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
	25CR	A. BUILDING: _____ B. WING _____	C 09/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HILL NURSING CENTER	927 COOPER RD JACKSON, MS 39212

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M 000	Initial Comments The State Agency (SA) conducted an abbreviated/partial extended survey investigation for a facility self-reported complaint, MS CI #16133, beginning and ending on 9/11/19. The complaint was substantiated. The SA determined the facility was not in compliance with the Mississippi Regulations for Minimum Standards for Institutions for Aged or Infirm with deficiencies cited at M640. Concerns identified in the complaint were related to accident hazards, failure to supervise, and failure to appropriately assess and implement the care plan before and after a fall for Resident #1. Resident #1 was dropped by a Certified Nurse Assistant (CNA) during an improper transfer from the chair to the bed. The CNA did not follow the assessment and plan of care for using a stand up lift with two (2) person assistance when she transferred Resident #1 from a chair to her bed, causing a fall with minor skin abrasions to her bilateral knees and bruising to the knees, arms, and buttock. The facility had a census of 74 at the time of the complaint survey, with a capacity for 87 beds.	M 000		
M 640	45.21.8 Accidents 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. This Statute is not met as evidenced by: Level II	M 640	1) The Minimum Data Set (MDS) Licensed Practical Nurse (L.P.N.) updated the	10/8/19

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M 640	Continued From page 1 Based on observation, record review, facility policy and procedure review, and staff interview, the facility failed to supervise staff in a manner to avoid an accident during an improper transfer, causing injury to Resident #1 of bruises to both arms, buttocks, and both knees; pain; and skin abrasions with bleeding to both knees, and a trip to the emergency room for Resident #1, one (1) of four (4) Residents reviewed for falls. Certified Nursing Assistant (CNA) #3 transferred Resident #1 without the use of a stand up lift and two (2) person assistance, as assessed and care planned, resulting in the resident's fall and minor injuries. The CNA also used a total lift to transfer the resident from the floor to the bed and did not report the fall to anyone. Findings include: Record review of the facility policy and procedure titled: "Lift Program Guidelines" dated 6-29-17, revealed: Mechanical lifts are mandatory. All Nursing Department staff should receive proper training, including residents' assessment (include all lift/transfer/assistance needs) General facility assessment -using census, weights, building diagram, and basic assessment guidelines. Individual, detailed, documented resident assessments conducted on each Resident are to be completed upon admission, quarterly, and with significant change. Assessment MUST include documentation to identify use of Total Lift from floor and appropriate sling. Review of the facility policy and procedure titled "Safe Lifting and Movement of Resident", Revised July 2017, revealed: In order to protect the safety and well-being of staff and residents, and to promote quality care, this facility uses appropriate techniques and devices to lift and	M 640	Comprehensive Care Plan to reflect a person-centered care plan on 9/12/19 and the Lift Assessment updated on 9/12/19.This Care Plan reflects the services that will be provided to attain the Resident #1□s highest practical, physical, mental, and psychosocial well-being. Certified Nursing Assistant (CNA) was suspended at the beginning of the investigation on 7/29/2019 and terminated post investigation on 8/02/2019. Resident #1 has been free from falls and proper assistance using a total lift with two (2) person assist being followed. 2) Seventy-four (74) Residents have the potential to be affected by this deficient practice. 3) The Minimum Data Set (MDS) or Assistant Director of Nursing (ADON) will monitor five (5) times per week all falls for appropriate interventions and Care Plan updates. Any issues noted with monitoring will be corrected immediately. An Inservice was conducted on 7/28/19 by the Director of Nursing (DON) regarding proper use of lifts and the Lift Program Guidelines. Lift Inservice was also conducted on August 6, 2019 by the Representative from the insurance company. A complete audit of all Residents was implemented on 9/27/19 by the Director of Nursing (DON), Assistant Director of Nursing, and Unit Managers to assess their needs during transfers. Changes to lifts/ Care Plans will be updated as indicated. Facility will Inservice twice a year on the types and usage of proper lifts and Lift Assessments will be conducted with quarterly and comprehensive assessments. Unit	

