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|---|---|---|---|
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| MS CARE CENTER OF DEKALB | 220 WILLOW AVENUE DE KALB, MS 39328 |

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| F 000 | INITIAL COMMENTS | F 000 | | |

CI MS 19227 and CI MS #19340

The State Agency (SA) conducted complaint investigations (CI) MS # 19227 and CI MS #19340 on 8/1/22 through 8/3/22. The facility was not in compliance with the requirements for participation in Medicare and Medicaid. The SA substantiated both CI MS #19227 and CI MS #19340 related to the facility's failure to notify the family, the physician, and administration of a change in a residents condition and of a fall to the floor with injuries and cited F580 Scope/Severity (S/S)=J; F600 S/S=J cited for abuse and neglect and failure to assess a resident's pain and failure to obtain pain medications for a resident voicing pain after a recent right hip surgery; F689 S/S=J was cited for failure to provide supervision to prevent falls and harm/injuries and a second fractured left hip; and F697 S/S=J cited for failure to provide pain management to a resident returned from a right hip fracture surgery and after a second fall with fractures in the facility.

On 6/2/22, Resident #1 had an unwitnessed fall resulting in a right hip fracture which required hospitalization for surgical repair. On 6/4/22, Resident #1 returned to the facility post hip repair. Resident #1 complained of pain and the facility failed to obtain pain medication and provide pain management treatment resulting in the resident becoming increasingly distressed and agitated. The facility failed to provide adequate supervision of Resident #1, who was distressed, agitated, and disoriented resulting in the resident sustaining a second fall. The facility nursing staff failed to notify the physician, family, and facility management of the second fall resulting in a

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| Electronically Signed | | 08/22/2022 |

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| F 000 | Continued From page 1 | F 000 | | |

delay in treatment and causing Resident #1 to suffer severe and avoidable pain until transferred to the hospital on 6/5/22 for unresolved pain. While at the hospital it was discovered the resident had a left hip fracture that resulted in surgical repair.

During the survey, the SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) , which occurred on 6/4/22 and existed at:

42 CFR(s) §483.12 Freedom from Abuse, Neglect, and Exploitation-F600-Scope and Severity "J"

42 CFR(s) §483.25(d)(1)(2) Accidents -F689-Scope and Severity "J"

42 CFR(s) §483.25(k) Pain Management-F697-Scope and Severity "J"

IJ existed at:

42 CFR(s) §483.10(g)(14)(i)(A)(B)(C)(D) Notification of Changes-F580-Scope and Severity "J"

This situation caused Resident #1 serious harm, injury and impairment and placed other residents at risk, in a situation that was likely to cause serious injury, serious harm, serious impairment or death.

Based on the facility's implementation of corrective actions completed on 6/16/22, the SA determined the IJ and SQC to be Past Non-Compliance (PNC) and the IJ was removed 6/16/22, prior to the SA's entrance on 8/1/22.

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| F 000 | Continued From page 2<br>The SA notified the facility's Administrator of the PNC IJ and SQC on 8/3/22 at 4 PM and provided the IJ Templates.<br><br>The facility census was 53 and the facility was licensed for 60 beds on 8/1/22. | F 000 | | |
| F 580 SS=J | Notify of Changes (Injury/Decline/Room, etc.)<br>CFR(s): 483.10(g)(14)(i)-(iv)(15)<br><br>§483.10(g)(14) Notification of Changes.<br>(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-<br>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;<br>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);<br>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or<br>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).<br>(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.<br>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-<br>(A) A change in room or roommate assignment | F 580 | | |

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| F 580 | Continued From page 3<br>as specified in §483.10(e)(6); or<br>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.<br>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).<br><br>§483.10(g)(15)<br>Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, staff interviews, family/Resident Representative (RR) interviews, and facility policy and procedure reviews, the facility failed to notify the physician, the facility administration, and the family/ RR on 06/04/2022 that Resident #1 was yelling out in pain and asking for pain medications after returning to the facility following right hip surgery. The facility failed to notify the DON, the facility administration, the physician, and the family/RR that Resident #1 had a second fall in the facility which resulted in a left hip fracture on 06/04/2022 at approximately 10:00 PM, after her return to the facility following surgery for a right hip fracture. Resident #1 was one (1) of six (6) residents reviewed for notification of change in condition.<br><br>On 06/02/2022, Resident #1 had an unwitnessed fall resulting in a right hip fracture which required | F 580 | Past noncompliance: no plan of correction required. | |

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| F 580 | Continued From page 4 | F 580 | | |

hospitalization for surgical repair. On 06/04/2022, Resident #1 returned to the facility post hip repair. Resident #1, who was distressed, agitated, and disoriented post hospital return sustained a second fall on 06/04/2022. The facility nursing staff failed to notify the physician, family, and facility management of the second fall resulting in a delay in treatment and causing Resident #1 to suffer severe and avoidable pain until transferred to the hospital on 06/05/2022, for unresolved pain. While at the hospital it was discovered the resident had a left hip fracture that resulted in surgical repair.
The facility's failure to notify the physician, facility administration, and the RR caused a situation that has caused Resident #1 serious harm, serious injury and serious impairment and placed other residents at risk for serious harm, serious injury, serious impairment, or death.

This situation was determined to be an Immediate Jeopardy (IJ) that began 06/04/2022 when the facility failed to notify the necessary parties of Resident #1's fall and pain. The facility Administrator was notified of the IJ on 08/03/2022 at 4:00 PM. The facility provide a Past Non-Compliance Corrective Action Plan in which the facility alleged all corrective actions were completed to remove the IJ on 06/16/2022, and the IJ was removed on 06/16/2022.

The State Agency (SA) determined the IJ was removed on 06/16/2022, prior to the SA's entrance on 08/01/2022 and was Past Non-Compliance (PNC).

Findings include:

Record review of the undated facility policy titled

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"Change In Resident Medical Status" revealed: A change in medical status is defined as any physical, psychological, and/or medical deviation as compared to the resident's status as noted in the initial assessment. These changes may include: fall and/or injury, fever, refusal to eat after 24 hour period, confusion or other change in mental behavior. These changes must be noted in: a) Clinical Record, b) Care Plan if significant, c) Accident/Incident Report (if due to fall or injury) ... A facility must immediately inform the resident, the physician, responsible party when there is: 1. A need to alter treatment 2. An accident involving the resident which results in injury and has the potential for requiring physician intervention. 3. A significant change in the resident's physical, mental or psychological status. 4. A decision to transfer or discharge the resident from the facility. If the physician is unable to be reached for resident condition change requiring alterative treatment, you should do the following: 1. Notify the Medical Director. If unable to reach, 2. Call the ambulance and transfer to hospital."

Interview on 08/01/2022 at 12:00 PM, with the facility Administrator (ADM) revealed that the facility had received Resident #1 back to the facility on Saturday 06/04/2022 at approximately 3:00 PM from the hospital where Resident #1 had a pin placed surgically to her right hip as a result of a fall in the facility on Thursday 06/02/2022. At the time of the first fall on Thursday 06/02/2022, Resident #1 was able to relay to the facility staff that she had fallen in her room as she was attempting to toilet herself. On Thursday 06/02/2022, Resident #1 was independently ambulatory with the assistance of a cane and was continent of bowel and bladder. Resident #1 was found on the floor of the bathroom with a cut to

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her eye and pain to her right hip. On Thursday 06/02/2022, Resident #1 was transported via ambulance to the local hospital. The hospital x-rayed Resident #1 and found her to have a fractured right hip and placed 10 stitches to the cut on her eye. The local hospital transferred Resident #1 to the orthopedic unit in another town approximately 50 miles from the facility via ambulance in order to obtain surgery to the right fractured hip. On Friday 06/03/2022, Resident #1 had surgery to her right hip and a pin was placed to the hip. On Saturday 06/04/2022, at approximately 3:00 PM, Resident #1 arrived back to the facility via ambulance accompanied by her daughter. Later, the daughter inquired about the pain medications for Resident #1. Registered Nurse (RN) #2 told the daughter that the hospital had not sent any orders for pain medications, only Tylenol as needed (PRN) for pain. The daughter told (RN#2) that Resident #1 was voicing pain and needed to have some pain medications ordered. The ADM stated that RN #2 called the hospital nurse and was told that the family had requested no pain medications for Res #1 because it made her "loopy." RN #2 called the facility physician to obtain a verbal order for "Norco" pain medication per the request of the daughter. RN #2 called the pharmacy and gave the verbal order for "Norco" pain medication and the pharmacy told her that they would call back with the approval and would deliver the medications if approved. RN #2 left the facility at 5:00 PM on Saturday 06/04/2022 and passed the information to the other nurses at the facility. Later, in the evening of Saturday 06/04/2022 at approximately 7:15 PM, the pharmacy called the facility and told the 7:00 PM to 7:00 AM nurse Licensed Practical Nurse (LPN) #1 that they were not allowed to fill a prescription with a verbal

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order for pain medications (Norco) and that a "hard copy" with a physician's signature was required for all pain medications. LPN #1 did not attempt to obtain the required physician's signature, did not contact/notify the facility physician, did not notify/report to the family, did not call/notify the facility DON or ADM that the medications were not available, as per facility policy and procedure for notifying. The ADM stated that the facility had a local pharmacy and a back-up pharmacy for obtaining medications.
The staff at the facility reported to the ADM on Friday 06/10/2022, that Resident #1 expressed pain and had periods of "yelling out" in pain with restlessness and confusion throughout the night of Saturday 06/04/2022 and early morning of Sunday 06/05/2022. None of the behaviors of Resident #1 were documented, reported, and/or assessed by the facility staff on Saturday 06/04/2022 and 06/05/2022, after a night of pain and restlessness and no pain medications. On 06/05/2022 at approximately 10:00 AM, Resident #1 was transferred to the local hospital, with a diagnosis of "uncontrolled pain." The Administrative staff was not notified until 06/10/2022 during staff interviews, that Resident #1 had fallen in her room on the evening of 06/04/2022 at the facility. The ADM reported that she received a call from the daughter of Resident #1 inquiring about a second fall that had resulted in a second fracture to the opposite (left) side/hip. The ADM reported that during the first interviews with the evening staff (RN #1, LPN #2, and the Certified Nursing Assistants (CNA's) they all reported that they had no knowledge of a second fall of Resident #1 on the evening of Saturday 06/04/2022. There were no documented reports of a fall for Resident #1 on Saturday 06/04/2022.
On Friday 06/10/2022, CNA #2 reported to the

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facility Social Service Designee (SSD) that there had been a second facility fall for Resident #1 in her room on 06/04/2022 and she had helped to manually pick Resident #1 up and place her back in her bed, along with the RN #1, LPN #1, and CNA #1.The ADM stated that none of the facility policies and procedures for notifying, falls/accidents, reporting and assessments had been followed by the staff on Saturday 06/04/2022 during the evening shift. As soon as the ADM had received the report on 06/10/2022 that the staff had not "told the truth about the fall" of Resident #1, the ADM obtained the hall security camera video and saw the incident of the staff running to Resident #1's room at approximately 10:00 PM. The hall camera activity had been identified by the facility ADM and the Director of Nurses (DON) and the video confirmed the incident had occurred on 06/04/2022 at 2155 (9:55 PM) and the staff had responded to Resident #1's room. The ADM stated that she had saved the video for her records. The ADM then called all the staff back in and obtained handwritten statements from all staff involved. The ADM stated that RN #1 and LPN #1 were both terminated, and all other staff received counseling with a write up placed in their personnel records. All facility staff were in-serviced on Lifts, Notifying/Reporting; Incidents and Accidents; Pain Management; Obtaining MD and Pharmacy Orders; Visitors Policy; Abuse/Neglect; and Assessments. The facility began working on the investigation and conducted a Quality Assurance (QA) meeting, reviewed the facility policies and procedures, and in-serviced all facility staff. The facility ADM stated that they admit that the facility staff did not follow the policies and procedures of the facility and that an Immediate Jeopardy (IJ) had existed

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prior to the State Agency (SA) entering the facility on 08/01/2022. The ADM stated that they immediately on 06/10/2022 assessed all residents in the building and did a complete audit of 100% of all incidents and accidents that had occurred since January 2022. They interviewed all residents that were interviewable on 06/10/2022 and none heard or saw anything with Resident #1 on 06/04/2022. The ADM stated that the facility had reported the incident to the Attorney General's Office and to the Mississippi (MS) State Board of Nursing and to the State Agency on 06/10/2022. The facility ADM stated that the facility had completed the removal of the (IJ) on 06/16/2022.

Interview on 08/01/2022 at 12:45 PM, with the DON revealed that she did not know that Resident #1 was back in the facility on 06/04/2022, until she got to work on Monday 06/06/2022. The DON confirmed that she had not been given any reports that Resident #1 had no pain medications and/or no orders for pain medications and she had no idea that Resident #1 had had a second fall in the facility on Saturday 06/04/2022. The DON stated that there was no documentation of a fall for Resident #1 in the facility for 06/04/2022. The DON stated that the facility had begun in-serving and investigating immediately on 06/10/2022 when it was discovered that Resident #1 had fallen a second time in the facility on 06/04/2022. The DON stated that LPN #1 and RN #1 were both terminated. The DON confirmed that RN #1 was the nurse supervisor for the 7:00 PM to 7:00 AM shift for weekends. The DON stated that the nursing staff on 06/04/2022 to 06/05/2022 had not followed the facility's policies and procedures for notifying of change in conditions and had not

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obtained the treatments and medications needed by Resident #1.
Interview on 08/01/2022 at 3:00 PM, with Resident #1's daughter who is her RR, revealed that she had been staying with her mother at the hospital after a fall in the facility on 06/02/2022 in which Resident #1 received a fractured right hip and a cut with stitches to her eye. The RR stated that Resident #1 had surgery at the hospital on Friday 06/03/2022 and had been given strong pain medication such as Morphine while at the hospital. The RR stated that she accompanied her mother upon re-entering the facility on 06/04/2022 at approximately 3:00 PM and after approximately 30 minutes of being back in the facility Resident #1 began to complain of pain. The RR went to the nursing station and asked if they could give Resident #1 some pain medications and was it possible to get her some "Norco" because that seemed to agree with her better and ease her pain. LPN#1 told the RR that she would call and get an order for pain meds because the hospital had not sent any orders with her for pain medications. The RR assumed that the pain meds would be given to Resident #1 when they arrived. The RR stated that her mother was not hollering out and was not restless when she was with her in her room. Upon the arrival of her brother the RR left and went home leaving her brother there with Resident #1. No one at the facility notified her or any member of her family that Resident #1 had been without pain meds, and no one notified them of any change in Resident #1's condition on 06/04/2022. The RR stated that her brother had reported to her that Resident #1 was voicing pain while he was at the facility, up until approximately 8:00 PM, when he left the facility. The RR stated that she was told by the facility nurse that (Formal Name of

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Hospital) had not given them orders as to the treatment and medication needed for Resident #1. The RR stated that she assumed that the facility was obtaining the orders for Resident #1's pain medication and treatment orders. The RR stated that on Sunday morning 06/05/2022, her brother arrived at the facility at approximately 8:00 AM to sit with Resident #1 and found that his mother was in uncontrolled pain and Resident #1 was sitting in a recliner in her room alone calling out in pain. Her brother was told by the nurse that they put Res #1 in the recliner because she had been trying to get out of bed and she was in pain. Staff told her brother that Resident #1 was more relaxed and calmer in the recliner and was refusing to stay in bed. The RR and brother were concerned about Resident #1 being out of bed and sitting up in a chair on her newly pinned right hip. LPN #1 told her brother that they had called the facility physician and had obtained an order to transfer Resident #1 to the local hospital for uncontrolled pain. LPN #1 told her brother that the pain medication never arrived, and that Resident #1 had been without pain medications since arriving back to the facility. The family accompanied Resident #1 to the hospital emergency room (ER) on 06/05/2022 at approximately 10:00 AM. The RR stated that on Thursday 06/09/2022 the Physical Therapist (PT) went to assess Resident #1 at the hospital and found Resident #1 to be in pain and unable to receive PT services, therefore the PT asked that Resident #1 have x-rays and that is when they found the left hip to be fractured and in need of a second surgery. The RR and her family had been with Resident #1 and knew that she had not had an injury in the hospital, but the only time they had not stayed with Resident #1 was at the nursing home. The hospital physician told the

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family that a second fall or injury had to have occurred after Resident #1 was returned to the facility. The RR called the Nursing Home Administrator and told her what had been told to them by the hospital physician. The facility Administrator stated to the RR that there were no reported falls for Resident #1 on 06/04/2022 to 06/05/2022. The RR stated that on 06/10/2022 she expressed her anger to the facility SSD. The RR stated that it was not long after that she received a phone call from the facility Administrator telling her that they had discovered that an unreported fall had occurred on 06/04/2022 and that the staff had been disciplined and the nurses terminated. The RR stated that her brother did not want Resident #1 returned to the facility because they had neglected her and had lied and withheld the fall report. The RR stated that Resident #1 was mentally more confused, and her cognitive status had declined since having the falls.

In an interview with CNA #3 on 08/01/2022 at 4:00 PM, she stated that she was working the 3:00 PM to 11:00 PM shift on 06/04/2022. CNA #3 stated that Resident #1 was calm and relaxed and was not yelling out while her family was with her in her room. CNA #3 stated that after Resident #1's family left the facility at approximately 7:30 PM to 8:00 PM, Resident #1 progressively became more restless and more verbal. CNA #3 stated that she had served Resident #1 her supper tray at approximately 5:20 PM and the son was in the room with Resident #1. When CNA #3 went in to Resident #1's room and her family was present Resident #1 did not appear in pain and did not voice pain. CNA #3 passed by Resident #1's room at approximately 6:30 PM and Resident #1 was in

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her bed and appeared agitated and she was talking "out of her head." I would say she was "out of it." Resident #1 was hollering out things like "what y'all doing?" Resident #1 was yelling and was trying to get out of her bed. At about 7:00 PM, was when the agency nurse (LPN #1) came to work that "B"Hall and she was the nurse for Resident #1. There was also an agency (CNA #1) that was assigned to work with Resident #1 from 3:00 PM to 11:00 PM on 06/04/2022. CNA #3 stated that Resident #1 fell out of her bed and on to the floor at approximately 7:30 to 8:00 PM, shortly after her family had left the facility. CNA #3 was standing out in the hall in front of Resident #1's door talking to a housekeeping/laundry staff when they saw Resident #1 on the floor. The laundry worker called out for help. CNA #3 stated that CNA #1, CNA #2, RN #1 (Nurse Supervisor) and (LPN #1) went into Resident #1's room at approximately 8:00 PM and lifted Resident #1 from the floor to the bed. CNA #3 stated that after the fall of Resident #1, LPN #1 said that she was going to go and sit in the room with Resident #1 to try and keep her in the bed. CNA #3 stated that Resident #1 "yelled out" and "hollered" off and on the remainder of her shift. CNA #3 stated that the CNA 's was required to document all changes and all incidents that their assigned residents have during their shift. CNA #3 stated that she had no idea that none of the staff had not reported the fall. But only learned on 06/10/2022 that it was not reported and documented. CNA #3 stated that she assumed that the nurse supervisor (RN #1) had taken care of everything since she was the one that helped to get Resident #1 up after her fall. CNA #3 stated that the entire facility staff had attended numerous in-services after the incidents with Res #1. CNA

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#3 stated that they were in-serviced on the proper use of lifts; falls; reporting/notifying; documenting incidents; assessments; visiting, and ethics.

