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	255320	A. BUILDING _____ B. WING _____	C 08/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK NURSING AND REHAB CENTER	100 LAUREN DRIVE BOONEVILLE, MS 38829

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an onsite complaint investigations (CI) on 08/29/22 through 08/30/22 for CI MS18622 and CI MS19399. A Focused Infection Control (FIC) survey was conducted with no deficiencies cited. The SA determined that the facility was not in substantial compliance with the requirements for participation in Medicare and Medicaid. The SA substantiated CI MS19399 related to Resident #1 sustained a fall from a hoyer lift while being transferred without two staff members present resulting in a laceration to the ear and transfer to the emergency department. Deficiencies were written at F656 and F689 at a scope and severity (S/S) of "G". CI MS18622 was not substantiated and no deficiencies were cited for alleged Covid-19 infection control procedures not followed. The resident census was 65 and the facility had 80 licensed beds.	F 000		
F 656 SS=G	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and	F 656		9/30/22

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

Electronically Signed | 09/26/2022

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F 656	Continued From page 1 (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, policy and procedure reviews, record review and interviews, the facility failed to follow the care plan for fall prevention for Resident (Res) #1. Resident #1 was care planned to use a hoyer lift with a two (2) person assist for all transfers in order to prevent falls. Res #1 was injured when she fell from a hoyer lift that a facility Certified Nursing Assistant (CNA) used independently. Res #1 received injury of a laceration to her right ear with bleeding and was transported to the Emergency Room (ER) for evaluation. Res #1 was one (1) of eight (8)	F 656	F 656 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 for evaluation and treatment on 7/18/2022. The plan of care was reviewed and updated upon return by the	

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F 656	Continued From page 2 residents reviewed for Care Plans. Findings include: The facility policy titled "Comprehensive Plan of Care", revised 11/28/2017, revealed, "Plans of Care are developed by the interdisciplinary team, to coordinate and communicate care approaches and goals for the resident related to clinical diagnosis or identified concerns." Record review of the Care Plan for Res #1 revealed a care plan with a start date of 3/5/2021 for falls: "Resident Risk for falls will be reduced with interventions through the next review date, intervention: Hoyer lift x2 person assist for all transfers." Interview on 08/29/2022 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 hoyer lift with two persons to assist and that the facility policy and procedure requires two (2) persons to assist with the use of a hoyer lift. She did not ask a second person to assist her with the use of the hoyer lift. CNA #1 used the hoyer lift alone while transferring Res #1 from the shower chair back to her bed. CNA #1 dropped Res #1 from the hoyer lift to the floor. Res. #1 sustained a laceration to her ear which required an evaluation at the local ER. The ADM confirmed that the facility care plan was not followed for fall prevention interventions for Res #1. Interview on 08/29/2022 at 3:20 PM, with the Director of Nursing (DON) revealed the DON went to Res #1's room on 07/18/2022 after a call	F 656	Director of Nursing on 7/18/2022. 2. The facility has determined that all 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. 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 no deficient practices noted. An in-service was immediately initiated by the staff development nurse with all nursing staff on the importance of following plan of care on all residents with the utilization of lift on 7-18-2022. 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. 4. The Quality Assurance Nurse will review incidents and accidents beginning 9/1/2022 after the nurse management teams review has been completed to ensure that the appropriate interventions	

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F 656	Continued From page 3 over the walkie talkie of "Code Purple", where she saw the resident on the floor with blood coming from her ear. The resident's head was on the leg of the hoyer 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 hoyer lift alone and had not called for a second person to assist with the lift as required per the facility care plan. Interview on 08/30/2022 at 3:00 PM, with Licensed Practical Nurse (LPN) #1 revealed that she is the Care Plan Nurse and Minimum Data Set (MDS) Nurse for the facility. LPN #1 confirmed that the CNA did not follow the care plan for the use of a two (2) person assist when using a hoyer lift. LPN #1 stated that CNA #1 was terminated for not following the facility policy and the care plan for Resident #1. Record review of Res #1 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. The Minimum Data Set (MDS) revealed that Res #1 had a Brief Interview of Mental Status (BIMS) score of 3 which indicated that she had severe cognitive impairment. Record review of the facility's investigation revealed, "Summary of facts constituting the above offense: Used hoyer lift without second person assist. Did not follow facility Policy on hoyer lift use...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 hoyer lift. Investigation	F 656	were implemented, and that the plan of care has been updated to prevent any further incidents or occurrences with lifts for 6 consecutive weeks until such time compliance has been achieved. This will be completed by the Quality Assurance Nurse on a weekly basis effective 9/1/2022 to ensure the residents receive adequate supervision and assistance with lifts to prevent accidents for 6 consecutive weeks or until such time compliance has been achieved. 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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F 656	Continued From page 4 revealed that (CNA #1) was not following (facility) policy for hoyer lift use, and was using lift without the benefit of a second person..."	F 656		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observation, facility policy review and interviews, the facility failed to prevent an avoidable accident when a Certified Nursing Assistant (CNA) used a hoyer lift without the required two (2) person assistance to operate the lift. Resident #1 fell from the hoyer 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: 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..."	F 689	F 0689 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 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.	9/30/22

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F 689	Continued From page 5 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 requires the use of hoyer 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 hoyer lift. Investigation revealed that (CNA #1) was not following (facility) policy for hoyer 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	F 689	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. 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	

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F 689	Continued From page 6 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 hoyer 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 hoyer lift. The ADM stated that the facility staff were trained and in-serviced to use the hoyer 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 hoyer lift in accordance with the facility policy and procedure and she did not ask a second person to assist her with the use of the hoyer lift. CNA #1 used the hoyer lift alone while transferring Res #1 from the shower chair back to her bed and CNA #1 dropped Res #1 from the hoyer 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	F 689	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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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 hoyer 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 hoyer 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 hoyer 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.

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

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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 hoyer 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 hoyer 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 hoyer 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 hoyer 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 hoyer 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 hoyer lift.

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 hoyer lift

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transfer of Res #1. CNA #3 stated that she had been trained and in-serviced to use two (2) persons to assist with the hoyer 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 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

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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."