

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 59LM	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/30/2022
NAME OF PROVIDER OR SUPPLIER LANDMARK NURSING AND REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 100 LAUREN DRIVE BOONEVILLE, MS 38829		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) conducted an onsite complaint investigation (CI) on 08/29/22 through 08/30/22 for CI MS19399 related to Resident #1 sustained a fall from a hoier lift while being transferred without two staff members present resulting in a laceration to the ear and transfer to the emergency department. The SA determined that the facility was not in substantial compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements at M. The SA substantiated MS19399 and cited M 640 at a Level III. The resident census was 65 and the facility had 80 licensed beds.	M 000		
M 640	45.21.8 Accidents Accidents. The facility shall ensure that the residents' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies. This Statute is not met as evidenced by: Level III Based on record review, observation, facility policy review and interviews, the facility failed to prevent an avoidable accident when a Certified Nursing Assistant (CNA) used a hoier lift without the required two (2) person assistance to operate the lift. Resident #1 fell from the hoier lift and received a laceration to her right ear and required transfer to the emergency department for evaluation. Resident #1 was one (1) of eight (8) residents reviewed for incidents and accidents. Findings include:	M 640	M640 1. C N A (certified nursing assistant) number one was terminated on 7/18/2022 by the Director of Nursing for failure to use 2 person assist while utilizing the Hoyer lift with resident number 1 which resulted in a fall from the lift with injury. Resident number one was sent to the emergency department on 7/18/2022 for evaluation and treatment. 2. The facility has determined that all	9/30/22

Mississippi State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

09/26/22

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M 640	Continued From page 1 The facility policy and procedure titled "Safe Lifting Program (Including Hoyer Lift)" revised 08/10/2015 revealed "...Hoyer Lift:...Residents of (Proper Name of Facility) facilities who are unable to transfer themselves independently or with minimum assistance shall be transferred safely with the Hoyer Lift...At least two (2) nursing staff are needed to transfer a resident when using a Hoyer Lift..." Record review of the the "Resident Transfer Protocol (Safety Techniques)" dated 6/6/2014 revealed "Policy:Residents of (Proper Name of Facility) who are unable to transfer themselves independently or with minimum assistance shall be transferred following the principles of this policy to allow for maximum safety during resident transfer. Full lift transfers shall always be conducted following the principles of proper body mechanics and resident safety... Transferring Residents with an Assistive Lift Device:...At least (2) staff members are needed to transfer a resident when using a lift device..." Record review of the facility's investigation confirmed that CNA #1 was terminated on 07/18/2022 for "failure to obey orders, Regulations, Policies and/or Procedures." "Summary of facts constituting the above offense : Used hoyer lift without second person assist. Did not follow facility Policy on hoyer lift use." Personnel Action for termination was signed by CNA #1 and the DON on 07/18/2022. The facility Investigation Report, documented by the DON revealed: " Res #1 is a long term care resident at this facility. She has active diagnoses of: Dementia with behavioral disturbances, hypertension, seizure disorder, hyperlipidemia. She is dependent on staff for all care and	M 640	residents that have an order to use the Hoyer lift have the potential to be affected. 3. The following measures were put into place to ensure deficient practice did not occur again. An in-service was immediately initiated by the staff development nurse on 7/18/2022 with all nursing staff on the importance of following the plan of care on all residents with the utilization of lift on 7-18-2022. On 7/18/2022 a In-service was initiated on the education and the safety/proper use of the Hoyer lift with successful return demonstration of the Hoyer lift in order to ensure that the residents receive adequate supervision and assistant with lifts to prevent accidents. In-service was completed on all nursing personnel per the staff development nurse on 7/29/2022. The Quality Assurance (QA) Coordinator completed a 100% audit on the residents smart charting and activities of daily living care plans on all residents with orders to use a Hoyer lift on 7/20/22 with deficient practices noted. Performance improvement project was initiated per Quality Assurance (QA) Coordinator, and the QA committee on 8/30/2022, Meeting was also held by the committee with the Medical Director on 8/31/2022 to discuss the results of our complaint survey that was held on 8/29/2022 through 8/30/2022 and the Plan of corrective Action that had been implemented.	

