MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MS38BM	A. BUILDING: _____ B. WING _____	C 03/31/2023

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

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M 000	Initial Comments The State Agency (SA) conducted a Complaint Investigation (CI), MS #20966, at the facility from 3/13/23 through 3/14/23, and then returned to the facility for an extended survey from 3/27/23 through 3/31/23. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirement . The SA investigated MS #20966 for Neglect and Services not provided per the Plan of Care and Physician's Orders and cited M640 . The SA identified Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) that began on 2/27/23 when facility staff first transferred Resident #1 using a pivot transfer and not the sit-to-stand mechanical lift as required per the plan of care. Resident #1 sustained right and left (bilateral) tibia/fibula (two bones in the lower leg) fractures and suffered avoidable pain. IJ and SQC existed at: Rule 45.21.8 Accidents M640 Level IV The facility Administrator was notified of the IJs and SQC on 3/28/23 at 4:25 PM and was presented with the IJ Templates. The facility provided an acceptable Removal Plan on 3/30/23, in which they alleged all corrective actions to remove the IJ and SQC were completed on 3/29/23, and the IJ removed on 3/30/23. The SA validated the Removal Plan on 3/31/23 and determined that the IJ was removed on 3/30/23, prior to exit. Therefore, the scope and severity for Rule 45.21.8 Accidents M640 was	M 000		

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M 000	Continued From page 1 lowered from Level IV to Level II while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. The facility had a license for 120 beds, with a census of 91.	M 000		
M 640 SS=J	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 IV Based on interviews, record review, and facility policy review, the facility failed to ensure a resident was free from accident hazards when a resident who was determined to require a sit to stand mechanical lift for transfers was transferred without a lift, for one (1) of three (3) sampled residents. Resident #1 The facility's failure to ensure that the resident was transferred with a sit-to-stand mechanical lift resulted in Resident #1 sustaining right and left (bilateral) tibia/fibula (two bones in the lower leg) fractures and placed other residents who required a mechanical lift transfer at risk for sustaining serious injury, serious harm, serious impairment, or death.	M 640	The careplan and lift assessment for Resident #1 were updated on 3/3/23. All Residents transferred via mechanical lift have the potential to be affected by the deficient practice. Lift assessments have ben completed and updated on all residents by Registered Nurse Supervisor beginning on 3/3/23 and completed on 3/4/23. All Nursing Staff were in-serviced on Falls, Accidents and proper use of mechanical lifts by the Director of Nursing beginning on 3/3/23 and completed on 3/21/23. Additional training was started on 3/28/23 for all staff on Accidents and completed on 3/30/23. The Registered Nurse Supervisor or	5/1/23

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M 640	Continued From page 2 The situation was determined to be an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) that began on 2/27/23 when facility staff transferred Resident #1 using a pivot transfer and did not use the sit-to-stand mechanical lift as required. The facility Administrator was notified of the IJ on 3/28/23 at 4:25 PM and was presented with the IJ Template. The facility provided an acceptable Removal Plan on 3/30/23, in which they alleged all corrective actions to remove the IJ were completed on 3/29/23, and the IJ removed on 3/30/23. The State Agency (SA) validated the Removal Plan on 3/31/23 and determined that the IJ was removed on 3/30/23, prior to exit. Therefore, the scope and severity for Rule 45.21.8 Accidents M640 was lowered from a Level IV to a Level II while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include: A review of the facility's policy, "Safe Transfer and Lifting of Residents," Revised 8/2/22, revealed, "Policy Statement: In order to protect the safety and well-being of staff and residents, and to promote quality care, this facility uses appropriate techniques and devices to lift and move residents. Policy Interpretation and Implementation I. General Guidelines ...3. Staff is responsible for knowing/following the transfer assessment before transferring any resident. Any deviation from the transfer assessment must be approved by the nurse and documented by the approving nurse ...II Assessment Guidelines:... 9. Resident safety, dignity, comfort and medical condition will be incorporated into goals and	M 640	Resident Care Coordinator will complete 5 audits of transfers per week for one month, then 10 transfers per month for 2 months to ensure the appropriate lift is used for transfers. The transfer audit began on 4/12/2023. The transfer audits will be monitored and reviewed in the monthly Quality Assessment and Assurance Committee meeting to ensure sustained compliance for 2 months beginning 5/1/23. and ending 6/22/23.	

