STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255328	A. BUILDING _____ B. WING _____	C 01/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CARE CENTER OF MARION	6434 A DALE DR MARION, MS 39342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted a Complaint Survey, MS #15571, at the facility beginning 1/3/19 through 1/4/19. The complaint identified two (2) areas of concern: 1) Failure to follow a resident's Comprehensive Care Plan, and 2) Accidents and Hazards, specifically a fall sustained by Resident #1. The SA substantiated that the facility failed to follow Resident #1's Care Plan and as a result, Resident #1 suffered a fall in which she sustained a femur fracture. During the survey the SA determined that the facility was not in compliance with the requirements for participation in Medicare and Medicaid and cited deficiencies at F656 and F689. The census at time of the survey was 110 and the facility is licensed for 120 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 (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not	F 656		2/10/19

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

Electronically Signed | 02/12/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 656	Continued From page 1 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 interview, facility policy review, and record review, the facility failed to follow the Comprehensive Care Plan for toileting/changing assistance for one (1) of five (5) residents reviewed, Resident #1. Findings include: Review of the facility document entitled "Using the Care Plan", with a review date of January 2015, revealed the care plan shall be used in developing the resident's daily care routines and will be available to staff personnel who have the responsibility for providing care and services to	F 656	*Resident #1 was reassessed for lift/transfer assistance upon return from the hospital on 12/13/18, by Registered Nurse (RN) Supervisor. Lift/Transfer Assessment indicated Resident #1 requires transfer per total lift X two (2) assist with medium sling and an additional person for left leg support. Resident #1□s care plan for decreased ability to transfer was reviewed and revised on 12/13/18 by RN Supervisor, related to the amount of assistance needed with toileting needs to include added intervention Transfer per total lift X two (2)	

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F 656	Continued From page 2 the resident. The Nurse Supervisor uses the care plan to direct care provided by Certified Nurse Assistants (CNA's) and nurses daily. Review of Resident #1's current Comprehensive Care Plan revealed a stated problem, with an original date of 12/31/15, and an effective date of 10/16/18, that the resident required extensive assistance from staff for toilet use due to frequent incontinent episodes. An intervention, with an effective date of 11/8/17, noted to provide extensive assistance of two (2) for changing/toileting needs. Further review of the resident's care plan revealed a problem, with an original date of 1/4/16, and an effective date of 10/5/18, that indicated the resident was at risk for falls related to difficulty with balance, and a past history of falls on 1/28/17, 7/12/18, and 10/2/18. Stated goal for this problem was to be free from injury related to falls. Interventions included ensure transfer with one (1) person assist and one (1) person stand by (which equals to two staff available) and with extensive assistance of two (2) when having fatigue and weakness. Review of the facility's CNA information sheet in the Kiosk revealed Resident #1 required extensive assistance of two (2) for cleaning and changes/toileting needs. A review of the facility document, titled "Alleged Abuse Incident Report", dated 12/12/18, revealed Resident #1 was standing while peri-care was being performed by CNA #1 the resident lost her balance and was eased to the floor. The resident's physician was notified and orders were obtained for an X-ray of the resident's left hip. The conclusions documented in the report revealed: Investigation revealed CNA did not	F 656	assist medium sling with an additional person for left leg support. Certified Nursing Assistant (CNA) #1 was terminated from employment on 12/13/18. *All residents requiring assistance from staff for toilet use and all residents requiring supervision with transfers have the potential to be affected by this practice. Beginning 1/30/19, the Fall Risk Assessment and Lift/Transfer Assessment was completed on 100% of residents by the Director of Nursing (DON), Resident Care Coordinators, Minimum Data Set Registered Nurse, RN Supervisors, and RN Staff Development Nurse and completed 2/2/19. Beginning on 1/30/19 through 2/2/19, care plans of 100% of residents were reviewed and revised as needed for assistance with transfers by the Director of Nursing (DON), Resident Care Coordinators, Minimum Data Set Registered Nurse, RN Supervisors, and RN Staff Development Nurse. *Beginning on 12/18/18, inservices were started for CNAs, Licensed Practical Nurses (LPN), and RNs by the Staff Development Nurse (SDN) and Administrator Following Care Plans Related to Transfers and Level of Staff Assistance Required. Beginning 1/29/19, inservices were started by the Director of Nursing (DON) and Administrator including Following Care Plans and Locating the Care Plan on the Kiosk. On 1/31/19, the topic Defining Stand By Assistance was added to the inservice Following Care Plans and Locating the	