In an interview on 08/01/2022 at 4:30 PM, with LPN #2 stated that she was not the assigned nurse for "B-hall" where Resident #1's room was located, but she was the assigned nurse for "A-hall." LPN #2 stated that she worked the 7 AM to 7 PM shift as the "A-Hall" nurse. LPN #2 stated that she left the facility at 7:00 PM on 06/04/2022 and the family was still visiting with Resident #1 in her room. LPN #2 stated that the second shift nurse supervisor was RN #1. LPN #2 stated that the facility had required that all staff have in-service training after the incidents with Resident #1 on 06/04/2022 and they had been in-serviced on the policies and procedures of the facility, lifts, pharmacy orders, ethics, falls, reporting/notifying, and many others. LPN #2 stated that it had always been the facility policy and procedure to notify the doctor, the family, and the DON of all changes and all incidents. LPN #2 stated that the CNA's and the nurses all knew that a fall had to be assessed and an incident report was to have been completed.

In an interview on 08/02/2022 at 12:30 PM, with CNA #1 stated that she had been terminated from the facility as a result of the fall of Res #1 on 06/04/2022. CNA #1 confirmed that she was an agency employee for the nursing company and had been assigned as the CAN for Resident #1 on 06/04/2022. CNA #1 stated that she had worked with Resident #1 several times during her contract at the facility and she had knowledge of Resident #1's surgery on 06/03/2022. CNA #1 stated that a laundry worker called out to the nurse that Resident #1 was on the floor and the

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nurses ran to Resident #1's room prior to CNA #1. When CNA #1 got to Resident #1's room she saw RN #1, LPN #1, and CNA #2 in the room with Resident #1 who was on the floor. RN #1 told them all to assist her in manually picking up Resident #1 and putting her back in bed. CNA #1 stated that they all followed the directions of their supervisor. CNA #1 stated that she did not document the fall and did not complete an incident report. CNA #1 stated that Resident #1 had been agitated most all night and did yell out in pain. CNA #1 stated that after Resident #1 was found on the floor of her room LPN #1 sat with Resident #1 in her room the rest of the night. CNA #1 stated that she had been terminated from the facility for failure to report and document the incident, but no one had asked her to document. The Nurse Supervisor (RN #1) was at the scene of Resident #1's fall and was advising them on what to do. CNA #1 assumed that RN #1 and LPN #1 completed the reporting and documenting. CNA #1 stated that she had attended all the in-services for reporting, lifting, documenting, and visiting prior to her termination. Interview on 08/02/2022 at 1:20 PM, with CNA #2 revealed that she was working the 3:00 PM to 11:00 PM shift. CNA #2 stated that she was not assigned to Resident #1 on 06/04/2022 that CNA #1 was assigned to Resident #1. CNA #2 stated that she helped RN #1 and LPN #1 and CNA #1 to pick up Res #1 manually and put her back in the bed from the floor. I did not document the fall and I did not report the fall because she was not my assigned resident and I assumed that her CNA and the nurse supervisor would have done all of that. All the facility staff had to attend in-services and give written statements after the incident with Resident #1 on 06/04/2022.

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In an interview and video observation on 08/02/2022 at 3:30 PM, with the ADM she confirmed that she had the video of the staff running in to Resident #1's room at about 10:00 PM on 06/04/2022. The ADM stated that she and the DON and the corporate staff had all viewed the video numerous times and they had identified that the first persons to enter the room of Resident #1 was CNA #2 and CNA #3. The Nurse Supervisor (RN#1) was the third person to run down the hall and enter the room of Resident #1 at approximately 10:00 PM. The ADM confirmed that Res #1 did not have a roommate on 06/04/2022 and was alone in her room. The observation of the facility video revealed that the facility staff were rushing to Resident #1's room that was located on Hall B. The ADM identified each of the staff as we watched the video of them running to get to Resident #1's room. The time and date on the video were 06/04/2022 at 2155 (military time for 9:55 PM). The video showed RN #1 running to Resident #1's room and she entered through the door. In a few seconds afterwards, LPN #1 ran to Resident #1's room. LPN #1 was the last person to enter Resident #1's room. After a few minutes RN #1 came out of Resident #1's room and returned to the nursing station. LPN #1 came out of Resident #1's room and went to the nursing station and got her backpack and some other items and went back to Resident #1's room. The ADM stated that through watching the video they were able to see the time of the events and who had knowledge of the events. By watching the video, they knew who to interview because the staff had denied the event when first questioned by the ADM on 06/10/2022. The ADM confirmed that all the staff had had one on one counseling and had received write-ups placed in their personnel records. The

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ADM confirmed that all the staff "knew better." The ADM confirmed in-services that the staff had to attend prior to reporting for work on 06/10/2022 to 06/13/2022. The ADM stated that the IJ corrective action plan was completed on 06/16/2022. The ADM provided a "timeline" of the corrective actions that the facility completed on 06/16/2022.

Interview on 08/03/2022 at 8:45 AM, with the facility Medical Director (MD) revealed that he had been called on 06/04/2022 by the facility nurse and was asked for a pain medication for Resident #1 and he gave a verbal order for pain medication of Norco but had never been contacted that the pharmacy would not accept a verbal order for pain medications. The MD stated that he would have expected the staff to have called him and informed him of what was going on with Resident #1, but they never called him back with a report and never asked for a transfer of Resident #1 to the hospital for pain control. The MD stated that the nurses should have contacted him when they were unable to get the pain medication for Resident #1 and Resident #1 should never have had to endure pain. The MD stated that on the morning of 06/05/2022 he received a call from the nurse that Resident #1's medication had not been delivered as ordered and that Resident #1 had uncontrolled pain. The MD stated that he told the nurse to send Resident #1 out immediately to the ER for uncontrolled pain. The MD stated that the hospital should not have sent Resident #1 back to the facility without pain medications and without orders for treatment. But that once Resident #1 arrived back to the facility the nurses should have obtained orders for treatment from the hospital. The MD stated that he had not been the surgeon

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and had no idea what the hospital wanted the facility to do for Resident #1 once she arrived back to the facility and that was why he told the nurse to send Resident #1 to the ER for treatment of pain. The MD stated that no one at the facility had contacted him to tell him that Resident #1 had fallen a second time at the facility on 06/04/2022. The MD stated that immediately after Resident #1 fell in her room on 06/04/2022 she should have been sent out to the ER for evaluation. The MD stated that he was made aware on 06/10/2022 that Resident #1 had a second fall in the facility. The MD stated that the Quality Assurance (QA) committee met, and they reviewed all their policies and procedures and that they were all in place and were established prior to the fall of Resident #1 and the staff choose not to follow the facility policies and procedures.

Interview with RN #1 on 08/03/2022 at 9:00 AM, revealed that she had no idea that LPN #1 had not notified the facility administration that Resident #1 had fallen. RN #1 stated that she had no idea that LPN #1 had not documented the fall. RN #1 stated that she asked LPN #1 if she was an RN and she said "Yes." RN #1 stated that LPN #1 was the nurse on the "B" Hall and RN #1 was the nurse for the "A" hall. RN #1 stated that she did not learn until after the incident that she (RN #1) was the Nurse Supervisor, she thought LPN #1 was the Nurse Supervisor. RN #1 stated that LPN #1 was an agency nurse, and she did not know her prior to that evening. RN #1 stated that she had served as the Nurse Supervisor for the 7 PM to 7 AM shift at the facility. RN #1 stated that she along with three other CNAs had manually picked up Resident #1 and put her back in her bed. RN #1 stated that she did not

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complete an incident and accident report for Resident #1. RN #1 stated that LPN #1 did not wear a name tag and she did not know her name and did not know she was an LPN. RN #1 stated that Resident #1 hollered and yelled out during the night. RN #1 stated that hollering and yelling out was not a new behavior for Resident #1. RN #1 stated that Resident #1 usually hollered out and yelled most nights prior to her right hip surgery. RN #1 stated that the facility terminated her for not following the facility's policies and procedures for falls and incidents and accidents. RN #1 stated that she did not assess Resident #1 after she was found on the floor. RN #1 assumed that LPN #1 had assessed Resident #1. RN #1 stated that LPN #1 had gone in Resident #1's room and sat with her after the fall but that Resident #1 continued to holler out and yell.

In an interview on 08/04/2022 at 5:30 PM, with RN #2 revealed that RN #2 stated that she worked from 6:00 AM to 5:00 PM on Saturday 06/04/2022 and she received Resident #1 at approximately 3:00 PM from the hospital. RN #2 stated that she ordered the Norco for Resident #1 and left the facility at 5:00 PM with the impression that the pharmacy was delivering the pain medications. RN #2 stated that Resident #1 did not complain of pain or holler out prior to 5:00 PM on 06/04/2022. RN #2 stated that the family was with Resident #1, and she was calm and relaxed upon entering the facility from the hospital. RN #2 stated that LPN #1 had told her on 06/05/2022 that Resident #1 had yelled out and hollered all during the night. RN #2 discovered that the pain medications for Resident #1 had not been obtained and she immediately called the MD and got orders to have Resident #1 sent to the local hospital for uncontrolled pain. RN #2 stated that

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she had not received any report that Resident #1 had fallen in the facility on 06/04/2022.

Record review of Resident #1's Face Sheet revealed that Resident #1 had been admitted to the facility on 02/01/2022 with diagnoses that included but were not limited to Parkinson's Disease, Psychotic Disorder with Hallucinations due to known physiological condition, Disorientation, Altered Mental Status, Muscle Weakness, Unspecified osteoarthritis, unspecified site. The daughter (RR) of Resident #1 was listed on the Face Sheet as the primary RR.

Record review of the facility's investigation report on Friday 06/10/2022 revealed that handwritten statements had been obtained and the facility staff had admitted in the handwritten statements that Resident #1 was found on the floor of her bedroom and the facility staff had manually lifted Resident #1 from the floor to her bed on Saturday 06/04/2022 at approximately 10:00 PM under the directions and supervision of the Nurse Supervisor, (RN #1) and LPN #1. The facility staff documented in the handwritten statements that no staff had documented the incident and no staff had reported the incident to the facility or to the family. The staff documented in the handwritten statements that the facility's policies and procedures had not been followed for notifications.

Record review of the hand written statement taken by the ADM from a telephone interview with RN #1 dated 06/10/2022 revealed: "A employee hollered that Resident #1 was on floor. I was at nurse's station. I went in room. LPN #1 in room with 4 others and I went into see if they needed

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help. I helped to manually lift her off floor and onto the bed. LPN #1 assessed her on floor. LPN #2 told Resident #1's daughter that her brother could not stay with his mom. "I told (Formal Name of LPN #1) she may want to call the DON. I told her to get all her stuff and sit with her Resident #1 the rest of night." LPN #1 asked me near 6 AM if she needed to send Resident #1 out and call the doctor. I did not tell her to send Resident #1 out." She needed to go to the ER. I thought LPN #1 was an RN and she should know what to do.

Record review revealed an undated handwritten statement signed by (RN #1) that read "On 6-4-22 I was working with an agency nurse and one of our residents was screaming and hollering. We asked had she had any pain medication, other nurses stated family did not want her to have any. I tried to give her a Tylenol resident stated "no that's poison." We were called to room saying that resident was in floor, that wasn't witnessed. I was under the assumption the nurse was an RN because I had asked her before, and she had said yes. I told her to call the DON about it. I told her it looked like she would have to take all her stuff in the room due to her getting up. If I had known the agency nurse wasn't an RN, I would have handled the situation myself, and should have done that anyway." The undated handwritten statement was signed by RN #1 with her phone number and her address attached.

Record review of the hand written dated 06/10/2022 statement and signed by LPN #1 with her address and phone number revealed "8:00 PM Saturday -Standing on side of bed-CNA helped to get her back in bed. 7:49 Son asked to stay with resident but (LPN #1) did not know the

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policy and would have to ask. He never mentioned it again and I did not find out what policy was. (Res #1) was standing on side of bed and we assisted her back to bed. I left room and another employee said (Res #1) was lying on floor. Near wall on right side. I asked (Res #1) what happened and she said "I tried to walk and fell "my hip is broke." Assessed her on floor and manually picked her up. 3 others (RN #1) helped to the bed. Did not c/o (complain of) pain. Did not document. Did not call anyone.
9:51 PM I asked (Formal Name of RN #1) about incident report. She said it was too long, don't worry about it. I went and got my food and went to room to sit with her. Resident complained of pain, and I went and got 2 Tylenol, but she only took one. "One is enough, I guess I got to die someway." I tried to get her to take another one, but she would not take it. I sat with her to monitor pain. Pain level 8-9. At 7 AM Sunday 6/5/22 I gave report to (RN #2) stating that I tried to give her Tylenol for pain, but she wouldn't take it...Never reported fall. (RN #1) came in room we were just talking I told her (Resident #1) will not take the Tylenol for pain and that what shall I do to try to make her take medicine because I knew she had to be in pain. RN #1 came around the bed and said with hand motion to mouth "zip it." I would not say a thing you assess her there were no bruises."

Record review of the dated and handwritten statement signed and dated 06/10/2022 by (CNA #1) and an addendum dated 6/12/2022 revealed, "(Resident #1) was up out of bed one time I went to check on her standing by the bed by her recliner. We helped her back in bed. Later after telling her to stay in bed, we didn't want her to fall. I heard real loud yelling coming from her room. I

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went in she was on the floor between the wall and the chair. I went and got LPN #1 b/c (because) she had that B-Hall. She checked Resident #1 for bruises and told me to get RN #1 which I did. RN #1 checked her also and asked her was she hurt she said "no". We assisted her back in bed. LPN #1 said she was gonna stay in the room with her so she wouldn't get back out of bed." "When RN #1 came in she asked LPN #1 was she an RN and she said no she's an LPN. I didn't hear her tell not to report the fall." Signed by CNA #1 dated 6/12/22.

In response to the Immediate Jeopardy's (IJs) Past Non-Compliance (PNC) that were cited on 08/03/2022 at 4:00 PM the facility submitted the following IJ Corrective Action Plan (CAP) that was accepted by the SA as Past Non-Compliance (PNC) on 08/03/2022 at 4:00 P.M.

The CAP IJ-Residents will be assessed and medications, treatments, and services will be obtained for residents experiencing a change in their condition and/or experiencing pain, the facility will notify the family, the physician, the DON and the facility administrative staff-Corrective Actions :

1. The facility conducted a thorough investigation and obtained statements from all staff in the facility and determined that an incident had occurred on 06/04/2022 at approximately 10:00 P.M. of a second fall that resulted in a second left hip fracture to Res #1 that went unreported until 06/10/2022. The facility reported the incident to the family of Res #1 on 06/10/2022.

2. The facility conducted an Emergency Quality Assurance Committee meeting on 06/10/2022

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with the Medical Director, DON, ADM, SSD, and QA staff all present. The QA committee reviewed all the facility policies and procedures for obtaining MD orders, delivery of medications, Pharmacy procedures and Abuse and Neglect; Using Lifts; Notifications of MD and family and DON and ADM; Care Plans; and Accident Prevention. The facility conducted three (3) additional QA Committee meetings from 06/10/2022-06/16/2022, with the fourth (4th) conducted on 06/16/2022.

3.100% audit of all Incident and Accidents and Falls that had occurred in the facility since January 2022 have been evaluated, reassessed, and reviewed by the QA Committee and Administration of the facility.

4. The facility contacted/reported to the MS State Department of Health, The MS Attorney General's Office; Area Ombudsman, and the MS Board of Nursing, on 06/10/2022 as soon as the unreported fall with a second left hip fracture was reported to the facility.

5. On 06/10/2022 100% Room to Room resident reviews were conducted along with interviews with all residents to assess them for safety and quality of care. All residents were checked for physical and emotional well-being by SSD, DON, and Nursing Staff with no negative findings and no harm was identified.

6. On 06/10/2022 all staff were mandated to attend in-service training on Lifts; Reporting; Assessing Residents; Obtaining Medication Orders; Notifying of Resident Change; Abuse/Neglect; Falls; and Ethics.

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7. On 06/10/2022 all staff that worked 7:00 AM-7:00 PM and 7:00 PM- 7:00 AM on 06/04/2022 and 06/05/2022 were issued one on one counseling and write ups of discipline were placed in their personnel records. Three (3) staff, RN #1; LPN #1; and CNA #1 were terminated for failure to report an incident and fall for Res #1 and for not following the facility policies and procedures.

8. Resident #1 was transferred to the hospital located approximately 50 miles away for a second left hip surgery on 06/10/2022. Resident #1 was reassessed upon readmission to the facility and new measures put in to place to protect Res #1 from future falls and injuries. Res #1 had pain medications at the facility upon readmission to the facility after the second hip surgery.

9. Facility alleges the relieving of the immediacy of the Immediate Jeopardy (IJ) on 06/16/2022 and Past Non-Compliance.

The SA validations of the Facility's Removal Plan/Corrective Action Plans Past Non-Compliance (PNC) were completed by interviews, policy and procedure reviews, record reviews, and observations on 08/01/2022 at 12:00 P.M. - 08/03/2022 at 6:00 P.M. with all staff in the building and via telephone interviews with staff that were terminated or scheduled to work at the facility. The SA validated through record review and observations that the facility had completed their Corrective Actions and had removed the IJ prior to the SA entering the facility. The Past Non-Compliance was validated and the IJ removed on 06/16/2022.

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1- The SA validated through record reviews and interviews from 08/03/2022-08/03/2022 that the facility had conducted a thorough investigation and obtained statements from all staff in the facility and determined that an incident had occurred on 06/04/2022 at approximately 10:00 P.M. of a second fall that resulted in a second left hip fracture to Res #1 that went unreported until 06/10/2022. The SA validated through family (RR) interviews that the facility had reported the incident to the family of Res #1 on 06/10/2022.

