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
	61BH	A. BUILDING: _____ B. WING _____	C 01/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR HILL REST HOME	1201 GUNTER ROAD FLORENCE, MS 39073

(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 The State Agency (SA) conducted a complaint survey beginning 12/19/18, and was placed on hold due to a quarantine at the facility, continued on 1/2/19, and completed on 1/3/19. Two (2) complaints were investigated with the following results: MS #15512, which was substantiated for accidents/supervision related to the failure to use a lift for Resident #1, as care planned, resulting in a fracture of the hip/femur on 10/21/18. Deficiencies were cited at M640. MS#15501, which was not substantiated for failure to admit Resident #4. Resident #4 was not safe to admit at that time and the facility did not admit the resident. No deficiencies cited. The SA determined the facility was not in compliance with the Mississippi Regulations for Minimum Standards for Institutions for Aged or Infirm. The facility held a license for 60 beds and the census was 55 at the time of survey.	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 III	M 640	1. Immediate action(s) taken for the resident(s) found to have been affected	2/15/19

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M 640	Continued From page 1 Based on observation, interview, and record review, and policy review, the facility failed to prevent accidents for Resident #1 by the facility's failure to use two (2) person assistance and use a mechanical lift for transfer, for one (1) of four (4) residents reviewed, Resident #1. A Certified Nursing Assistant transferred the resident without assistance of two (2) staff and the lift as assessed and care planned, and Resident #1 sustained a fracture of the right hip, which required hospitalization with non-surgical treatment. Findings include: Review of the facility policy, "Accidents and Supervision", dated 10/3/18, revealed the resident environment remains as free of accident hazards as is possible; and each resident receives the adequate supervision and assistive devices to prevent accidents. This includes...Implementing interventions to reduce hazard(s) and risk(s). Review of Resident #1's Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 9/3/18, revealed Resident #1 was assessed for two (2) plus (+) persons for transfer. Review of the care plan, dated 5/11/18, revealed Resident #1 was care planned for two (2) person assist, with the use of a lift for transfers. Review of the facility's incident report and investigation, dated 10/24/18, revealed that CNA #1 did not used a lift or assistance when transferring Resident #1 on 10/21/18, while attempting to put a clean shirt on the resident. The facility's investigation determined that CNA #1 was, careless and non-compliant with the Policy and procedure that resulted in a safety	M 640	include: Resident # 1 was immediately assessed by Register Nurse Supervisor on 10/21/2018. Registered Nurse Supervisor assessment showed Resident right leg was bent up under her. Tylenol was given for pain. Medical Director□s Nurse Practitioner and Resident Representative was notified on 10/21/2018. Resident was sent to Baptist emergency room and was admitted on 10/21/2018. Resident # 1 was reassessed by the Registered Nurse Supervisor after her hospitalization for a fractured right femur on 10/25/2018 to verify the need and safety risks associated with the use of the mechanical total lift. Certified Nursing Assistant was sent home on 10/22/2018 pending investigation which revealed she had made false statements on day the incident occurred. All Resident care plans and daily care guides involving the lifts was updated 1/14/2019 by the Minimum Data Set Nurse. All Lift assessments was completed by Register Nurse Supervisor on 10/25/2018. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that 27 residents that require the use of mechanical lifts have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: An in-service education program was conducted by the Staff Development Nurse and Director of Nursing Services on 10/21/18 and 01/11/19 with direct care staff addressing the importance of	

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M 640	Continued From page 2 violation. The report noted Resident #1 fell during a transfer by one (1) person (CNA #1) and no mechanical lift was used, resulting in a hip fracture for the resident. This investigation revealed CNA #1 was terminated on 10/24/18 (for failure to follow the policy). Record review of the local Hospital's "Adult Daily Progress Note", for Resident #1, revealed the Resident was admitted to the hospital on 10/21/18, with a Displaced Intratrochanteric Fracture of Right Femur, after a reported mechanical fall at the nursing home. X-ray results for the right hip, dated 10/21/18, revealed a moderately displaced right femoral neck fracture with suspected intratrochanteric fracture component. Interview with Certified Nursing Assistant (CNA) #1, on 1/3/19 at 8:04 AM, confirmed she was transferring Resident #1 alone and without a lift on 10/21/18, when Resident #1 fell to the floor, which resulted in a hip fracture for the resident. CNA #1 stated, "I didn't intend for her (Resident #1) to get hurt". CNA #1 confirmed she willfully transferred Resident #1 by herself and without the use of a lift. Review of CNA #1's written statement, dated 10/22/18, revealed she had transferred Resident #1 to the Geri-chair by herself, and the resident slid out of the chair, with her legs crossed and under her body, as she placed the resident on the floor. Interview with RN #1 on 1/3/19 at 12:25 PM, revealed on 10/21/18, she was called to Resident #1's room by CNA #1, and Resident #1 was on the floor. RN #1 stated that CNA #1 reported to her that she was transferring Resident #1 when Resident #1 grabbed onto her arm and the CNA eased the resident to the floor. RN #1 stated	M 640	following the Lift Program and Care plan policy and procedure which is using the correct lift, correct type of sling and the number of person used. An in-service education program was conducted by the Director of Nursing Services on 10/22/18 and 01/11/19 with direct care staff addressing the importance of following the Lift Program and Care Plan policy and procedures along with Abuse and Neglect. An in-service education program was conducted by the Director of Nursing Services on 02/15/2019 with the direct care staff addressing the importance of following the Accident and Supervision policy and procedures which is using the correct lift, correct type of sling and the number of person used. Newly hired nursing staff will be in-serviced upon hire and quarterly and as needed by the Staff Development Nurse or Director of Nursing. An in-service education program was conducted with direct care staff on 01/25/19 by Staff Development Nurse concerning demonstration of the stand lift. An in-service education program was conducted with direct care staff on 10/23/18 by facility vendor on the Lift program and Mechanical lift procedures. An in-service education program was conducted by the Director of Nursing Services on 01/03/2019 with interdisciplinary team addressing the importance of following the Care Plan, Abuse and Neglect. An in-service education program on Abuse and Neglect which included lift information and following doctors orders and care	