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F 656	Continued From page 3 follow the careplan for the resident and the CNA was immediately suspended and terminated as a result. Review of the X-ray report, dated 12/9/18, revealed an acute fracture of the proximal femoral joint. Resident #1 was sent to the Emergency Room for further evaluation where it was determined she had an acute Comminuted Fracture of the Proximal Left Femur. Resident #1 was admitted to the hospital and underwent surgery on 12/10/18, for Left Femur Intramedullary Nailing. A review of the written statement made by CNA #1 on 12/10/18, revealed: "It took several minutes to clean her." The statement noted, "I was putting the new brief between her legs she started to lose her balance." Further review revealed when CNA #2 came to assist the two (2) CNA's tried to assist the resident to her chair but were unable to do so. The resident was lowered to the floor. The statement documented, "Once on the floor, her left leg was bent underneath her right leg". Review of a written statement from CNA #1, dated 12/9/18, revealed her answer to the question, did anything unusual happening during the care interaction, was "she (the resident) was weaker than usual". An interview with the Director of Nursing (DON) on 1/4/18 at 1:30 PM revealed the facility expects staff to follow the care plans. The DON stated that care plans were located in the Kiosk on the hall and staff used them to know how to care for residents. She stated the CNA's are taught to use the care plan. She confirmed that if a care plan stated two (2) people are needed and only one	F 656	Care Plan on the Kiosk. The inservices beginning on 1/29-1/31/19 were provided for CNAs, LPNs, and RNs. Training on following care plans related to transfers, toileting and amount of assistance required will be provided monthly for three (3) months in regular inservices conducted by the SDN and incorporated into orientation for all new hires. * On 1/25/19, resident care observations of CNAs related to following care plans providing transfer assistance with toileting with or without use of lifts, were initiated by SDN, Resident Care Coordinator, Minimum Data Set Nurses, and Lead CNA. Training will be provided at the time of the observation by the observer for CNAs who required additional training or coaching. Weekly observations by RNs and LPNs of CNAs following care plans in providing assistance with toileting and transfers will continue for three (3) months. The findings of the observations will be presented by the Director of Nursing to the monthly Quality Assurance Committee for review and recommendations for further actions.	

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F 656	Continued From page 4 (1) is present, the care plan was not followed. Interview with Registered Nurse #1, the Staff Development Nurse, on 1/4/19 at 3:27 PM, revealed staff are taught to use a resident's care plan and are expected to follow each resident's care plan. Review of the facility documentation revealed CNA #1 was in-serviced and demonstrated competence in accessing the Kiosk for information regarding resident care. In a telephone interview with CNA #1 on 01/07/19 at 4:00 PM, she confirmed that she had attempted to change Resident #1 without assistance of another person. CNA #1 also confirmed that she had been taught to use the Kiosk to find out what kind of assistance a resident needed. She further stated, "I knew this resident was a one (1) person assist and one (1) person stand by. The only thing I didn't do was have someone on stand-by". A post survey telephone interview with CNA #2, on 01/21/19 at 3:15 PM, revealed CNA #1 was in the room alone with the resident at the time of the incident. She further stated that CNA's at the facility were taught to use the Kiosk to determine the level of assistance a resident required. Review of Resident #1's face sheet revealed the facility admitted the resident on 1/11/18. Resident #1's diagnoses included Hypertension, Chronic Renal Failure, Muscle Weakness, Lack of Coordination, Alzheimer's, Dysphagia, and History of falls. Review of Resident #1's most recent Minimum	F 656		

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F 656	Continued From page 5 Data Set (MDS) with an Assessment Reference Date (ARD) of 12/20/18, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 14, indicating the resident was cognitively intact.	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 interview, facility policy review, and facility record review, the facility failed to ensure adequate assistance to prevent falls, resulting in a fall with fracture for one (1) of five (5) residents reviewed, Resident #1. Findings include: A review of the facility's policy titled "Safety and Supervision of Residents", with a revision date of July 2017, revealed our facility strives to make the environment as free from accidents and hazards as possible. Resident safety, supervision and assistance to prevent accidents are facility wide priorities. Further review of the policy revealed the care team analyzes information obtained from assessments and observations to identify any specific accident hazards or risks for individual residents. The care team shall target interventions to reduce risks related to the	F 689	*Resident #1 was reassessed for lift/transfer assistance upon return from the hospital on 12/13/18, by Registered Nurse (RN) Supervisor. Lift/Transfer Assessment indicated Resident #1 requires transfer per total lift X two (2) assist with medium sling and an additional person for left leg support. Resident #1□s care plan for decreased ability to transfer was reviewed and revised on 12/13/18 by RN Supervisor, related to the amount of assistance needed with toileting needs to include added intervention Transfer per total lift X two (2) assist medium sling with an additional person for left leg support. Certified Nursing Assistant (CNA) #1 was terminated from employment on 12/13/18. *All residents requiring assistance from	2/10/19

