STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255307	A. BUILDING _____ B. WING _____	C 11/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN AGE NURSING HOME	2901 HIGHWAY 82 EAST GREENWOOD, MS 38930

(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 Complaint #CI MS #14866 The State Agency (SA) conducted an abbreviated complaint survey on 11/15/17 through 11/16/17 . The SA substantiated complaint #14866 and cited deficiencies at F 282 and F 323. The census was 131 at the time of survey and the facility held a license for 150 beds.	F 000		
F 282 SS=G	SERVICES BY QUALIFIED PERSONS/PER CARE PLAN CFR(s): 483.21(b)(3)(ii) (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, policy and procedure review and interview, the facility failed to follow the care plan to provide the care for one (1) of five residents reviewed (Resident #1) as outlined in her care plan, as evidenced by Resident #1, who was transferred by one (1) Certified Nursing Assistant (CNA) and was care planned for a two (2) person assist transfer in a Vander lift. Resident fell from the lift on on 10/25/17, and experienced a fractured Right Femur. Findings include: Review of the facility's, "Total Care Plan",	F 282	F282 1. Certified Nursing Assistant #1 was removed from the schedule 10/26/2017 and was terminated 10/30/2017. In-service initiated 10/26/17 by Director of Nursing on policy review of Nurse Aide Care Plan, Total/Comprehensive Care Plan, review of reporting all incidents and lift procedure requiring two (2) person assist for Certified Nursing Assistants, Licensed Practical Nurses and Registered	12/8/17

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

Electronically Signed | 12/08/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 282	Continued From page 1 policy/procedure, revised 11/30/06, revealed the Interdisciplinary Care Plan will "Identify problems that affect the Resident and his/her care needs" and "Identify the interventions related to the specific problems". The care plan will be maintained. Review of the "Nurse Aide Care Plan (NACP) Form and Verification of Daily Resident Care Form", revised 6/16/11, revealed The Nurse Aide Care Plan Form will be personalized by circling areas in black ink. The Verification of daily Resident Care Form will be reviewed daily every shift by the primary CNA for the Resident. CNAs are to familiarize themselves with the NACP before care is given. Failure to follow the NACP can result in suspension and/or termination. Review of Resident #1's "Nurse Aide Care Plan" dated 3/8/17, has -Mechanical Lift" "Vander" and "total lift" circled. (The policy required two (2) person assist with the Vander lift). Review of Resident #1's Nursing Care Plan, initiated 8/10/15, revealed: Perform all transfers with use of Vander lift with two (2) staff. Interview with Resident #1 at 5:30 PM on 11/15/17, revealed her stating only one (1) CNA was using the "swing" lift and she "slid" out of the sling. The Resident stated she had pain after that but didn't recall if she told anyone. She is unable to identify the CNA by name that was with her when she slid out of the lift. Review of the facility's written report, dated 10/31/17, revealed Resident #1 reported falling from the lift when CNA #1 transferred her with the use of a lift by herself. Resident #1 sustained a	F 282	Nurses. In-service initiated 10/26/17 by Staff Development Nurse on policy review of Lift Policy for Certified Nursing Assistants, Licensed Pratical Nurses and Registered Nurses. 2. All Residents have the potential to be affected. Lift Assessments were completed 10/26/17 on all Residents using a lift. Total/Comprehensive Care Plans and Nurse Aide Care Plans were reviewed and updated on 10/26/17 with lift assessment. On 10/26/17 a return demonstration and review of lift policy was initiated for all Certified Nursing Assistants, Licensed Practical Nurses and Registered Nurses that were hired in the last 4 months. CNA #1 was hired at the facility within the last 4 months. 3. In-service initiated by Administrator 11/16/17 on Lifts, Reporting, Care plans, Residents Rights, Neglect and Code of Conduct for Certified Nursing Assistants, Licensed Practical Nurses and Registered Nurses. Lift Policy Review and lift return demonstration was initiated by Director of Nursing and Staff Development Coordinator on 11/29/17 for all Certified	

