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	255110	A. BUILDING _____ B. WING _____	03/31/2022

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MS CARE CENTER OF ALCORN COUNTY, INC-SNF	3701 JOANNE DRIVE CORINTH, MS 38834

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey at the facility from 03/28/22 through 03/31/22 along with Complaint Investigations (CI) MS00018373, MS00018327, MS00017878 and MS00017936. During the survey the SA found that the facility was not in compliance with Medicare and Medicaid regulations. The SA cited F689 related to a fall from a mechanical lift and F880 for infection control on the annual survey. MS00017878, MS00017936, MS00018373, and MS00018327 were not substantiated. The facility held a license for 106 beds and had a census of 84.	F 000		
F 689 SS=D	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 resident and staff interview, facility policy review and record review the facility failed to ensure that a resident was free from falls during a transfer for one (1) of three (3) fall investigations reviewed. Resident #22. Findings include: A review of facility policy titled "Modified Lifting Policy", undated, revealed, "(Proper name of	F 689	F689 1) Resident #22 suffered no negative effects from the improper use of the lift. Certified Nursing Assistant #3, Certified Nursing Assistant #4, and Certified Nursing Assistant #5 were in-serviced on the proper placement of the Vander Lift Sling Straps by the Director of Nursing on 1/26/22 and 04/20/22. 2) All residents who require Vander lift	5/20/22

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

Electronically Signed | 04/22/2022

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F 689	Continued From page 1 facility) will provide a safe work environment for resident care areas by providing and requiring the use of safety materials, equipment, and training designed to prevent personnel and resident injury." Record review of the "Proper Name" Skilled and Look Back Documentation dated 1/26/22, revealed that Resident #22 sustained a fall from a mechanical lift during transfer. An interview on 03/28/22 at 11:55 AM, with Resident #22 revealed she had a fall from the lift when being moved. She stated the staff was moving her in the lift and she was dropped on the floor. She stated she was sent to the hospital and returned to the facility. An interview on 3/30/22 at 12:00 PM, with the Director of Nursing revealed Resident #22 had a fall from the lift and the incident occurred when the staff did not cross the lift pad's straps on the Vandergard lift and the resident slid through the opening between the two straps. She stated the resident landed on her knees and did not hit her head. She revealed there was a miscommunication and misinterpretation of the technique for using the lift and pad. She stated the Certified Nursing Assistant (CNA) Supervisor (CNA #5) had told the CNAs to not cross the straps and when telling this she was meaning the loop straps on the pad, not the two long pad straps that support the resident, but CNA #3 and CNA #4 misunderstood and thought she meant the pad straps, so they did not cross and the resident slid through. An interview on 3/31/22 at 10:25 AM, with CNA #3 revealed Resident #22 was in the bed and	F 689	transfers have the potential to be affected. 3) A step by step “Vander Lift Check Off “was developed on 04/20/22 by the Director of Nursing and the Assistant Director of Nursing utilizing Manufacturer’s instruction. The Staff Development Coordinator initiated education on 04/20/2022 “Vander”, related to using the Vander lift to transfer Residents. A completion rate of 100% was achieved by 04/22/2022. Vander Lift Check-Offs by the Director of Nurses, Assistant Director of Nursing and Quality Assurance Nurse, were initiated with Nursing Staff on 04/20/2022 and completed on 4/26/22 to ensure proper placement of Vander Lift Sling Straps. “Vander Lift Check Off “will be conducted on hire and annually. 4) A Quality Assurance Committee meeting was conducted 4/4/2022 at 9:00AM to 9:25AM to review the possible deficiencies relayed during the exit with Surveyors. Beginning the week of 04/20/2022, the Quality Assurance Nurse will audit four (4) Vander Lift transfers weekly times four (4) weeks, followed by monthly for three (3) months, then quarterly ongoing using Vander lift Transfer Audit to validate proper procedure/technique. Audit findings will be brought to the Quality Assurance and Performance Improvement Coordinator weekly upon completion. The Quality Assurance and Performance Improvement Coordinator will make report monthly to the Quality Assessment and	

