STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255297	A. BUILDING _____ B. WING _____	C 04/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CARE CTR-MONROE HALL	300 CAHAL STREET HATTIESBURG, MS 39401

(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 Complaint Investigation (CI) MS #18689 and CI MS #18729 at the facility from 4/13/22 through 4/14/22. The SA returned to the facility from 4/18/22 through 4/19/22 and 4/26/22 through 4/28/22 to obtain additional information. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid. CI MS #18729 was not substantiated. CI MS #18689 was substantiated for a resident fall that resulted in multiple fractures and F600, F609, F656, and F689 was cited. The facility had a license for 80 beds, with a census of 73.	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 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 interviews, record review, and facility policy review, the facility neglected to ensure an	F 600	Bedford Care Center-Monroe Hall, LLC (facility)acknowledges receipt of the	5/5/22

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

Electronically Signed | 05/03/2022

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F 600	Continued From page 1 assistive device was used during a transfer, causing a resident to be lowered to the floor by staff which resulted in multiple fractures for one (1) of four (4) residents sampled. Resident #1. (See F689 for additional information.) Findings include: A record review of the facility's policy "Safe Transfer and Lifting of Residents" with a revised date of 09/2013 revealed "Policy Statement 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 move residents. Policy Interpretation and Implementation ...II. Assessment Guidelines ...10. Nursing staff, in conjunction with the rehabilitation staff, shall assess individual residents' needs for transfer assistance ...13. Transfer assessments will be documented in the resident's care plan and in the resident's profile in the KIOSK ..." A record review of the facility's written investigation revealed that at 8:30 AM on 3/11/22, Resident #1 was noted by Certified Nurse Assistant (CNA) #1 to have bruising to her bilateral lower extremities. CNA #1 immediately reported the bruising to Licensed Practical Nurse (LPN) #1. LPN #1 was unaware of any accident or injury to the resident and immediately evaluated the resident and notified the Director of Nursing (DON). At 9:00 AM, the DON assessed the resident and bruising to bilateral lower extremities and external rotation to the left lower extremity was noted. The resident was stable and in no acute distress. An investigation began immediately after the DON reported her findings to the Administrator 9:05 AM. The Nurse	F 600	Statement of Deficiencies and proposes this Plan of Correction to the extent of the summary of findings is factually correct and in compliance with applicable rules and regulations. Please accept this Plan of Correction our credible allegation of compliance. On 3/11/2022 at 0830 AM, Resident #1 was noted by Certified Nurse Assistant (CNA) #1, to have bruising to bilateral lower extremities. CNA #1 immediately reported the bruising to Licensed Practical Nurse (LPN) #1. LPN #1 immediately evaluated the resident and notified the Director of Nursing (DON) of the unexplained bruising. At 0900, the DON assessed the resident and confirmed the findings from LPN #1. Investigation began immediately after DON reported her findings to the Administrator, at 0905. The Nurse Practitioner (NP), was notified of the patient condition at 0905 and gave verbal orders to send the resident to the local Emergency Room (ER) for evaluation. At 0920 the resident□s Responsible Representative (RR) was notified of the situation and the need to transport the resident to the hospital for evaluation. The ambulance arrived at the facility at 0930 and at 0945 the resident was loaded onto the ambulance and began transport from the facility to the local ER. All residents have the potential to be affected by the stated deficient practice. On 3/11/2022, an emergency Quality	

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F 600	Continued From page 2 Practitioner (NP) was notified of Resident #1's condition and gave verbal orders to send the resident to the local Emergency Room (ER) for evaluation. At 9:20 AM, the resident's Responsible Representative (RR) was notified of the situation and the need to transport the resident to the hospital for evaluation. The RR agreed that the resident needed to be evaluated and the ambulance service was notified of the need for patient transportation to the Emergency Room. The ambulance arrived at the facility at 9:30 AM and at 0945 9:45 AM, the resident was loaded into the ambulance and began transport from the facility to the local Emergency Room. The Quality Assessment and Assurance Committee (QAC) on 3/11/22 for an emergency meeting. The facility Medical Director and the residents Primary Care Physician were both made aware of the incident and participated in the QAC review via phone conference. After reviewing a Root Cause Analysis (RCA) was conducted and the QAC has determined that Contract Agency staff members CNA #2 and NA #3, did not follow the residents plan of care when attempting to transfer the resident. The resident is to be transferred using a lift, but no lift was utilized during a transfer on 3/10/2022 at approximately 1:45 PM, per video review and corroborating statements from staff. The resident subsequently sustained an assisted fall, per CNA #2 and NA #3's written statement review. Also, CNA #2 and NA #3, in separate interviews held with the DON and the Administrator, both stated that the incident was not reported up the chain of command to the resident's primary nurse, nurse manager, or to Administration as per the facility policy. CNA #4, also an employee of the Contract Agency per written statement, interview, and video recording review, entered the resident's	F 600	Assessment and Assurance Committee (QAC) meeting was held to discuss findings from the facilities internal investigation of the resident□s injuries. Staff interviews, written statements, electronic medical record review, and video recording review where provided to the QAC. The facility Medical Director and the residents Primary Care Physician were both made aware of the incident and participated in the QAC review via phone conference. After review a Root Cause Analysis (RCA) was conducted and the QAC has determined that contract staff members, CNA #2 and NA #3, did not follow the resident□s plan of care when attempting to transfer the resident nor did they follow the facility policy and procedure as trained and instructed through orientation. The resident is to be transferred using a lift but no lift was utilized during a transfer on 3/10/2022 at approx. 1345, per video review and corroborating statements from staff. CNA #2 and NA #3 were immediately suspended from working in Bedford Care Center □ Monroe Hall, LLC after their interviews conducted the morning of 3/11/2022. The employer of CNA #2 and NA #3 was notified via email of the incident and suspension of staff on 3/11/2022. Upon completion of the QAC review and findings, immediate training of all facility staff began on 3/11/2022 by the Staff Development Nurse. This training included the topic of Abuse and Neglect, Residents Rights, Resident Transfer	