2- The SA validated through record reviews and interviews conducted during the complaint investigation on 08/01/2022- 08/03/2022 that the facility had conducted an Emergency Quality Assurance Committee meeting on 06/10/2022 with the Medical Director, DON, ADM, SSD, and QA staff all present. The QA committee reviewed all the facility policies and procedures for obtaining MD orders, delivery of medications, Pharmacy procedures and Abuse and Neglect; Using Lifts; Notifications of MD and family and DON and ADM; Care Plans; and Accident Prevention. The facility provided documentation and interviews that they had conducted three (3) additional QA Committee meetings from 06/10/2022-06/16/2022, with the fourth (4th) conducted on 06/16/2022.

3- The SA validated through interviews and documentation reviews that the facility had conducted 100% audit of all Incident and Accidents and Falls that had occurred in the facility since January 2022 have been evaluated, reassessed, and reviewed by the QA Committee and Administration of the facility.

4- The SA validated through record review and

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interviews on 08/01/2022 - 08/03/2022 that the facility contacted/reported to the MS State Department of Health, The MS Attorney General's Office; Area Ombudsman, and the MS Board of Nursing, on 06/10/2022 as soon as the unreported fall with a second left hip fracture was reported to the facility.

5- The SA validated through interviews, observations, and record reviews that on 06/10/2022, 100% Room to Room resident reviews were conducted along with interviews with all residents to assess them for safety and quality of care. All residents were checked for physical and emotional well-being by the facility's SSD, DON, and Nursing Staff with no negative findings and no harm was identified.

6- The SA validated through staff and family (RR) interviews and record reviews that on 06/10/2022 all staff were mandated to attend in-service training on Lifts; Reporting; Assessing Residents; Obtaining Medication Orders; Notifying of Resident Change; Abuse/Neglect; Falls; and Ethics. The SA validated that all facility staff had been in-serviced from 06/10/2022-06/16/2022. The SA also validated that facility in-services and training were on-going and conducted by the facility and cooperate staff on a regular basis.

7- The SA validated through staff interviews, personnel record reviews, and through record reviews that on 06/10/2022 all staff that worked 7:00 AM-7:00 PM and 7:00 PM- 7:00 A.M. on 06/04/2022 and 06/05/2022 were issued one on one counseling and write ups of discipline were placed in their personnel records. Three (3) staff, RN #1; LPN #1; and CNA #1 were terminated for

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| F 580 | Continued From page 28<br>failure to report an incident and fall for Res #1 and for not following the facility policies and procedures. The SA validated through interviews with RN #1 and CNA #1 that they had been terminated from the facility for failure to follow facility policies and procedures and for not reporting a fall of Res #1. The SA was unable to interview LPN #1 as she would not take calls for interviews. The SA attempted unsuccessfully to obtain telephone interviews with LPN #1. The SA did validate through record reviews and through interviews with facility staff that LPN #1 was terminated.<br><br>8- The SA validate through staff interviews, observations, family (RR) interviews, and record reviews that Resident #1 was transferred to the hospital located approximately 50 miles away for a second left hip surgery on 06/10/2022. Resident #1 was reassessed upon readmission to the facility and new measures put in to place to protect Res #1 from future falls and injuries. Res #1 had pain medications at the facility upon readmission to the facility after the second hip surgery.<br><br>9- The SA validated through interviews, record reviews and observations that the immediacy of the Immediate Jeopardy (IJ) was removed on 06/16/2022 and Past Non-Compliance (PNC). | F 580 | | |
| F 600 SS=J | Free from Abuse and Neglect<br>CFR(s): 483.12(a)(1)<br><br>§483.12 Freedom from Abuse, Neglect, and Exploitation<br>The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This | F 600 | | |

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| F 600 | Continued From page 29<br>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.<br><br>§483.12(a) The facility must-<br><br>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, interviews, record reviews, and facility policy and procedure reviews, the facility failed to ensure Resident #1 was free from neglect when she returned to the facility following right hip surgery and suffered a second fall in the facility which resulted in a second left hip fracture. Res #1 was calling out in pain and the nursing staff neglected to obtain pain medications, to assess and treat Res #1's pain and report a fall. Res #1 was one (1) of six (6) residents reviewed for neglect.<br><br>On 06/02/2022, Resident #1 had an unwitnessed fall resulting in a right hip fracture which required hospitalization for surgical repair. On 06/04/2022, Resident #1 returned to the facility post hip repair. Resident #1 complained of pain and the facility neglected to obtain pain medication and provide pain management treatment resulting in the resident becoming increasingly distressed and agitated. Resident #1, who was distressed, agitated, and disoriented sustained a second fall. The facility nursing staff failed to notify the physician, family, and facility management of the second fall resulting in a delay in treatment and causing Resident #1 to suffer severe and avoidable pain until transferred to the hospital on | F 600 | Past noncompliance: no plan of correction required. | |

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06/05/2022, for unresolved pain. While at the hospital it was discovered the resident had a left hip fracture that resulted in surgical repair.

The facility's failure to notify the physician, facility administration, and the Resident Representative of a second fall and neglected to address Resident #1's pain has caused Resident #1 serious harm, injury, and impairment. This placed other residents in a situation that was likely to cause serious harm, serious injury, serious impairment, or death.

This situation was determined to be an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) that began on 06/04/2022 when the facility failed to assess and treat Resident #1's pain and notify the necessary parties of Resident #1's fall and pain. The facility Administrator was notified of the IJ and SQC on 08/03/2022 at 4:00 PM. The facility provide a Past Non-Compliance Corrective Action Plan in which the facility alleged all corrective actions were completed to remove the IJ and SQC on 06/16/2022, and the IJ and SQC was removed on 06/16/2022.

The State Agency (SA) determined the IJ and SQC was removed on 6/16/22, prior to the SA's entrance on 08/01/2022 and was Past Non-Compliance (PNC).

Findings include:

Review of the facility policy titled: "Freedom from Abuse, Neglect, and Exploitation F600-F610" dated revised November 2016. The policy revealed "Neglect" is a failure of the facility, its employees or service providers to provide goods

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and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.

During an interview on 08/01/2022 at 12:00 PM, with the facility Administrator (ADM) revealed that the facility had received Resident #1 (Res) back to the facility on Saturday 06/04/2022 at approximately 3:00 PM, from the hospital where Res #1 had had a pin placed surgically to her right hip as a result of a fall in the facility on Thursday 06/02/2022. At the time of the first fall on Thursday 06/02/2022, Res #1 was able to relay to the facility that she had fallen in her room as she was attempting to toilet herself. On Thursday 06/02/2022, Res #1 was independently ambulatory with the assistance of a cane and was continent of bowel and bladder. Res #1 was able to relay to the facility staff how she had fallen. The resident was found on the floor of the bathroom with a cut to her eye and pain to her right hip. On Thursday 06/02/2022, Res #1 was transported via ambulance to the local hospital. X-ray found her to have a fractured right hip and placed 10 stitches to the cut on her eye. The local hospital transferred Res #1 to the orthopedic unit in another town approximately 50 miles from the facility via ambulance in order to obtain surgery to the right fractured hip. On Friday 06/03/2022, Res #1 had surgery to her right hip and a pin was placed to the hip. On Saturday 06/04/2022, at approximately 3:00 PM, Res #1 arrived back to the facility via ambulance accompanied by her daughter. Later, the daughter inquired about the pain medications for Res #1. Registered Nurse (RN) #2 told the daughter that the hospital had not sent any orders for pain medications, only Tylenol as needed (PRN). The daughter told RN#2 that Res #1 was

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voicing pain and needed to have some pain medications ordered. The ADM stated that RN #2 called the hospital and the nurse at the hospital told her that the family had requested no pain medications for Res #1 because it made her "loopy." RN #2 called the facility Medical Director (MD) to obtain a verbal order for "Norco" pain medication per the request of the daughter, who was at the facility with Res #1. RN #2 called the pharmacy and gave the verbal order for "Norco" pain medication and the pharmacy told her that they would call back with the approval and would deliver the medications if approved. RN #2 left the facility at 5:00 PM on Saturday 06/04/2022 and passed on the information to the other nurses at the facility. Later, in the evening of Saturday 06/04/2022 at approximately 7:15 PM, the pharmacy called the facility back and told the 7:00 PM - 7:00 AM nurse, Licensed Practical Nurse (LPN) #1, that they were not allowed to fill a prescription with a verbal order for pain medications (Norco) and that a "hard copy" with a physician's signature was required for all pain medications. LPN #1 did not attempt to obtain the required physician's signature, did not contact/notify the facility physician, did not notify/report to the family, did not call/notify the facility Director of Nursing (DON) and did not notify/call the ADM that the medications were not available, as per facility policy and procedure for notifying. The ADM stated that the facility had a local pharmacy and a back-up pharmacy for obtaining medications. The facility policy is that if a "hard copy" with a physician's signature is needed or that a medication needs to be obtained, the nurse was supposed to have called the ADM and the DON and they would obtain the "hard copy" and go pick the medications up and deliver them to the facility. No one contacted the

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ADM or the DON per facility policy. The staff at the facility reported to the ADM on Friday 06/10/2022 that Res #1 expressed pain and had periods of "yelling out" in pain with restlessness and confusion throughout the night of Saturday 06/04/2022 and early morning of Sunday 06/05/2022. None of the behaviors of Res #1 were documented, reported, and/or assessed by the facility staff on Saturday 06/04/2022 and 06/05/2022. After a night of pain and restlessness and no pain medications, on 06/05/2022 at approximately 10:00 AM, Res #1 was transferred to the local hospital, with a diagnosis of "uncontrolled pain." The administrative staff at the facility had not been notified that Res #1 had fallen in her room on the evening of Saturday 06/04/2022, until Friday 06/10/2022 during interviews with staff. The ADM reported that she received a call from the daughter of Res #1 inquiring about a second fall that had resulted in a second fracture to the opposite (left) side/hip. The ADM reported that during the first interviews with the evening staff, RN #1, LPN #2, and the Certified Nursing Assistants (CNA) all reported that they had no knowledge of a second fall of Res #1 on the evening of Saturday 06/04/2022. There were no documented reports of a fall for Res #1 on Saturday 06/04/2022. Later on, Friday 06/10/2022 CNA #2 reported to the facility Social Service Designee (SSD) that there had been a second facility fall for Res #1 in her room on 06/04/2022 and she had helped to manually pick Res #1 up and place her back in her bed, along with the RN #1, LPN #1, and CNA #1. The four (4) nursing staff picked Res #1 up off the floor manually and placed her back in her bed after she was found on the floor by the facility laundry worker. The ADM stated that the methods that

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were reported by CNA #2 were not in accordance with the facility policy and procedure. The ADM stated that the facility policy and procedure for lifting a resident up from the floor after a fall was to obtain the full body lift and get them off the floor with the lift and place back in the bed for assessment by the nurse. The ADM stated that none of the facility policies and procedures for notifying, falls/accidents, reporting and assessments had been followed by the staff on Saturday 06/04/2022 during the evening shift. As soon as the ADM had received the report on 06/10/2022 that the staff had not "told the truth" about the fall of Res #1, the ADM obtained the hall security camera video and saw the incident of the staff running to Res #1's room at approximately 10:00 PM. The hall camera activity had been identified by the facility ADM and the DON and the video confirmed the incident had occurred on 06/04/2022 at 9:55 PM and the staff had responded to Res #1's room. The ADM stated that she had saved the video for her records. The ADM then called all the staff back in and obtained handwritten statements from all staff involved. The ADM stated that RN #1 and LPN #1 were both terminated, and all other staff received counseling with a write up placed in their personnel records. All facility staff were in-serviced on Lifts, Notifying/Reporting; Incidents and Accidents; Pain Management; Obtaining MD and Pharmacy Orders; Visitors Policy; Abuse/Neglect; and Assessments. The facility began working on the investigation and conducted a Quality Assurance (QA) Meeting; reviewed the facility policies and procedures; and in-serviced all the facility staff. The facility ADM stated that they admit that the facility staff did not follow the policies and procedures of the facility and that an Immediate Jeopardy (IJ) had existed

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prior to the State Agency (SA) entering the facility on 08/01/2022. The ADM stated that they immediately on 06/10/2022 assessed all residents in the building and did a complete audit of 100% of all incidents and accidents that had occurred since January 2022. They interviewed all residents that were interviewable on 06/10/2022 and none heard or saw anything with Res #1 on 06/04/2022. The ADM stated that RN #1 was the weekend nurse supervisor and had been employed at the facility since 2016. The LPN #1 was an agency nurse/employee that had worked several weekends at the facility. This was not her first time working on 7:00 PM to 7:00 AM. The ADM stated that the facility had reported the incident to the Attorney General's Office, the MS State Board of Nursing and to the State Agency on 06/10/2022. The facility ADM stated that the facility had completed the removal of the (IJ) on 06/16/2022.

During an interview with the DON on 08/01/2022 at 12:45 PM, revealed that she had been contacted by the hospital on the evening of 06/03/2022 that Res #1 had had surgery to her right hip and a pin had been put in the right hip. The hospital asked the DON if the facility planned on allowing Res #1 to return to the facility after discharge from the hospital and the DON stated "of course." The DON stated that the hospital did not give any information, nor did she ask for any information, she was merely asked if the facility was willing to accept Res #1 back upon hospital discharge. DON stated that on Saturday 06/04/2022 that no facility staff contacted her that Res #1 had been transferred back to the facility. DON stated that she did not know that Res #1 was back in the facility on 06/04/2022, until she got to work on Monday 06/06/2022. The DON

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confirmed that she had not been given any reports that Res #1 had no pain medications and/or no orders for pain medications and she had no idea that Res #1 had had a second fall in the facility on Saturday 06/04/2022. She stated that there was no documentation of a fall for Res #1 in the facility for 06/04/2022. The DON stated that the facility had begun in-serving and investigating immediately on 06/10/2022 when it was discovered that Res #1 had fallen a second time in the facility on 06/04/2022. She stated that the LPN #1 and RN #1 were both terminated. The DON stated that the nursing staff on 06/04/2022-06/05/2022 had not followed the facility's policies and procedures for assessing falls, documenting falls, using lifts, notifying of change in conditions, and had not obtained the treatments and medications needed by Res #1. The nursing staff had neglected to manage Res 1's pain.

Observation of Resident #1 on 08/01/2022 at 1:00 PM, revealed that Res #1 was in her room on A-hall reclined with feet up in a recliner sleeping soundly. There was an alarm attached to her chair. Resident did not awaken. There was a wing backed padded wheelchair parked in her room.

An interview on 08/01/2022 at 3:00 P.M. with Res. #1's daughter, Resident Representative (RR), revealed that she had been staying with her mother at the hospital after a fall in the facility on 06/02/2022 in which Res #1 received a fractured right hip and a cut with stitches to her eye. RR stated that Res #1 had surgery on Friday 06/03/2022 and had been given strong pain medication such as Morphine while at the hospital. The family had not left Res #1

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unattended in the hospital from 06/02/2022-06/04/2022. She stated that she accompanied her mother upon re-entering the facility on 06/04/2022 at approximately 3:00 PM and after approximately 30 minutes of being back in the facility Res #1 began to complain of pain. RR went to the nursing station and asked if they could give Res #1 some pain medications and was it possible to get her some "Norco" because that seemed to agree with her better and ease her pain. The nurse told the RR that she would call and get an order for pain meds because the hospital had not sent any orders with her for pain medications. The RR assumed that the pain meds would be given to Res #1 when they arrived. She stated that her mother was not hollering out and was not restless when she was with her in her room. Upon the arrival of her brother the RR left and went home leaving her brother there with Res #1. No one at the facility notified her or any member of her family that Res #1 had been without pain meds, and no one notified them of any change in Res #1's condition on 06/04/2022. The RR stated that her brother had reported to her that Res #1 was voicing pain while he was at the facility with Res #1 up until approximately 8:00 PM when he left the facility. The RR stated that she was told by the facility nurse that the hospital had not given them orders as to the treatment and medication needed for Res #1. The RR stated that she assumed that the facility was obtaining the orders for Res #1's pain medication and treatment orders. The RR stated that on Sunday morning 06/05/2022 her brother arrived at the facility at approximately 8:00 AM to sit with Res #1 and found that his mother was in uncontrolled pain and Res #1 was sitting in a recliner in her room alone calling out in pain. Her brother was told by the nurse that they

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put Res #1 in the recliner because she had been trying to get out of bed and she was in pain. Staff told her brother that Res #1 was more relaxed and calmer in the recliner and was refusing to stay in bed. The RR and her brother were concerned about Res #1 being out of bed and sitting up in a chair on her newly pinned right hip. The nurse told her brother that they had called the facility physician and had obtained an order to transfer Res #1 to the local hospital for uncontrolled pain. The nurse told him that the pain medication never arrived, and that Res #1 had been without pain medications since arriving back to the facility. The family accompanied Res #1 to the hospital Emergency Room (ER) on 06/05/2022 at approximately 10:00 AM. The RR stated that on Thursday 06/09/2022 the Physical Therapist (PT) went to assess Res #1 at the hospital and found Res #1 to be in pain and unable to receive PT services, therefore the PT asked that Res #1 have x-rays and that is when they found the left hip to be fractured and the resident in need of a second surgery. The RR and her family had been with Res #1 and knew that she had not had an injury in the hospital, but the only time they had not been with Res #1 was at the nursing home. The hospital physician told the family that a second fall or injury had to have occurred after Res #1 was returned to the facility. RR called the nursing home Administrator and told her what had been told to them by the hospital physician. The facility Administrator stated to the RR that there were no reported falls for Res #1 on 06/04/2022-06/05/2022. The RR stated that later on 06/10/2022 she expressed her anger to the facility Social Services Designee (SSD). The RR stated that it was not long after that she received a phone call from the facility Administrator telling her that they had discovered

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that an unreported fall had occurred on 06/04/2022 and that the staff had been disciplined and the nurses terminated. The RR stated that her brother did not want Res #1 returned to the facility because they had neglected her and had lied and withheld the fall report. The RR stated that since the falls that Res #1 had greatly declined and was no longer independently ambulatory with a cane and now she was incontinent of bowel and bladder. RR stated that Res #1 was mentally more confused, and her cognitive status had declined since having the falls. The RR stated that they hope this type of incident will not ever occur to another resident because it could have been avoided if the nursing staff had done their job and watched out more closely for the resident.

Observation on 08/01/2022 at 3:50 P.M. revealed Res #1 sitting with a group of several residents in the front lobby of the facility near the entrance door. Res #1 was sitting in a reclined wing back wheelchair that was padded and was in the reclined position. She presented as quiet and relaxed. When asked questions Res #1 answered with incomplete sentences and "word salad phrases." When asked how she felt today Res #1 stated "waiting on Saturday." Res #1 was not interviewable on 08/01/2022.