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F 689	Continued From page 6 environment, adequate supervision and assuasive devices. Implementation of interventions to reduce accidents and hazards shall include: communication of specific all relevant staff, assignment of responsibility for carrying out interventions and ensuring interventions are implemented. A review of the facility Document, titled "Fall Risk Assessment", and dated 11/3/18, revealed Resident #1 had balance problems while standing. Further review revealed the resident had diagnoses predisposing her to falls and a history of falls in the past three (3) months. Review of the facility documentation of "point of care training", revealed CNA #1 was in-serviced on 9/4/18, and demonstrated competence in accessing the Kiosk for information regarding resident care. Review of the facility's CNA information sheet in the Kiosk revealed Resident #1 required extensive assistance of two (2) for cleaning and changes/toileting needs. A review of Resident #1's chart revealed a nurse's note from 12/09/18 at 2:30 PM, which stated, "Upon entering room saw the resident upright on bottom with left leg bent under right leg and CNA's holding resident up". A review of the facility document, titled, "Alleged Abuse Incident Report", dated 12/12/18, revealed the resident was standing while peri-care was being performed by CNA #1 the resident lost her balance and was eased to the floor. The resident's physician was notified and orders were obtained for an x-ray of the resident's left hip. The	F 689	staff for toilet use and all residents requiring supervision with transfers have the potential to be affected by this practice. Beginning 1/30/19, the Fall Risk Assessment and Lift/Transfer Assessment was completed on 100% of residents by the Director of Nursing (DON), Resident Care Coordinators, Minimum Data Set Registered Nurse, RN Supervisors, and RN Staff Development Nurse and completed 2/2/19. Beginning on 1/30/19 through 2/2/19, care plans of 100% of residents were reviewed and revised as needed for assistance with transfers by the Director of Nursing (DON), Resident Care Coordinators, Minimum Data Set Registered Nurse, RN Supervisors, and RN Staff Development Nurse. *Beginning on 12/18/18, inservices were started for CNAs, Licensed Practical Nurses (LPN), and RNs by the Staff Development Nurse (SDN) and Administrator Following Care Plans Related to Transfers and Level of Staff Assistance Required. Beginning 1/29/19, inservices were started by the Director of Nursing (DON) and Administrator including Following Care Plans and Locating the Care Plan on the Kiosk. On 1/31/19, the topic Defining Stand By Assistance was added to the inservice Following Care Plans and Locating the Care Plan on the Kiosk. The inservices beginning on 1/29-1/31/19 were provided for CNAs, LPNs, and RNs. Training on following care plans related to transfers, toileting and amount of assistance required will be provided monthly for three	

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F 689	Continued From page 7 x-ray revealed an acute fracture of the proximal femoral joint. Resident #1 was sent to the Emergency Room for further evaluation where it was determined she had an acute Comminuted Fracture of the Proximal Left Femur. Resident #1 was admitted to the hospital and underwent surgery on 12/10/18, for Left Femur Intramedullary Nailing. The conclusions documented in the report revealed: Investigation revealed CNA did not follow the careplan for the resident and the CNA was immediately suspended and terminated as a result. Review of the hospital history and physical, dated 12/9/18, for Resident #1, revealed the resident is a 100 year old, wheel chair bound female, with very limited mobility. She presents with history of fall at a nursing facility with severe pain, deformity, and shortening of her left leg. Review of the hospital operative note for Resident #1, dated 12/10/18, revealed a diagnosis of Left Sub-trochanteric Femur Fracture. The procedure to repair the fracture was a Left Femur Intramedullary Nailing and was carried out under general anesthesia. A review of the written statement made by CNA #1, dated 12/10/18, revealed, "It took several minutes to clean her, and when I was putting the new brief between her legs she started to lose her balance. I noticed she was wobbling and put my knee up so she could rest on it. I tried to assist her back to the chair but was unable to do so safely." Further review revealed when CNA #2 came to assist the two (2) CNA's tried to assist the resident to her chair but were unable to do so. The resident was lowered to the floor. "Once on the floor her left leg was bent underneath her	F 689	(3) months in regular inservices conducted by the SDN and incorporated into orientation for all new hires. On 1/25/19, resident care observations of CNAs related to following care plans providing transfer assistance with toileting with or without use of lifts, were initiated by SDN, Resident Care Coordinator, Minimum Data Set Nurses, and Lead CNA. Training will be provided at the time of the observation by the observer for CNAs who required additional training or coaching. *Weekly observations by RNs and LPNs of CNAs following care plans in providing assistance with toileting and transfers will continue for three (3) months. The findings of the observations will be presented by the Director of Nursing to the monthly Quality Assurance Committee for review and recommendations for further actions.	