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F 600	Continued From page 3 room and noted the resident to be on the floor. CNA #4 failed to notify nursing staff or Administration of the incident but did explain to CNA #2 and NA #3 the requirement to report the incident. CNA #2 and NA #3 were immediately suspended from working in facility, after their interviews were conducted the morning of 3/11/2022. Record review of the written statement signed by CNA #2 and dated 3/12/22 revealed, " ...Nurse (Proper Name) entered the room and told (Proper Name of NA #3) she could have used the stand up lift because she could stand ...I went back to help her get dressed and be put back to bed. We did not use the total lift because we was told she could stand ...We scooted her to the end and grabbed both side getting onto the floor standing straight ...she began to holler 'My Legs' and bending them going to the floor (sitting on her legs) when we got her lowered to the ground, making sure she didn't fall..." Record review of the written statement signed by NA #3 and dated 3/11/22 revealed, " ...I asked (Proper Name of CNA #2) to go get the shower bed because another aide had told me she was total ...assisted me with the lift in the process of it a nurse ...walked in and said 'You don't have to use the total lift she can stand up they normally put her in the chair to bath' ...After the shower I asked (Proper Name of CNA #2) to assist me with transferring her since the nurse had said she could stand up ...When we stood her up all the way she didn't stand up she crossed her legs and went down, but she ended up sitting on her knees ...Me and (Proper Name of CNA #2) tuned her onto her right side to get her legs from under her ..."	F 600	Policy, and Accident and Injury Reporting. Training of all staff was completed on 3/24/22. On 3/11/2022, the QAC adopted additional steps to ensure all direct care staff who are employed by a staffing agency are completing agency orientation and competencies prior to working in the facility. The person scheduling the agency staff at the facility will alert the DON of any agency staff who have not worked in the facility by placing them on the New Agency Roster. The DON will communicate the need for new agency orientation to the on duty nursing staff. Upon completion of the training the agency staff member will sign an acknowledgement that training was completed and content is understood. Also, the nurse on duty conducting the orientation will sign as a witness that the orientation was completed. The agency orientation content will include but is not limited to Vulnerable Adults Law, Resident□s Rights, Falls, Incidents and Accidents, Resident Lift and Transfer Policy, and CNA Documentation (includes the Kardex or care plan). When possible, the new agency staff will be assigned to a unit with a facility staff CNA to provide extra support and assistance during their first shift worked. Beginning 4/29/2022, the Staff Development nurse or Registered Nurse began conducting random resident transfer observations, 10 times per week for 2 weeks and then 5 times weekly for 2 months ending July 4, 2022. The observer will confirm that staff are able to	

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F 600	Continued From page 4 Record review "Emergency Department (ED) Provider Notes" revealed, " ...3/11/22 patient reportedly fell yesterday, unwitnessed. "Impression" revealed, " ...she is 84-year-old female who was brought to the hospital after a fall. She is found to have left proximal tibial and fibular fracture and right distal femur fracture." On 4/14/22 at 1:00 PM, the State Agency (SA) observed video surveillance recorded on 3/10/22 at 1:45 PM, that revealed CNA #2 and NA #3 walking in the hallway with Resident #1 on the shower bed. They entered the resident's room and did not take the mechanical lift into the resident's room. The mechanical lift was noted to be in the hallway the entire time they were in the resident's room. CNA #4 went into the room and exited. CNA #2 and NA #3 were in the resident's room for seven (7) minutes before exiting the room with the empty shower bed. Record review of the "Admission Record" revealed Resident #1 was admitted to the facility on 8/3/18 with diagnoses including Alzheimer's Disease, Periprosthetic Fracture around Internal Prosthetic Right Hip Joint, and Periprosthetic Fracture around Internal Prosthetic Left Hip Joint. Record review of quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/9/22 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 03, which indicated she is severely cognitively impaired, and she required an extensive two-person assist for transfers. Record review of Resident #1 "Visual/Bedside Kardex Report" as of 3/1/2022 revealed the	F 600	access the residents care plan on the Kardex, determine the appropriate type of transfer required, access the appropriate equipment as necessary and perform the transfer per policy and procedure. The observations will be documented on the Observation Form. Beginning 4/29/2022, the DON will collect all agency orientation acknowledgement forms weekly to ensure compliance with agency staff orientation. Any variances observed will require immediate correction and training with successful return demonstration of the observed process prior to the staff member being able to return to work. All variances identified will be documented and filed for review. Variances will be submitted to the QAC for review by the Medical Director and the Steering Committee to ensure sustained compliance monthly times 2 months beginning 5/4/2022 and ending July 4, 2022. On 5/5/2022, Bedford Care Center □ Monroe Hall, LLC corrective actions will be completed. On going monitoring, observations, and QAC review will continue for 2 months ending July 4, 2022.	

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F 600	Continued From page 5	F 600		

resident required the use of a mechanical stand-up lift (medium belt-blue straps) with two staff extensive assistance for transfers at the time of the fall.

Record review of Resident #1's "Progress Note" revealed a nurses note written by the DON with an effective date of 3/11/22 at 9:00 AM, "Primary nurse stated to myself, "I need to tell you something." Nurse proceeded to tell me that a CNA had reported an injury to her LPN, when assessed elder lower extremities noted with extensive bruising purple and reddish in color, left leg noted to be externally rotated, elder not voice pain at this time, notified RN (Registered Nurse) unit manager to call NP and RR".

Record review of Resident #1's "Progress Note" revealed a nurses note by RN #1 with an effective date of 3/11/22 at 9:16 AM, "Entered resident's room and noted bruising to BLE (Bilateral Lower Extremity). Also noted gross deformity to LLE (Left Lower Extremity) distal knee. (Proper Name of Nurse Practitioner) notified. New order to transfer to (Proper Name of Local Hospital) ER for evaluation".

On 4/13/22 at 10:40 AM, an interview with LPN #2 revealed that on 3/10/22, she walked into Resident #1's room and saw CNA #2 and NA #3 using a full body mechanical lift to transfer the resident from her bed to the shower stretcher. She explained to them that Resident #1 was to be transferred with a stand-up lift and to let her know when they transferred her back to bed and she would give them assistance. The CNAs did not request her help to get Resident #1 back to bed and she had no idea the resident had been assisted to the floor during the transfer back to

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bed until the next morning. LPN #2 stated that all staff and agency CNAs are instructed to use the computer system so they may see the care plans and Kardex on each resident, for which type of lifts to use, and care that is required for residents.

On 4/13/22 at 1:15 PM, during an interview with the DON, she confirmed the fall related to Resident #1 occurred on 3/10/22 with no one reporting it to the appropriate staff at the time the event occurred. Then on 3/11/22 when staff were making rounds, Resident #1 had bruising of her lower extremities and she was immediately sent to the local ER and the facility began an investigation. Contract staff are trained when they come to the facility on how to read the resident's Kardex on the kiosk. She agreed it is very important for staff to follow the Kardex related to how to transfer a resident to avoid injuries.

On 4/14/22 at 9:58 AM in an interview with CNA #4, she stated that she walked into Resident #1's room to obtain the shower bed and noticed the resident was on the floor next to her bed, with CNA #2 and NA #3 in the room with her. There was no mechanical lift in room. CNA #2 and NA #3 informed CNA #4 that when they were transferring the resident from the shower bed to her bed, her legs went weak, and they slid her to the floor. CNA #4 assisted CNA #2 and NA #3 in transferring the resident from the floor to her bed and advised them to notify the supervisor and the DON of the accident. The CNA's agreed they would, and CNA #4 went to go take care of her residents. CNA #4 said that she really assumed they notified their nurse and DON. She confirmed that she was trained when she came to work at the facility on how to look at the kiosk to

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F 600	Continued From page 7	F 600		

see how a resident should be transferred.