During an interview with CNA #3 on 08/01/2022 at 4:00 PM, she stated that she was working the 3:00-11:00 PM shift on 06/04/2022. CNA #3 stated that Res #1 was calm and relaxed and was not yelling out while her family was with her in her room. CNA #3 stated that after Res #1's family left the facility at approximately 7:30-8:00 PM, Res #1 progressively became more restless and more verbal. Res #1 was hollering out things like

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"what y'all doing?" Res #1 was yelling and was trying to get out of her bed. At about 7:00 PM was when the agency nurse (LPN #1) came to work on the "B"hall and she was the nurse for Res #1. There was also an agency (CNA #1) that was assigned to work with Res #1 from 3:00 PM to 11:00 PM on 06/04/2022. CNA #3 stated that Res #1 fell out of her bed and on to the floor at approximately 7:30-8:00 PM, shortly after her family had left the facility. CNA #3 was standing out in the hall in front of Res #1's door talking to a housekeeping/laundry staff when they saw Res #1 on the floor. The laundry worker called out for help. CNA #3 stated that CNA #1, CNA #2, RN #1 nurse supervisor and LPN #1 went into Res #1's room at approximately 8:00 PM and lifted Res #1 from the floor to the bed. CNA #3 stated that after the fall of Res #1 LPN #1 said that she was going to go and sit in the room with Res #1 to try and keep her in the bed. CNA #3 stated that Res #1 "yelled out" and "hollered" off and on the remainder of her shift. CNA #3 stated that she left the facility at 11:00 PM on 06/04/2022. CNA #3 stated that the CNAs were required to document all changes and all incidents that their assigned residents have during their shift. CNA #3 stated that she had no idea that none of the staff had not reported the fall and she had no idea that Res #1 had no treatment orders. CNA #3 stated that it had always been the policy of the facility to use a full body lift to pick a resident up off the floor after a fall. CNA #3 stated that by not using a lift to pick up a resident that it may cause more unnecessary injury. CNA #3 stated that she was aware that the staff did not follow the facility's policies and procedures for the use of a full body lift after a fall to the floor for Res #1 but only learned on 06/10/2022 that it was not reported and documented. CNA #3 stated that the entire

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facility staff had attended numerous in-services after the incidents with Res #1. CNA #3 stated that they were in-serviced on the proper use of lifts; falls; reporting/notifying; documenting incidents; assessments; visiting, and ethics.

During an interview on 08/02/2022 at 12:30 PM, with CNA #1 she stated that she had been terminated from the facility as a result of the fall of Res #1 on 06/04/2022. CNA #1 confirmed that she had been assigned as the CNA for Res #1 on 06/04/2022. CNA #1 stated that she had worked with Res #1 several times during her contract at the facility and she had knowledge of Res #1's surgery on 06/03/2022. CNA #1 stated that a laundry worker called out to the nurse that Res #1 was on the floor. When CNA #1 got to Res #1's room she saw RN #1, LPN #1 and CNA #2 in the room with Res #1 who was on the floor. RN #1 told them all to assist her in manually picking up Res #1 and putting her back in bed. CNA #1 stated that they all followed the directions of their supervisor. CNA #1 stated that she did not document the fall and did not complete an incident report. CNA #1 stated that Res #1 had been agitated most all night and did yell out in pain. CNA #1 stated that she had been terminated from the facility for failure to report and document the incident, but no one had asked her to document. The nurse supervisor RN #1 was at the scene of Res #1's fall and was advising them on what to do. CNA #1 stated that she had been trained that the facility policy was to use a full body lift to pick up a resident from the floor. CNA #1 stated that even though she knew the facility policy for lifting, she also followed the directions of her supervisor RN #1. CNA #1 stated that she had attended all the in-services for reporting, lifting; documenting, and visiting

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prior to her termination.

During an interview on 08/02/2022 at 1:10 PM, with the facility Social Services Designee (SSD) revealed that prior to Res #1's first fall on 06/02/2022, Res #1 walked about the facility with a cane and was able to toilet herself and care for most of her own Activities of Daily Living (ADLs) with some supervision from staff. The SSD stated that since the falls and surgeries Res #1 had declined and was no longer independent of her ADLs. SSD stated that she attended in-services for supervision of residents; reporting; falls; incident reports; lifts; and abuse and neglect.

During an interview on 08/02/2022 at 1:20 PM with CNA #2 revealed that on 06/04/2022 she was working 3:00 PM to 11:00 PM. CNA #2 stated that she helped RN #1, LPN #1 and CNA #1 to pick up Res #1 manually and put her back in the bed from the floor. CNA #2 stated that the incident happened so long ago that the details were now "fuzzy" to her, and she was unable to recall who all was working as CNAs that night of 06/04/2022. To the best of her memory, she thought that the laundry worker might have been the one that saw Res #1 on the floor and reported it to the nurses. "I think (name of HK) said "she's on the floor" and the nurses and me went running to her room." The RN #1 told us to manually pick Res #1 up and put her in the bed. We did what we were supposed to do and followed the supervisor's instructions. We had all been taught that you never manually pick a resident up from the floor. CNA #2 stated that the fall of Res #1 had occurred at approximately 8:30 P.M. on 06/04/2022. CNA #2 stated that "yes" we could hear her hollering out wanting to get up and out of

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the bed. We went on our lunch break shortly after that and Res #1 was "keeping up some noise." (LPN #1) went in and sat with Res #1. I did not document the fall and I did not report the fall because she was not my assigned resident and I assumed that her CNA and the nurse supervisor would have done all of that. I think it was three (3) or maybe four (4) of us CNA's along with the nurse supervisor (RN #1) and LPN #1 that manually picked Res #1 up off the floor and put her back in her bed. Nobody asked me anything about the incident until about a week after it happened. We should have used a full body lift to put Res #1 back in her bed after she was found on the floor.

During an interview and video observation on 08/02/2022 at 3:30 PM, with the ADM she confirmed that she had the video of the staff running in to Res #1's room at about 10:00 PM on 06/04/2022. The time and date on the video was 06/04/2022 at 2155 (military time for 9:55 PM). The ADM stated that she, the DON and the cooperate staff had all viewed the video numerous times and they had identified that the first persons to enter the room of Res #1 was CNA #2 and CNA #3. The RN #1 nurse supervisor was the third person to run down the hall and enter the room of Res #1 at approximately 10:00 PM. The ADM confirmed that she had the video saved on her computer and she invited the surveyor to view the video as she narrated the events and identified each staff member that entered Res #1's room. ADM confirmed that Res #1 did not have a roommate on 06/04/2022 and was alone in her room. The observation of the facility video revealed that the facility staff were rushing to Res #1's room that was located on Hall B on the left-hand side of the

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hall at about the first or second room behind the nursing station. The ADM identified each of the staff as we watched the video of them running to get to Res #1's room. The video showed RN #1 running to Res #1's room and she entered through the door. In a few seconds afterwards, the LPN #1 ran to Res #1's room and was the last person to enter Res #1's room. After a few minutes RN #1 came out of Res #1's room and returned to the nursing station. LPN #1 came out of Res #1's room and went to the nursing station and got her backpack and some other items and went back to Res #1's room. The ADM stated that through watching the video they were able to see the time of the events and who had knowledge of the events. That was how they knew who to interview because the staff had denied the event when first questioned by the ADM on 06/10/2022. The ADM confirmed that the staff did not do the "right thing" for Res #1 and that they did not follow the facility's policies and procedures. The ADM confirmed that all the staff involved had had one on one counseling and had received write-ups placed in their personnel records. ADM provided copies of all the discipline and counseling sessions that were completed prior to 06/16/2022. The ADM confirmed that all the staff "knew better." The ADM confirmed and provided copies of the in-services that the staff had to attend prior to reporting for work on 06/10/2022-06/13/2022. The ADM stated that all corrective actions were completed on 06/16/2022 and provided a "timeline" of the corrective actions that the facility completed on 06/16/2022.

During an interview on 08/03/2022 at 8:45 AM, with the facility Medical Director (MD) revealed that he had been called on 06/04/2022 by the

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facility nurse and was asked for a pain medication for Res #1. He gave a verbal order for pain medication of Norco but had never been contacted that the pharmacy would not accept a verbal order for pain medications. The MD stated that he would have expected the staff to have called him and informed him of what was going on with Res #1 but they never called him back with a report and never asked for a transfer of Res #1 to the hospital for pain control. The MD stated that the nurses should have contacted him when they were unable to get the pain medication for Res #1. MD stated that Res #1 should never have had to endure pain. MD stated that on the morning of 06/05/2022 he received a call from the nurse that Res #1's medication had not been delivered as ordered and that Res #1 had uncontrolled pain. MD stated that he told the nurse to send Res #1 out immediately to the ER for uncontrolled pain. MD stated that the hospital should not have sent Res #1 back to the facility without pain medications and without orders for treatment. He said that once Res #1 arrived back to the facility the nurses should have obtained orders for treatment from the hospital. MD stated that he had not been the surgeon and had no idea what the hospital wanted the facility to do for Res #1 once she arrived back to the facility. That was why he told the nurse to send Res #1 to the ER for treatment of pain. MD stated that no one at the facility had contacted him to tell him that Res #1 had fallen a second time at the facility on 06/04/2022. The MD stated that immediately after Res #1 fell in her room on 06/04/2022 she should have been sent out to the ER for evaluation. The MD stated that he was made aware on 06/10/2022 that Res #1 had a second fall in the facility. The MD stated that the Quality Assurance (QA) committee met and they

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reviewed all their policies and procedures and that they were all in place and were established prior to the fall of Res #1. The staff choose not to follow the facility policies and procedures.

During an interview with RN #1 on 08/03/2022 at 9:00 AM, revealed RN #1 had no idea that the LPN #1 had not notified the facility administration that Res #1 had fallen. RN #1 stated that she had no idea that LPN #1 had not documented the fall. RN #1 stated that she asked LPN #1 if she was an RN and she said "yes." RN #1 stated that LPN #1 was an agency nurse, and she did not know her prior to that evening. RN #1 stated that LPN #1 did not wear a name tag and she did not know her name and did not know she was an LPN. RN #1 stated that LPN #1 was the nurse on the "B" Hall and RN #1 was the nurse for the "A" hall. RN #1 stated that she did not learn until after the incident that she (RN #1) was the nurse supervisor, she thought LPN #1 was the nurse supervisor. RN #1 stated that she had served as the nurse supervisor for the 7 PM -7 AM shift at the facility. RN #1 stated that she along with three (3) other CNAs had manually picked up Res #1 and put her back in her bed. RN #1 stated that the facility policy was to use a full body lift to get a resident up from the floor. RN #1 stated that she did not complete an incident and accident report for Res #1. RN #1 stated that Res #1 hollered and yelled out during the night. RN #1 stated that hollering and yelling out was not a new behavior for Res #1. Res #1 usually hollered out and yelled most nights prior to her right hip surgery. RN #1 stated that the facility terminated her for not following the facility's policies and procedures for falls and incidents and accidents. RN #1 stated that she did not assess Res #1 after she was found on the floor,

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she assumed that LPN #1 had assessed Res #1. RN #1 stated that LPN #1 had gone in Res #1's room and sat with her after the fall but that Res #1 continued to holler out and yell.

During an interview on 08/04/2022 at 5:30 PM, with RN #2 revealed she worked from 6:00 AM to 5:00 PM on Saturday 06/04/2022 and she received Res #1 at approximately 3:00 PM from the hospital. RN #2 stated that Res #1 walked with the assistance of a cane prior to the right hip fracture. Res #1 was continent of bowel and bladder and was able to take herself to the toilet. She had no issues with hollering out at night prior to the fall on 06/02/2022. RN #2 stated that Res #1 had declined in her physical and mental status after the fall. RN #2 stated that she ordered the Norco for Res #1 and left the facility at 5:00 P.M. with the impression that the pharmacy was delivering the pain medications. RN #2 stated that Res #1 did not complain of pain or holler out prior to 5:00 PM on 06/04/2022. RN #2 stated that the family was with Res #1 and she was calm and relaxed upon entering the facility from the hospital. RN #2 stated that LPN #1 had told her on 06/05/2022 that Res #1 had yelled out and hollered all during the night. RN #2 discovered that the pain medications for Res #1 had not been obtained and she immediately called the MD and got orders to have Res #1 sent to the local hospital for uncontrolled pain. RN #2 stated that she had not received any report that Res #1 had fallen in the facility on 06/04/2022.

Record review of a Departmental Note dated 06/04/2022 at 4:24 PM, revealed "Resident complained of pain to right hip, resident's daughter at bedside and requested that resident have some Norco, the resident took some while

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she was in the hospital and it seemed help, (Formal Name of MD) notified, new order received for Norco 5-325 MG (milligrams) tablet, give 1 (one) tablet by mouth every 6 (six) hours as needed for pain X (times) 3 (three) days." Signed by RN #2.

Record review of the June 2022 electronic Medication Administration Record (MAR) revealed "Norco 5-325 tablet give 1 tablet by mouth every 6 hours as needed for pain X 3 days" with handwritten "entered wo (without)/ Dr. signed prescription" and "Tylenol 1000MG (milligrams) (give 2 (two) X 500MG) by mouth every eight hours PRN pain (not to exceed 3GM (grams) daily)" There was no documentation that this medication was administered. There was no pain scale on the MAR.

Record review of Res. #1's medical record revealed no pain assessment was completed 06/04/2022 and 06/05/2022.

Record review of Res #1's Face Sheet revealed that Res #1 had been admitted to the facility on 02/01/2022 with diagnoses that included but were not limited to Parkinson's Disease; Psychotic Disorder with Hallucinations due to known physiological condition; Disorientation; Altered Mental Status; Muscle Weakness; Unspecified osteoarthritis, unspecified site; among other diagnoses.

Record review of the Minimum Data Set (MDS) dated 2/08/2022 documented that Res #1 had a Brief Interview for Mental Status (BIMS) score of 8 which indicated that Res #1 had moderate cognitive impairment. The MDS dated 4/27/22 documented that Res #1 had a Brief Interview of

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Mental Status (BIMS) score of "9" which indicated slight improvement from admission. The MDS dated 7/13/2022 documented that Res #1 had a BIMS score of "99" which indicated that a BIMS score was not obtainable. The BIMS score of "99" on the MDS dated 7/25/2022 documented a BIMS was unobtainable.

The record review of the Departmental Note dated 2/01/2022 at 10:44 AM, revealed "81-year-old admitted to room B-3 to SNF (Skilled Nursing Facility) Unit with a DX (diagnosis of Parkinson's DS, Parkinson's Related Psychosis, Confusion, Hallucinations, Altered Mental Status, Muscle Weakness. Admitted here from local hospital. Traveled by private car with her daughter. She walked into the building. She uses a cane or walker, gait is unsteady. She is alert but some confusion especially at night. Short term memory deficit, long term pretty good. Some difficulty with decision making. Daughter says that as long as she gets her medicine that she doesn't have behavior problems. No Hx (history) of falls reported. She wants ¼ size rails up to help with positioning. She doesn't have much pain. She can ambulate and transfer with walker or cane. She will need assist of one for other ADL care. She is continent of B and B (bawl and bladder), able to go to the bathroom per self. She worked here years ago in the kitchen and knew me from that time. She seems a little sad to me but would smile when I started talking to her about old times. Her daughter is still here with her."

Record review revealed that the Departmental Note dated 7/1/2022 at 5:34 PM revealed: 81 year old readmitted to Regular bed A1B at 355 PM with Parkinson's Disease with Hallucinations,

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Transient Ischemic Attack (TIA); Gastroesophageal Reflux Disease (GERD); Dementia, Hypertension (HTN), Restless Leg Syndrome, Closed neck fracture right femur with surgical pinning repair on 6/3/2022, Closed Displaced Left Femoral Neck Fracture with Hemiarthroplasty on 6/12/2022, Osteoarthritis, Confusion, Altered Mental Status, Muscle Weakness, Hyperlipidemia, Vitamin D Deficiency, UTI Treated in the Hospital with IV Levaquin, and Atrial Fibrillation (AFIB). Resident was ambulatory with cane prior to falls. She will need assist of 1-2 for ADL care. Use of full body lift 2 assist for transfers at this time until therapy eval. Wears adult briefs. Will require assistance to toilet and incontinent care Q2 hours and as needed. Resident does have Resident does have Stage 3 sacral pressure injury that measures 1.5 x 0.8 x 0.3 MM. Noted with yellow tissue. No drainage. No foul odor. No redness or signs of infection noted.

Record review of the facility's investigation report of Friday 06/10/2022 revealed that handwritten statements had been obtained and the facility staff had documented in the handwritten statements that Res #1 was found on the floor of her bedroom and the facility staff had manually lifted Res #1 from the floor to her bed on Saturday 06/04/2022 at approximately 10:00 P.M. under the directions and supervision of the nurse supervisor, RN #1 and LPN #1. The facility staff admitted in the handwritten statements that no staff had documented the incident and no staff had reported the incident to the facility or to the family. The staff admitted in the handwritten statements that the facility's policies and procedures had not been followed for notifications; for reporting falls; for lifting residents

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after a fall; or for assessing a resident after an incident/accident.

The facility implemented the following Corrective Action Plan on 06/16/22 prior to the SA's entrance on 08/01/2022:

Corrective Action Plan-Residents will be assessed, and medications, treatments, and services will be obtained for residents voicing pain-Corrective Actions:

1- The facility conducted a thorough investigation and obtained statements from all staff in the facility and determined that an incident had occurred on 06/04/2022 at approximately 10:00 P.M. of a second fall that resulted in a second left hip fracture to Res #1 that went unreported until 06/10/2022. The facility reported the incident to the family of Res #1 on 06/10/2022.

2- The facility conducted an Emergency Quality Assurance Committee meeting on 06/10/2022 with the Medical Director, DON, ADM, SSD, and QA staff all present. The QA committee reviewed all the facility policies and procedures for obtaining MD orders, delivery of medications, Pharmacy procedures and Abuse and Neglect; Using Lifts; Notifications of MD and family and DON and ADM; Care Plans; and Accident Prevention. The facility conducted three (3) additional QA Committee meetings from 06/10/2022-06/16/2022, with the fourth (4th) conducted on 06/16/2022.

3- 100% audit of all Incident and Accidents and Falls that had occurred in the facility since January 2022 have been evaluated, reassessed,

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and reviewed by the QA Committee and Administration of the facility.

4- The facility contacted/reported to the MS State Department of Health, The MS Attorney General's Office; Area Ombudsman, and the MS Board of Nursing, on 06/10/2022 as soon as the unreported fall with a second left hip fracture was reported to the facility.