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M 640	Continued From page 2 move residents. Resident safety, dignity, comfort, and medical condition will be incorporated into goals and decisions regarding the safe lifting and moving of residents. Manual lifting of residents shall be eliminated when feasible. Nursing staff, in conjunction with the rehabilitation staff, shall assess individual residents' needs for transfer assistance on an ongoing basis. Staff will document resident transferring and lifting needs in the care plan. Such assessment shall include: Resident mobility (degree of dependency); Resident's size; Weight-bearing ability; Cognitive status; Whether the resident is usually cooperative with staff. Review of the Med Care Products Operation Manual revealed: Lifting residents/patients is a challenging task that demands your utmost attention, skill and care. This manual will show you how to use Med Care Lifts and Stands to make lifting easier and safer. It is important that you use the proper lifting procedures indicated in this manual. Learning the proper technique for safe, smooth and efficient lifts and transfers will help maximize the safety and comfort of staff and residents/patients. Assessment: The Med Care Stand is an assistive device, it should only be used with residents/patients can bear the requisite amount of weight as determined by your facility. It also requires that residents/patients possess more advanced motor skills than for the Med Care Lift. It is important to first determine the appropriateness of this piece of equipment for a particular resident/patient. The standard belt is used for residents/patients that have consistent and reliable motor functions. Review of a "Lift/Transfer Assistance" assessment, dated 6/18/19, revealed revealed that Resident #1 was assessed for the use of a	M 640	Managers or Assistant Director of Nursing (ADON) beginning 9/30/19 will observe two (2) Residents per week for three (3) weeks then monthly beginning for compliance on following Lift Program Guidelines. Any issues noted with monitoring will be corrected immediately. On 10/08/19, the Quality Assurance (QA) Committee, consisting of Administrator, Medical Director, Director of Nursing (DON), Assistant Director of Nursing/Infection Control Preventionist, Social Services Director, Wound Care Nurse, Minimum Data Set Nurse (MDS), Admission Coordinator, Unit One Manager, Unit Two Manager, Dietary Manager, Environmental Supervisor, Medical Records Clerk, Therapy Supervisor , reviewed the policy and procedures, Lift Program Guidelines and Safe Lifting and Movements of Residents, with no recommended changes at this time. The Minimum Data Set Licensed Practical Nurse (LPN) or Assistant Director of Nursing (DON) will monitor all incidents daily for appropriate interventions and Care Plan updates. 4. Weekly monitoring of the lift compliance program by the Unit Managers and Assistant Director of Nursing (ADON) will be documented on the Skill Performance Checklist for Lifting and Transfers Log two (2) times per week for three (3) weeks then monthly beginning on 9/30/2019 with results brought to the Quality Assurance (QA) Committee quarterly for review.	

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M 640	Continued From page 3	M 640		

stand-up mechanical lift, with a large sling. (Resident was not assessed or care planned for the use of a Total Body Lift). The assessment revealed the patient's level of assistance to be dependent-patient requires more than 50 percent (%) assistance from staff or is unpredictable in the amount of assistance required. The assessment is documented "No" for the resident having upper extremity strength to safely support her weight during the transfer.

Review of a facility written investigative report, signed by the Administrator, revealed she received a call on 7/28/19 at 8:43 PM, of an incident involving Resident #1 and Certified Nursing Assistant (CNA) #3. The resident reported that CNA #3 attempted to pick her up, she was too heavy, and she fell to the floor on her knees. The resident stated that CNA #3 picked her up from the floor and placed her into bed. The report documented that Resident #1 was transferred to the Emergency Room and returned with no fractures. The report revealed that CNA #1 confirmed she had attempted to transfer the resident by herself, without the use of a stand-up lift, thus not following the procedures needed for the transfer. CNA #3 confirmed she used a total body lift to place the resident in bed, after the fall, and failed to report the fall to anyone. The investigative report included a documented statement, dated 7/29/19, and signed by CNA #3, which revealed she didn't follow the procedure that needed to be used to put Resident #1 to bed on 7/27/19. She documented that she should have used the stand up lift, but instead she pivoted Resident #1 during the transfer, causing the resident to fall. CNA #3 documented that she didn't report the fall and used the total lift to pick the resident up out of the floor and put her to bed.

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M 640	Continued From page 4	M 640		

Review of the nursing notes, dated 7/28/19 at 8:28 PM, revealed: This nurse was summons to Resident's room per CNAs. Noted Resident with bright red bruises to bilateral knees. Resident informed staff that CNA (#3) had attempted to pick her up and put her in bed and dropped her. (Resident #1 identified CNA #3 by name). Resident stated this occurred the day before.

Record review of nurses notes dated 7/28/19 at 10:14 PM, revealed: Resident also observed with discoloration to both arms. Resident was unable to describe what happened at this time. Called on-call MD and received an order to send Resident out for evaluation. Resident presently alert with complaint of mild pain to knees; Tylenol given.

Review of a nursing note dated 7/28/19 at 11:14 PM, revealed (name of ambulance service) in facility to transport resident to (name of hospital). Able to make needs known verbally. Resident placed on stretcher and taken to ambulance.

Review of a nursing note, dated 7/30/19 at 3:22 AM, revealed Tylenol given for signs of grimacing. Skin tears noted to knees bilaterally. Bruising noted to left forearm and upper arm. Discoloration noted to right buttock.

Record review of Resident #1's Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 6/18/2019, revealed that Resident #1 had diagnoses of: "Alzheimer's Disease, unspecified; Hemiplegia following cerebral infarct affecting left non-dominate side; Muscle weakness (generalized); Difficulty in walking, not elsewhere classified; Cognitive communication deficit; and Personal history of adult psychological abuse. The MDS documented that Resident #1

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M 640	Continued From page 5	M 640		

required two (2) person assist for transfer. The MDS, documented Resident #1 as cognitive and able to make decisions for herself, with a Brief Interview for Mental Status (BIMS) score of 15.