On 4/14/22 at 11:00 AM, an interview with the Administrator revealed Resident #1's fall occurred on 3/10/22 and both CNA #2 and NA #3 admitted they had lowered her to the floor and did not use the mechanical lift while transferring her from the shower bed to her bed. CNA #2 and NA #3 were suspended
immediately and not allowed to work at the facility. The facility held a QAC meeting and in-services were completed for all facility and agency staff on the topics of abuse, neglect, use of mechanical lifts, and the reporting of incidents. The Administrator confirmed all staff are trained on how to transfer a resident and to look at the resident's care plan or Kardex to find out how a resident is to be transferred.

On 4/14/22 at 11:30 AM, an interview with Contract Agency Representative #1 revealed that the contract agency completes reference checks and background checks on their staff and conducts a CNA skills evaluation. Each facility has the obligation to orientate the contract staff to their facility.

On 4/18/22 at 3:00 PM, during an interview with the DON, she explained the facility implemented additional steps in the orientation process for agency staff. When the Scheduler schedules an agency staff member that has never worked at the facility, the Scheduler will alert the DON to ensure orientation training is conducted for the agency staff member explaining policies and procedures. The agency staff will sign acknowledgement of receiving the education and this will be completed prior to the agency staff providing any direct resident care. When at all

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F 600	Continued From page 8	F 600		

possible, the agency staff who is new to the facility will be assigned to a unit in which facility staff are also assigned to provide extra support and assistance during their first shift worked. The contract staff member will receive specific training and sign an acknowledgment (located in a binder at each nurse's station) on how to access a resident's Kardex which will provide information on how to care for the resident, including the type of transfer required. The binders will be readily available at the nurse's station with step-by-step instruction on accessing the Kardex and will be a tool for new contract staff and for contract staff who may work intermittently at the facility. Also, as another check, the nurse on duty will confirm that all staff knows how to access the Kardex through the kiosk during "huddle", which is a communication meeting that occurs every shift with CNA's and nurses.

On 4/19/22 at 11:35 AM, an interview with LPN #2, MDS nurse, revealed that the CNAs can view the Kardex from the KIOSK for all residents. The Kardex includes information about the resident including the type of lift required for transfers.

Record review of the facility's "Agency Orientation for Certified Nursing Assistants" revealed "Policy and Procedures ...5. Falls 6. Incident and Accidents 7. Resident Lift and Transfer Policy ...Additional Topics ...CNA Documentation - Care Tracker/Kiosk ...". CNA #2 signed the document on 3/1/22 which indicated she received training on the facility's policy for resident lifting and transferring and documentation on the kiosk.

Record review of the contract agency's "Certified Nursing Assistant (CNA) - Skills Checklist" revealed CNA #2 completed a competency

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F 600	Continued From page 9 checklist on 2/18/22 and listed, "Familiar with various assistive devices/techniques ...4.0 Proper use of Hoyer lifts" as an experience level of "5" which indicated she could supervise/train others in the skill. Record review of the facility's "Agency Orientation for Certified Nursing Assistants" revealed "Policy and Procedures ...5. Falls 6. Incident and Accidents 7. Resident Lift and Transfer Policy ...Additional Topics ...CNA Documentation - Care Tracker/Kiosk ..." NA #3 signed the document on 3/7/22, which indicated she received training on the facility's policy for resident lifting and transferring and documentation on the kiosk. Record review of the contract agency's "Certified Nursing Assistant (CNA) - Skills Checklist, revealed NA#3 completed a competency checklist on 2/28/22 and listed "Familiar with various assistive devices/techniques ...4.0 Proper use of Hoyer lifts" as an experience level of "4" which indicated she is proficient in the skill.	F 600		
F 609 SS=G	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if	F 609		5/5/22

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F 609	Continued From page 10 the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interviews, record review and facility policy review, the facility staff failed to report a fall with major injury which occurred during a transfer in which the resident sustained multiple fractures for one (1) of four (4) residents reviewed, Resident #1. Findings include: A record review of the facility's policy "Accidents and Incidents-Investigation and Reporting" with a revised date of 9/21 revealed, "Policy Statement All accidents or incidents involving residents shall be investigated and reported to the Director of Nursing and the Administrator. Policy Interpretation and Implementation ...1. The Nurse Supervisor/Charge Nurse, or License Practical Nurse (LPN) shall promptly initiate and document investigation of the accident or incident by completing an Incident/Accident form in the electronic medical record. This nurse will notify	F 609	Bedford Care Center-Monroe Hall, LLC (facility)acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent of the summary of findings is factually correct and in compliance with applicable rules and regulations. Please accept this Plan of Correction our credible allegation of compliance. On 3/11/2022 at 0830 AM, Resident #1 was noted by Certified Nurse Assistant (CNA) #1, to have bruising to bilateral lower extremities. CNA #1 immediately reported the bruising to Licensed Practical Nurse (LPN) #1. LPN #1 immediately evaluated the resident and notified the Director of Nursing (DON) of the unexplained bruising. At 0900, the DON assessed the resident and confirmed the findings from LPN #1. Investigation	

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F 609	Continued From page 11 the Director of Nursing and Administrator of the incident." A record review of the facility's written investigation revealed that at 8:30 AM on 3/11/22, Resident #1 was noted by Certified Nurse Assistant (CNA) #1 to have bruising to her bilateral lower extremities. CNA #1 immediately reported the bruising to Licensed Practical Nurse (LPN) #1. LPN #1 was unaware of any accident or injury to the resident and immediately evaluated the resident and notified the Director of Nursing (DON). At 9:00 AM, the DON assessed the resident and bruising to bilateral lower extremities and external rotation to the left lower extremity was noted. The resident was stable and in no acute distress. An investigation began immediately after the DON reported her findings to the Administrator 9:05 AM. The Nurse Practitioner (NP) was notified of Resident #1's condition and gave verbal orders to send the resident to the local Emergency Room for evaluation. At 9:20 AM, the resident's Responsible Representative (RR) was notified of the situation and the need to transport the resident to the hospital for evaluation. The Quality Assessment and Assurance Committee (QAC) on 3/11/22 for an emergency meeting. The facility Medical Director and the residents Primary Care Physician were both made aware of the incident and participated in the QAC review via phone conference. The resident subsequently sustained an assisted fall, per CNA #2 and NA #3's written statement review. Also, CNA #2 and NA #3, in separate interviews held with the DON and the Administrator, both stated that the incident was not reported up the chain of command to the resident's primary nurse, nurse manager, or to Administration as per the facility	F 609	began immediately after DON reported her findings to the Administrator, at 0905. The Nurse Practitioner (NP), was notified of the patient condition at 0905 and gave verbal orders to send the resident to the local Emergency Room (ER) for evaluation. At 0920 the resident□s Responsible Representative (RR) was notified of the situation and the need to transport the resident to the hospital for evaluation. The ambulance arrived at the facility at 0930 and at 0945 the resident was loaded onto the ambulance and began transport from the facility to the local ER. All residents have the potential to be affected by the stated deficient practice. On 3/11/2022, an emergency Quality Assessment and Assurance Committee (QAC) meeting was held to discuss findings from the facilities internal investigation of the resident□s injuries. Staff interviews, written statements, electronic medical record review, and video recording review where provided to the QAC. The facility Medical Director and the residents Primary Care Physician were both made aware of the incident and participated in the QAC review via phone conference. After review a Root Cause Analysis (RCA) was conducted and the QAC has determined that contract staff members, CNA #2 and NA #3, did not follow the resident□s plan of care when attempting to transfer the resident nor did they follow the facility policy and procedure as trained and instructed	