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F 689	Continued From page 8 right leg." An interview with Registered Nurse (RN) #1, Staff Development Nurse, on 1/4/19, at 3:27 PM, revealed CNA's are taught to check to Kiosk every shift under the information tab. Under that tab there is information concerning specific requirements for the care of each resident. They are taught that they must follow these guidelines when giving care. An interview with Resident #1 on 1/4/19 at 1:30 PM, revealed only one (1) CNA was assisting her when the accident occurred. She further stated, "That girl dropped me and broke my leg, I told her to let me hold on to the chair but she said she could do it, she let go and I fell." Resident #1 also stated that she continued to have pain and continued to require therapy. She further stated that she had been able to get around much better before the incident. Interviews with CNA's #3, #4, #5, #6, #7, and #8 on 1/4/19 between 2:00 PM and 2:45 PM, revealed they had all been trained to check the Kiosk daily to determine the level of assistance each resident required. CNA #3 confirmed that failure to use the care plan to provide care was equal to neglect. In a telephone interview with CNA #1 on 01/07/19 at 4:00 PM, she confirmed that she had attempted to change Resident #1 without assistance of another person and the resident got weak and lost her balance. She stated that she got down on one (1) knee and let the resident slide down and rest on the other knee. She stated Resident #1's roommate pushed the call light and went out into the hallway to get help. She stated	F 689		

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F 689	Continued From page 9	F 689		

that when CNA #2 came into the room, "We tried to get her up to her wheelchair, but she was too weak so we let her slide down onto the floor." She stated, "That's when I noticed her leg was bent under her." CNA #1 confirmed that she had been taught to use the Kiosk to find out what kind of assistance a resident needed. She further stated, "I knew this resident was a one (1) person assist and one (1) person stand by. The only thing I didn't do was have someone on stand-by."

A post survey telephone interview with CNA #2, on 01/21/19 at 3:15 PM, revealed when she got to the room, CNA #1 was in the room alone and there was no stand-up lift in the room. She further stated that she was aware that the resident required two (2) person assist for cleaning and changing/toileting. She further stated that CNA's at the facility were taught to use the Kiosk to determine the level of assistance a resident required.

A review of the facility's time sheets and schedule, for CNA #1, confirmed that CNA #1 was scheduled to work the 7 am-3 pm shift on 12/09/18, and clocked in at 7:14 AM, and clocked out at 4:38 PM, on 12/09/18, the date of the incident. The CNA did not clock in to work thereafter.

Review of Resident #1's face sheet revealed the facility admitted the resident on 1/11/18. Resident #1's diagnoses included Hypertension, Chronic Renal Failure, Muscle Weakness, Lack of Coordination, Alzheimer's, Dysphagia, and History of falls.

Review of Resident #1's most recent Minimum Data Set (MDS) with an Assessment Reference

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F 689	Continued From page 10 Date (ARD) of 12/20/18, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 14, indicating the resident was cognitively intact.	F 689		