5- On 06/10/2022 100% Room to Room resident reviews were conducted along with interviews with all residents to assess them for safety and quality of care. All residents were checked for physical and emotional well being by SSD, DON, and Nursing Staff with no negative findings and no harm was identified.

6- On 06/10/2022 all staff were mandated to attend in-service training on Lifts; Reporting; Assessing Residents; Obtaining Medication Orders; Notifying of Resident Change; Abuse/Neglect; Falls; and Ethics.

7- On 06/10/2022 all staff that worked 7:00 AM-7:00 PM and 7:00 PM- 7:00 A.M. on 06/04/2022 and 06/05/2022 were issued one on one counseling and write ups of discipline were placed in their personnel records. Three (3) staff, RN #1; LPN #1; and CNA #1 were terminated for failure to report an incident and fall for Res #1 and for not following the facility policies and procedures.

8- Resident #1 was transferred to the hospital located approximately 50 miles away for a second left hip surgery on 06/10/2022. Resident #1 was reassessed upon readmission to the facility and new measures put in to place to

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protect Res #1 from future falls and injuries. Res #1 had pain medications at the facility upon readmission to the facility after the second hip surgery.

9- Facility alleges the relieving of the immediacy of the Immediate Jeopardy (IJ) on 06/16/2022 and Past Non Compliance.

The SA validations of the Facility's Removal Plan/Corrective Action Plans Past Non-Compliance (PNC) were completed by interviews, policy and procedure reviews, record reviews, and observations on 08/01/2022 at 12:00 P.M. - 08/03/2022 at 6:00 P.M. with all staff in the building and via telephone interviews with staff that were terminated or scheduled to work at the facility. The SA validated through record review and observations that the facility had completed their Corrective Actions and had removed the IJ and SQC prior to the SA entering the facility. The Past Non-Compliance was validated and the IJ removed on 06/16/2022.

1- The SA validated through record reviews and interviews from 08/03/2022-08/03/2022 that the facility had conducted a thorough investigation and obtained statements from all staff in the facility and determined that an incident had occurred on 06/04/2022 at approximately 10:00 P.M. of a second fall that resulted in a second left hip fracture to Res #1 that went unreported until 06/10/2022. The SA validated through family (RP) interviews that the facility had reported the incident to the family of Res #1 on 06/10/2022.

2- The SA validated through record reviews and interviews conducted during the complaint

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investigation on 08/01/2022- 08/03/2022 that the facility had conducted an Emergency Quality Assurance Committee meeting on 06/10/2022 with the Medical Director, DON, ADM, SSD, and QA staff all present. The QA committee reviewed all the facility policies and procedures for obtaining MD orders, delivery of medications, Pharmacy procedures and Abuse and Neglect; Using Lifts; Notifications of MD and family and DON and ADM; Care Plans; and Accident Prevention. The facility provided documentation and interviews that they had conducted three (3) additional QA Committee meetings from 06/10/2022-06/16/2022, with the fourth (4th) conducted on 06/16/2022.

3- The SA validated through interviews and documentation reviews that the facility had conducted 100% audit of all Incident and Accidents and Falls that had occurred in the facility since January 2022 have been evaluated, reassessed, and reviewed by the QA Committee and Administration of the facility.

4- The SA validated through record review and interviews on 08/01/2022 - 08/03/2022 that the facility contacted/reported to the MS State Department of Health, The MS Attorney General's Office; Area Ombudsman, and the MS Board of Nursing, on 06/10/2022 as soon as the unreported fall with a second left hip fracture was reported to the facility.

5- The SA validated through interviews, observations, and record reviews that on 06/10/2022, 100% Room to Room resident reviews were conducted along with interviews with all residents to assess them for safety and quality of care. All residents were checked for

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physical and emotional well-being by the facility's SSD, DON, and Nursing Staff with no negative findings and no harm was identified.

6- The SA validated through staff and family (RR) interviews and record reviews that on 06/10/2022 all staff were mandated to attend in-service training on Lifts; Reporting; Assessing Residents; Obtaining Medication Orders; Notifying of Resident Change; Abuse/Neglect; Falls; and Ethics. The SA validated that all facility staff had been in-serviced from 06/10/2022-06/16/2022. The SA also validated that facility in-services and training were on-going and conducted by the facility and cooperate staff on a regular basis.

7- The SA validated through staff interviews, personnel record reviews, and through record reviews that on 06/10/2022 all staff that worked 7:00 AM-7:00 PM and 7:00 PM- 7:00 A.M. on 06/04/2022 and 06/05/2022 were issued one on one counseling and write ups of discipline were placed in their personnel records. Three (3) staff, RN #1; LPN #1; and CNA #1 were terminated for failure to report an incident and fall for Res #1 and for not following the facility policies and procedures. The SA validated through interviews with RN #1 and CNA #1 that they had been terminated from the facility for failure to follow facility policies and procedures and for not reporting a fall of Res #1. The SA was unable to interview LPN #1 as she would not take calls for interviews. The SA attempted unsuccessfully to obtain telephone interviews with LPN #1. The SA did validate through record reviews and through interviews with facility staff that LPN #1 was terminated.

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| F 600 | Continued From page 56<br>8- The SA validate through staff interviews, observations, family (RR) interviews, and record reviews that Resident #1 was transferred to the hospital located approximately 50 miles away for a second left hip surgery on 06/10/2022. Resident #1 was reassessed upon readmission to the facility and new measures put in to place to protect Res #1 from future falls and injuries. Res #1 had pain medications at the facility upon readmission to the facility after the second hip surgery.<br><br>9- The SA validated through interviews, record reviews and observations that the immediacy of the Immediate Jeopardy (IJ) was removed on 06/16/2022 and Past Non Compliance (PNC). | F 600 | | |
| F 689 SS=J | Free of Accident Hazards/Supervision/Devices<br>CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record reviews, staff interviews, Resident Representative (RR) interview, and facility policy and procedure reviews, the facility failed to ensure Resident (Res) #1 was free of accidents as evidenced by an unwitnessed fall with major injury that occurred on 06/04/2022 after re-admission to the facility following surgery to repair a right hip fracture. The staff utilized improper manual lifting | F 689 | Past noncompliance: no plan of correction required. | |

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techniques when transferring Res #1 from the floor after the fall on 06/04/2022 and failed to document, assess Res. #1 and report to the oncoming shift and administration that the fall had occurred. Res #1 was one (1) of six (6) residents reviewed for accidents/hazards and supervision.

On 06/04/2022, Resident #1 had an unwitnessed fall resulting in a right hip fracture which required hospitalization for surgical repair. On 06/04/2022, Resident #1 returned to the facility post hip repair. Resident #1 complained of pain and the facility failed to obtain pain medication and provide pain management treatment. The facility failed to provide adequate supervision of Resident #1, who was distressed, agitated, and disoriented and sustained a second fall. The facility nursing staff failed to notify the physician, family, and facility management of the second fall resulting in a delay in treatment and causing Resident #1 to suffer severe and avoidable pain until transferred to the hospital on June 5, 2022, for unresolved pain. While at the hospital it was discovered the resident had a left hip fracture that resulted in surgical repair.

The facility's failure to supervise Resident #1 causing Resident #1 to fall from bed and sustained a second fractured hip. This situation that has caused Resident #1 serious harm, injury and impairment. This placed other residents in a situation that was likely to cause serious harm, serious injury, serious impairment, or death.

This situation was determined to be an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) that began on 06/04/2022 when the facility failed to notify the necessary parties of Resident #1's fall and pain. The facility

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Administrator was notified of the IJ and SQC on 8/3/22 at 4:00 PM and provided the IJ Template. The facility provide a Past Non-Compliance Corrective Action Plan in which the facility alleged all corrective actions were completed to remove the IJ and SQC on 06/16/2022, and the IJ was removed on 06/16/2022.

The State Agency (SA) determined the IJ was removed on 06/16/2022, prior to the SA's entrance on 08/01/2022 and was Past Non-Compliance (PNC).

Findings include:

Review of the facility policy titled "Accident / Incident Reporting" dated, 01/04, revealed 1. All accidents including residents ... will be reported to the Charge Nurse and to the appropriate department head immediately when it occurs, to be evaluated... If there is a fall, the nurse, Certified Nursing Assistant (CNA), or other first responders, completes Form AD-040 and returns it to the Administrator and Director of Nurse (DON) for further investigation and follow-up ... Outcomes must be included in this report. Description by Witnesses must be completed using Form AD-031. Witness' statements must accompany all reports. 7. Information regarding accidents/incidents that involve a resident will be recorded in the resident's medical record in the nurses' notes. The attending physician and the responsible party will be notified of the accident /incident according to state guidelines ..."

Record review of the facility policy and procedure "Modified Lifting Policy" date 01/04, revealed (Formal Name of Facility) will provide a safe work

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environment for resident care areas by providing the use of safety materials equipment and training designed to prevent personnel and resident injury ...Purpose ...Mechanical resident lifts are a key component in this effort. . Failure to utilize a mechanical resident lift when the use of this equipment is indicated in resident care plan could result in a disciplinary action up to and including termination of employment ..."

On 08/01/2022 at 12:00 PM, an interview with the facility Administrator (ADM) revealed that the facility had received Res #1 back to the facility on Saturday 06/04/2022 at approximately 3:00 PM from the hospital where Res #1 had had a pin placed surgically to her right hip as a result of a fall in the facility on Thursday 06/02/2022. At the time of the first fall on Thursday 06/02/2022, Res #1 was able to relay to the facility that she had fallen in her room as she was attempting to toilet herself. On Thursday 06/02/2022 Res #1 was independently ambulatory with the assistance of a cane and was continent of bowel and bladder. Res #1 was able to relay to the facility staff how she had fallen. Resident was found on the floor of the bathroom with a cut to her eye and pain to her right hip. On Thursday 06/02/2022 Res #1 was transported via ambulance to the local hospital. Hospital x-rayed Res #1 and found her to have a fractured right hip and placed 10 stitches to the cut on her eye. The local hospital transferred Res #1 to the orthopedic unit in another town approximately 50 miles from the facility via ambulance in order to obtain surgery to the right fractured hip. On Friday 06/03/2022 Res #1 had surgery to her right hip and a pin was placed to the hip. On Saturday 06/04/2022 at approximately 3:00 PM, Res #1 arrived back to the facility via ambulance accompanied by her

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daughter. Later, the daughter inquired about the pain medications for Res #1. The nurse Registered Nurse (RN) #2 told the daughter that the hospital had not sent any orders for pain medications only Tylenol as needed (PRN) for pain. The daughter told RN#2 that Res #1 was voicing pain and needed to have some pain medications ordered. The ADM stated that RN #2 called the hospital and the nurse at the hospital told her that the family had requested no pain medications for Res #1 because it made her "loopy." RN #2 called the facility Medical Director (MD) to obtain a verbal order from for "Norco" pain medication per the request of the daughter. RN #2 called the pharmacy and gave the verbal order for "Norco" pain medication and the pharmacy told her that they would call back with the approval and would deliver the medications if approved. RN #2 left the facility at 5:00 PM on Saturday 06/04/2022 and passed on the information to the other nurses at the facility. Later, in the evening of Saturday 06/04/2022 at approximately 7:15 PM, the pharmacy called the facility back and told the 7:00 PM. - 7:00 AM Licensed Practical Nurse (LPN) #1 that they were not allowed to fill a prescription with a verbal order for pain medications (Norco) and that a "hard copy" with a physician's signature was required for all pain medications. LPN #1 did not attempt to obtain the required physician's signature, did not contact or notify the facility physician, did not notify/report to the family, did not call/notify the facility Director of Nursing (DON) and did not notify/call the ADM that the medications were not available, as per facility policy and procedure for notifying. The ADM stated that the facility had a local pharmacy and a back-up pharmacy for obtaining medications. The facility policy is that if a "hard copy" with a

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physician's signature is needed or that a medication needs to be obtained, the nurse was supposed to have called the ADM and the DON and they would obtain the "hard copy" and go pick the medications up and deliver them to the facility. No one contacted the ADM or the DON per facility policy. The staff at the facility reported to the ADM on Friday 06/10/2022 that Res #1 expressed pain and had periods of "yelling out" in pain with restlessness and confusion throughout the night of Saturday 06/04/2022 and early morning of Sunday 06/05/2022. None of the behaviors of Res #1 were documented, reported, and/or assessed by the facility staff on Saturday 06/04/2022 and 06/05/2022. After a night of pain and restlessness and no pain medications, on 06/05/2022 at approximately 10:00 AM, Res #1 was transferred to the local hospital, with a diagnosis of "uncontrolled pain." The administrative staff at the facility had not been notified that Res #1 had fallen in her room on the evening of Saturday 06/04/2022, until Friday 06/10/2022 during interviews with staff. The ADM reported that she received a call from the daughter of Res #1 inquiring about a second fall that had resulted in a second fracture to the opposite (left) hip. The ADM reported that during the first interviews with the evening staff (RN #1, LPN #2, and the CNA's) they all reported that they had no knowledge of a second fall of Res #1 on the evening of Saturday 06/04/2022. There were no documented reports of a fall for Res #1 on Saturday 06/04/2022. On Friday 06/10/2022 CNA #2 reported to the facility Social Service Designee (SSD) that there had been a second facility fall for Res #1 in her room on 06/04/2022 and she had helped to manually pick Res #1 up and place her back in her bed, along with the RN

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#1, LPN #1, and CNA #1. The four (4) nursing staff picked Res #1 up off the floor manually and placed her back in her bed after she was found on the floor by the facility laundry worker. The ADM stated that the method of lifting that was reported by CNA #2 was not in accordance with the facility policy and procedure. The ADM stated that the facility policy and procedure for lifting a resident up from the floor after a fall was to obtain the full body lift and get them off the floor with the lift and place back in the bed for assessments by the nurse. The ADM stated that none of the facility policies and procedures for notifying, falls/accidents, reporting and assessments had been followed by the staff on Saturday 06/04/2022 during the evening shift. As soon as the ADM had received the report on 06/10/2022 that the staff had not "told the truth", about the fall of Res #1, the ADM obtained the hall security camera video and saw the incident of the staff running to Res #1's room at approximately 10:00 PM. The hall camera activity had been identified by the facility ADM and the DON and the video confirmed the incident had occurred on 06/04/2022 at 2155 (9:55 PM) and the staff had responded to Res #1's room. The ADM stated that she had saved the video for her records. The ADM then called all the staff back in and obtained handwritten statements from all staff involved. She stated that RN #1 and LPN #1 were both terminated, and all other staff received counseling with a write up placed in their personnel records. All facility staff were in-serviced on Lifts, Notifying/Reporting; Incidents and Accidents; Pain Management; Obtaining MD and Pharmacy Orders; Visitors Policy; Abuse/Neglect; and Assessments. The facility began working on the investigation and conducted a Quality Assurance (QA) Meeting;

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reviewed the facility policies and procedures; and in-serviced all the facility staff. The facility ADM stated that the facility staff did not follow the policies and procedures of the facility and that an Immediate Jeopardy (IJ) had existed prior to the State Agency (SA) entering the facility on 08/01/2022. The ADM stated that they immediately on 06/10/2022 assessed all residents in the building and did a complete audit of 100% of all incidents and accidents that had occurred since January 2022. They interviewed all residents that were interviewable on 06/10/2022 and none heard or saw anything with Res #1 on 06/04/2022. The ADM stated that the facility had reported the incident to the Attorney General's Office, the Mississippi State Board of Nursing and to the SA on 06/10/2022. The facility ADM stated that the facility had completed the removal of the (IJ) on 06/16/2022. The ADM had all the investigation materials and the IJ removal documentation in a binder and presented the completed information to the surveyor on 08/01/2022 at 12:45 PM.

On 08/01/2022 at 12:45 PM, an interview with the Director of Nursing (DON) revealed that on Saturday 06/04/2022 no facility staff contacted her that Res #1 had been transferred back to the facility. She did not know that Res #1 was back in the facility on 06/04/2022, until she got to work on Monday 06/06/2022. DON confirmed that she had not been given any reports that Res #1 had no pain medications and/or no orders for pain medications and she had no idea that Res #1 had had a second fall in the facility on Saturday 06/04/2022. The DON stated that there was no documentation of a fall for Res #1 in the facility for 06/04/2022. DON stated that the facility had begun in-serving and investigating immediately

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on 06/10/2022 when it was discovered that Res #1 had fallen a second time in the facility on 06/04/2022. DON stated that the nursing staff on 06/04/2022-06/05/2022 had not followed the facility's policies and procedures for assessing falls, documenting falls, using lifts, notifying of change in conditions, and had not obtained the treatments and medications needed by Res #1.

Observation of Resident #1 on 08/01/2022 at 1:00 PM revealed that Res #1 was in her room on A-hall reclined with feet up in a recliner in her room sleeping soundly. There was an alarm attached to her chair. Resident did not awaken. There was no roommate in Res #1 room. Res #1's room was the first door on the left on A-Hall near to the nursing station. Resident was neatly dressed in season appropriate clothing. There was a wing backed padded wheelchair parked in her room.