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F 282	Continued From page 2 fracture o the right femur. CNA #1 admitted to not reviewing the residents care plan prior to transferring the resident with a lift, knew she was supposed to and stated, "I don't know why..I just didn't." The report noted that CNA #1 failed to follow the policy/procedure and as a result the resident was injured. CNA #1 was terminated because she knew to follow the care plan and did not. The 10/26/17 X-ray of Resident #1's right leg, dated 10/26/17, revealed "Fracture of distal femur in the supracondylar region with minimal impaction. Fracture is predominantly seen along the medial aspect. Degenerative arthritis. Osteoporosis, Joint effusion." Record Review of Resident #1's "Lift/Transfer/Assistance Assessment" dated 10/23/17, revealed that she was assessed to be transferred with a Vander lift with the assist of two (2) staff members. An interview with the Director of Nurses (DON) on 11/16/17 at 3:10 PM, revealed "The Activities Daily Living (ADL) Care Plan info is based off of the admit assessments and risk assessments. The assessments let us know what ADL's are required. That is updated every 90 days and as needed. The ADL's are kept behind the nurses desk." Interview with the Director of Nurses (DON) on 11/15/17 at 5:00 PM, revealed her investigation revealed that CNA #1 attempted a Vander lift with Resident #1 without assist of another staff member, thus she did not follow the care plan. Resident #1 fell out of the lift. She was sent out on 10/26/17, for an evaluation and X-ray that	F 282	Nursing Assistants, Licensed Practical Nurses and Registered Nurses. Lift review included review/follow Nurse Aide Care Plan, reporting any incidents immediately, two people assist for lift transfer. Certified Nursing Assistants, Licensed Practical Nurses, and Registered Nurses hired after 11/29/17 will do a return lift demonstration after two (2) weeks of scheduled work in addition to training upon hire and skills check off upon hire. 4. Quality Assurance Committee reviewed an immediate plan of action on 10/26/17. To monitor for sustained correction, four (4) lift transfers will be observed weekly for 12 weeks by the Unit Manager. Lift Transfer Observation checklist will be used to monitor compliance The audits will be presented to the Quality Assurance Committee quarterly at a minimum or as often as needed to assure continued performance Quality Assurance Committee reviewed Plan of Correction 12/6/17	

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F 282	Continued From page 3 revealed a fractured Right femur. Review of personnel records and the facility's written report, revealed CNA #1's employment has been terminated by the facility as a result of the facility investigation and failure to follow the CNA care plan. Multiple attempts to contact CNA #1 were unsuccessful during survey. Interview with CNA #2 on 11/16/17 at 2:30 PM, revealed CNA #1 busted through the door of the room she was in and said I need you right now (in Resident #1's room). CNA #2 stated she went in the room saw Resident #1 sitting on the floor between the bathroom door and room door and a Vander lift beside the resident. (CNA #2's written statement, dated 10/17/17, revealed she told CNA #1 she should have waited until she was in the room to transfer the resident.) CNA #2 stated that CNA #1 said she was just trying to get the resident to the bed. CNA #2 stated they were trained on using two (2) people with the lift and the care guides (NACP) were behind the nurse's desk to know which lift to use with the resident. Review of Resident #1's medical record revealed an admission date of 8/10/15, with the diagnoses of Age-related osteoporosis, Chronic Obstructive Pulmonary Disease and Hypertension. She does have a history of prior fractures. Review of Resident #1's Quarterly Minimum Data Set (MDS) with as Assessment Reference Date (ARD) of 10/24/17, revealed her Brief Interview for Mental Status (BIMS) was a 15, an MDS with an ARD on 11/3/17, revealed a BIMS of 14, and a BIMS, conducted on 11/16/17, scored scored 15,	F 282		

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F 282	Continued From page 4 all meaning the resident had no cognitive impairment. Both MDS documents indicated Resident #1 required total assistance with two (2) persons for transfer.	F 282		
F 323 SS=G	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3) (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on record review, interview and policy/procedure review, the facility failed to provide the adequate supervision and assistive	F 323	F323 1.	12/8/17

