10/20, 03/12/20, 03/13/20, 03/14/20, 03/15/20, 03/17/20, 03/19/20, 03/20/20 and 03/23/20 and received either Tylenol 325 mg 2	M 505		

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tablets, or Baclofen 10 mg tablets, or Ultram 50 mg 2 tablets as needed for pain.

Record review of x-ray dated 02/17/20 "No acute fracture."

Record review of the Employee file of CNA #1 revealed that she had signed the Abuse/Neglect Policy on 07/25/18, and again on 01/18/20, and attended a facility wide in-service.

An interview with the Administrator on 10/07/20, at 3:00 PM, stated that CNA #1 was aware of the reporting policy and also confirmed that she should have informed her Nurse Supervisor immediately of the incident of the fall but that the CNA failed to do this and she was suspended 02/28/20, when the facility was made aware of the fracture and was terminated on 03/02/20.

An Interview with the DON on 10/07/20, at 2:00PM, confirmed that CNA #1 had an Ipad that had the Kardex (care guide) for each resident to inform them of the care and the amount of staff needed to care for each resident and she also confirmed that they have Abuse/Neglect in-services quarterly and sometimes more often, so she was aware that she should have reported the incident immediately to her Nurse Supervisor.

The MDS nurse was out of the building during the SA investigation into this incident but the DON verified that the MDS assessment needs are carried over to the Kardex for the care that should be provided for the resident.

An Interview with the Medical Director on 10/08/20, at 2:00 pm, confirmed that she was aware of the incident, she had heard about it but the physician group that Resident #1's doctor was

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with is no longer in the facility. The MD confirmed that the CNA neglected care from the resident by not reporting the fall immediately to her supervisor like she had been in-serviced and knew to do.

Interview on 10/07/20, at 1:25 PM, with CNA #2 who has worked at the facility for two (2) years stated that the CNA's have in-services quarterly regarding abuse and neglect and that he knows to call for help and doesn't transfer or move a patient alone without help and he also verbalized that they use the Kardex to see what care the resident requires if you are not sure. He also verbalized that he knew who to report incidents and allegations to his supervisor for that shift.

Interview on 10/07/20 at 1:45 PM with CNA #3 stated that she has worked at the facility for 3 weeks and has been provided training and in-serviced on abuse and neglect and that if she witnessed an incident or abuse and neglect that she would know to report it to her supervisor and she stated that she has a fellow CNA on her hall to help her with residents who require 2 person assistance.

Review of the employee file for CNA #1 revealed that she was hired at the facility on 07/25/18, and had a disciplinary action dated 05/09/19, that stated, "resident was left heavily soiled to include the bed linen." Employee received her final termination on 03/02/20, for "Employee did not follow care plan guidelines for 2 person assist with a resident. Employee also moved a resident and put resident back in bed without notifying a nurse to assess patient after a fall."

Record review OF WHAT revealed that Resident #1 was admitted to the facility on 08/06/19, with

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M 505	Continued From page 18 diagnosis of Major Depressive Disorder, Muscle Weakness, Abnormalities of Gait and Mobility, Cognitive Communication Deficit, Parkinson's Disease and Need for Assistance with Personal Care and expired in the facility with hospice services on 04/09/20, that was unrelated to this incident. Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/27/20, revealed a Brief Interview for Mental Status (BIMS) score on 01/27/20, prior to the resident's fracture on 02/15/20, revealed a BIMS score of 07, indicating severe cognitive impairment and a functional status score of 3/3 for bed mobility indicating that the resident required two person physical assist with moving to and from lying position, turning side to side, and positions body while in bed requires two person physical assist and resident is a 4 for bathing, indicating total dependence from staff. Based on record review, interview, and facility policy review, the facility failed to prevent neglect in the facility as evidenced by Resident #1 sustained a fall with a fracture that was not immediately reported by a Certified Nursing Assistant (CNA) and also the CNA failed to utilize the appropriate number of staff to turn and re-position the resident during the Activity of Daily Living (ADL) care that allowed the resident to fall from the bed sustaining, an injury, for one (1) of 16 residents reviewed for neglect.	M 505		