Observation and interview of Resident #1 on 9/11/19 at approximately 11:00 AM, revealed that Resident #1 was obese. Resident #1 was sitting alone in the hallway in a wheelchair with her head bent over in a downward position. The resident presented as weak and unable to move her left hand and arm. Resident #1 held her left hand and arm with her right hand. There appeared to be some atrophy to the left arm and hand as it laid without movement across her lap. Resident #1 spoke softly with a weak, hard-to-understand, voice. Resident #1 never made eye contact. Her facial expression remained flat and unchanged during the interview. She kept her head down and answered questions with short phrases and mostly "yes" or "no" answers. Resident #1 stated that a nurse dropped her to the floor when she tried to transfer her to the bed from her chair. Resident stated that she did not remember the nurse's name. Resident stated that she was in pain for a few days after the fall. Resident did not elaborate the details of the incident, but she did say that she was dropped to her knees by the nurse. Resident #1 presented as dependent upon others for all her needs.

Interviews of Certified Nursing Assistants (CNA) #1 and #2, on 9/11/19 at 10:00 AM, revealed that they went to Resident #1's room during the evening shift on 7/28/19, prior to the supper meal, and Resident #1 told them that she was in pain and hurting because another (CNA #3) had dropped her while putting her to bed on 7/27/19, before supper at approximately 5:00 PM. Both CNA's #1 and #2 stated that they observed blood

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M 640	Continued From page 6	M 640		

and abrasions to both knees of Resident #1 and bruises to her arms, buttocks, and both knees. They stated that Resident identified CNA #3 by name to them both. The CNA's stated they reported to the the Charge Nurse for the evening shift on 7/28/19, and the Charge Nurse assessed Resident #1 and sent her out to the hospital for treatment and X-rays. The CNA's stated that Resident #1 told them that CNA #3 had dropped her, while solely transferring her without assistance, from the chair to the bed. Both CNAs stated Resident #1 told them that CNA #3 dropped her and picked her up from the floor, showered her, and cleaned the blood from her knees on 7/27/19, prior to putting her back to bed. They stated CNA #3 had worked the first and second shifts back to back on 7/27/19, and then returned to work on the morning shift (7:00 AM-3:00 PM) on 7/28/19. The interviews revealed that never during the two (2) shifts that CNA #3 had worked on 7/27/19, and/or during the morning shift (first shift 7 AM to 3 PM) of 7/28/19, did CNA#3 report to any one that she had dropped Resident #1 on 7/27/19 at 5:00 PM, and caused Resident #1's injuries.

Record review of a hand written statement from CNA #3, dated 7/29/2019, revealed: I (name of CNA #3) was assigned to care for (name of Resident #1 and her room #). (Resident #1) requested to go to bed before dinner at 5:00 PM. I attempted to assist the resident, but in doing so, I didn't follow the procedure that needed to be used to put her in bed. She should have been put in bed using the stand-up lift, but I pivoted her instead, causing her to fall. I also failed to report this incident. I used the total body lift to pick her up from the floor and placed her back in bed. I changed (name of Resident #1) and asked her if she was ok. She stated that she was fine. I

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M 640	Continued From page 7	M 640		

understand the severity of this situation, there's no reason to justify my actions. This incident occurred on July 27, 2019. (The written statement was signed with the name CNA #3).

An attempt was made to call CNA #3 on 9/11/19, and the phone number provided had been disconnected.

Record review revealed that on 10/23/18, CNA #3 had received training on the use of lifts. There was a signed document by CNA #3, dated 10/23/18, concerning training for lifts.

During interviews on 9/11/19 at 8:30 AM, with the Director of Nursing (DON) and the facility Administrator, both stated that CNA #3 was terminated on 7/28/19, for not following the assessment and care plan for transferring Resident #1; and, for failure to report the injury to the nursing staff for Resident #1, on 7/27/2019. Both the DON and the Administrator confirmed that Resident #1 was injured from a fall during an improper transfer by the CNA #3 on 7/27/19. They stated that CNA #3 should not have attempted to transfer Resident #1 alone, and she should have reported the incident when it happened, on 7/27/19 at 5:00 PM. The DON and Administrator both confirmed that the injuries to Resident #1 were discovered during the evening shift (3:00 PM-11:00 PM) on 7/28/19.

The record review revealed no new interventions that were person-centered and specific to the actual current needs of Resident #1 were documented and/or put in to place after the fall with injury to Resident #1 on 7/27/19. The facility did not follow the recommendations outlined in the Operations Manual for the Med Care Stand Lift for transfer. The facility did not put measures

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M 640	Continued From page 8 in place to prevent the avoidable fall with injury to Resident #1, before or after the fall, on 7/27/19, due to lack of supervision to ensure appropriate transfer of Resident #1. This caused the fall and minor injuries when the Certified Nursing Assistant dropped Resident #1 to the floor during an improper transfer, without the assessed stand-up lift, from a chair to the bed.	M 640		