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F 323	Continued From page 5 devices necessary for one (1) of five (5) Residents reviewed, Resident #1, as evidenced by on 10/25/17, Certified Nurses Assistant (CNA) #1 attempted to transfer Resident #1, using a Vander (full body total lift), without getting assistance from another staff member, as required per assessment. Resident #1 slid out of the lift during the attempted transfer, landed on the floor and fractured her right distal femur, which required surgical intervention. Resident #1 was assessed and care-planned for a Vander total lift with two (2) persons for transfers. Findings include: Policy/procedure review of the facility's "Modified Lifting Policy" last revised 9/2017, revealed: Staff will follow the documented lifting protocol deemed appropriate for each Resident" and "Two (2) people will be present when using a lift on each Resident." Review of the facility's investigation revealed that during the 3:00 PM - 11:00 PM shift on10/25/17, Resident #1 was transferred by CNA #1 using a Vander total lift. CNA #1 did not wait for staff assistance and attempted the transfer by herself. Resident #1 came out of the sling and landed on the floor. CNA #1 then left the resident on the floor to get assistance from CNA # 2. The two (2) CNA's put Resident #1 back into the bed and did not alert a nurse to the incident. Further review of the facility's investigation revealed a hand-written, signed statement by CNA#1, stating that she and CNA #2 used the lift to put Resident #1 in the bed. She does not mention a fall or slide from the Vander total lift. CNA #2 refuted CNA #1's statement and reported that she walked into the room, after CNA #1 summoned her, and Resident	F 323	Certified Nursing Assistant #1 was removed from the schedule 10/26/2017 and was terminated 10/30/2017. Certified Nursing Assistant #2 was given a two day suspension 10/26/17 and a 1:1 inservice training on reporting In-service initiated 10/26/17 by Director of Nursing on policy review of Nurse Aide Care Plan, Total/Comprehensive Care Plan, review of reporting all incidents and lift procedure requiring two (2) person assist for Certified Nursing Assistants, Licensed Practical Nurses and Registered Nurses In-service initiated 10/26/17 by Staff Development Nurse on policy review of Lift Policy for Certified Nursing Assistants, Licensed Pratical Nurses and Registered Nurses. 2. All Residents have the potential to be affected. Lift Assessments were completed 10/26/17 on all Residents using a lift. Total/Comprehensive Care Plans and Nurse Aide Care Plans were reviewed and updated on 10/26/17 with lift assessment. On 10/26/17 a return demonstration and review of lift policy was initiated for all Certified Nursing Assistants, Licensed Practical Nurses and Registered Nurses that were hired in the last 4 months. CNA #1 was hired at the facility within the last 4 months.	

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F 323	Continued From page 6 #1 was on the floor and the Vander lift was bedside the resident. CNA #2 stated that she told CNA #1 she should have waited until she was in the room to transfer Resident #1. Resident #1's statement was that only one (1) CNA, identified by the resident as CNA #1, had transferred her with the lift and she had slid out of the sling during the transfer. Review of Resident #1's X-ray report of the right leg, dated 10/26/17, revealed: "Fracture of distal femur in the supracondylar region with minimal impaction. Fracture is predominantly seen along the medial aspect. Degenerative arthritis. Osteoporosis. Joint effusion." Review of the hospital record, revealed Resident #1 had an open reduction-internal fixation of the right femur surgical procedure on 10/27/17. Record Review of Resident #1's "Lift/Transfer/Assistance Aassessment" dated 10/23/17, revealed that she was assessed to be transferred with a Vander lift with the assist of two (2) staff members. Review of the care plan also revealed she had a nursing care plan in place for two (2) person assistance with the use of the Vander lift. During an interview, on 11/15/17 at 5:00 PM, the Director of Nurses (DON) stated her investigation revealed that CNA #1 attempted a Vander lift transfer with Resident #1 without assistance of another staff member. Resident #1 fell out of the lift. She was sent out on 10/26/17, for an evaluation and X-ray that revealed a fractured Right femur. The DON stated that CNA #1 wrote a statement that she and CNA #2 used the lift to transfer the resident but does not mention a fall.	F 323	3 In-service initiated by Administrator 11/16/17 on Lifts, Reporting, Care plans, Residents Rights, Neglect and Code of Conduct for Certified Nursing Assistants, Licensed Practical Nurses and Registered Nurses. Lift Policy Review and lift return demonstration was initiated by Director of Nursing and Staff Development Coordinator on 11/29/17 for all Certified Nursing Assistants, Licensed Practical Nurses and Registered Nurses. Lift review included review/follow Nurse Aide Care Plan, reporting any incidents immediately, two people assist for lift transfer. Certified Nursing Assistants, Licensed Practical Nurses, and Registered Nurses hired after 11/29/17 will do a return lift demonstration after two (2) weeks of scheduled work in addition to training upon hire and skills check off upon hire. 4. Quality Assurance Committee reviewed an immediate plan of action on 10/26/17. To monitor for sustained correction, four (4) lift transfers will be observed weekly for 12 weeks by the Unit Manager. Lift Transfer Observation checklist will be	