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M 505	Continued From page 19 Review of the facility policy titled, "Abuse Prohibition Policy," dated 12/12/19, stated, "Any employee who becomes aware of an allegation of abuse, neglect or misappropriation of resident property, shall report the incident to the Abuse Coordinator immediately. Failure to do so will result in disciplinary action, up to and including termination." Record review of the Facility Reported Incident (FRI) stated that the facility investigation revealed on 02/15/20, Resident #1 was being cared for by CNA#1 and that a bed bath was being given when the resident rolled out of bed. The investigation revealed that CNA#1 stated that she attempted to catch the resident but she was unsuccessful and the resident rolled onto the floor and that she picked the resident up and placed her back into the bed. The FRI revealed that the CNA told Licensed Practical Nurse (LPN) #2 that the resident, "almost fell out of the bed but that she had caught her before she rolled out of bed." LPN #2 stated that she did not fill out an incident report because it was reported to her that the resident did not fall, but that she had gone in to assess the resident immediately and did not see any bruises or issues at that time. Record review a Nurses Note revealed that on 02/17/20, Resident #1 was complaining of pain to her right upper leg. An x-ray was obtained and revealed no fractures noted. Resident #1 was placed on Baclofen for muscle spasms. Resident #1 complained of pain on several occasions but would take the Baclofen and would be relieved. On 02/27/20, the resident continued to complain of pain and the physician ordered a Computed Tomography (CT) scan. Results of the CT scan revealed an intratrochanteric fracture of the proximal right femur. The facility investigation into the incident revealed that the fracture was	M 505		

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reported to the Attorney General's Office (AG) and the State Agency (SA) and in-services on Abuse/ Neglect, Resident Rights and Vulnerable Adults Act were completed by all staff. The FRI revealed that statements were gathered and the statement from CNA #1 was a written statement, "I was giving (proper name) a bed bath and she rolled off the bed after yelling "I'm Falling." I attempted to catch her as quickly as I can but she was already on the floor. After I looked her over, I put her back in the bed then notified her nurse."

An interview with LPN #2 on 10/07/20, at 12:15 pm, stated that she was the LPN for Resident #1 on the day of 02/15/20 and that CNA #1 had come to her and said that she had hurt her shoulder giving Resident #1 a bath and I asked her what happened and she told me that she interrupted a fall during her bath and caught Resident #1 before she fell and that she had hurt her shoulder. LPN #2 stated that she had asked her if she wanted her to fill out an incident report on her and CNA #1 said no. LPN #2 stated that she asked her again about Resident #1 and she told her that the resident didn't fall out of the bed, that she had caught her. LPN #2 stated that she went to the room and looked in on the resident and assessed her and did not see any bruises or concerns so she did not fill out an incident report because she was told it was not a fall. LPN #2 stated that she had reported it to the oncoming nurse. The nurse stated that later in the next couple of days the staff saw bruises on her right side and groin area, that's when the resident had the x-ray. LPN #2 said she asked the CNA again, are you sure she didn't fall, but she denied she fell. Then when we got the CT scan back on 02/28/20, and it showed a fracture, I asked the CNA again if she had fell that day and she said yeah, I told you she did. I told her no you didn't tell

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me that, so you better go now and tell the Director of Nursing (DON) the truth and that you lied. The Administrator got a statement from both of us and we were both suspended pending the investigation on 02/28/20, when we knew she had a fracture. LPN #2 stated that she would have completed the incident report but she was told that she didn't have a fall. LPN #2 stated that she did not see CNA #1 anymore after that because the facility suspended CNA #1 and then fired her.

The State Agency (SA) attempted to call CNA #1 on 10/07/20, at 10:50 am, and again at 1:40 pm, and left a voicemail that we needed to speak with her regarding the incident and she did not return the call.