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M 640	Continued From page 2 requires the use of hooyer lift for all transfers. On this date (07/18/2022) at 11:15 A.M. I was notified of resident sliding out of the lift sling/pad feet first and landing on the floor with her head on the leg of the hooyer lift. Investigation revealed that (CNA #1) was not following (facility) policy for hooyer lift use, and was using lift without the benefit of a second person. She said that it takes too long for someone to come when she asks for a second person." DON documented: "First aid for ear laceration was provided by staff following body assessment. Body assessment revealed scraped area above left ear and some red areas to right side of back, besides the approximately 2.5 cm laceration to right ear. Vital signs were obtained and neuro checks initiated. MD was notified of incident and order for Emergency room transfer for evaluation. Resident went to emergency room for evaluation of ear laceration and head injury. CT of the head revealed no acute abnormality though does have severe senescent changes and small vessel ischemic changes. CT of cervical spine revealed no acute fracture Ear laceration was cleaned and glued in ER." On 8/29/2022 during an interview at 3:00 PM with the facility Administrator (ADM) revealed that Res #1 was a total care resident and was dependent upon staff for all of her needs. The ADM stated that Res #1 was to be transferred with a hooyer lift with two persons to assist. The ADM stated that the facility policy and procedure requires (2) persons to assist with the use of a hooyer lift. The ADM stated that the facility staff were trained and in-serviced to use the hooyer lift with (2) persons and that CNA #1 had been trained. The ADM revealed that CNA #1 did not follow the facility policy and procedure and she did not use the hooyer lift in accordance with the facility policy and procedure and she did not ask a	M 640	4. Effective 9/1/2022 the nurse management team will review each incident during their morning meeting Monday thru Friday to ensure appropriate interventions are implemented along with the POC updated. This will be done weekly for 6 consecutive weeks or until compliance has been meet and maintained. Beginning 9/1/2022 indefinitely the education of the safety and proper use of the Hoyer lift with successful return demonstration of use of the Hoyer lift will be done on all new nursing personnel by the Staff Development Nurse and annual competency checks will be completed as well to ensure that the residents receive adequate supervision and assistance with lifts to prevent accidents. Any abnormal findings will be brought to the Director of Nursing immediately for corrective action. All findings from the weekly observations will be documented and brought to the Quality Assurance committee monthly meeting on 9/29/22 then monthly for 3 months or until such time compliance has been achieved. The committee will make recommendations and/or changes as needed.	

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M 640	Continued From page 3 second person to assist her with the use of the hooyer lift. CNA #1 used the hooyer lift alone while transferring Res #1 from the shower chair back to her bed and CNA #1 dropped Res #1 from the hooyer lift to the floor causing a laceration to her ear which required an evaluation at the local Emergency Room (ER). The facility investigated and terminated CNA #1 on 07/18/2022 for not following the facility policy. Interview with the Director of Nursing (DON) on 08/29/2022 at 3:20 PM, revealed that she was in her office on 07/18/2022 when she heard a "Code Purple" alert come across her walkie talkie from CNA #1. CNA #1 called a "Code Purple" which signaled that help was needed in Res #1's room. The DON went to Res #1's room where she saw Res #1 on the floor with blood coming from her ear. Res #1's head was on the leg of the hooyer lift and CNA #1 stated that she was transferring Res #1 to her bed from her shower chair when she fell from the lift. CNA #1 stated that she was using the hooyer lift alone and had not called for a second person to assist with the lift as required per the facility policy. The DON revealed that the incident occurred around mid morning at approximately 11:00 AM on 07/18/2022. The DON stated that she and several other staff put Res #1 on a draw sheet and lifted her from the floor to the bed for a full body assessment and to apply pressure to the bleeding ear. The Resident was sent out to the local ER for evaluation and CNA #1 was terminated. The DON confirmed that CNA #1 should have followed the facility policy and procedure for two (2) persons to assist with the use of the hooyer lift and she confirmed that CNA #1 did not utilize two people for the transfer of the resident from the shower chair to the bed and caused the resident to sustain injuries.	M 640		