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F 609	Continued From page 12	F 609		

policy. CNA #4, also an employee of Contract Agency per written statement, interview, and video recording review, entered the resident's room and noted the resident to be on the floor. CNA #4 failed to notify nursing staff or Administration of the incident but did explain to CNA #2 and NA #3 the requirement to report the incident. CNA #2 and NA #3 were immediately suspended from working in facility, after their interviews were conducted the morning of 3/11/2022.

On 4/13/22 at 1:15 PM, during an interview with the DON, she confirmed Resident #1's fall occurred on 3/10/22 with no one reporting the fall to staff at the facility. Then on 3/11/22 when staff was making rounds, Resident #1 was noticed to have bruising of her lower extremities. The DON verified that Agency staff are trained on the facility's policies and procedures related to incidents and accidents, which includes reporting, and lowering the resident to the floor is an incident should have been reported.

A record review of the facility's written investigation revealed the facility submitted the investigative report to the State Agency (SA) and Attorney General (AG) on 3/11/22 at 9:30 AM.

On 4/14/22 at 9:31 AM, an interview with LPN #1 revealed that she was at work on 3/10/22 during the day shift and no staff mentioned anything about Resident #1 falling or slipping to the floor. On 3/11/22, CNA #1 reported to her that Resident #1 had bruising to both her lower extremities and one leg looked misshaped. LPN #1 assessed the resident and reported her findings immediately to the DON. She confirmed that the CNAs should have reported the fall on 3/10/22 when they through orientation. The resident is to be transferred using a lift but no lift was utilized during a transfer on 3/10/2022 at approx. 1345, per video review and corroborating statements from staff. Also, CNA #2 and NA #3, in separate interviews held with the DON and Administrator, both stated that the incident was not reported up the chain of command to the resident□s primary nurse, nurse manager or to Administration as per facility policy. CNA #2 and NA #3 were immediately suspended from working in Bedford Care Center □ Monroe Hall, LLC after their interviews conducted the morning of 3/11/2022. The employer of CNA #2 and NA #3 was notified via email of the incident and suspension of staff on 3/11/2022.

Upon completion of the QAC review and findings, immediate training of all facility staff began on 3/11/2022 by the Staff Development Nurse. This training included the topic of Abuse and Neglect, Residents Rights, Resident Transfer Policy, and Accident and Injury Reporting. Training of all staff was completed on 3/24/22. On 3/11/2022, the QAC adopted additional steps to ensure all direct care staff who are employed by a staffing agency are completing agency orientation and competencies prior to working in the facility. The person scheduling the agency staff at the facility will alert the DON of any agency staff who have not worked in the facility by placing them on the New Agency Roster. The DON will communicate the need for new agency

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F 609	Continued From page 13 lowered the resident to the floor. On 4/14/22 at 9:58 AM, an interview with CNA #4 revealed that she walked into Resident #1's room and noticed the resident was on the floor next to her bed and CNA #2 and NA #3 were in the room. CNA #4 advised them to notify the supervisor and DON of the accident and they relayed they would. CNA #4 confirmed that both aides stated that the resident didn't fall because they had lowered her to the floor. On 4/14/22 at 11:00 AM, an interview with the Administrator revealed that the accident on Resident #1 occurred on 3/10/22 because both CNAs admitted Resident #1 sustained an assisted fall. The Administrator stated he couldn't believe it had happened and the agency staff should have known that lowering a resident to the floor is considered a fall or incident and they should have reported it. It is his expectation that all resident incidents are reported. Record review of the written statement signed by CNA #2 and dated 3/12/22, revealed, " ...We scooted her to the end and grabbed both side getting onto the floor standing straight ...she began to holler 'My Legs' and bending them going to the floor (sitting on her legs) when we got her lowered to the ground, making sure she didn't fall...We then explained to that she never fell, we lowered her to the floor to keep her from falling because she was complaining about her legs ...On the day of accident, we did not notify the DON and/or staff, because she did not fall, she slipped to the floor." Record review of the written statement signed by NA #3 and dated 3/11/22 revealed, " ...When we	F 609	orientation to the on duty nursing staff. Upon completion of the training the agency staff member will sign an acknowledgement that training was completed and content is understood. Also, the nurse on duty conducting the orientation will sign as a witness that the orientation was completed. The agency orientation content will include but is not limited to Vulnerable Adults Law, Resident□s Rights, Falls, Incidents and Accidents, Resident Lift and Transfer Policy, and CNA Documentation (includes the Kardex or care plan). When possible, the new agency staff will be assigned to a unit with a facility staff CNA to provide extra support and assistance during their first shift worked. The facility interdisciplinary team discusses all incidents and accidents each morning, Monday through Friday, to review the incident or accident and ensure appropriate measures have been put into place to reduce further risk to the resident. This review process was already in place prior to 3/10/2022 and continues to be an ongoing process used to monitor all incidents and accidents to ensure all reportable incidents have been reported to administrative staff, investigated, and reported to the appropriate agencies. This documentation begins with the on duty staff at the time of the incident. This is another step to ensure all reportable incidents have been addressed and reported to the appropriate agencies. Beginning 4/29/2022, the Staff Development nurse or Registered Nurse	

