STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255311	A. BUILDING _____ B. WING _____	C 11/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREAT OAKS REHABILITATION AND HEALTHCARE CENTER	111 CHASE STREET BYHALIA, MS 38611

(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 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interview, and facility policy review, the facility failed to report timely an allegation of abuse and neglect for Resident #10 for one (1) of four (4) residents reviewed. Findings include:	F 609	1. The facility corrected the deficient practice immediately by suspending the nurse supervisor (RN#1) on duty while a full investigation was conducted on 10/21/22. Upon return RN#1 was immediately in serviced by the DON (Director of Nurses) on timely and proper	12/29/22

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

Electronically Signed | 12/05/2022

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F 609	Continued From page 1 Review of the facility policy and procedure titled "Policy for Resident Incident and Visitor Accident Report" with a revision date of 7/23/18 revealed, " ...A. Procedure Reporting of Resident Incidents and Visitor Accidents: Any employee witnessing or having knowledge of an incident or accident involving a resident or visitor must immediately report such occurrence to his/her supervisor...Regardless of how minor an incident/accident appears to be, it must be reported to the Department Supervisor, Administrator, or DON(Director for Nursing)/designee." The facility Abuse Prohibition Policy with a revision date of 5/28/2021 revealed Neglect is defined as the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Record review of the Facility Reported Incident reported to the state agency revealed that on 10/21/22 the facility DON was made aware of an incident that had occurred on 10/19/22 with Resident #10 while being lifted in a mechanical lift by Certified Nurse Aide (CNA) #1. The incident resulted in the left arm of Resident #10 hitting the frame of the lift when CNA #1 was utilizing a mechanical lift independently and the lift sling unraveled along the seam on the left side causing the resident to fall back slightly into her wheelchair. The incident was not reported until 10/21/22 to the DON by Registered Nurse (RN) #1 when the resident began to complain of left arm pain. An interview on 11/14/22 at 11:15 AM, with Resident #10 revealed, "One of the pulleys that	F 609	reporting on 10/24/22. RN#1 was given a written reprimand on 11/24/22 explaining that any failure to report in the future could result in termination and that any questionable situation by reported to the Director of Nursing and Administrator immediately. 2. In review of the facility residents on 12/1/22, there are 17 residents that use mechanical lifts and have the potential to be affected. Failure to report will result in immediate final notice of employment as approved by the Quality Assurance and Performance Improvement committee on 12/6/22. The facility will inquire on any potential missed reportable daily in our morning administrative standup meeting beginning 12/7/22. 3. All staff were in- serviced on 10/21/22 by the Staff Development Coordinator, on timely and proper reporting. The Staff Development Coordinator will provide all employees an inservice on timely reporting twice per month for two months and then once a quarter after the initial in services. The in services will be conducted on timely and proper reporting. The Staff Development Coordinator will be responsible for all timely in- servicing and presenting the report to the Quality Assurance and Performance Improvement committee. Our approved plan will begin in- servicing two times monthly beginning 12/4/22 for 2 months and then quarterly thereafter.	

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F 609	Continued From page 2 pulls people out of the chair broke loose and I fell back into the wheelchair." An interview on 11/15/22 at 10:50 AM, with Registered Nurse (RN) #1 revealed on 10/19/22 Certified Nurse Aide (CNA) #1 came out of the resident's room and into the hallway and said she needed help with Resident #10, that she had tried to lift her with the Hoyer lift and the left side of the bottom of the sling broke. RN#1 confirmed that CNA #1 had attempted to transfer the resident by herself, and that Resident #10 was to be transferred by two staff members when utilizing the Hoyer lift. She revealed, "I didn't report it and I should have. I honestly thought since I was the RN supervisor that I made the right decision in getting her back in bed and assessing her and making sure the defective sling was thrown away and I didn't think about reporting that she didn't utilize the lift according to our lift policy." Interview on 11/15/22 at 1:10 PM, the Director of Nursing (DON) revealed that she first had knowledge of the incident on 10/21/22 when RN #1 came to her and told her that they needed to get an x-ray on Resident #10. The DON stated that she asked her why and RN#1 told her because there was an incident the other day and the lift sling tore while CNA #1 was lifting the resident for a transfer and the resident fell back into her wheelchair and now, she had complaints of her left arm hurting. She confirmed that RN #1 did not report that CNA #1 was utilizing the lift by herself, and the incident was not reported or documented per the facility policy and procedure. Record review of Resident #10's Admission Record revealed that she was admitted to the facility on 12/06/2019 with diagnoses of	F 609	4. The Administrator and Director of Nursing are responsible for monitoring and compliance daily through shift reports 2 times daily beginning 12/7/22. The shift reports will include all incidents that occurred on the shift and ask clarifying questions on any incident. This was approved by the Quality Assurance and Improvement Committee on 12/6/22.	