An interview with LPN #1, Staff Development and CNA Instructor, stated that she began working at the facility in October 2019, and that she works with the CNAs and nurses at the facility to provide training. She reviewed the Kardex, which is the guide that a CNA would use to document and provide care to a resident and the Kardex for Resident #1 indicated that she was a extensive assist by two staff to turn and reposition in bed and required extensive assist for bathing. The Staff Development LPN #1 stated that anything on the resident's care plan and Minimum Data Set (MDS) pulls over to the Kardex and the CNA uses that to know what care the resident needs. She also confirmed that staff are educated and in-serviced to report any falls and injuries immediately to their supervisor and in this incident it was revealed that CNA #1 did not report the fall to anyone immediately and she failed to utilize two (2) staff to assist Resident #1.

Interview with LPN #3 on 10/07/20, at 12:45 pm, stated that she remembered the incident very well

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and when she came into work on 02/17/20, she stated we were at the nurse's desk and CNA #1 had made the comment that they had a very busy weekend and that Resident #1 had almost fell out of the bed. I had not even asked her, I just remember her saying that and offering up the information but she kept saying she had almost fell. So when I went in to give her meds that morning she was hurting and I had noticed a bruise to her right hip and her right knee was red and I looked back into the nurse's notes to see if an incident report had been made and there wasn't one. The Nurse Practitioner (NP) was here that day so he went in and assessed her and ordered an x-ray and I gave her Tylenol for the pain.

Record review revealed Medical Doctor (MD) order dated 02/17/20, stated, "Get right femur and knee x-ray. Give Baclofen for right thigh." Record review of a physician progress note from the NP dated 02/17/20, stated, "Long term care resident complaints of pain yesterday to right leg, right leg spasm but pt.(patient) wasn't relieved of pain. Pt appears to be dehydrated will give one liter normal saline. Right knee abrasion but staff has no stated fall."

Record review of MD order dated 02/27/20 stated, "Start Mobic 15 mg 1 by mouth daily."

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Record review of MD order dated 03/02/20 stated, "Ultram tablet 50 mg give 2 tablets by mouth every six hours as needed for pain."

Record review of MD order dated 03/03/20 stated, "Orthopedic appt (appointment) 03/04/20 for follow up of right femur fracture."

Review of the Medication Administration Record (MAR) revealed that resident complained of pain on 02/17/20, 02/18/20, 02/21/20, 02/22/20, 02/23/20, 02/26/20, 02/27/20, 03/01/20, 03/02/20, 03/03/20, 03/04/20, 03/05/20, 03/06/20, 03/07/20, 03/09/20, 03/10/20, 03/12/20, 03/13/20, 03/14/20, 03/15/20, 03/17/20, 03/19/20, 03/20/20 and 03/23/20 and received either Tylenol 325 mg 2 tablets, or Baclofen 10 mg tablets, or Ultram 50 mg 2 tablets as needed for pain.

Record review of x-ray dated 02/17/20 "No acute fracture."

Record review of the Employee file of CNA #1 revealed that she had signed the Abuse/Neglect Policy on 07/25/18, and again on 01/18/20, and attended a facility wide in-service.

An interview with the Administrator on 10/07/20, at 3:00 PM, stated that CNA #1 was aware of the reporting policy and also confirmed that she should have informed her Nurse Supervisor immediately of the incident of the fall but that the CNA failed to do this and she was suspended 02/28/20, when the facility was made aware of the fracture and was terminated on 03/02/20.

An Interview with the DON on 10/07/20, at 2:00PM, confirmed that CNA #1 had an Ipad that had the Kardex (care guide) for each resident to inform them of the care and the amount of staff

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needed to care for each resident and she also confirmed that they have Abuse/Neglect in-services quarterly and sometimes more often, so she was aware that she should have reported the incident immediately to her Nurse Supervisor.

The MDS nurse was out of the building during the SA investigation into this incident but the DON verified that the MDS assessment needs are carried over to the Kardex for the care that should be provided for the resident.

An Interview with the Medical Director on 10/08/20, at 2:00 pm, confirmed that she was aware of the incident, she had heard about it but the physician group that Resident #1's doctor was with is no longer in the facility. The MD confirmed that the CNA neglected care from the resident by not reporting the fall immediately to her supervisor like she had been in-serviced and knew to do.