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F 609	Continued From page 14 stood her up all the way she didn ' t stand up she crossed her legs and went down, but she ended up sitting on her knees ...Me and (Proper Name of CNA #2) tuned her onto her right side to get her legs from under her ... have to get her off the floor, we lowered her to the floor, but she didn ' t fall ...We didn't file a fall report and/or tell anyone because we didn't consider it as a fall since we lowered her ..." Record review "Emergency Department (ED) Provider Notes" revealed, " ...3/11/22 patient reportedly fell yesterday, unwitnessed. "Impression" revealed, " ...she is 84-year-old female who was brought to the hospital after a fall. She is found to have left proximal tibial and fibular fracture and right distal femur fracture." Record review "Admission Record" Resident #1 was admitted to the facility on 8/3/18 with diagnoses including Alzheimer's Disease, Periprosthetic Fracture around Internal Prosthetic Right Hip Joint, and Periprosthetic Fracture around Internal Prosthetic Left Hip Joint. Record review of quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/9/22 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 03, which indicated she is severely cognitively impaired, and she required an extensive two-person assist for transfers. Record review of the facility's "Agency Orientation for Certified Nursing Assistants" revealed "Policy and Procedures ...5. Falls 6. Incident and Accidents ..." CNA #2 signed the document on 3/1/22 which indicated she received training on the facility's policy for falls and incidents and	F 609	began conducting random resident transfer observations, 10 times per week for 2 weeks and then 5 times weekly for 2 months ending July 4, 2022. The observer will confirm that staff are able to access the residents care plan on the Kardex, determine the appropriate type of transfer required, access the appropriate equipment as necessary and perform the transfer per policy and procedure. The observations will be documented on the Observation Form. Beginning 4/29/2022, the DON will collect all agency orientation acknowledgement forms weekly to ensure compliance with agency staff orientation. Any variances observed will require immediate correction and training with successful return demonstration of the observed process prior to the staff member being able to return to work. All variances identified will be documented and filed for review. Variances will be submitted to the QAC for review by the Medical Director and the Steering Committee to ensure sustained compliance monthly times 2 months beginning 5/4/2022 and ending July 4, 2022. On 5/5/2022, Bedford Care Center □ Monroe Hall, LLC corrective actions will be completed. On going monitoring, observations, and QAC review will continue for 2 months ending July 4, 2022.	

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F 609	Continued From page 15 accidents. Record review of the facility's "Agency Orientation for Certified Nursing Assistants" revealed "Policy and Procedures ...5. Falls 6. Incident and Accidents ..." NA #3 signed the document on 3/7/22, which indicated she received training on the facility's policy for falls and incidents and accidents.	F 609		
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.	F 656		5/5/22

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F 656	Continued From page 16 (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 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 staff interview, record review and facility policy review, the facility failed to ensure a resident's care plan was implemented related to the use of an assistive device when a resident sustained multiple fractures during a transfer for one (1) of four (4) residents care plans reviewed. Resident #1. Findings include: A record review of the facility's policy "Care Plans-Comprehensive", with a revised date of January 2013 revealed, "Policy Statement, an individual Comprehensive Person-Centered Care Plan that includes measurable objectives and timetable to meet the resident's medical, nursing, mental and psychological needs is developed for each resident." "Policy Interpretation and Implementation" revealed, " ...1. Our facility Care Planning/Interdisciplinary Team, attending physician, registered nurse responsible for the resident, nurse aide responsible for the resident in coordination with the resident, his/her family or	F 656	Bedford Care Center-Monroe Hall, LLC (facility)acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent of the summary of findings is factually correct and in compliance with applicable rules and regulations. Please accept this Plan of Correction our credible allegation of compliance. On 3/11/2022 at 0830 AM, Resident #1 was noted by Certified Nurse Assistant (CNA) #1, to have bruising to bilateral lower extremities. CNA #1 immediately reported the bruising to Licensed Practical Nurse (LPN) #1. LPN #1 immediately evaluated the resident and notified the Director of Nursing (DON) of the unexplained bruising. At 0900, the DON assessed the resident and confirmed the findings from LPN #1. Investigation began immediately after DON reported her findings to the Administrator, at 0905.	

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F 656	Continued From page 17 representative (sponsor), develops and maintains a comprehensive person-centered care plan for each resident that identifies the highest level of functioning the resident may be expected to attain." Record review of the Admission Record Resident #1 was admitted to the facility on 8/3/18 with diagnoses including Alzheimer's Disease and Dementia. Record review of quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/9/22 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 03, which indicated she is severely cognitively impaired, and she required an extensive two-person assist for transfers. Record review of Resident #1 "Care Plan" initiated 11/12/19 revealed, "Problem The resident has an ADL (activities of daily living) self-care performance deficit related to Alzheimer's Dementia...Interventions/Task ...TRANSFER: the resident requires mechanical STAND UP lift (medium belt-blue straps) with times 2 (X2) staff extensive assistance X2 for transfers..." Record review of Resident #1 "Visual/Bedside Kardex Report" as of 3/1/2022, revealed the resident required the use of a mechanical stand-up lift (medium belt-blue straps) with two staff extensive assistance for transfers at the time of the fall. Record review of the written statement signed by CNA #2 and dated 3/12/22 revealed, " ...We did not use the total lift because we was told she	F 656	The Nurse Practitioner (NP), was notified of the patient condition at 0905 and gave verbal orders to send the resident to the local Emergency Room (ER) for evaluation. At 0920 the resident□s Responsible Representative (RR) was notified of the situation and the need to transport the resident to the hospital for evaluation. The ambulance arrived at the facility at 0930 and at 0945 the resident was loaded onto the ambulance and began transport from the facility to the local ER. All residents have the potential to be affected by the stated deficient practice. On 3/11/2022, an emergency Quality Assessment and Assurance Committee (QAC) meeting was held to discuss findings from the facilities internal investigation of the resident□s injuries. Staff interviews, written statements, electronic medical record review, and video recording review where provided to the QAC. The facility Medical Director and the residents Primary Care Physician were both made aware of the incident and participated in the QAC review via phone conference. After review a Root Cause Analysis (RCA) was conducted, all transfer care plans were reviewed by the Minimum Data Set (MDS) nurse on 3/11/2022, and the QAC determined that contract staff members, CNA #2 and NA #3, did not follow the resident□s plan of care when attempting to transfer the resident nor did they follow the facility policy and procedure as trained and	