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F 689	Continued From page 2 they were going to transfer her to the chair for therapy. She stated she and CNA #4 were at the bedside and they discussed whether or not the proper procedure was to cross the straps and they thought they were instructed not to cross them and this led to the accident. She stated they lifted the resident and had begun swinging her around and she was still above the bed, but she slipped through the opening and landed on the floor on her knees but she did not hit her head. She stated the resident was sent to the emergency room for evaluation and returned to the facility without injury. She stated "we did the wrong thing and learned the hard way" on proper use. She stated she had been in-serviced and had used the lift before without incident but this time they "made a mistake and did it the wrong way." A phone interview on 3/31/22 at 12:05 PM, with the CNA Supervisor (CNA #5) revealed she did not witness the incident, but had trained CNAs on the proper technique to use the lift. She stated they were trained to use the pad underneath the resident with the pad legs crossed and are instructed to position the resident in a seating type position during lift. She stated two staff members are required for lift use. She stated once the lift pad with crossed leg pads is in place, the pad is attached to the lift and the resident is lifted and transferred to the chair. She stated the crossed legs of the sling pad prevents the resident from sliding through and prevents shearing, tearing, or pinching of resident's skin. She stated she was told that CNA #3 and CNA #4 misunderstood the instructions. She stated they were trained before and after incident. A phone interview on 3/31/22 at 12:28 PM, with	F 689	Assurance Committee beginning 05/18/2022, and monthly ongoing. The Quality Assurance Committee will review findings and make recommendations and changes as needed to ensure continued compliance.	

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F 689	Continued From page 3	F 689		

CNA #4 revealed she and CNA #3 were in Resident #22's room to get her up for therapy. She stated they were both at the lift and they put the pad under the resident without the pad legs crossed. She stated they lifted the resident off of the bed and as they were about to rotate to put her in chair, the resident slid through the opening. She stated the resident caught herself with her arms and landed on her knees. The resident was sent to the emergency room to be checked and she did not have an injury. She stated she was trained before and after the incident.

An interview on 3/31/22 at 2:45 PM, with the DON confirmed the facility failed to ensure the safety of the resident during a lift transfer due to improper training. She confirmed the resident could have sustained an injury due to the improper lift technique used.

A record review of an in-service titled, "CNA - Safely Moving Residents - Lifting and Transferring", dated 11/17/2021 and an in-service titled "Mechanical Lifts" dated 11/23/2021 revealed CNA #3 and CNA #5 Supervisor attended these. A record review of "CNA/Student Clinical Skills Check Off" revealed CNA #4 completed skill check off for "Transfer Using Vander Lift" on 12/14/2021.

A record review of Resident #22's Facesheet list of diagnoses include Nontraumatic Subarachnoid Hemorrhage, Cerebral Infarction, Hemiplegia and Hemiparesis following Nontraumatic Intracerebral Hemorrhage affecting right dominant side, Hypertension.

A record review of the most recent Minimum Data Set (MDS) Section C dated 1/13/22, revealed the

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F 689	Continued From page 4 resident had a Brief Interview for Mental Status (BIMS) score of 12, indicating the resident was mildly impaired cognitively.	F 689		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be	F 880		5/20/22

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F 880	Continued From page 5 reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and facility policy review the facility failed to maintain proper placement of a urinary catheter bag (Resident #18) and perform medication administration utilizing proper hand hygiene to prevent the possible spread of infection for three	F 880	F-880 1) Resident #18's indwelling catheter bag was re-positioned to ensure the bag was positioned below the bladder, off the floor, and the emptying spout was clamped and secured in its cover. Resident #18	