Interview on 10/07/20, at 1:25 PM, with CNA #2 who has worked at the facility for two (2) years stated that the CNA's have in-services quarterly regarding abuse and neglect and that he knows to call for help and doesn't transfer or move a patient alone without help and he also verbalized that they use the Kardex to see what care the resident requires if you are not sure. He also verbalized that he knew who to report incidents and allegations to his supervisor for that shift.

Interview on 10/07/20 at 1:45 PM with CNA #3 stated that she has worked at the facility for 3 weeks and has been provided training and in-serviced on abuse and neglect and that if she witnessed an incident or abuse and neglect that she would know to report it to her supervisor and she stated that she has a fellow CNA on her hall

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M 505	Continued From page 25 to help her with residents who require 2 person assistance. Review of the employee file for CNA #1 revealed that she was hired at the facility on 07/25/18, and had a disciplinary action dated 05/09/19, that stated, "resident was left heavily soiled to include the bed linen." Employee received her final termination on 03/02/20, for "Employee did not follow care plan guidelines for 2 person assist with a resident. Employee also moved a resident and put resident back in bed without notifying a nurse to assess patient after a fall." Record review the Admission Record revealed that Resident #1 was admitted to the facility on 08/06/19, with diagnosis of Major Depressive Disorder, Muscle Weakness, Abnormalities of Gait and Mobility, Cognitive Communication Deficit, Parkinson's Disease and Need for Assistance with Personal Care and expired in the facility with hospice services on 04/09/20, that was unrelated to this incident. Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/27/20, revealed a Brief Interview for Mental Status (BIMS) score on 01/27/20, prior to the resident's fracture on 02/15/20, revealed a BIMS score of 07, indicating severe cognitive impairment and a functional status score of 3/3 for bed mobility indicating that the resident required two person physical assist with moving to and from lying position, turning side to side, and positions body while in bed requires two person physical assist and resident is a 4 for bathing, indicating total dependence from staff.	M 505		

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Based on record review, interview, and facility policy review, the facility failed to prevent neglect in the facility as evidenced by Resident #1 sustained a fall with a fracture that was not immediately reported by a Certified Nursing Assistant (CNA) and also the CNA failed to utilize the appropriate number of staff to turn and re-position the resident during the Activity of Daily Living (ADL) care that allowed the resident to fall from the bed sustaining, an injury, for one (1) of 16 residents reviewed for neglect.

Review of the facility policy titled, "Abuse Prohibition Policy," dated 12/12/19, stated, "Any employee who becomes aware of an allegation of abuse, neglect or misappropriation of resident property, shall report the incident to the Abuse Coordinator immediately. Failure to do so will result in disciplinary action, up to and including termination."

Record review of the Facility Reported Incident (FRI) stated that the facility investigation revealed on 02/15/20, Resident #1 was being cared for by CNA#1 and that a bed bath was being given when the resident rolled out of bed. The investigation revealed that CNA#1 stated that she attempted to catch the resident but she was unsuccessful and the resident rolled onto the floor and that she picked the resident up and placed her back into the bed. The FRI revealed that the CNA told Licensed Practical Nurse (LPN) #2 that the resident, "almost fell out of the bed but that she had caught her before she rolled out of bed."

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LPN #2 stated that she did not fill out an incident report because it was reported to her that the resident did not fall, but that she had gone in to assess the resident immediately and did not see any bruises or issues at that time. Record review a Nurses Note revealed that on 02/17/20, Resident #1 was complaining of pain to her right upper leg. An x-ray was obtained and revealed no fractures noted. Resident #1 was placed on Baclofen for muscle spasms. Resident #1 complained of pain on several occasions but would take the Baclofen and would be relieved. On 02/27/20, the resident continued to complain of pain and the physician ordered a Computed Tomography (CT) scan. Results of the CT scan revealed an intratrochanteric fracture of the proximal right femur. The facility investigation into the incident revealed that the fracture was reported to the Attorney General's Office (AG) and the State Agency (SA) and in-services on Abuse/ Neglect, Resident Rights and Vulnerable Adults Act were completed by all staff. The FRI revealed that statements were gathered and the statement from CNA #1 was a written statement, "I was giving (proper name) a bed bath and she rolled off the bed after yelling "I'm Falling." I attempted to catch her as quickly as I can but she was already on the floor. After I looked her over, I put her back in the bed then notified her nurse."