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F 656	Continued From page 18 could stand ...We scooted her to the end and grabbed both side getting onto the floor standing straight ...she began to holler 'My Legs' and bending them going to the floor (sitting on her legs) when we got her lowered to the ground, making sure she didn't fall..." Record review of the written statement signed by NA #3 and dated 3/11/22 revealed, " ...After the shower I asked (Proper Name of CNA #2) to assist me with transferring her since the nurse had said she could stand up ...When we stood her up all the way she didn't stand up she crossed her legs and went down, but she ended up sitting on her knees ...Me and (Proper Name of CNA #2) tuned her onto her right side to get her legs from under her ..." On 4/13/22 at 1:15 PM, during an interview with the DON, she confirmed agency staff are trained when they come to the facility on how to read the resident's Kardex on the kiosk which is where the care plan interventions are located. She agreed it is very important for staff to follow the Care Plan/Kardex related to how to transfer a resident to avoid injuries. She also confirmed CNA #2 and NA #3 did not follow Resident #1's ADL care plan when they transferred her without using the stand-up lift. On 4/14/22 at 11:00 AM, an interview with the Administrator confirmed that CNA #2 and NA #3 did not follow the care plan on transferring Resident #1 when the fall occurred because they did not use the stand-up lift. His expectation is that all staff will follow the care plan. On 4/19/22 at 11:35 AM, an interview with LPN #2, MDS nurse revealed that she expects the	F 656	instructed through orientation. The resident is to be transferred using a lift but no lift was utilized during a transfer on 3/10/2022 at approx. 1345, per video review and corroborating statements from staff. CNA #2 and NA #3 were immediately suspended from working in Bedford Care Center □ Monroe Hall, LLC after their interviews conducted the morning of 3/11/2022. The employer of CNA #2 and NA #3 was notified via email of the incident and suspension of staff on 3/11/2022. Upon completion of the QAC review and findings, immediate training of all facility staff began on 3/11/2022 by the Staff Development Nurse. This training included the topic of Abuse and Neglect, Residents Rights, Resident Transfer Policy, and Accident and Injury Reporting. Training of all staff was completed on 3/24/22. On 3/11/2022, the QAC adopted additional steps to ensure all direct care staff who are employed by a staffing agency are completing agency orientation and competencies prior to working in the facility. The person scheduling the agency staff at the facility will alert the DON of any agency staff who have not worked in the facility by placing them on the New Agency Roster. The DON will communicate the need for new agency orientation to the on duty nursing staff. Upon completion of the training the agency staff member will sign an acknowledgement that training was completed and content is understood. Also, the nurse on duty conducting the	

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F 656	Continued From page 19 staff to follow the care plan/Kardex to prevent injuries and she confirmed that CNA #2 and NA #3 did not follow the resident's care plan when they transferred Resident #1 without using the stand-up lift.	F 656	orientation will sign as a witness that the orientation was completed. The agency orientation content will include but is not limited to Vulnerable Adults Law, Resident□s Rights, Falls, Incidents and Accidents, Resident Lift and Transfer Policy, and CNA Documentation (includes the Kardex or care plan). When possible, the new agency staff will be assigned to a unit with a facility staff CNA to provide extra support and assistance during their first shift worked. Beginning 4/29/2022, the Staff Development nurse or Registered Nurse began conducting random resident transfer observations, 10 times per week for 2 weeks and then 5 times weekly for 2 months ending July 4, 2022. The observer will confirm that staff are able to access the residents care plan on the Kardex, determine the appropriate type of transfer required, access the appropriate equipment as necessary and perform the transfer per policy and procedure. The observations will be documented on the Observation Form. Beginning 4/29/2022, the DON will collect all agency orientation acknowledgement forms weekly to ensure compliance with agency staff orientation. Any variances observed will require immediate correction and training with successful return demonstration of the observed process prior to the staff member being able to return to work. All variances identified will be documented and filed for review. Variances will be submitted to the QAC for review by the Medical Director and the Steering	

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F 656	Continued From page 20	F 656	Committee to ensure sustained compliance monthly times 2 months beginning 5/4/2022 and ending July 4, 2022. On 5/5/2022, Bedford Care Center □ Monroe Hall, LLC corrective actions will be completed. On going monitoring, observations, and QAC review will continue for 2 months ending July 4, 2022.	
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to ensure an assistive device was used during a transfer, causing a resident to be lowered to the floor by staff which caused multiple fractures for one (1) of four (4) residents sampled. Resident #1 (See F600 for additonal information.) Findings include: A record review of the facility's policy "Safe Transfer and Lifting of Residents" with a revised date of 09/2013 revealed "Policy Statement In order to protect the safety and well-being of staff	F 689	Bedford Care Center-Monroe Hall, LLC (facility)acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent of the summary of findings is factually correct and in compliance with applicable rules and regulations. Please accept this Plan of Correction our credible allegation of compliance. On 3/11/2022 at 0830 AM, Resident #1 was noted by Certified Nurse Assistant (CNA) #1, to have bruising to bilateral lower extremities. CNA #1 immediately	5/5/22

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F 689	Continued From page 21 and residents, and to promote quality care, this facility uses appropriate techniques and devices to lift and move residents. Policy Interpretation and Implementation ...II. Assessment Guidelines ...10. Nursing staff, in conjunction with the rehabilitation staff, shall assess individual residents' needs for transfer assistance ...13. Transfer assessments will be documented in the resident's care plan and in the resident's profile in the KIOSK ..." A record review of the facility's written investigation revealed that at 8:30 AM on 3/11/22, Resident #1 was noted by Certified Nurse Assistant (CNA) #1 to have bruising to her bilateral lower extremities. CNA #1 immediately reported the bruising to Licensed Practical Nurse (LPN) #1. LPN #1 was unaware of any accident or injury to the resident and immediately evaluated the resident and notified the Director of Nursing (DON). At 9:00 AM, the DON assessed the resident and bruising to bilateral lower extremities and external rotation to the left lower extremity was noted. The resident was stable and in no acute distress. An investigation began immediately after the DON reported her findings to the Administrator 9:05 AM. The Nurse Practitioner (NP) was notified of Resident #1's condition and gave verbal orders to send the resident to the local Emergency Room (ER) for evaluation. At 9:20 AM, the resident's Responsible Representative (RR) was notified of the situation and the need to transport the resident to the hospital for evaluation. The RR agreed that the resident needed to be evaluated and the ambulance service was notified of the need for patient transportation to the Emergency Room. The ambulance arrived at the facility at 9:30 AM and at 0945 9:45 AM, the resident was	F 689	reported the bruising to Licensed Practical Nurse (LPN) #1. LPN #1 immediately evaluated the resident and notified the Director of Nursing (DON) of the unexplained bruising. At 0900, the DON assessed the resident and confirmed the findings from LPN #1. Investigation began immediately after DON reported her findings to the Administrator, at 0905. The Nurse Practitioner (NP), was notified of the patient condition at 0905 and gave verbal orders to send the resident to the local Emergency Room (ER) for evaluation. At 0920 the resident□s Responsible Representative (RR) was notified of the situation and the need to transport the resident to the hospital for evaluation. The ambulance arrived at the facility at 0930 and at 0945 the resident was loaded onto the ambulance and began transport from the facility to the local ER. All residents have the potential to be affected by the stated deficient practice. On 3/11/2022, an emergency Quality Assessment and Assurance Committee (QAC) meeting was held to discuss findings from the facilities internal investigation of the resident□s injuries. Staff interviews, written statements, electronic medical record review, and video recording review where provided to the QAC. The facility Medical Director and the residents Primary Care Physician were both made aware of the incident and participated in the QAC review via phone conference. After review a Root Cause	