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F 880	Continued From page 6 (3) of four (4) days of survey. Findings include: Review of the facility policy titled, "Handwashing/Hand Hygiene - F880," undated, revealed, "Policy Statement - This facility considers hand hygiene the primary means to prevent the spread of infections. Policy interpretation and implementation... 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors... 7. Use an alcohol-based hand hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations:... b. Before and after direct contact with residents; c. Before preparing or handling medications... p. Before and after assisting a resident with meals;..." Resident #18 An observation on 03/28/22 at 3:00 PM, revealed Resident #18's bed in low position. The foley catheter drainage bag was hanging on the right side of the bed with the emptying spout clamped but not secured in it's cover. The spout was laying on the floor. An observation on 03/30/22 at 9:30 AM, revealed Resident #18's bed in low position. The foley catheter drainage bag was hanging on the right side of the bed but laying on the floor. The spout was clamped and secured in it's cover. An interview on 3/30/22 at 10:20 AM, with	F 880	suffered no negative effects. Certified Nursing Assistant #1 was in-serviced on 03/31/2022 by the Staff Development Coordinator to ensure the indwelling catheter bag was positioned below the bladder, off the floor, and the emptying spout was clamped and secured in its cover. Licensed Practical Nurse #1 was in-serviced 03/29/22 by the Staff Development Coordinator on utilizing proper hand hygiene to perform medication administration 2) All residents with indwelling catheters have the potential to be affected. All residents who receive medications have the potential to be affected by improper hand hygiene. 3) Nursing Staff were in-serviced on 03/31/2022 by the Staff Development Coordinator to ensure the indwelling catheter bag was positioned below the bladder, off the floor, and the emptying spout was clamped and secured in its cover. Licensed Nursing Staff were assigned, “Indwelling Urinary Catheters-https://www.train.org/cdctrain/course/1081809/” on 04/18/22 by the Staff Development Coordinator, with a completion date of 04/22/22. Staff Development Coordinator began education of the Nursing Staff 04/20/22 regarding proper placement of indwelling catheter bags being below the bladder, not resting on the floor, and emptying spouts being clamped and secured in its cover on, with a completion date of 04/20/22. A Root Cause Analysis was	

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F 880	Continued From page 7 Certified Nursing Assistant (CNA) #1 revealed that she did not know about foley catheter bag care. She also revealed that in-service information was sent out a couple days ago about catheters but she had not looked at it. An interview on 3/30/22 at 10:25 AM, with Licensed Practical Nurse (LPN) #2 revealed that she stated the catheter bag needs to be in the bag cover at all times and not on the floor. She stated that the catheter bag being on the floor could cause infection. An interview on 3/31/22 at 9:10 AM, with Licensed Practical Nurse (LPN) #3, Staff Development Nurse, revealed that leaving a catheter bag on the floor is a big infection control problem. An interview on 3/31/22 at 9:15 AM, with Director of Nursing (DON) revealed the foley catheter bag should not be on the floor because this would be a big infection control issue. An interview on 3/31/22 at 10:28 AM, with DON revealed that it does not matter if the foley catheter bag is inside the black privacy bag, it should not be touching the floor. An interview on 3/31/22 at 10:30 AM, with LPN #3 revealed that the facility policy does not specifically state that catheter bags should remain off of the floor, but revealed the staff are instructed to keep foley catheter bags in privacy bags and off of the floor. An interview on 3/31/22 at 10:35 AM, with Certified Nursing Assistant (CNA) #2 revealed that foley catheter bags should be kept below the	F 880	done on proper positioning of catheter bags on 04/18/2022 and completed on 04/19/2022 by the Administrator, Director of Nursing, Assistant Director of Nursing, Quality Assurance Performance Improvement Coordinator, Infection Preventionist, Staff Development Coordinator, Quality Assurance Nurse. On 04/18/22 All Staff were assigned, “Clean Hands-https://youtube/xmYMUly7qiE” by the Staff Development Coordinator, with a completion date of 04-22-22. The Director of Nursing, Assistant Director of Nursing and Infection Preventionist initiated the Infection Control Medication Administration Audits beginning on 04/19/22, with a completion date of 04/22/2022. A Root Cause Analysis was done on proper hand hygiene on 04/18/2022 and completed on 04/19/2022 by the Administrator, Director of Nursing, Assistant Director of Nursing, Quality Assurance Performance Improvement Coordinator, Infection Preventionist, Staff Development Coordinator, Quality Assurance Nurse. 4) A Quality Assurance Committee meeting was conducted 4/4/2022 at 9:00AM to 9:25AM to review the possible deficiencies relayed during the exit with Surveyors. Audits were done using the Foley Catheter Audit starting on 4/20/22, and will be done weekly for four weeks, then monthly for three months, then quarterly ongoing, by the Quality Assurance Nurse to ensure proper	