An interview with LPN #2 on 10/07/20, at 12:15 pm, stated that she was the LPN for Resident #1 on the day of 02/15/20 and that CNA #1 had come to her and said that she had hurt her shoulder giving Resident #1 a bath and I asked her what happened and she told me that she interrupted a fall during her bath and caught Resident #1 before she fell and that she had hurt her shoulder. LPN #2 stated that she had asked her if she wanted her to fill out an incident report

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on her and CNA #1 said no. LPN #2 stated that she asked her again about Resident #1 and she told her that the resident didn't fall out of the bed, that she had caught her. LPN #2 stated that she went to the room and looked in on the resident and assessed her and did not see any bruises or concerns so she did not fill out an incident report because she was told it was not a fall. LPN #2 stated that she had reported it to the oncoming nurse. The nurse stated that later in the next couple of days the staff saw bruises on her right side and groin area, that's when the resident had the x-ray. LPN #2 said she asked the CNA again, are you sure she didn't fall, but she denied she fell. Then when we got the CT scan back on 02/28/20, and it showed a fracture, I asked the CNA again if she had fell that day and she said yeah, I told you she did. I told her no you didn't tell me that, so you better go now and tell the Director of Nursing (DON) the truth and that you lied. The Administrator got a statement from both of us and we were both suspended pending the investigation on 02/28/20, when we knew she had a fracture. LPN #2 stated that she would have completed the incident report but she was told that she didn't have a fall. LPN #2 stated that she did not see CNA #1 anymore after that because the facility suspended CNA #1 and then fired her.

The State Agency (SA) attempted to call CNA #1 on 10/07/20, at 10:50 am, and again at 1:40 pm, and left a voicemail that we needed to speak with her regarding the incident and she did not return the call.

An interview with LPN #1, Staff Development and CNA Instructor, stated that she began working at the facility in October 2019, and that she works with the CNAs and nurses at the facility to provide training. She reviewed the Kardex, which is the

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guide that a CNA would use to document and provide care to a resident and the Kardex for Resident #1 indicated that she was a extensive assist by two staff to turn and reposition in bed and required extensive assist for bathing. The Staff Development LPN #1 stated that anything on the resident's care plan and Minimum Data Set (MDS) pulls over to the Kardex and the CNA uses that to know what care the resident needs. She also confirmed that staff are educated and in-serviced to report any falls and injuries immediately to their supervisor and in this incident it was revealed that CNA #1 did not report the fall to anyone immediately and she failed to utilize two (2) staff to assist Resident #1.

Interview with LPN #3 on 10/07/20, at 12:45 pm, stated that she remembered the incident very well and when she came into work on 02/17/20, she stated we were at the nurse's desk and CNA #1 had made the comment that they had a very busy weekend and that Resident #1 had almost fell out of the bed. I had not even asked her, I just remember her saying that and offering up the information but she kept saying she had almost fell. So when I went in to give her meds that morning she was hurting and I had noticed a bruise to her right hip and her right knee was red and I looked back into the nurse's notes to see if an incident report had been made and there wasn't one. The Nurse Practitioner (NP) was here that day so he went in and assessed her and ordered an x-ray and I gave her Tylenol for the pain.

Record review revealed Medical Doctor (MD) order dated 02/17/20, stated, "Get right femur and knee x-ray. Give Baclofen for right thigh." Record review of a physician progress note from the NP dated 02/17/20, stated, "Long term care

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resident complaints of pain yesterday to right leg, right leg spasm but pt.(patient) wasn't relieved of pain. Pt appears to be dehydrated will give one liter normal saline. Right knee abrasion but staff has no stated fall."

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Record review of x-ray dated 02/17/20 "No acute fracture."

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