MSDH - Health Facilities Licensure and Certification

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 25WC | A. BUILDING: _____ B. WING _____ | C 10/03/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WILLOW CREEK RETIREMENT CENTER | 49 WILLOW CREEK LANE JACKSON, MS 39272 |

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| M 640 SS=D | 45.21.8 Accidents<br><br>Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies.<br><br>This Statute is not met as evidenced by:<br>Level II<br><br>Complaint #MS #16115<br><br>Based on staff interview, record review, and facility policy review, the facility failed to provide adequate supervision and assistance, related to the use of mechanical lifts, to prevent falls with minor injury for one (1) of four (4) residents reviewed for accidents, Resident #9.<br><br>Findings include:<br><br>Review of the facility's "Modified Lifting Policy", revised 5/29/15, revealed the staff would follow the documented lifting protocol deemed appropriate for each resident. The policy also revealed the information related to the lift would be documented in the smart charting and a sticker system, which was located on each lift.<br><br>Review of a "Resident Incident Report", dated 7/20/19, and the facility investigative report, dated 7/26/19, revealed Resident #9 was found lying on her right side on the floor in her room. The incident report documented that Certified Nurse Aide (CNA) #2 used the wrong lift to transfer the resident; she used the sit-to-stand lift and the resident had been assessed for the total lift. The | M 640 | 1. Immediate Actions taken for the residents found to have been affected include: The Certified Nursing Assistant involved in this deficient practice was terminated on 7/20/2019. The Licensed Practical Nurse Charge Nurse on duty performed an In-service on Proper Body Mechanics, Proper Use of a Mechanical Lift and the Dot Identifier System for using the correct lift on 7/20/2019 the morning of the incident. The Staff Development Nurse performed an In-Service on Facility Policy on 7/20/2019 requiring two people assisting when using any lift while transferring a Resident. This In-service also includes the use of the Dot Identifier System for identifying the correct mechanical lift and using the Kiosk System, placed throughout the facility, to find the lift requirements for residents. This In-Service was performed on 7/20/2019.<br><br>2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected by this deficient practice. | 11/1/19 |

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| M 640 | Continued From page 1<br><br>CNA reported Resident #9 didn't stand up, while using the lift, so she lowered her to the floor. Resident #9 was transferred to the hospital, where X-rays revealed a dislocation of the right shoulder. Treatment included a shoulder immobilizer.<br><br>Review of Resident #9's Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 3/26/19, revealed the resident needed extensive assist of two (2) persons to transfer. The care plan, initiated 3/19/19, revealed Resident #9 required the use of the total lift with two (2) person assistance.<br><br>Review of the "Departmental Notes", dated 7/20/19 at 7:17 AM, documented by LPN #4, revealed a CNA reported she was transferring Resident #9 with the sit-to-stand lift and the resident was unable to stand up, so she assisted her to the floor, lying on her right side. Resident #9 complained of pain in her right shoulder, the physician was notified and a new order received for a stat X-ray to the right arm. Tylenol 650 milligram (mg) administered for pain.<br><br>Interview on 10/01/19 at 09:46 AM, with the Administrator revealed the facility policy was to use two (2) people for all lifts, and to transfer residents according to the resident assessment. The Administrator stated CNA #2 was terminated after the investigation on 7/21/19, for failure to follow the facility policy.<br><br>An attempt to call CNA #2 at 10/01/19 at 02:59 PM, was unsuccessful, with a message left to return the call. Review of CNA #2's personnel file revealed she was terminated on 7/21/19, for wrong or improper lift with a resident causing an injury. | M 640 | 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Nursing Services will be In-Serviced by the Director of Nursing Services, Staff Development Nurse or Registered Nurse Supervisor on the policy for Accidents and Supervision beginning 10/21/2019 to be completed by 11/01/2019. All Resident Falls/Accidents will be reviewed daily by the Interdisciplinary Team during the Morning Stand Up Meeting to ensure appropriate implementation of safety interventions including updating the Plan of Care.<br><br>4. How the Corrective Actions will be monitored to ensure the practice will not reoccur: The Interdisciplinary Team and the Director of Nursing Services, Facility Administrator or RN Supervisor will review each incident report upon occurrence beginning 10/04/2019 to ensure appropriate interventions are implemented and an updated Plan of Care is complete. The Director of Nursing Services or RN Supervisor will complete weekly chart audits for two months through December 2019 and will review all fall incident reports to ensure that appropriate interventions have been put in place to reduce the risk of falls/accidents and that Care Plans have been updated to reflect these interventions. Audited records will be reviewed by the High Risk Committee weekly beginning 11/01/2019 and the Quality Assurance Performance Improvement Committee will review monthly and will make recommendations and changes as needed until such time consistent substantial compliance has | |

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| M 640 | Continued From page 2<br><br>During an interview on 10/01/19 at 3:46 PM, LPN #4 said she first became aware of the incident after CNA #2 called for help and Resident #9 was already on the floor. LPN #4 said the stand-up-lift was still in the resident's room. LPN #4 stated Resident #9 complained of pain in her shoulder, so she notified the Physician, received orders for an X-ray, and gave the resident Tylenol.<br><br>Review of the Departmental Notes dated 7/20/19 at 11:25 AM revealed Resident #9 was transferred to the hospital for evaluation.<br><br>Review of the "Radiology Report", dated 7/20/19, revealed the humerus of Resident #9's right shoulder was anteriorly and inferiorly dislocated, with respect to the glenoid. There was no fracture. Conclusion: Anterior shoulder dislocation.<br><br>Review of the Emergency Department form, dated 7/20/19, revealed the reason for visit was shoulder pain-swelling, shoulder dislocation/fall. The final Diagnosis: shoulder dislocation, unspecified subluxation of right shoulder joint.<br><br>Review of Nurse's Notes, dated 7/20/19 at 11:25 AM, revealed Resident #9 returned to the facility at 8:00 AM with a should immobilizer in place, however the care plan addressed the resident's refusal of the care.<br><br>An observation on 10/02/19 at 10:55 AM, revealed Resident #9 was transferred with a full body lift and two (2) staff, without difficulty or distress. There was no noted injury to Resident #9.<br><br>Interview on 10/02/19 at 03:18 PM, with the | M 640 | been achieved as determined by the Quality Assurance Performance Improvement Committee. | |

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| M 640 | Continued From page 3<br>Director of Nursing (DON), revealed she was not working at this facility when the incident happened with Resident #9. The DON said the check off with the lifts, for CNA #2, could not be located. There was a documented "New Hire Orientation Video Checklist", dated 10/31/18, signed by CNA #2, for a 25 minute video completion for Vander and Vera lifts.<br><br>Review of facility "Face Sheet" revealed Resident #9 was admitted on 4/14/15, with a diagnosis of dementia, unspecified. | M 640 | | |