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F 880	Continued From page 8 waist and always in a black privacy bag to keep from touching the floor. Record review, of "C.N.A./STUDENT CLINICAL SKILLS CHECK OFF Non-Invasive Procedures" revealed that CNA #1 performed a check off on 2/14/22 which included "#11. Catheter care, tubing placement, leg strap, privacy bag." Record review of Resident #18's Facesheet revealed she was admitted to the facility on 02/11/2000 with diagnoses including Cerebral Infarction and Neuromuscular dysfunction of bladder. Record review of Resident #18's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/07/22 revealed a Brief Interview for Mental Status (BIMS) score of 99 indicating the resident was unable to participate in the BIMS. An observation on 03/29/22 at 08:38 AM, revealed Licensed Practical Nurse (LPN) #1 failed to wash her hands or use hand sanitizer properly, as evidenced by placing hand sanitizer on the palm of her hand and rubbing her palms	F 880	placement of urinary catheter bag positioned below the bladder, off the floor, and the emptying spout clamped and secured in its cover. Audit findings will be brought to the Quality Assurance and Performance Improvement Coordinator weekly upon completion. Audits began on 4/20/22 and will be done weekly for four weeks, then monthly for three months, then quarterly ongoing, by the Infection Preventionist to ensure proper hand hygiene during medication administration. Audit findings will be brought to the Quality Assurance and Performance Improvement Coordinator weekly upon completion. The Quality Assurance and Performance Improvement Coordinator will make reports monthly to the Quality Assessment and Assurance Committee beginning 05/18/2022, and monthly ongoing. The Quality Assurance Committee will review findings and make recommendations and changes as needed to ensure continued compliance.	

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F 880	Continued From page 9	F 880		

together. LPN #1 failed to rub the sanitizer through fingers and on top of her hands for at least twenty seconds before setting up the medications from the medication cart. The LPN entered resident room number 405A and set the tray barrier on the overbed table. LPN #1 did not wash her hands before giving the medications. After the oral medications were administered, LPN #1 gave a subcutaneous (Sub Q) injection without washing her hands. LPN #1 completed the medication administration and exited the room. LPN #1 failed to wash her hands or use hand sanitizer upon return to the medication cart.

An interview, on 03/29/22 at 09:00 AM, with LPN #1 confirmed, she realized she didn't properly wash her hands when she went into the resident's room. She confirmed she should have washed her hands before giving the medications and in between the subcutaneous injection and oral mediations and upon return to the medication cart. LPN #1 also confirmed she should have washed her hands to prevent cross-contamination and prevent infections.

In an interview on 03/31/22 at 10:50 AM, with the Director of Nursing (DON), revealed that when the staff sanitizes hands they should be covering all of the hand when washing.

An interview on 03/31/22 at 01:25 PM, with LPN#3/Staff Development Nurse confirmed LPN #1 was in-serviced on hand hygiene in October 2021.

A record review of SNFCLINIC In-service revealed LPN #1 completed Basic Infection Control titled, "Handwashing" on Dec 3, 2021, and Feb 10, 2022.

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