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M 640	Continued From page 4 Interview with Registered Nurse (RN #1) and the Minimum Data Set (MDS) Nurse on 08/29/2022 at 3:45 PM revealed that she was the charge nurse on 07/18/2022 when the fall of Res #1 occurred. She stated that she received a "Code Purple" alert on her "walkie talkie" and she went to Res #1's room where she assisted to lift Res #1 from the floor with a draw sheet to her bed after a fall from the hooyer lift. Res #1 had a laceration to her right ear and there was a fair amount of blood from the injury. Res #1 hit her right ear and head on the leg of the hooyer lift. Res #1 was sent to the local ER for evaluation of a head injury and ear laceration. RN #1 assessed Res #1 after the fall from the hooyer lift and stated that Res #1 had been non-verbal for years and was unable to speak, but that the resident did have facial grimaces and expressions of pain after the fall and her gown was wet and she was making blowing motions with her lips during the time the staff were assessing her from the fall. RN #1 stated that Res #1 is totally dependent upon staff for all her needs and is unable to care for herself and that she called Res #1's daughter to report the fall and the ER admission. RN #1 stated that CNA #1 did not follow the facility policy for using a two (2) person assist with hooyer lifts. Interview on 08/30/2022 at 1:35 PM with CNA #2 revealed that she worked first shift on 07/18/2022 and had been working since April 1, 2022 on first shift, which was 7 AM to 3 PM. She confirmed that she was working with CNA #1 that day and that she did not ask her to assist with the hooyer lift transfer of Res #1 on 07/18/2022. CNA #2 stated that they had been trained and in-serviced that two (2) persons must assist with the use of a hooyer lift.	M 640		

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M 640	Continued From page 5 Interview on 08/30/2022 at 1:45 PM CNA #3 revealed that she had worked at the facility for eight (8) years. She stated that she was working as a CNA on 07/18/2022 on first shift and CNA #1 had not asked her to assist with the hooyer lift transfer of Res #1. CNA #3 stated that she had been trained and in-serviced to use two (2) persons to assist with the hooyer lift transfers of Res #1. CNA #3 stated that she assisted CNA #2 and RN #1 to transfer Res #1 from the floor to the bed for assessment. CNA #3 stated that Res #1 had a cut to her ear and blood was present. Record review of the ED (Emergency Department) Provider Notes dated 07/18/2022 revealed "History...Patient...from local nursing home...slid out of the sling struck her head...ED Course...Lac (Laceration) Repair...Location details:Right ear...Laceration length (cm) centimeter:1...Skin Closure: Glue...Final diagnosis...Laceration of right ear lobe, initial encounter..." Interview on 08/30/2022 at 2:10 PM, with the Resident Representative (RR) of Res #1, revealed that she was contacted by the facility that a CNA had not followed the policy and had dropped Res #1 from the lift during a transfer. RR stated that she did not know how that could have happened and she was greatly upset that Res #1 had been injured and sent to the ER for evaluation. RR stated that she came to the facility later on 07/18/2022 to check on Res #1 and found her in her bed with a fair amount of dried blood on her ear. RR stated that she reported to the nurse that Res #1's ear looked "crusty" and bloody. The nurse told RR that the ER had glued the laceration and because of that she was afraid to try to clean the ear at that time	M 640		

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M 640	Continued From page 6 in fear that it may become un-glued and may start to bleed again. RR stated that Res #1 had been non-verbal for a long time and had to depend upon staff for all of her needs. RR stated that Res #1 was bruised and had grim facial expressions when she saw her several hours after the incident. Observation of Res #1 on 08/30/2022 at 2:30 PM revealed that she was lying on her back in bed. Res #1 was starring straight ahead and she did not respond in any way when her name was called. Res #1 was not interviewable on 08/30/2022. Her facial expression was flat and fixed and never varied. Record review of Res #1's Face Sheet revealed that she was admitted to the facility on 08/31/2018 with diagnoses of Dementia with Behavioral disturbances; Peripheral vascular disease, among other diagnoses. Record review of the Minimum Data Set (MDS) revealed that Res #1 had a Brief Interview for Mental Status (BIMS) score of 3 which indicated that she had severe cognitive impairment. Record review of Res #1's Physician's Orders dated July 2022 revealed an order written on 03/05/2021 "Use Hoyer Lift x 2 Person Assist with Large Lift Pad."	M 640		