On 08/01/2022 at 3:00 PM, an interview with the Resident Representative (RR), Res. #1's daughter, revealed that she had been staying with her mother at the hospital after a fall in the facility on 06/02/2022 in which Res #1 received a fractured right hip and a cut with stitches to her eye. The RR stated that Res #1 had surgery at the hospital on Friday 06/03/2022 and had been given strong pain medication such as Morphine while at the hospital. The family had not left Res #1 unattended in the hospital from 6/2/22-6/4/22 RR stated that her brother came to the facility at approximately 6:00 P.M. on 06/04/2022. The RR stated that she accompanied her mother upon re-entering the facility on 06/04/2022 at approximately 3:00 PM and after approximately 30 minutes of being back in the facility Res #1 began to complain of pain. She went to the

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nursing station and asked if they could give Res #1 some pain medications and was it possible to get her some "Norco" because that seemed to agree with her better and ease her pain. Nurse told RR that she would call and get an order for pain meds because the hospital had not sent any orders with her for pain medications. She assumed that the pain meds would be given to Res #1 when they arrived. The RR stated that her mother was not hollering out and was not restless when she was with her in her room. Upon the arrival of her brother the RR left and went home leaving her brother there with Res #1. No one at the facility notified her or any member of her family that Res #1 had been without pain meds, and no one notified them of any change in Res #1's condition on 06/04/2022. The RR stated that her brother had reported to her that Res #1 was voicing pain while he was at the facility with Res #1 up until approximately 8:00 P.M. when he left. The RR stated that she was told by the facility nurse that the hospital had not given them orders as to the treatment and medication needed for Res #1. The RR stated that she assumed that the facility was obtaining the orders for Res #1's pain medication and treatment orders. She stated that on Sunday morning 06/05/2022 her brother arrived at the facility at approximately 8:00 AM to sit with Res #1 and found that his mother was in uncontrolled pain and Res #1 was sitting in a recliner in her room alone calling out in pain. Her brother was told by the nurse that they put Res #1 in the recliner because she had been trying to get out of bed and she was in pain. Staff told her brother that Res #1 was more relaxed and calm in the recliner and was refusing to stay in bed. RR and brother were concerned about Res #1 being out of bed and sitting up in a chair on her newly

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pinned right hip. The nurse told her brother that they had called the facility physician and had obtained an order to transfer Res #1 to the local hospital for uncontrolled pain. The nurse told brother that the pain medication never arrived, and that Res #1 had been without pain medications since arriving back to the facility. The family accompanied Res #1 to the hospital Emergency Room (ER) on 06/05/2022 at approximately 10:00 AM. RR stated that on Thursday 06/09/2022 the Physical Therapist (PT) went to assess Res #1 at the hospital and found Res #1 to be in pain and unable to receive PT services, therefore the PT asked that Res #1 have x-rays and that is when they found the left hip to be fractured and the resident was in need of a second surgery. RR and her family had been with Res #1 and knew that she had not had an injury in the hospital, but the only time they had not stayed with Res #1 was at the nursing home. The hospital physician told the family that a second fall or injury had to have occurred after Res #1 was returned to the facility. RR called the nursing home administrator and told her what had been told to them by the hospital physician. The facility administrator stated to the RR that there were no reported falls for Res #1 on 06/04/2022-06/05/2022. RR stated that later on 06/10/2022 she expressed her anger to the facility Social Services Designee (SSD) and that it was not long after that she received a phone call from the facility administrator telling her that they had discovered that an unreported fall had occurred on 06/04/2022 and that the staff had been disciplined and the nurses terminated. RR stated that her brother did not want Res #1 returned to the facility because they had neglected her and had lied and withheld the fall report. RR stated that Res #1 has now got a bed

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alarm and a wheelchair alarm in place to signal that she is trying to get up. The RR stated that none of those fall prevention measures were in place for Res #1 on 06/04/2022 when she returned from her first surgery. The RR stated that since the falls that Res #1 had greatly declined and was no longer independently ambulatory with a cane and now she was incontinent of bowel and bladder. RR stated that Res #1 was mentally more confused, and her cognitive status had declined since having the falls. The RR stated that they hope this type of incidents will not ever occur to another resident because it could have been avoided if the nursing staff had done their job and watched out more closely for the resident.

Observation on 08/01/2022 at 3:50 P.M. revealed Res #1 sitting with a group of several residents in the front lobby of the facility near the entrance door. Res #1 was sitting in a reclined wing back wheel chair that was padded and was in the reclined position. She presented as quiet and relaxed. When asked questions Res #1 answered with incomplete sentences and "salad phrases." When asked how she felt today Res #1 stated "waiting on Saturday." Res #1 was not interviewable on 08/01/2022. Res #1 was oriented to self. Res #1 did not present as being in any distress. Her affect was sad and flat.

In 08/01/2022 at 4:00 PM, during an interview with CNA #3 she stated that she was working the 3:00-11:00 PM shift on 06/04/2022. CNA #3 stated that Res #1 was calm and relaxed and was not yelling out while her family was with her in her room. CNA #3 stated that after Res #1's family left the facility at approximately 7:30-8:00 PM, Res #1 progressively became more restless and

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more verbal. CNA #3 passed by Res #1's room at approximately 6:30 P.M. and Res #1 was in her bed and appeared agitated and she was talking "out of her head" I would say she was "out of it." Res #1 was hollering out things like "what y'all doing?" Res #1 was yelling and was trying to get out of her bed. At about 7:00 P.M. was when LPN #1 came to work on "B"hall and she was the nurse for Res #1. There was also CNA #1 that was assigned to work with Res #1 from 3:00 PM to 11:00 PM on 06/04/2022. CNA #3 stated that Res #1 fell out of her bed and on to the floor at approximately 7:30-8:00 PM, shortly after her family had left the facility. CNA #3 was standing out in the hall in front of Res #1's door talking to a housekeeping/laundry staff when they saw Res #1 on the floor. Laundry worker called out for help. CNA #3 stated that CNA #1, CNA #2 and RN #1 (nurse supervisor) and LPN #1 went into Res #1's room at approximately 8:00 P.M. and lifted Res #1 from the floor to the bed. CNA #3 stated that after the fall of Res #1 the LPN #1 said that she was going to go and sit in the room with Res #1 to try and keep her in the bed. CNA #3 stated that Res #1 "yelled out" and "hollered" off and on the remainder of her shift. CNA #3 stated that she left the facility at 11:00 PM on 06/04/2022. CNA #3 stated that the CNAs were required to document all changes and all incidents that their assigned residents have during their shift. CNA #3 stated that she had no idea that none of the staff had not reported the fall and she had no idea that Res #1 had no treatment orders. CNA #3 stated that it had always been the policy of the facility to use a full body lift to pick a resident up off the floor after a fall. CNA #3 stated that by not using a lift to pick up a resident that it may cause more unnecessary injury. CNA #3 stated that she was

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aware that the staff did not follow the facility's policies and procedures for the use of a full body lift after a fall to the floor for Res #1. She only learned on 06/10/2022 that it was not reported and documented. CNA #3 stated that she had attended numerous in-services after the incidents with Res #1. CNA #3 stated that they were in-serviced on the proper use of lifts; falls; reporting/notifying; documenting incidents; assessments; visiting, and ethics.

On 08/02/2022 at 12:30 PM, an interview with (CNA #1) she stated that she had worked in the facility on the 7 AM-7PM shift since March of 2022 (approximately 4-5 months). CNA #1 stated that she had been terminated from the facility as a result of the fall of Res #1 on 06/04/2022. CNA #1 confirmed she had been assigned as the CNA for Res #1 on 06/04/2022. CNA #1 stated that she had worked with Res #1 several times during her contract at the facility and she had knowledge of Res #1's surgery on 06/03/2022. CNA #1 stated that a laundry worker called out to the nurse that Res #1 was on the floor and the nurses ran to Res #1's room prior to CNA #1. When CNA #1 got to Res #1's room she saw RN #1, LPN #1 and CNA #2 in the room with Res #1 who was on the floor. RN #1 told them all to assist her in manually picking up Res #1 and putting her back in bed. CNA #1 stated that they all followed the directions of their supervisor. CNA #1 stated that she did not document the fall and did not complete an incident report. CNA #1 stated that Res #1 had been agitated most all night and did yell out in pain. CNA #1 stated that after Res #1 was found on the floor of her room the LPN #1 sat with Res #1 in her room the rest of the night. CNA #1 stated that she had been terminated from the facility for failure to report

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and document the incident, but no one had asked her to document. The nurse supervisor RN #1 was at the scene of Res #1's fall and was advising them on what to do. CNA #1 assumed that the RN #1 and LPN #1 completed the reporting and documenting. CNA #1 stated that she had been trained that the facility policy was to use a full body lift to pick up a resident from the floor. CNA #1 stated that even though she knew the facility policy for lifting, she also followed the directions of her supervisor (RN #1). CNA #1 stated that she had attended all the in-services for reporting, lifting; documenting, and visiting prior to her termination.

On 08/02/2022 at 1:10 PM, an interview with the facility Social Services Designee (SSD) revealed that she had been the SSD since 1990 and had been a CNA. SSD stated that prior to Res #1's first fall on 06/02/2022, Res #1 walked about the facility with a cane and was able to toilet herself and care for most of her own Activities of Daily Living (ADL's) with some supervision from staff. SSD stated that since the falls and surgeries Res #1 had declined and was no longer independent of her ADL's. SSD stated that the facility staff had all attended in-services for supervision of residents; reporting; falls; incident reports; lifts; and abuse and neglect.

On 08/02/2022 at 1:20 PM, an interview with CNA #2 revealed that on 06/04/2022 she was working 3:00 PM to 11:00 PM. CNA #2 stated that she helped RN #1, LPN #1 and CNA #1 to pick up Res #1 manually and put her back in the bed from the floor. CNA #2 stated that the incident happened so long ago that the details were now "fuzzy" to her, and she was unable to recall who all was working as CNA's that night of

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06/04/2022. To the best of her memory, she thought that the laundry worker might have been the one that saw Res #1 on the floor and reported it to the nurses. "I think (name of HK) said "she's on the floor" and the nurses and me went running to her room." I don't know where CNA #1 was but she came in later and helped to pick Res #1 up off the floor and get her in the bed. The RN #1 told us to manually pick Res #1 up and put her in the bed. We did what we were supposed to do and followed the supervisor's instructions. We had all been taught that you never manually pick a resident up from the floor. CNA #2 stated that the fall of Res #1 had occurred at approximately 8:30 P.M. on 06/04/2022. CNA #2 stated that "yes" we could hear her hollering out wanting to get up and out of the bed. We went on our lunch break shortly after that and Res #1 was "keeping up some noise." LPN #1 went in and sat with Res #1. I did not document the fall and I did not report the fall because she was not my assigned resident and I assumed that her CNA and the nurse supervisor would have done all of that. I think it was three (3) or maybe four (4) of us CNAs along with the nurse supervisor (RN #1) and LPN #1 that manually picked Res #1 up off the floor and put her back in her bed. All the facility staff has had to attend in-services and give written statements after the incident with Res #1 on 06/04/2022. Nobody asked me anything about the incident until about a week after it happened. We should have used a full body lift to put Res #1 back in her bed after she was found on the floor.

During an interview and video observation on 08/02/2022 at 3:30 PM, with the ADM she confirmed that she had the video of the staff running in to Res #1's room at about 10:00 P.M. on 06/04/2022. ADM stated that she, the DON

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and the cooperate staff had all viewed the video numerous times and they had identified that the first persons to enter the room of Res #1 was CNA #2 and CNA #3. The RN #1 nurse supervisor was the third person to run down the hall and enter the room of Res #1 at approximately 10:00 PM. The ADM confirmed that she had the video saved on her computer and she invited the surveyor to view the video as she narrated the events and identified each staff member that entered Res #1's room. The ADM confirmed that Res #1 did not have a roommate on 06/04/2022 and was alone in her room. The observation of the facility video revealed that the facility staff were rushing to Res #1's room that was located on Hall B on the left-hand side of the hall at about the first or second room behind the nursing station. The ADM identified each of the staff as we watched the video of them running to get to Res #1's room. The time and date on the video were 06/04/2022 at 2155 (military time for 9:55 P.M.). The video showed RN #1 running to Res #1's room and she entered through the door. A few seconds afterwards, LPN #1 ran to Res #1's room. LPN #1 was the last person to enter Res #1's room. After a few minutes RN #1 came out of Res #1's room and returned to the nursing station. LPN #1 came out of Res #1's room and went to the nursing station and got her backpack and some other items and went back to Res #1's room. The ADM gave the surveyor a written statement that she had saved the video of the events of 06/04/2022 to her computer in her office because the video does not automatically safe after a certain length of time and that she was fortunate to have been able to secure the video in a timely manner prior to it being erased. The ADM stated that through watching the video they were able to see the time of the events and

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who had knowledge of the events. That was how they knew who to interview because the staff had denied the event when first questioned by the ADM on 06/10/2022. ADM stated that they did not follow the facility's policies and procedures. ADM confirmed that all the staff had had one on one counseling and had received write-ups placed in their personnel records. ADM provided copies of all the discipline and counseling sessions that were completed prior to 06/16/2022. The ADM confirmed that all the staff "knew better." The ADM confirmed and provided copies of the in-services that the staff had to attend prior to reporting for work on 06/10/2022-06/13/2022. The ADM stated that the IJ removal plan was completed on 06/16/2022. The ADM provided a "timeline" of the corrective actions that the facility completed on 06/16/2022.

On 08/03/2022 at 8:45 AM, an interview with the Medical Director (MD) revealed that he had been called on 06/04/2022 by the facility nurse and was asked for a pain medication for Res #1 and he gave a verbal order for pain medication of Norco but had never been contacted that the pharmacy would not accept a verbal order for pain medications. MD stated that he would have expected the staff to have called him and informed him of what was going on with Res #1, but they never called him back with a report and never asked for a transfer of Res #1 to the hospital for pain control. MD stated that the nurses should have contacted him when they were unable to get the pain medication for Res #1. MD stated that Res #1 should never have had to endure pain. MD stated that on the morning of 06/05/2022 he received a call from the nurse that Res #1's medication had not been delivered as ordered and that Res #1 had

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uncontrolled pain. MD stated that he told the nurse to send Res #1 out immediately to the ER for uncontrolled pain. MD stated that the hospital should not have sent Res #1 back to the facility without pain medications and without orders for treatment. But that once Res #1 arrived back to the facility the nurses should have obtained orders for treatment from the hospital. MD stated that he had not been the surgeon and had no idea what the hospital wanted the facility to do for Res #1 once she arrived back to the facility. That was why he told the nurse to send Res #1 to the ER for treatment of pain. MD stated that no one at the facility had contacted him to tell him that Res #1 had fallen a second time at the facility on 06/04/2022. MD stated that immediately after Res #1 fell in her room on 06/04/2022 she should have been sent out to the ER for evaluation. The MD stated that he was made aware on 06/10/2022 that Res #1 had a second fall in the facility. MD stated that the Quality Assurance (QA) committee met, and they reviewed all their policies and procedures and that they were all in place and were established prior to the fall of Res #1, the staff choose not to follow the facility policies and procedures.

On 08/03/2022 at 9:00 AM, in an interview RN #1 stated that she had no idea that the LPN #1 had not notified the facility administration that Res #1 had fallen nor that LPN #1 had not documented the fall. RN #1 stated that she asked LPN #1 if she was an RN and she said "yes." RN #1 stated that LPN #1 was an agency nurse, and she did not know her prior to that evening. RN #1 stated that LPN #1 did not wear a name tag and she did not know her name and did not know she was an LPN. RN #1 stated that LPN #1 was the nurse on the "B" Hall and RN #1 was the nurse for the

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"A" hall. RN #1 stated that she did not learn until after the incident that she (RN #1) was the nurse supervisor, she thought LPN #1 was the nurse supervisor. RN #1 stated that she had served as the nurse supervisor for 7 PM -7 AM shift at the facility. RN #1 stated that she along with three (3) other CNAs had manually picked up Res #1 and put her back in her bed. RN #1 stated that the facility policy was to use a full body lift to get a resident up from the floor. RN #1 stated that she did not complete an incident and accident report for Res #1. RN #1 stated that Res #1 hollered and yelled out during the night. RN #1 stated that hollering and yelling out was not a new behavior for Res #1. Res #1 usually hollered out and yelled most nights prior to her right hip surgery. RN #1 stated that the facility terminated her for not following the facility's policies and procedures for falls and incidents and accidents. RN #1 stated that she did not assess Res #1 after she was found on the floor, she assumed that LPN #1 had assessed Res #1. RN #1 stated that LPN #1 had gone in Res #1's room and sat with her after the fall but that Res #1 continued to holler out and yell.

On 08/04/2022 at 5:30 PM, in an interview with RN #2 stated that she worked from 6:00 AM to 5:00 PM on Saturday 06/04/2022 and she received Res #1 at approximately 3:00 PM from the hospital. RN #2 stated that Res #1 walked with the assistance of a cane prior to the right hip fracture. Res #1 was continent of bowel and bladder, was able to take herself to the toilet, and had no issues with hollering out at night prior to the fall on 06/02/2022. RN #2 stated that Res #1 had declined in her physical and mental status after the fall. RN #2 stated that she ordered the Norco for Res #1 and left the facility at 5:00 PM

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with the impression that the pharmacy was delivering the pain medications. RN #2 stated that Res #1 did not complain of pain or holler out prior to 5:00 PM on 06/04/2022. RN #2 stated that the family was with Res #1 and she was calm and relaxed upon entering the facility from the hospital. RN #2 discovered that the pain medications for Res #1 had not been obtained and she immediately called the MD and got orders to have Res #1 sent to the local hospital for uncontrolled pain. RN #2 stated that she had not received any report that Res #1 had fallen in the facility on 06/04/2022.

Record review of Res #1's Face Sheet revealed that Res #1 had been admitted to the facility on 02/01/2022 with diagnoses that included but were not limited to Parkinson's Disease; Psychotic Disorder with Hallucinations due to known physiological condition; Disorientation; Altered Mental Status; Muscle Weakness; Essential Hypertension; Unspecified osteoarthritis, unspecified site; among other diagnoses.

Record review of the Minimum Data Set (MDS) dated 2/08/2022 documented that Res #1 had a Brief Interview for Mental Status (BIMS) score of 8 which indicated that Res #1 had moderate cognitive impairment. The MDS dated 4/27/22 documented that Res #1 had a BIMS score of "9" which indicated slight improvement from admission. The MDS dated 7/13/2022 documented that Res #1 had a BIMS score of "99" which indicated that a BIMS score was not obtainable. The BIMS score of "99" on the MDS dated 7/25/2022 documented a BIMS was unobtainable.

The record review of the Departmental Note

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dated 2/01/2022 revealed "81 year old admitted to room... to SNF (Skilled Nursing Facility) Unit with a DX (diagnosis of) Parkinson's DS, Parkinson's Related Psychosis, Confusion, Hallucinations, Altered Mental Status, Muscle Weakness. Admitted here from local hospital. Traveled by private car with her daughter. She walked into the building. She uses a cane or walker, gait is unsteady. She is alert but some confusion especially at night. Short term memory deficit, Long term pretty good. Some difficulty with decision making. Daughter says that as long as she gets her medicine that she doesn't have behavior problems. No Hx (history) of falls reported. She wants ¼ size rails up to help with positioning. She doesn't have much pain. She can ambulate and transfer with walker or cane. She will need assist of one for other ADL (activity of daily living) care. She is continent of B and B (bowel and bladder), able to go to the bathroom per self. She worked here years ago in the kitchen and knew me from that time. She seems a little sad to me but would smile when I started talking to her about old times. Her daughter is still here with her."

Record review revealed that the Departmental Note dated 7/1/2022 at 5:34 PM revealed: 81 year old readmitted to Regular bed ...at 355 PM with Parkinson's Disease with Hallucinations, Transient Ischemic Attack (TIA);... Dementia,... Closed neck fracture right femur with surgical pinning repair on 6/3/2022, Closed Displaced Left Femoral Neck Fracture with Hemiarthroplasty on 6/12/2022, Osteoarthritis, Confusion, Altered Mental Status, Muscle Weakness.... Resident was ambulatory with cane prior to falls. She will need assist of 1-2 for ADL care. Use of full body lift 2 (two) assist for transfers at this time until

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therapy eval. Wears adult briefs. Will require assistance to toilet and incontinent care Q(every)2 hours and as needed. Resident does have Resident does have Stage 3 sacral pressure injury that measures 1.5 x 0.8 x 0.3 MM. Noted with yellow tissue. No drainage. No foul odor. No redness or signs of infection noted."