MSDH - Health Facilities Licensure and Certification

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(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 Level III The State Agency (SA) determined during an annual recertification survey, conducted from 1/3/19 through 1/4/19, the facility was not in compliance with the Mississippi Regulations for Minimum Standards for Institutions for Aged or Infirm with deficiencies cited at M640. The census at time of the survey was 110 and the facility is licensed for 120 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: Based on interview, facility policy review, and facility record review, the facility failed to ensure adequate assistance to prevent falls, resulting in a fall with fracture for one (1) of five (5) residents reviewed, Resident #1. Findings include: A review of the facility's policy titled "Safety and Supervision of Residents", with a revision date of July 2017, revealed our facility strives to make the environment as free from accidents and hazards as possible. Resident safety, supervision and assistance to prevent accidents are facility wide priorities. Further review of the policy revealed the	M 640	*Resident #1 was reassessed for lift/transfer assistance upon return from the hospital on 12/13/18, by Registered Nurse (RN) Supervisor. Lift/Transfer Assessment indicated Resident #1 requires transfer per total lift X two (2) assist with medium sling and an additional person for left leg support. Resident #1□s care plan for decreased ability to transfer was reviewed and revised on 12/13/18 by RN Supervisor, related to the amount of assistance needed with toileting needs to include added intervention Transfer per total lift X two (2) assist medium sling with an additional	2/10/19

MSDH - Health Facilities Licensure and Certification

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M 640	Continued From page 1 care team analyzes information obtained from assessments and observations to identify any specific accident hazards or risks for individual residents. The care team shall target interventions to reduce risks related to the environment, adequate supervision and assuasive devices. Implementation of interventions to reduce accidents and hazards shall include: communication of specific all relevant staff, assignment of responsibility for carrying out interventions and ensuring interventions are implemented. A review of the facility Document, titled "Fall Risk Assessment", and dated 11/3/18, revealed Resident #1 had balance problems while standing. Further review revealed the resident had diagnoses predisposing her to falls and a history of falls in the past three (3) months. Review of the facility documentation of "point of care training", revealed CNA #1 was in-serviced on 9/4/18, and demonstrated competence in accessing the Kiosk for information regarding resident care. Review of the facility's CNA information sheet in the Kiosk revealed Resident #1 required extensive assistance of two (2) for cleaning and changes/toileting needs. A review of Resident #1's chart revealed a nurse's note from 12/09/18 at 2:30 PM, which stated, "Upon entering room saw the resident upright on bottom with left leg bent under right leg and CNA's holding resident up". A review of the facility document, titled, "Alleged Abuse Incident Report", dated 12/12/18, revealed the resident was standing while peri-care was	M 640	person for left leg support. Certified Nursing Assistant (CNA) #1 was terminated from employment on 12/13/18. *All residents requiring assistance from staff for toilet use and all residents requiring supervision with transfers have the potential to be affected by this practice. Beginning 1/30/19, the Fall Risk Assessment and Lift/Transfer Assessment was completed on 100% of residents by the Director of Nursing (DON), Resident Care Coordinators, Minimum Data Set Registered Nurse, RN Supervisors, and RN Staff Development Nurse and completed 2/2/19. Beginning on 1/30/19 through 2/2/19, care plans of 100% of residents were reviewed and revised as needed for assistance with transfers by the Director of Nursing (DON), Resident Care Coordinators, Minimum Data Set Registered Nurse, RN Supervisors, and RN Staff Development Nurse. *Beginning on 12/18/18, inservices were started for CNAs, Licensed Practical Nurses (LPN), and RNs by the Staff Development Nurse (SDN) and Administrator Following Care Plans Related to Transfers and Level of Staff Assistance Required. Beginning 1/29/19, inservices were started by the Director of Nursing (DON) and Administrator including Following Care Plans and Locating the Care Plan on the Kiosk. On 1/31/19, the topic Defining Stand By Assistance was added to the inservice Following Care Plans and Locating the Care Plan on the Kiosk. The inservices beginning on 1/29-1/31/19 were provided	