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F 689	Continued From page 22 loaded into the ambulance and began transport from the facility to the local Emergency Room. The Quality Assessment and Assurance Committee (QAC) on 3/11/22 for an emergency meeting. The facility Medical Director and the residents Primary Care Physician were both made aware of the incident and participated in the QAC review via phone conference. After reviewing a Root Cause Analysis (RCA) was conducted and the QAC has determined that Contract Agency staff members CNA #2 and NA #3, did not follow the residents plan of care when attempting to transfer the resident. The resident is to be transferred using a lift, but no lift was utilized during a transfer on 3/10/2022 at approximately 1:45 PM, per video review and corroborating statements from staff. The resident subsequently sustained an assisted fall, per CNA #2 and NA #3's written statement review. Also, CNA #2 and NA #3, in separate interviews held with the DON and the Administrator, both stated that the incident was not reported up the chain of command to the resident's primary nurse, nurse manager, or to Administration as per the facility policy. CNA #4, also an employee of the Contract Agency per written statement, interview, and video recording review, entered the resident's room and noted the resident to be on the floor. CNA #4 failed to notify nursing staff or Administration of the incident but did explain to CNA #2 and NA #3 the requirement to report the incident. CNA #2 and NA #3 were immediately suspended from working in facility, after their interviews were conducted the morning of 3/11/2022. Record review of the written statement signed by CNA #2 and dated 3/12/22 revealed, " ...Nurse (Proper Name) entered the room and told (Proper	F 689	Analysis (RCA) was conducted and the QAC has determined that contract staff members, CNA #2 and NA #3, did not follow the resident□s plan of care when attempting to transfer the resident nor did they follow the facility policy and procedure as trained and instructed through orientation. The resident is to be transferred using a lift but no lift was utilized during a transfer on 3/10/2022 at approx. 1345, per video review and corroborating statements from staff. CNA #2 and NA #3 were immediately suspended from working in Bedford Care Center □ Monroe Hall, LLC after their interviews conducted the morning of 3/11/2022. The employer of CNA #2 and NA #3 was notified via email of the incident and suspension of staff on 3/11/2022. Upon completion of the QAC review and findings, immediate training of all facility staff began on 3/11/2022 by the Staff Development Nurse. This training included the topic of Abuse and Neglect, Residents Rights, Resident Transfer Policy, and Accident and Injury Reporting. Training of all staff was completed on 3/24/22. On 3/11/2022, the QAC adopted additional steps to ensure all direct care staff who are employed by a staffing agency are completing agency orientation and competencies prior to working in the facility. The person scheduling the agency staff at the facility will alert the DON of any agency staff who have not worked in the facility by placing them on the New Agency Roster. The DON will	

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F 689	Continued From page 23 Name of NA #3) she could have used the stand up lift because she could stand ...I went back to help her get dressed and be put back to bed. We did not use the total lift because we was told she could stand ...We scooted her to the end and grabbed both side getting onto the floor standing straight ...she began to holler 'My Legs' and bending them going to the floor (sitting on her legs) when we got her lowered to the ground, making sure she didn't fall..." Record review of the written statement signed by NA #3 and dated 3/11/22 revealed, " ...I asked (Proper Name of CNA #2) to go get the shower bed because another aide had told me she was total ...assisted me with the lift in the process of it a nurse ...walked in and said 'You don't have to use the total lift she can stand up they normally put her in the chair to bath' ...After the shower I asked (Proper Name of CNA #2) to assist me with transferring her since the nurse had said she could stand up ...When we stood her up all the way she didn't stand up she crossed her legs and went down, but she ended up sitting on her knees ...Me and (Proper Name of CNA #2) tuned her onto her right side to get her legs from under her ..." Record review "Emergency Department (ED) Provider Notes" revealed, " ...3/11/22 patient reportedly fell yesterday, unwitnessed. "Impression" revealed, " ...she is 84-year-old female who was brought to the hospital after a fall. She is found to have left proximal tibial and fibular fracture and right distal femur fracture." On 4/14/22 at 1:00 PM, the State Agency (SA) observed video surveillance recorded on 3/10/22 at 1:45 PM, that revealed CNA #2 and NA #3	F 689	communicate the need for new agency orientation to the on duty nursing staff. Upon completion of the training the agency staff member will sign an acknowledgement that training was completed and content is understood. Also, the nurse on duty conducting the orientation will sign as a witness that the orientation was completed. The agency orientation content will include but is not limited to Vulnerable Adults Law, Resident□s Rights, Falls, Incidents and Accidents, Resident Lift and Transfer Policy, and CNA Documentation (includes the Kardex or care plan). When possible, the new agency staff will be assigned to a unit with a facility staff CNA to provide extra support and assistance during their first shift worked. Beginning 4/29/2022, the Staff Development nurse or Registered Nurse began conducting random resident transfer observations, 10 times per week for 2 weeks and then 5 times weekly for 2 months ending July 4, 2022. The observer will confirm that staff are able to access the residents care plan on the Kardex, determine the appropriate type of transfer required, access the appropriate equipment as necessary and perform the transfer per policy and procedure. The observations will be documented on the Observation Form. Beginning 4/29/2022, the DON will collect all agency orientation acknowledgement forms weekly to ensure compliance with agency staff orientation. Any variances observed will require immediate correction and training with	

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F 689	Continued From page 24 walking in the hallway with Resident #1 on the shower bed. They entered the resident's room and did not take the mechanical lift into the resident's room. The mechanical lift was noted to be in the hallway the entire time they were in the resident's room. CNA #4 went into the room and exited. CNA #2 and NA #3 were in the resident's room for seven (7) minutes before exiting the room with the empty shower bed. Record review of the "Admission Record" revealed Resident #1 was admitted to the facility on 8/3/18 with diagnoses including Alzheimer's Disease, Periprosthetic Fracture around Internal Prosthetic Right Hip Joint, and Periprosthetic Fracture around Internal Prosthetic Left Hip Joint. Record review of quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/9/22 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 03, which indicated she is severely cognitively impaired, and she required an extensive two-person assist for transfers. Record review of Resident #1 "Visual/Bedside Kardex Report" as of 3/1/2022 revealed the resident required the use of a mechanical stand-up lift (medium belt-blue straps) with two staff extensive assistance for transfers at the time of the fall. Record review of Resident #1's "Progress Note" revealed a nurses note written by the DON with an effective date of 3/11/22 at 9:00 AM, "Primary nurse stated to myself, "I need to tell you something." Nurse proceeded to tell me that a CNA had reported an injury to her LPN, when assessed elder lower extremities noted with	F 689	successful return demonstration of the observed process prior to the staff member being able to return to work. All variances identified will be documented and filed for review. Variances will be submitted to the QAC for review by the Medical Director and the Steering Committee to ensure sustained compliance monthly times 2 months beginning 5/4/2022 and ending July 4, 2022. On 5/5/2022, Bedford Care Center □ Monroe Hall, LLC corrective actions will be completed. On going monitoring, observations, and QAC review will continue for 2 months ending July 4, 2022.	