Record review of the facility's investigation report of Friday 06/10/2022 revealed that hand written statements had been obtained and the facility staff had admitted in the hand written statements that Res #1 was found on the floor of her bedroom and the facility staff had manually lifted Res #1 from the floor to her bed on Saturday 06/04/2022 at approximately 10:00 P.M. under the directions and supervision of the nurse supervisor (RN #1) and (LPN #1). The facility staff admitted in the handwritten statements that no staff had documented the incident and no staff had reported the incident to the facility or to the family. The staff admitted in the handwritten statements that the facility's policies and procedures had not been followed for notifications; for reporting falls; for lifting residents after a fall; or for assessing a resident after an incident/accident.

In response to the Immediate Jeopardy's (IJ's) Past Non-Compliance (PNC) that were cited on 08/03/2022 at 4:00 PM the facility submitted the following IJ Corrective Action Plan that was accepted by the SA as Past Non-Compliance (PNC) on 08/03/2022 at 4:00 P.M.

Removal Plan IJ-Residents will be assessed, and medications, treatments, and services will be obtained for residents voicing pain-Corrective Actions:

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1- The facility conducted a thorough investigation and obtained statements from all staff in the facility and determined that an incident had occurred on 06/04/2022 at approximately 10:00 P.M. of a second fall that resulted in a second left hip fracture to Res #1 that went unreported until 06/10/2022. The facility reported the incident to the family of Res #1 on 06/10/2022.

2- The facility conducted an Emergency Quality Assurance Committee meeting on 06/10/2022 with the Medical Director, DON, ADM, SSD, and QA staff all present. The QA committee reviewed all the facility policies and procedures for obtaining MD orders, delivery of medications, Pharmacy procedures and Abuse and Neglect; Using Lifts; Notifications of MD and family and DON and ADM; Care Plans; and Accident Prevention. The facility conducted three (3) additional QA Committee meetings from 06/10/2022-06/16/2022, with the fourth (4th) conducted on 06/16/2022.

3- 100% audit of all Incident and Accidents and Falls that had occurred in the facility since January 2022 have been evaluated, reassessed, and reviewed by the QA Committee and Administration of the facility.

4- The facility contacted/reported to the MS State Department of Health, The MS Attorney General's Office; Area Ombudsman, and the MS Board of Nursing, on 06/10/2022 as soon as the unreported fall with a second left hip fracture was reported to the facility.

5- On 06/10/2022 100% Room to Room

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resident reviews were conducted along with interviews with all residents to assess them for safety and quality of care. All residents were checked for physical and emotional well being by SSD, DON, and Nursing Staff with no negative findings and no harm was identified.

6- On 06/10/2022 all staff were mandated to attend in-service training on Lifts; Reporting; Assessing Residents; Obtaining Medication Orders; Notifying of Resident Change; Abuse/Neglect; Falls; and Ethics.

7- On 06/10/2022 all staff that worked 7:00 AM-7:00 PM and 7:00 PM- 7:00 A.M. on 06/04/2022 and 06/05/2022 were issued one on one counseling and write ups of discipline were placed in their personnel records. Three (3) staff, RN #1; LPN #1; and CNA #1 were terminated for failure to report an incident and fall for Res #1 and for not following the facility policies and procedures.

8- Resident #1 was transferred to the hospital located approximately 50 miles away for a second left hip surgery on 06/10/2022. Resident #1 was reassessed upon readmission to the facility and new measures put in to place to protect Res #1 from future falls and injuries. Res #1 had pain medications at the facility upon readmission to the facility after the second hip surgery.

9- Facility alleges the relieving of the immediacy of the Immediate Jeopardy (IJ) on 06/16/2022 and Past Non-Compliance.

The SA validations of the facility's Corrective

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Action Plan Past Non-Compliance (PNC) were completed by interviews, policy and procedure reviews, record reviews, and observations on 08/01/2022 at 12:00 PM- 08/03/2022 at 6:00 PM with all staff in the building and via telephone interviews with staff that were terminated or scheduled to work at the facility. The SA validated through record review and observations that the facility had completed their Corrective Actions and had removed the IJ prior to the SA entering the facility on 08/01/2022. The Past Non-Compliance was validated and the IJ removed on 06/16/2022.

1- The SA validated through record reviews and interviews from 08/03/2022-08/03/2022 that the facility had conducted a thorough investigation and obtained statements from all staff in the facility and determined that an incident had occurred on 06/04/2022 at approximately 10:00 P.M. of a second fall that resulted in a second left hip fracture to Res #1 that went unreported until 06/10/2022. The SA validated through family (RR) interviews that the facility had reported the incident to the family of Res #1 on 06/10/2022.

2- The SA validated through record reviews and interviews conducted during the complaint investigation on 08/01/2022- 08/03/2022 that the facility had conducted an Emergency Quality Assurance Committee meeting on 06/10/2022 with the Medical Director, DON, ADM, SSD, and QA staff all present. The QA committee reviewed all the facility policies and procedures for obtaining MD orders, delivery of medications, Pharmacy procedures and Abuse and Neglect; Using Lifts; Notifications of MD and family and DON and ADM; Care Plans; and Accident Prevention. The facility provided documentation

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and interviews that they had conducted three (3) additional QA Committee meetings from 06/10/2022-06/16/2022, with the fourth (4th) conducted on 06/16/2022.

3- The SA validated through interviews and documentation reviews that the facility had conducted 100% audit of all Incident and Accidents and Falls that had occurred in the facility since January 2022 have been evaluated, reassessed, and reviewed by the QA Committee and Administration of the facility.

4- The SA validated through record review and interviews on 08/01/2022 - 08/03/2022 that the facility contacted/reported to the MS State Department of Health, The MS Attorney General's Office; Area Ombudsman, and the MS Board of Nursing, on 06/10/2022 as soon as the unreported fall with a second left hip fracture was reported to the facility.

5- The SA validated through interviews, observations, and record reviews that on 06/10/2022, 100% Room to Room resident reviews were conducted along with interviews with all residents to assess them for safety and quality of care. All residents were checked for physical and emotional well-being by the facility's SSD, DON, and Nursing Staff with no negative findings and no harm was identified.

6- The SA validated through staff and family (RR) interviews and record reviews that on 06/10/2022 all staff were mandated to attend in-service training on Lifts; Reporting; Assessing Residents; Obtaining Medication Orders; Notifying of Resident Change; Abuse/Neglect; Falls; and Ethics. The SA validated that all facility

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staff had been in-serviced from 06/10/2022-06/16/2022. The SA also validated that facility in-services and training were on-going and conducted by the facility and cooperate staff on a regular basis.

7- The SA validated through staff interviews, personnel record reviews, and through record reviews that on 06/10/2022 all staff that worked 7:00 AM-7:00 PM and 7:00 PM- 7:00 A.M. on 06/04/2022 and 06/05/2022 were issued one on one counseling and write ups of discipline were placed in their personnel records. Three (3) staff, RN #1; LPN #1; and CNA #1 were terminated for failure to report an incident and fall for Res #1 and for not following the facility policies and procedures. The SA validated through interviews with RN #1 and CNA #1 that they had been terminated from the facility for failure to follow facility policies and procedures and for not reporting a fall of Res #1. The SA was unable to interview LPN #1 as she would not take calls for interviews. The SA attempted unsuccessfully to obtain telephone interviews with LPN #1. The SA did validate through record reviews and through interviews with facility staff that LPN #1 was terminated.

8- The SA validate through staff interviews, observations, family (RR) interviews, and record reviews that Resident #1 was transferred to the hospital located approximately 50 miles away for a second left hip surgery on 06/10/2022. Resident #1 was reassessed upon readmission to the facility and new measures put in to place to protect Res #1 from future falls and injuries. Res #1 had pain medications at the facility upon readmission to the facility after the second hip surgery.

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| F 689 | Continued From page 84<br><br>9- The SA validated through interviews, record reviews and observations that the immediacy of the Immediate Jeopardy (IJ) was removed on 06/16/2022 and Past Non Compliance (PNC). | F 689 | | |
| F 697 SS=J | Pain Management<br>CFR(s): 483.25(k)<br><br>§483.25(k) Pain Management.<br>The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record reviews, staff and Resident Represent (RR) interviews, and facility policy and procedure reviews, the facility failed to manage Res #1's pain after returning to the facility from her first right hip surgery on 06/04/2022 at 3:00 PM. The facility failed to obtain pain medications for Res #1 after she voiced pain and after the family's request for pain medications of Norco to be given to Res #1. Res #1 yelled out and screamed in pain through the night of 06/04/2022 and the facility failed to acquire methods of pain management for Res #1's verbalized pain. Res #1 sustained a second fall and a left fractured hip on 06/04/2022 at approximately 10:00 PM requiring a second hip surgery. Res #1 was one (1) of six (6) residents reviewed for pain.<br><br>On 06/02/2022, Resident #1 had an unwitnessed fall resulting in a right hip fracture which required hospitalization for surgical repair. On 06/04/2022, Resident #1 returned to the facility post hip repair. Resident #1 complained of pain and the facility | F 697 | Past noncompliance: no plan of correction required. | |

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failed to obtain pain medication and provide pain management treatment resulting in the resident becoming increasingly distressed and agitated. Resident #1 sustained a second fall at approximately 10:00 PM on 06/04/2022 and suffered severe and avoidable pain until transferred to the hospital on 06/05/2022 for unresolved pain. While at the hospital it was discovered the resident had a left hip fracture that resulted in surgical repair.

The facility's failure to effectively manage Resident #1's pain after a right hip surgery and after an additional fall on 06/04/2022 when Resident #1 returned to the facility post hospitalization for hip surgery. This situation caused Resident #1 serious harm, serious injury or serious impairment. This placed other residents in a situation that was likely to cause serious harm, serious injury, serious impairment, or death.

This situation was determined to be an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) that began on 06/04/2022 when the facility failed to assess and treat Resident #1's pain and notify the necessary parties of Resident #1's fall and pain. The facility Administrator was notified of the IJ and SQC on 08/03/2022 at 4:00 PM. The facility provide a Past Non-Compliance Corrective Action Plan in which the facility alleged all corrective actions were completed to remove the IJ and SQC on 06/16/2022, and the IJ and SQC was removed on 06/16/2022.

The State Agency (SA) determined the IJ and SQC was removed on 06/16/22, prior to the SA's entrance on 08/01/2022 and was Past

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Non-Compliance (PNC).

Findings include:

Review of the facility policy and procedure titled "Pain Management" dated 1/20/2021 revised 6/10/2022 revealed: The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. The facility will utilize a systematic approach for recognition, assessment, treatment, and monitoring of pain.

Record review of the undated facility policy titled "Change In Resident Medical Status" revealed: A change in medical status is defined as any physical, psychological, and/or medical deviation as compared to the resident's status as noted in the initial assessment. These changes may include fall and/or injury, fever, refusal to eat after 24-hour period, confusion,or other change in mental behavior. These changes must be noted in a) Clinical Record, b) Care Plan if significant, c) Accident/Incident Report (if due to fall or injury) ... A facility must immediately inform the resident, the physician, responsible party when there is: 1. A need to alter treatment 2. An accident involving the resident which results in injury and has the potential for requiring physician intervention. 3. A significant change in the resident's physical, mental or psychological status. 4. A decision to transfer or discharge the resident from the facility. If the physician is unable to be reached for resident condition change requiring alterative treatment, you should do the following: 1. Notify the Medical Director. If unable to reach, 2. Call the ambulance and transfer to hospital."

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Interview with the facility Administrator (ADM) on 08/01/2022 at 12:00 PM, revealed that the facility had received resident (Res #1) back to the facility on Saturday 06/04/2022 at approximately 3:00 P.M. from the hospital where Res #1 had had a pin placed surgically to her right hip because of a fall in the facility on Thursday 06/02/2022. At the time of the first fall on Thursday 06/02/2022, Res #1 was able to relay to the facility that she had fallen in her room as she was attempting to toilet herself. On Thursday 06/02/2022 Res #1 was independently ambulatory with the assistance of a cane and was continent of bowel and bladder. Res #1 was able to relay to the facility staff how she had fallen. Resident was found on the floor of the bathroom with a cut to her eye and pain to her right hip. On Thursday 06/02/2022, Res #1 was transported via ambulance to the local hospital. Hospital x-rayed Res #1 and found her to have a fractured right hip and placed 10 stitches to the cut on her eye. The local hospital transferred Res #1 to the orthopedic unit in another town approximately 50 miles from the facility via ambulance to obtain surgery to the right fractured hip. On Friday 06/03/2022, Res #1 had surgery to her right hip and a pin was placed to the hip. On Saturday 06/04/2022, at approximately 3:00 PM Res #1 arrived back to the facility via ambulance accompanied by her daughter. Registered Nurse (RN) #2 told the daughter that the hospital had not sent any orders for pain medications only Tylenol as needed (PRN) for pain. The daughter told RN#2 that Res #1 was voicing pain and needed to have some pain medications ordered. The ADM stated that RN #2 called the hospital and the nurse at the hospital told her that the family had requested no pain medications for Res #1 because it made her

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"loopy." RN #2 called the facility Medical Director (MD) to obtain a verbal order from for "Norco" pain medication per the request of the daughter, who was at the facility with Res #1. RN #2 called the pharmacy and gave the verbal order for "Norco" pain medication and the pharmacy told her that they would call back with the approval and would deliver the medications if approved. RN #2 left the facility at 5:00 PM on Saturday 06/04/2022 and passed on the information to the other nurses at the facility. Later, in the evening of Saturday 06/04/2022 at approximately 7:15 PM, the pharmacy called the facility back and told the 7:00 PM - 7:00 AM Licensed Practical Nurse (LPN #1) that they were not allowed to fill a prescription with a verbal order for pain medications (Norco) and that a "hard copy" with a physician's signature was required for all pain medications. LPN #1 did not attempt to obtain the required physician's signature, did not contact/notify the facility physician, did not notify/report to the family, did not call/notify the facility DON and did not notify/call the ADM that the medications were not available, as per facility policy and procedure for notifying. The ADM stated that the facility had a local pharmacy and a back-up pharmacy for obtaining medications. The facility policy is that if a "hard copy" with a physician's signature is needed or that a medication needs to be obtained, the nurse was supposed to have called the ADM and the DON and they would obtain the "hard copy" and go pick the medications up and deliver them to the facility. No one contacted the ADM or the DON per facility policy. The staff at the facility reported to the ADM on Friday 06/10/2022 that Res #1 expressed pain and had periods of "yelling out" in pain with restlessness and confusion throughout the night of Saturday

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06/04/2022 and early morning of Sunday 06/05/2022. None of the behaviors of Res #1 were documented, reported, and/or assessed by the facility staff on Saturday 06/04/2022 and 06/05/2022, after a night of pain and restlessness and no pain medications. On 06/05/2022 at approximately 10:00 AM Res #1 was transferred to the local hospital, with a diagnosis of "uncontrolled pain." The administrative staff at the facility had not been notified that Res #1 had fallen in her room on the evening of Saturday 06/04/2022, until Friday 06/10/2022 during interviews with staff. The ADM reported that she received a call from the daughter of Res #1 inquiring about a second fall that had resulted in a second fracture to the opposite (left) hip. The ADM reported that during the first interviews with the evening staff (RN #1, LPN #2, and the CNA's) they all reported that they had no knowledge of a second fall of Res #1 on the evening of Saturday 06/04/2022. There were no documented reports of a fall for Res #1 on Saturday 06/04/2022.

Interview with the Director of Nursing (DON) on 08/01/2022 at 12:45 PM, revealed that the nursing staff on 06/04/2022-06/05/2022 had not followed the facility's policies and procedures for assessing falls, documenting falls, using lifts, notifying of change in conditions, and had not obtained the treatments and medications needed by Res #1. The nursing staff had neglected to manage Res 1's pain.

Interview with the Resident Representative (RR) on 08/01/2022 at 3:00 PM, stated that she accompanied her mother upon re-entering the facility on 06/04/2022 at approximately 3:00 PM and after approximately 30 minutes of being back in the facility Res #1 began to complain of pain.

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RR went to the nursing station and asked if they could give Res #1 some pain medications and was it possible to get her some "Norco" because that seemed to agree with her better and ease her pain. Nurse told RR that she would call and get an order for pain meds because the hospital had not sent any orders with her for pain medications. RR assumed that the pain meds would be given to Res #1 when they arrived. RR stated that her mother was not hollering out and was not restless when she was with her in her room. Upon the arrival of her brother the RR left and went home leaving her brother there with Res #1. No one at the facility notified her or any member of her family that Res #1 had been without pain meds, and no one notified them of any change in Res #1's condition on 06/04/2022. RR stated that her brother had reported to her that Res #1 was voicing pain while he was at the facility with Res #1 up until approximately 8:00 PM when he left the facility. RR stated that she was told by the facility nurse that the hospital had not given them orders as to the treatment and medication needed for Res #1. The RR stated that she assumed that the facility was obtaining the orders for Res #1's pain medication and treatment orders. RR stated that on Sunday morning, 06/05/2022, her brother arrived at the facility at approximately 8:00 AM to sit with Res #1 and found that his mother was in uncontrolled pain and Res #1 was sitting in a recliner in her room alone calling out in pain. Brother was told by the nurse that they put Res #1 in the recliner because she had been trying to get out of bed and she was in pain. Staff told brother that Res #1 was more relaxed and calmer in the recliner and was refusing to stay in bed. RR and brother were concerned about Res #1 being out of bed and sitting up in a chair on her newly pinned right

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hip. Nurse told brother that they had called the facility physician and had obtained an order to transfer Res #1 to the local hospital for uncontrolled pain. Nurse told brother that the pain medication never arrived, and that Res #1 had been without pain medications since arriving back to the facility. The family accompanied Res #1 to the hospital Emergency Room (ER) on 06/05/2022 at approximately 10:00 AM. RR stated that on Thursday 06/09/2022 the Physical Therapist (PT) went to assess Res #1 at the hospital and found Res #1 to be in pain and unable to receive PT services, therefore the PT asked that Res #1 have x-rays and that is when they found the left hip to be fractured and in need of a second surgery.

In an interview with CNA #1 on 08/02/2022 at 12:30 PM, reported she had been assigned as the CNA for Res #1 on 06/04/2022. CNA #1 stated that Res #1 had been agitated most all night and did yell out in pain.

