STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255229	A. BUILDING _____ B. WING _____	C 10/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY SPRINGS REHABILITATION AND HEALTHCARE CENTER	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) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted a survey for complaint investigations MS00017072, MS00016852, MS00016826, MS00016696, MS00016904, MS00016897, MS00016782, MS00016561, MS00016549 and MS00017158 and a COVID-19 Focused Infection Control survey, 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 Medicare and Medicaid regulations of participation for MS00016696 and cited F600 and F656 at a "G" level. The SA found upon investigation that the facility failed to prevent neglect when 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. The other complaints were unsubstaintiated and no deficiencies were cited for the COVID-19 Focused Infection Control survey. Census at time of the survey was 114 with a bed capacity of 120.	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and	F 600		12/10/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 12/18/2020

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F 600	Continued From page 1 any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT 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. 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	F 600	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 plan/Kardex. RN Supervisor or LPN Unit	

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F 600	Continued From page 2 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 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	F 600	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. 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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F 600	Continued From page 3	F 600		

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 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,

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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 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

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F 600	Continued From page 5	F 600		

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

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."

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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 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

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F 600	Continued From page 7	F 600		

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.

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

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F 600	Continued From page 8 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.	F 600		
F 656 SS=G	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 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	F 656		12/10/20

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F 656	Continued From page 9 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: 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 because the CNA failed to utilize the appropriate number of staff that the care plan indicated to provide care to 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 resident care plans reviewed. Findings include: Record review of the facility policy titled, "Care Plans," dated 12/16, stated, "A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The care planning process will include an assessment of the resident's strengths and needs." Record review of the Facility Reported Incident (FRI) stated that the facility investigation revealed on 02/15/20, the resident was being cared for by CNA#1 and that a bed bath was being given when the resident rolled out of bed. The	F 656	1. On 3/2/2020, CNA # 1 was terminated for not following care plan/Kardex. On 2/28/2020, facility Director of Nursing conducted in-service with Certified Nursing Assistants(CNA's), Licensed Practical Nurses(LPN's), and Registered Nurses(RN's) on following care plan/Kardex when providing care. 2. Resident care plans were reviewed by Administrator to identify any residents that require two persons assist with activities of daily living(ADL's) on 3/3/2020. Thirty four(34) of one hundred and fourteen(114) residents were identified. 3. On 12/7/2020, all RN's and LPN's were in-serviced by Staff Development Coordinator on updating resident care plan and Kardex upon admission, quarterly, and as needed to accurately reflect resident's need for assistance with ADL's. On 12/7/2020, facility Director of Nursing audited all resident care plans to ensure ADL's match information on Kardex. Beginning 12/7/2020, RN Supervisor or LPN Unit Manager will perform ADL audits three times a week for	

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F 656	Continued From page 10 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 revealed that on 02/17/20, the resident was complaining of pain to her right upper leg. An x-ray was obtained and revealed no fractures noted. Resident 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 as follows, "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	F 656	4 weeks then weekly times four weeks to ensure care plan/Kardex is being followed. 4. Beginning 12/7/2020, Director of Nursing or Assistant Director of Nursing will audit resident care plans and Kardex after each admission and in conjunction with resident MDS schedule to ensure resident care plan and Kardex are updated and match weekly times three months. Audit results will be brought to monthly Quality Assurance/Performance Improvement Committee by Director of Nursing or Assistant Director of Nursing for review and recommendation monthly for three months. Administrator is responsible for monitoring and compliance.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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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 me that, so you better go now and tell the 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

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	255229	A. BUILDING _____ B. WING _____	C 10/13/2020

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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 required extensive assist by two (2) 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 staff to assist Resident #1.

Record review of resident's care plan revealed that a care plan was dated 11/06/19 through 02/18/20 stated, "The resident has an ADL self care performance deficit and requires interventions of extensive assistance by two staff to turn."

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,

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at 3:00 PM, stated that CNA #1 was aware how to utilize the Kardex and was aware that the resident required 2 person assistance for bathing and turning and that she did not follow the care plan appropriately and because of her negligence she was suspended on 02/28/20, when the facility was made aware of the fracture she was terminated on 03/02/20.

An Interview with the DON on 10/07/20, at 2:00 PM, confirmed that CAN #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.

The Minimum Data Set (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 by not utilizing the appropriate number of staff when giving Resident #1 a bath and this would have prevented her from rolling out of the bed. .

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

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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 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 MDS with an Assessment Reference Date of 1/27/20, 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 scored 4 for bathing, indicating total dependence from staff.