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F 609	Continued From page 3 Rheumatoid Arthritis, Age Related Osteoporosis, Cerebral Infarction, and Need for Assistance with Personal Care.	F 609		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, and facility policy review, the facility failed to ensure a resident was free of accidents/hazards during transfer from a wheelchair to bed when a two (2) person mechanical lift was operated by one (1) staff and the sling broke causing the resident to fall back into the wheelchair for 1 or four (4) residents reviewed for accidents, Resident #10. Findings include: The facility policy and procedure titled "Lifting Machine, using a Mechanical" dated 2001 and revised July 2017 revealed: At least two (2) nursing assistants are needed to safely move a resident with a mechanical lift. On 11/15/22 at 10:50 AM, an interview with Registered Nurse (RN) #1 revealed on 10/19/22 Certified Nurse Aide (CNA) #1 came out of the resident's room and into the hallway and said she	F 689	1. CNA #1 on 10/19/22 and used a lift against company policy alone. On 10/21/22, CNA #1 was immediately suspended pending a full investigation. CNA #1 was terminated on 10/24/22 for violating policy regarding mechanical lifts and abuse and neglect. The Assistant Director of Nursing conducted an in service with all employees regarding Mandatory 2 person lift usage, proper notification of faulty equipment and lockout/tagout procedure. These were completed 10/21 through 10/22/22. On 10/24, the administrators did interviews regarding CNA #1 regarding lift usage and abuse and neglect with no findings during Brief Interview for Mental Status 12 and above. For residents with Brief Interview Mental Status below 11, body audits were performed on 10/24. The routine monthly inspection of mechanical lifts was performed on 10/21/22 with no issues.	12/29/22

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F 689	Continued From page 4 needed help with Resident #10. She had tried to lift her with the Hoyer lift and the left side of the bottom of the sling broke. RN#1 confirmed that CNA #1 had attempted to transfer the resident by herself, and that Resident #10 was to be transferred by two staff members when utilizing the Hoyer lift. Interview by telephone on 11/15/22 at 1:05 PM, with CNA #1 confirmed that she had received an in-service before the incident on having two people when transferring a resident in the Hoyer lift and confirmed that she did not use a second person to help her. She confirmed that on 10/19/22 that she had gone into the room of Resident #10 to put her back to bed after lunch and stated, "I hooked her (Resident #10) onto the lift and started raising her up out of her wheelchair and had her up about a foot or two out of her wheelchair seat when the left bottom side of the mesh pad broke. I heard it rip and I quickly lowered her back into her wheelchair and went for help." She stated that when she stepped out of the room, she was able to get four other staff members to come and help her immediately and she knew she should have had a second person but failed to go get anyone and stated, "I just didn't ask anyone to help me." During an interview on 11/15/22 at 1:10 PM, the Director of Nursing (DON) revealed that she first had knowledge of the incident on 10/21/22 when Registered Nurse #1 came to her and told her that they needed to get an x-ray on Resident #10 and I asked her why and she said because there was an incident the other day and her lift sling tore while CNA #1 was lifting her for a transfer and now, she was complaining of pain in her left arm. "I asked who was helping the CNA (CNA#1)	F 689	Resident #10 is mandatory 2-person lift, therefore no one is allowed to enter the room with a lift without a second person present. 2. Currently 21 residents require the use of mechanical lifts have the potential to be affected. 3. The Staff Development Coordinator inserviced staff on 10/24/22 and will in service all staff monthly on proper lift usage, reporting of faulty lifts, and lockout/tagout once a month for 4 months beginning 12/2/22 for all employees. The Maintenance Director will perform weekly mechanical lift inspections beginning 12/2/22 for 4 months and then twice per month for 8 additional months. The facility ordered upgraded sling pads for the mechanical lifts on 11/02/22. 4. The Staff Development Coordinator is responsible for auditing proper lift usage 3 times a week for 4 weeks then 2 times a week for 4 weeks then monthly thereafter. This will be done by visual and recorded auditing proper lift usage and instant inservicing on any technique done incorrectly. Staff Development will report the findings to the Quality Assurance and Performance Improvement committee beinning with the 12/15/22 regular meeting. The Maintenance Director will conduct visual and performance lift inspection audits weekly and report	

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F 689	Continued From page 5 and she (RN#1) said that the CNA was in the room by herself utilizing the Hoyer lift. I immediately began to investigate the situation and suspended the CNA." An interview on 11/15/22 at 1:15 PM, with CNA #2 confirmed that she was working the other hall on the day of the incident but was immediately called over to assist and help transfer the resident back to bed. She confirmed that when she went into the room that the resident was sitting in her wheelchair and that the resident had fallen back into her wheelchair when the sling pad started to tear. Record review of Resident #10's Admission Record revealed that she was admitted to the facility on 12/06/2019 with diagnoses of Rheumatoid Arthritis, Age Related Osteoporosis, Cerebral Infarction, and Need for Assistance with Personal Care. Record review of the Minimum Data Set (MDS) revealed that Resident #10 had a Brief Interview of Mental Status (BIMS) score of 08 which indicated that she has moderate cognitive impairment.	F 689	findings to the Quality Assurance and Performance Improvement committee monthly. These actions were approved by the Quality Assurance and Performance Improvement Committee on 12/6/22 and will be reviewed monthly at the Quality Assurance and Performance Improvement Committee on 12/15/22 which is our regular meeting and monthly for 12 months.	