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M 640	Continued From page 3 there was no one in the room, nor was there a lift present, when she entered the room. In an interview on 1/2/19 at 3:25 PM, the facility Administrator stated that CNA #1 first lied to them about the incident and said she was using and lift and two (2) people were present during the lift; but after review of the video, CNA #1 was seen entering Resident #1's room alone and without a lift. The Administrator stated CNA #1 changed her story and admitted she was alone when she transferred Resident #1 without a lift. The Administrator stated this action resulted in CNA #1's termination. Interview with Registered Nurse (RN) #1 on 1/2/19 at 11:22 AM, revealed it is the facility's policy to use at least two (2) people when using any lift. Interview with the Director of Nursing (DON) on 1/3/19 at 10:30 AM, revealed that Resident #1 fell and sustained a hip fracture when CNA #1 lifted/transferred her by herself. When asked if she considered this willful, the DON responded, "Yes". In an interview with the DON on 1/3/19 at 12:00 PM, she stated during the investigation, it was determined that CNA #1 transferred Resident #1 on 10/21/18, by herself, without a lift, and the video recording revealed CNA #1 never took a lift into Resident #1's room. Interview with the Medical Director on 1/3/19 at 11:37 AM, revealed he was notified of the incident when Resident #1 fell and was transported to the hospital. He stated he did not remember details of the event at this time.	M 640	plan was conducted with direct care and line staff on 1/25/19 by a person with the Attorney Generals office. An in-service education program on Abuse and Neglect was conducted with nursing staff on 01/26/19 by Registered Nurse Supervisor. An in-service education program on Resident□s Rights was conducted with nursing staff on 1/31/19 by the Director of Nursing Services. An in-service education program was conducted with nursing staff on accidents and incidents and reporting timely by Director of Nursing on 02/07/19. An in-service education program was conducted with nursing staff concerning the changing of lifts for two residents by the Director of Nursing on 02/13/19. An in-service education program was conducted with nursing staff concerning accident and supervision, prevention and provision of Quality Care by the Director of Nursing Services on 02/15/19. Register Nurses, Licensed Practical Nurses and Certified Nursing Assistants were checked off on use of lifts by the Director of Nursing Services and Lead Certified Nursing Assistant on 1/4/19 through completion on 1/14/19. Approximately 43 employees have been checked off. Newly hired direct care staff will be checked off during orientation by Staff Development Nurse or Director of Nursing or Registered Nurse Supervisor as needed and quarterly thereafter. An audit on residents□ lift assessments were updated and reviewed by the Registered Nurse Supervisor and Director	

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M 640	Continued From page 4 Review of the facility's disciplinary report, dated 10/24/18, revealed CNA #1 was terminated from employment after the facility's investigation of Resident #1's fall/fracture. It was determined, during the investigation, that CNA #1 transferred Resident #1 from the bed to the chair alone, and without the use of a lift, resulting in a fall with fracture of the hip for Resident #1. Categories included carelessness, safety violation, and non-compliance of policy and procedure. Review of a signed acknowledgment, dated 6/15/18, revealed CNA #1 signed the acknowledgement of the facility's policies for the use of the Daily Care Guide and the Employee Handbook. Review of Resident #1's "ECARE TASK" sheet and Daily Care Guide, dated 5/16/17, revealed Resident #1 was Care Planned for a total lift for all transfers, with two (2) person assistance, using a medium sized sling. The Face Sheet indicated the facility admitted Resident #1 on 5/15/17, with the diagnoses of Anemia, High Blood Pressure, Non-Alzheimer's Dementia, and Paroxysmal Atrial Fibrillation.	M 640	of Nursing Services on 1/9/19, 1/10/19, and 1/14/19. Resident lift assessments reviewed with no concerns identified. Certified Nursing Assistant # 1 was terminated from employment on 10/24/18 for noncompliance with the Lift and Accident and Supervision policy and procedures. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Director of Nursing Services, or Staff Development nurse, will observe and monitor direct care staff for compliance with using the lifts according to the lift assessments and care plans on five (5) residents weekly for four (4) consecutive weeks starting 01/16/19. These residents will be observed to ensure that the reasons for use of mechanical lifts are properly identified, evaluated, documented and care planned. Findings of this audit will be discussed with the Administrator. This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met.	