Interview with the facility Medical Director (MD) on 08/03/2022 at 8:45 AM, revealed that he had been called on 06/04/2022 by the facility nurse and was asked for a pain medication for Res #1 and he gave a verbal order for pain medication of Norco but had never been contacted that the pharmacy would not accept a verbal order for pain medications. MD stated that he would have expected the staff to have called him and informed him of what was going on with Res #1, but they never called him back with a report and never asked for a transfer of Res #1 to the hospital for pain control. MD stated that the nurses should have contacted him when they were unable to get the pain medication for Res #1. MD stated that Res #1 should never have

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had to endure pain. MD stated that on the morning of 06/05/2022, he received a call from the nurse that Res #1's medication had not been delivered as ordered and that Res #1 had uncontrolled pain. MD stated that he told the nurse to send Res #1 out immediately to the ER for uncontrolled pain. MD stated that the hospital should not have sent Res #1 back to the facility without pain medications and without orders for treatment. But that once Res #1 arrived back to the facility the nurses should have obtained orders for treatment from the hospital. The MD stated that he had not been the surgeon and had no idea what the hospital wanted the facility to do for Res #1 once she arrived back to the facility. That was why he told the nurse to send Res #1 to the ER for treatment of pain. The MD stated that no one at the facility had contacted him to tell him that Res #1 had fallen a second time at the facility on 06/04/2022 and stated that immediately after Res #1 fell in her room on 06/04/2022 she should have been sent out to the ER for evaluation. The MD stated that he was made aware on 06/10/2022 that Res #1 had a second fall in the facility. The MD stated that the QA committee met, and they reviewed all their policies and procedures and that they were all in place and were established prior to the fall of Res #1 and the staff just chose not to follow the facility policies and procedures.

In an interview with RN #2 on 08/04/2022 at 5:30 PM, revealed that she worked from 6:00 AM to 5:00 PM on Saturday 06/04/2022 and she received Res #1 at approximately 3:00 PM from the hospital. RN #2 stated that she ordered the Norco for Res #1 and left the facility at 5:00 PM with the impression that the pharmacy was delivering the pain medications. RN #2 stated

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that Res #1 did not complain of pain or holler out prior to 5:00 PM on 06/04/2022. RN #2 stated that the family was with Res #1, and she was calm and relaxed upon entering the facility from the hospital. RN #2 stated that LPN #1 had told her on 06/05/2022 that Res #1 had yelled out and hollered all during the night. RN #2 discovered that the pain medications for Res #1 had not been obtained and she immediately called the MD and got orders to have Res #1 sent to the local hospital for uncontrolled pain. RN #2 stated that she had not received any report that Res #1 had fallen in the facility on 06/04/2022.

Record review of a Departmental Note dated 06/04/2022 at 4:24 PM, revealed "Resident complained of pain to right hip, resident's daughter at bedside and requested that resident have some Norco, the resident took some while she was in the hospital and it seemed help, (Formal Name of MD) notified, new order received for Norco 5-325 MG (milligrams) tablet, give 1 (one) tablet by mouth every 6 (six) hours as needed for pain X (times) 3 (three) days." Signed by RN #2.

Record review of the June 2022 electronic Medication Administration Record (MAR) revealed "Norco 5-325 tablet give 1 tablet by mouth every 6 hours as needed for pain X 3 days" with handwritten "entered wo (without)/ Dr. signed prescription" and "Tylenol 1000 MG (milligrams) (give 2 (two) X 500 MG) by mouth every eight hours PRN pain (not to exceed 3 GM (grams) daily)" There was no documentation that this medication was administered. There was no pain scale on the MAR.

Record review of Res. #1's medical record

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revealed no pain assessment was completed 06/04/2022 and 06/05/2022.

Record review of Res #1's Face Sheet revealed that Res #1 had been admitted to the facility on 02/01/2022 with diagnoses that included but were not limited to Parkinson's Disease; Psychotic Disorder with Hallucinations due to known physiological condition; Disorientation; Altered Mental Status; Muscle Weakness; Essential Hypertension; Gastro-esophageal reflux; Vitamin D deficiency; Unspecified osteoarthritis, unspecified site; among other diagnoses.

Record review revealed an undated hand-written statement signed by (RN #1) that read: "On 6-4-22 I was working with an agency nurse and one of our residents was screaming and hollering. We asked had she had any pain medication, other nurses stated family did not want her to have any. I tried to give her a Tylenol resident stated, "no that's poison."

Record review of the handwritten dated statement with LPN #1 and signed by LPN #1 and dated by LPN #1 on 6/10/2022 with her address and phone number revealed: "8:00 PM Saturday -Standing on side of bed-CNA helped to get her back in bed. 7:49 Son asked to stay with resident but (LPN #1) did not know the policy and would have to ask. He never mentioned it again and I did not find out what policy was. (Res #1) was standing on side of bed and we assisted her back to bed. I left room and another employee said (Res #1) was lying on floor. Near wall on right side. I asked (Res #1) what happened, and she said, "I tried to walk and fell "my hip is broke." Assessed her on floor and manually picked her up. 3 others (RN #1) helped to the bed. Did not c/o (complain

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of) pain. Did not document. Did not call anyone. 9:51 I asked (RN #1) about incident report. She said it was too long, don't worry about it. I went and got my food and went to room to sit with her. Resident complained of pain, and I went and got 2 Tylenol, but she only took one. "One is enough, I guess I got to die someway." I tried to get her to take another one, but she would not take it. I sat with her to monitor pain. Pain level 8-9. At 7AM Sunday 6/5/22 I gave report to (RN #2) stating that I tried to give her Tylenol for pain, but she wouldn't take it. Is there a standing order for Ibuprofen. At this time, she took 2 Ibuprofen at 6:50 AM. Never reported fall. (RN #1) came in room we were just talking I told her (Res #1) will not take the Tylenol for pain and that what shall I do to try to make her take medicine because I knew she had to be in pain. (RN #1) came around the bed and said with hand motion to mouth "zip it." I would not say a thing you assess her there were no bruises."

Record review of the 06/10/2022 signed handwritten statement of RN #3 revealed: "Resident (Res #1) returned to facility from hospital via Ambulance accompany by her daughter. (RN #2) did a full body assessment and vital signs. Weight done with full body lift. Daughter asks if mother could have something for pain after assessment and repositioning. Resident was not complaining of pain at this time. I took Tylenol to room. Daughter asks if she could have Norco. Explained to daughter that she did not have an order for Norco because the family had told hospital that she gets "loopy" with pain meds. RN #2 said she would call MD and see if she could get an order for Norco. Tylenol given as ordered. MD gave the order for Norco. Order sent to (Pharmacy). (Pharmacy) called

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later and said they needed a hard copy before they could send the Norco. Notified on coming nurse (LPN #1) that (Pharmacy) had called back and was not going to send the Norco without a hard copy. Resident had not complained of pain. Sunday June 5, 2022, received resident sitting up in recliner in room. Resident was trying to get out of recliner and was complaining of pain. Notified (RN #2) about the pain and she was in the process of trying to get her pain medicine. Parked medicine cart across from resident room to keep an eye on her while I gave medication. Son came to visit. He wanted to know why resident was in recliner and not in bed. Explained to him that she had been trying to get up out of bed and for her safety she was in the recliner. After son was in the room with her, I pushed cart on down the hall and continue to give medicine. "

Record review of the signed handwritten statement of (RN #2) dated 06/10/2022 revealed: "I returned to work Sunday June 5th at approximately 5:45 A.M. I received resident (Res #1) lying in bed awake no complaints of pain at that time. She wanted to know what I was doing. I explained that I was getting her vital signs. When I exited her room, (LPN #1) said that she was glad resident was quiet because she had been hollering and trying to get up throughout the night. I asked her if she had given her a pain pill, (LPN #1) said that it did not come, pharmacy could not send it without a prescription "hard copy." She said they had called back Saturday evening. (LPN #1) said she had tried giving resident Tylenol, but resident kept saying that they were trying to kill her with that medicine, so she would only take one Tylenol. I asked her if she may try to give her something else now since she was quiet. I continued to make my rounds.

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At approximately 7AM, CNA #5 came to nurse station and asked me to come to residents' room because she was trying to get up. Received resident sitting on edge of bed. Resident would not allow staff to assist her with lying back down, she kept trying to get up. Staff assisted resident to recliner. Resident appeared more relaxed/comfortable once placed in recliner. She did not try to get back up at that present time. Resident was not yelling/screaming prior to me exiting her room. (RN #3) later came in nurses' station and said that resident needed something for pain. I told her that I was in the process of getting it. I called pharmacy, they asked for reference number and said that they would have the on-call pharmacist to give me a call. After a while and no return call, I called MD (facility physician). He voiced that he was unable to get an actual prescription at this time and to send resident out to the ER. Resident's son was at bedside, and I explained that we were going to send resident out to the ER. I had previously talked to him and explained that we had gotten resident up to recliner because she was trying to get up from bed unassisted. He inquired about her not having pain medication. I told him that the nurse at the hospital said that the family did not want her to have any strong pain medicine because it made her "loopy," he dropped his head and stated, "we were talking about the morphine." I explained that if you all weren't specific then the hospital nurse thought they meant all strong pain meds and that I'm sure it was a miscommunication between them and the hospital. Resident was transferred to ER for evaluation."

Record review revealed a handwritten statement dated 6/10/22 and signed by (CNA #6) that read:

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"First time we transferred her she did not voice much pain. The second time she hollered as if she was in greater pain. She was coming out of the chair (8:30-9:00) CNA #13, RN #3, and myself pulled her up in chair. She was kicking legs as if nothing had happened to her (as if she hadn't fallen) at that point she was calling out in pain. Pain level was high (10). I did not go back into the room when I walked out resident was screaming", "y'all gonna pay for that."

Record review revealed a handwritten statement dated 6/10/22 and signed by (CNA #9) along with her address and phone number, the statement revealed: "Came in work on 6-4-22 at 11:00 PM. I heard her as soon as I walked in the door. Screaming, and I walk down there to see what was going on and the nurse was in there with her sitting in the chair and she continued all night. About 6:AM that morning I saw the agency nurse."

Record review revealed a handwritten statement dated 6/16/2022 signed by (CNA #10) that revealed: I first witnessed the resident when I noticed the (LPN #1) nurse was sitting at the bedside ... After talking with the nurse, she asked me to sit for a short moment while she stepped out of the room ... Later in the shift, the resident began hollering out loudly and could be heard when passing the room. The nurse again asked me to sit with the resident again while she stepped out. The older nurse (RN#1) also working came in the room with me and the resident. We all observed the resident, which the resident when questioned stated she was in pain. RN #1 suggested the resident needed something for pain. The resident had her mouth open and was crying out to RN #1. LPN #1 returned and

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both nurses were at the bedside.

Record review revealed a handwritten statement signed by three (3) Certified Nursing Assistants (CNA's) (CNA #13); (CNA #5); and (CNA #6). The statement was dated 6/10/22 and revealed: RN #2 came in room she is sitting on side of bed. I asked (RN #2) if we should put her in recliner she said "yes", and I called for (CNA #6) and (CNA #13) helped as (RN #2) cannot lift. I got under an arm (CNA #6) got one arm (CNA #13) supported both legs and we manually transported her to chair. She was hollering in pain.

The facility implemented the following Corrective Action Plan prior to the State Agency's entrance on 08/01/2022:

Corrective Action Plan IJ-Residents will be assessed, and medications, treatments, and services will be obtained for residents experiencing a change in their condition and/or experiencing pain, the facility will notify the family, the physician, the DON, and the facility administrative staff-Corrective Actions:

1- The facility conducted a thorough investigation and obtained statements from all staff in the facility and determined that an incident had occurred on 06/04/2022 at approximately 10:00 P.M. of a second fall that resulted in a second left hip fracture to Res #1 that went unreported until 06/10/2022. The facility reported the incident to the family of Res #1 on 06/10/2022.

2-The facility conducted an Emergency Quality Assurance Committee meeting on 06/10/2022 with the Medical Director, DON, ADM, SSD, and QA staff all present. The QA committee reviewed

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all the facility policies and procedures for obtaining MD orders, delivery of medications, Pharmacy procedures and Abuse and Neglect; Using Lifts; Notifications of MD and family and DON and ADM; Care Plans; and Accident Prevention. The facility conducted three (3) additional QA Committee meetings from 06/10/2022-06/16/2022, with the fourth (4th) conducted on 06/16/2022.

3-100% audit of all Incident and Accidents and Falls that had occurred in the facility since January 2022 have been evaluated, reassessed, and reviewed by the QA Committee and Administration of the facility.

4-The facility contacted/reported to the MS State Department of Health, The MS Attorney General's Office; Area Ombudsman, and the MS Board of Nursing, on 06/10/2022 as soon as the unreported fall with a second left hip fracture was reported to the facility.

5-On 06/10/2022 100% Room to Room resident reviews were conducted along with interviews with all residents to assess them for safety and quality of care. All residents were checked for physical and emotional well-being by SSD, DON, and Nursing Staff with no negative findings and no harm was identified.

6-On 06/10/2022 all staff were mandated to attend in-service training on Lifts; Reporting; Assessing Residents; Obtaining Medication Orders; Notifying of Resident Change; Abuse/Neglect; Falls; and Ethics.

7-On 06/10/2022 all staff that worked 7:00 AM-7:00 PM and 7:00 PM- 7:00 A.M. on

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06/04/2022 and 06/05/2022 were issued one on one counseling and write ups of discipline were placed in their personnel records. Three (3) staff, RN #1; LPN #1; and CNA #1 were terminated for failure to report an incident and fall for Res #1 and for not following the facility policies and procedures.

8-Resident #1 was transferred to the hospital located approximately 50 miles away for a second left hip surgery on 06/10/2022. Resident #1 was reassessed upon readmission to the facility and new measures put in to place to protect Res #1 from future falls and injuries. Res #1 had pain medications at the facility upon readmission to the facility after the second hip surgery.

9-Facility alleges the relieving of the immediacy of the Immediate Jeopardy (IJ) on 06/16/2022 and Past Non-Compliance.

The SA validations of the Facility's Removal Plan/Corrective Action Plans Past Non-Compliance (PNC) were completed by interviews, policy and procedure reviews, record reviews, and observations on 08/01/2022 at 12:00 P.M. - 08/03/2022 at 6:00 P.M. with all staff in the building and via telephone interviews with staff that were terminated or scheduled to work at the facility. The SA validated through record review and observations that the facility had completed their Corrective Actions and had Removed the IJ prior to the SA entering the facility. The Past Non-Compliance was validated and the IJ removed on 06/16/2022.

1- The SA validated through record reviews and

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interviews from 08/03/2022-08/03/2022 that the facility had conducted a thorough investigation and obtained statements from all staff in the facility and determined that an incident had occurred on 06/04/2022 at approximately 10:00 P.M. of a second fall that resulted in a second left hip fracture to Res #1 that went unreported until 06/10/2022. The SA validated through family (RP) interviews that the facility had reported the incident to the family of Res #1 on 06/10/2022.

2- The SA validated through record reviews and interviews conducted during the complaint investigation on 08/01/2022- 08/03/2022 that the facility had conducted an Emergency Quality Assurance Committee meeting on 06/10/2022 with the Medical Director, DON, ADM, SSD, and QA staff all present. The QA committee reviewed all the facility policies and procedures for obtaining MD orders, delivery of medications, Pharmacy procedures and Abuse and Neglect; Using Lifts; Notifications of MD and family and DON and ADM; Care Plans; and Accident Prevention. The facility provided documentation and interviews that they had conducted three (3) additional QA Committee meetings from 06/10/2022-06/16/2022, with the fourth (4th) conducted on 06/16/2022.

3- The SA validated through interviews and documentation reviews that the facility had conducted 100% audit of all Incident and Accidents and Falls that had occurred in the facility since January 2022 have been evaluated, reassessed, and reviewed by the QA Committee and Administration of the facility.

4- The SA validated through record review and interviews on 08/01/2022 - 08/03/2022 that the

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 255251 | A. BUILDING _____ B. WING _____ | C 08/03/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MS CARE CENTER OF DEKALB | 220 WILLOW AVENUE DE KALB, MS 39328 |

| (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 |
|---|---|---|---|---|
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facility contacted/reported to the MS State Department of Health, The MS Attorney General's Office; Area Ombudsman, and the MS Board of Nursing, on 06/10/2022 as soon as the unreported fall with a second left hip fracture was reported to the facility.

5- The SA validated through interviews, observations, and record reviews that on 06/10/2022, 100% Room to Room resident reviews were conducted along with interviews with all residents to assess them for safety and quality of care. All residents were checked for physical and emotional well-being by the facility's SSD, DON, and Nursing Staff with no negative findings and no harm was identified.

6- The SA validated through staff and family (RP) interviews and record reviews that on 06/10/2022 all staff were mandated to attend in-service training on Lifts; Reporting; Assessing Residents; Obtaining Medication Orders; Notifying of Resident Change; Abuse/Neglect; Falls; and Ethics. The SA validatedthat all facility staff had been in-serviced from 06/10/2022-06/16/2022. The SA also validated that facility in-services and training were on-going and conducted by the facility and cooperate staff on a regular basis.

7- The SA validated through staff interviews, personnel record reviews, and through record reviews that on 06/10/2022 all staff that worked 7:00 AM-7:00 PM and 7:00 PM- 7:00 A.M. on 06/04/2022 and 06/05/2022 were issued one on one counseling and write ups of discipline were placed in their personnel records. Three (3) staff, RN #1; LPN #1; and CNA #1 were terminated for failure to report an incident and fall for Res #1 and for not following the facility policies and

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|---|---|---|---|---|
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procedures. The SA validated through interviews with RN #1 and CNA #1 that they had been terminated from the facility for failure to follow facility policies and procedures and for not reporting a fall of Res #1. The SA was unable to interview LPN #1 as she would not take calls for interviews. The SA attempted unsuccessfully to obtain telephone interviews with LPN #1. The SA did validate through record reviews and through interviews with facility staff that LPN #1 was terminated.

8- The SA validate through staff interviews, observations, family (RP) interviews, and record reviews that Resident #1 was transferred to the hospital located approximately 50 miles away for a second left hip surgery on 06/10/2022. Resident #1 was reassessed upon readmission to the facility and new measures put in to place to protect Res #1 from future falls and injuries. Res #1 had pain medications at the facility upon readmission to the facility after the second hip surgery.

9- The SA validated through interviews, record reviews and observations that the immediacy of the Immediate Jeopardy (IJ) was removed on 06/16/2022 and Past Non-Compliance (PNC).