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F 323	Continued From page 7 Both CNA's were suspended. The DON stated that CNA #2 came into her office the next day saying she was not going to lie for anyone and was going to tell her what happened. The DON stated the written statement of CNA #2 recorded that she came in the room and the resident was already in the floor and the lift was beside the resident. The written statement also documented that CNA #2 told CNA #1 she should have waited until she was there to transfer the resident. The DON stated she had not been able to contact CNA #1 since she left the facility after giving her written, signed statement on 10/26/17, and that CNA #1's employment has been terminated by the facility as a result of the facility investigation. Multiple attempts to contact CNA #1 were unsuccessful by the surveyor. Review of CNA #1's written statement, not dated, revealed the CNA, after supper on 10/25/17, went to Resident #1's room to prepare her for bed. The resident asked to go to the bathroom, and CNA #1's statement documented she wasn't sure if the resident was allowed to sit on the toilet, so she went and asked another CNA (CNA #2), who said no, so she and CNA #2 used the lift and put the resident to bed. There was no mention of the resident on the floor or that an incident had occurred. Interview with Resident #1, on 11/15/17 at 5:30 PM, revealed she was alert and cognitive. Resident #1 stated that one (1) CNA used the "swing" lift and she "slid" out of the sling. Resident #1 stated she had pain after that and was unable to recall if she told anyone. Interview with Registered Nurse #1 (RN) on 11/16/17 at 11:10 AM, revealed Resident #1 was	F 323	used to monitor compliance The audits will be presented to the Quality Assurance Committee quarterly at a minimum or as often as needed to assure continued performance Quality Assurance Committee reviewed Plan of Correction 12/6/17	

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F 323	Continued From page 8 complaining of pain on 10/26/17, and her right knee was slightly swollen. She also stated that the resident had said she fell after supper the night before. The resident was sent out for an evaluation and X-ray. RN #1 stated she called CNA #1, who said she did take Resident #1 to the bathroom by herself, but didn't mention the lift. RN #1 stated CNA #2 was also interviewed and her statement was that she came into Resident #1's room and saw the resident on the floor with the Vander lift in the room and a Vera (sit-to-stand) sling, which was not supposed to be used with the Vander lift. RN #1 stated CNA #2 indicated that CNA #1 wanted her to say there had been no fall for Resident #1. RN #1 stated that staff are taught to use two (2) people with the Vera or Vander lift. Interview with CNA #2 on 11/16/17 at 2:30 PM, revealed it was after supper on 10/16/17, while picking up dinner trays, she was in the hall helping a resident to the bathroom. She stated that CNA #1 came and asked if she could help her with Resident #1. She stated she told CNA #1 that she would be there after she took her resident to the bathroom. CNA #2 stated that CNA#1 busted through the door and said "I need you right now". CNA #2 stated she went to Resident #1's room and saw the resident sitting on the floor between the bathroom door and room door. She stated that she saw the Vander lift beside the resident. CNA #2 stated she told CNA#1 to go get a nurse and CNA #1 replied she was going to get in trouble, she was just trying to get the resident in the bed. She never said she was using the lift. CNA #2 stated that Resident #1 didn't say anything until they started getting her back in the bed, using the Vander lift, then she complained of pain in her leg. She didn't say	F 323		

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F 323	Continued From page 9 which leg. CNA #2 stated that she told CNA #1 several times she needed to report this to the nurse. CNA #2 stated the very next morning she got a call to come talk to the DON. She stated that she and CNA #1 were waiting to talk to the DON and she picked up a piece of paper, CNA #1's written statement, which didn't document the truth about the incident. CNA #2 stated she read the statement and looked at CNA #1 and said, "You know I can't lie for you, right?",to which CNA #1 responded, "Oh well, I'm going to have to look for another job." Interview with Licensed Practical Nurse #1 on 11/20/17 at 12:45 PM, revealed she did see Resident #1 for the last time on 10/25/17 at approximately 9:00 PM. The resident was in bed with no complaints. Resident #1 did not mention a fall. LPN #1 says she never was told of a fall or incident during the shift. Review of Resident #1's medical record revealed the facility admitted the resident on 8/10/15, with diagnoses of Age-related osteoporosis, Chronic Obstructive Pulmonary Disease and Hypertension. She does have a history of prior fractures. Review of Resident #1's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/24/17, revealed her Brief Interview for Mental Status (BIMS) score was a 15, meaning no cognitive impairment. A second BIMS was performed on 11/16/17, during the complaint survey, which also scored 15. The MDS documented that Resident #1 required total assistance with transfers with the assistance of two (2) people.	F 323		