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extensive bruising purple and reddish in color, left leg noted to be externally rotated, elder not voice pain at this time, notified RN (Registered Nurse) unit manager to call NP and RR".

Record review of Resident #1's "Progress Note" revealed a nurses note by RN #1 with an effective date of 3/11/22 at 9:16 AM, "Entered resident's room and noted bruising to BLE (Bilateral Lower Extremity). Also noted gross deformity to LLE (Left Lower Extremity) distal knee. (Proper Name of Nurse Practitioner) notified. New order to transfer to (Proper Name of Local Hospital) ER for evaluation".

On 4/13/22 at 10:40 AM, an interview with LPN #2 revealed that on 3/10/22, she walked into Resident #1's room and saw CNA #2 and NA #3 using a full body mechanical lift to transfer the resident from her bed to the shower stretcher. She explained to them that Resident #1 was to be transferred with a stand-up lift and to let her know when they transferred her back to bed and she would give them assistance. The CNAs did not request her help to get Resident #1 back to bed and she had no idea the resident had been assisted to the floor during the transfer back to bed until the next morning. LPN #2 stated that all staff and agency CNAs are instructed to use the computer system so they may see the care plans and Kardex on each resident, for which type of lifts to use, and care that is required for residents.

On 4/13/22 at 1:15 PM, during an interview with the DON, she confirmed the fall related to Resident #1 occurred on 3/10/22 with no one reporting it to the appropriate staff at the time the event occurred. Then on 3/11/22 when staff were making rounds, Resident #1 had bruising of her

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lower extremities and she was immediately sent to the local ER and the facility began an investigation. Contract staff are trained when they come to the facility on how to read the resident's Kardex on the kiosk. She agreed it is very important for staff to follow the Kardex related to how to transfer a resident to avoid injuries.

On 4/14/22 at 9:58 AM in an interview with CNA #4, she stated that she walked into Resident #1's room to obtain the shower bed and noticed the resident was on the floor next to her bed, with CNA #2 and NA #3 in the room with her. There was no mechanical lift in room. CNA #2 and NA #3 informed CNA #4 that when they were transferring the resident from the shower bed to her bed, her legs went weak, and they slid her to the floor. CNA #4 assisted CNA #2 and NA #3 in transferring the resident from the floor to her bed and advised them to notify the supervisor and the DON of the accident. The CNA's agreed they would, and CNA #4 went to go take care of her residents. CNA #4 said that she really assumed they notified their nurse and DON. She confirmed that she was trained when she came to work at the facility on how to look at the kiosk to see how a resident should be transferred.

On 4/14/22 at 11:00 AM, an interview with the Administrator revealed Resident #1's fall occurred on 3/10/22 and both CNA #2 and NA #3 admitted they had lowered her to the floor and did not use the mechanical lift while transferring her from the shower bed to her bed. CNA #2 and NA #3 were suspended
immediately and not allowed to work at the facility. The facility held a QAC meeting and in-services were completed for all facility and

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agency staff on the topics of abuse, neglect, use of mechanical lifts, and the reporting of incidents. The Administrator confirmed all staff are trained on how to transfer a resident and to look at the resident's care plan or Kardex to find out how a resident is to be transferred.

On 4/14/22 at 11:30 AM, an interview with Contract Agency Representative #1 revealed that the contract agency completes reference checks and background checks on their staff and conducts a CNA skills evaluation. Each facility has the obligation to orientate the contract staff to their facility.

On 4/18/22 at 3:00 PM, during an interview with the DON, she explained the facility implemented additional steps in the orientation process for agency staff. When the Scheduler schedules an agency staff member that has never worked at the facility, the Scheduler will alert the DON to ensure orientation training is conducted for the agency staff member explaining policies and procedures. The agency staff will sign acknowledgement of receiving the education and this will be completed prior to the agency staff providing any direct resident care. When at all possible, the agency staff who is new to the facility will be assigned to a unit in which facility staff are also assigned to provide extra support and assistance during their first shift worked. The contract staff member will receive specific training and sign an acknowledgment (located in a binder at each nurse's station) on how to access a resident's Kardex which will provide information on how to care for the resident, including the type of transfer required. The binders will be readily available at the nurse's station with step-by-step instruction on accessing the Kardex and will be a

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tool for new contract staff and for contract staff who may work intermittently at the facility. Also, as another check, the nurse on duty will confirm that all staff knows how to access the Kardex through the kiosk during "huddle", which is a communication meeting that occurs every shift with CNA's and nurses.

On 4/19/22 at 11:35 AM, an interview with LPN #2, MDS nurse, revealed that the CNAs can view the Kardex from the KIOSK for all residents. The Kardex includes information about the resident including the type of lift required for transfers.

Record review of the facility's "Agency Orientation for Certified Nursing Assistants" revealed "Policy and Procedures ...5. Falls 6. Incident and Accidents 7. Resident Lift and Transfer Policy ...Additional Topics ...CNA Documentation - Care Tracker/Kiosk ...". CNA #2 signed the document on 3/1/22 which indicated she received training on the facility's policy for resident lifting and transferring and documentation on the kiosk.

Record review of the contract agency's "Certified Nursing Assistant (CNA) - Skills Checklist" revealed CNA #2 completed a competency checklist on 2/18/22 and listed, "Familiar with various assistive devices/techniques ...4.0 Proper use of Hoyer lifts" as an experience level of "5" which indicated she could supervise/train others in the skill.

Record review of the facility's "Agency Orientation for Certified Nursing Assistants" revealed "Policy and Procedures ...5. Falls 6. Incident and Accidents 7. Resident Lift and Transfer Policy ...Additional Topics ...CNA Documentation - Care Tracker/Kiosk ..." NA #3 signed the document on

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F 689	Continued From page 29 3/7/22, which indicated she received training on the facility's policy for resident lifting and transferring and documentation on the kiosk. Record review of the contract agency's "Certified Nursing Assistant (CNA) - Skills Checklist, revealed NA#3 completed a competency checklist on 2/28/22 and listed "Familiar with various assistive devices/techniques ...4.0 Proper use of Hoyer lifts" as an experience level of "4" which indicated she is proficient in the skill.	F 689		