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M 640	Continued From page 2 being performed by CNA #1 the resident lost her balance and was eased to the floor. The resident's physician was notified and orders were obtained for an x-ray of the resident's left hip. The x-ray revealed an acute fracture of the proximal femoral joint. Resident #1 was sent to the Emergency Room for further evaluation where it was determined she had an acute Comminuted Fracture of the Proximal Left Femur. Resident #1 was admitted to the hospital and underwent surgery on 12/10/18, for Left Femur Intramedullary Nailing. The conclusions documented in the report revealed: Investigation revealed CNA did not follow the careplan for the resident and the CNA was immediately suspended and terminated as a result. Review of the hospital history and physical, dated 12/9/18, for Resident #1, revealed the resident is a 100 year old, wheel chair bound female, with very limited mobility. She presents with history of fall at a nursing facility with severe pain, deformity, and shortening of her left leg. Review of the hospital operative note for Resident #1, dated 12/10/18, revealed a diagnosis of Left Sub-trochanteric Femur Fracture. The procedure to repair the fracture was a Left Femur Intramedullary Nailing and was carried out under general anesthesia. A review of the written statement made by CNA #1, dated 12/10/18, revealed, "It took several minutes to clean her, and when I was putting the new brief between her legs she started to lose her balance. I noticed she was wobbling and put my knee up so she could rest on it. I tried to assist her back to the chair but was unable to do so safely." Further review revealed when CNA #2 came to assist the two (2) CNA's tried to assist	M 640	for CNAs, LPNs, and RNs. Training on following care plans related to transfers, toileting and amount of assistance required will be provided monthly for three (3) months in regular inservices conducted by the SDN and incorporated into orientation for all new hires. On 1/25/19, resident care observations of CNAs related to following care plans providing transfer assistance with toileting with or without use of lifts, were initiated by SDN, Resident Care Coordinator, Minimum Data Set Nurses, and Lead CNA. Training will be provided at the time of the observation by the observer for CNAs who required additional training or coaching. *Weekly observations by RNs and LPNs of CNAs following care plans in providing assistance with toileting and transfers will continue for three (3) months. The findings of the observations will be presented by the Director of Nursing to the monthly Quality Assurance Committee for review and recommendations for further actions.	

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M 640	Continued From page 3	M 640		

the resident to her chair but were unable to do so. The resident was lowered to the floor. "Once on the floor her left leg was bent underneath her right leg."

An interview with Registered Nurse (RN) #1, Staff Development Nurse, on 1/4/19, at 3:27 PM, revealed CNA's are taught to check to Kiosk every shift under the information tab. Under that tab there is information concerning specific requirements for the care of each resident. They are taught that they must follow these guidelines when giving care.

An interview with Resident #1 on 1/4/19 at 1:30 PM, revealed only one (1) CNA was assisting her when the accident occurred. She further stated, "That girl dropped me and broke my leg, I told her to let me hold on to the chair but she said she could do it, she let go and I fell." Resident #1 also stated that she continued to have pain and continued to require therapy. She further stated that she had been able to get around much better before the incident.

Interviews with CNA's #3, #4, #5, #6, #7, and #8 on 1/4/19 between 2:00 PM and 2:45 PM, revealed they had all been trained to check the Kiosk daily to determine the level of assistance each resident required. CNA #3 confirmed that failure to use the care plan to provide care was equal to neglect.

In a telephone interview with CNA #1 on 01/07/19 at 4:00 PM, she confirmed that she had attempted to change Resident #1 without assistance of another person and the resident got weak and lost her balance. She stated that she got down on one (1) knee and let the resident slide down and rest on the other knee. She stated

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M 640	Continued From page 4 Resident #1's roommate pushed the call light and went out into the hallway to get help. She stated that when CNA #2 came into the room, "We tried to get her up to her wheelchair, but she was too weak so we let her slide down onto the floor." She stated, "That's when I noticed her leg was bent under her." CNA #1 confirmed that she had been taught to use the Kiosk to find out what kind of assistance a resident needed. She further stated, "I knew this resident was a one (1) person assist and one (1) person stand by. The only thing I didn't do was have someone on stand-by." A post survey telephone interview with CNA #2, on 01/21/19 at 3:15 PM, revealed when she got to the room, CNA #1 was in the room alone and there was no stand-up lift in the room. She further stated that she was aware that the resident required two (2) person assist for cleaning and changing/toileting. She further stated that CNA's at the facility were taught to use the Kiosk to determine the level of assistance a resident required. A review of the facility's time sheets and schedule, for CNA #1, confirmed that CNA #1 was scheduled to work the 7 am-3 pm shift on 12/09/18, and clocked in at 7:14 AM, and clocked out at 4:38 PM, on 12/09/18, the date of the incident. The CNA did not clock in to work thereafter. Review of Resident #1's face sheet revealed the facility admitted the resident on 1/11/18. Resident #1's diagnoses included Hypertension, Chronic Renal Failure, Muscle Weakness, Lack of Coordination, Alzheimer's, Dysphagia, and History of falls. Review of Resident #1's most recent Minimum	M 640		

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M 640	Continued From page 5 Data Set (MDS) with an Assessment Reference Date (ARD) of 12/20/18, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 14, indicating the resident was cognitively intact.	M 640		