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decisions regarding the safe transfer and lifting of residents. 10. Nursing staff, in conjunction with the rehabilitation staff, shall assess individual residents' needs for transfer assistance ..."

A record review of the "Admission Record" revealed the facility admitted Resident #1 on 05/24/2018 with a diagnosis of Unspecified Dementia.

A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/2/2023 revealed Resident #1 required extensive two (2) person assistance with transfers.

Record review of the facility's "Change of Transfer Status" form, dated 2/26/20, revealed Resident #1 had a "Current Transfer Status" of "sit to stand lift. Assist of 2. Med (Medium) belt". The form was signed by the Physical Therapist (PT) and a nurse.

Record review and interview on 3/27/23 at 1:01 PM, with Registered Nurse (RN) #2 of the facility's "Lift/Transfer Evaluation", dated 2/2/23, revealed that Resident #1 could not bear weight, was not cooperative with transfers, and did not have upper extremity strength. The evaluation was signed by Registered Nurse (RN) #2. She confirmed that she completed the "Lift/Transfer Evaluation" on 2/2/23 for Resident #1. She stated the evaluation is a tool used to determine appropriate transfers for residents. She commented that she completed the evaluation incorrectly because Resident #1 was able to bear weight, cooperative with transfers, and had upper body strength.

A record review of the "Facility Investigation"

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M 640	Continued From page 4 (undated) revealed, " ...At approximately 11:10 AM on Friday, March 3, 2023 (Proper Name of Nurse Practitioner) came into the conference room to report ... (Proper Name of Resident #1) ...Legs were warm and tender to touch with bruising ...ordered x-rays and an ultrasound. X-rays were obtained and revealed fractures of the right and left tibia/fibula ..." A record review of the facility's investigation timeline revealed, that on 2/27/23 at 5:13 AM, CNA #1 "Brought resident out of room in wheelchair ...admitted she did not use a lift when getting resident up ...", on 2/28/23 at 5:53 PM, CNA #3, "Entered room ...with resident in w/c (wheelchair), no lift, and then left at 18:10 (6:10 PM) with dirty linens ...", and on 3/1/23 at 12:30 PM, CNA #4, " ...pushed resident into room ... (without a lift) and then came out alone ..." Record review of the Nurse Practitioner (NP) "Progress Note", dated 3/3/23 revealed, " ...Pt (patient) seen today per facility request for c/o (complain) pain in bilateral legs ...Pt noted to be in pain at time of evaluation ...Pt noted to have swelling, erythema (redness), and bruising to bilateral tibia ...X-rays were obtained and revealed fractures of left and right tibia and fibula ..." Record review of the "Radiology Interpretation" dated 3/3/23 revealed, " ...Left Tibia/Fibula X-ray ...Findings: There is a fracture of the proximal tibia and fibula. There is moderate impaction and angulation. Impression: Fractures of the tibia and fibula with angulation, of uncertain age ...Right Tibia/Fibula X-ray ...Impression: Fractures of the tibia and fibula of uncertain age ..." On 3/13/23 at 11:00 AM, in an interview with the	M 640		

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M 640	Continued From page 5 Interim Administrator, she stated that on 3/3/23, the NP informed the staff at the facility that Resident #1 had a bilateral fracture of the tibia and fibula. The facility transferred Resident #1 to the local Emergency Department (ED) and immediately began their investigation. During their investigation that began on 3/3/23, the facility interviewed staff and watched surveillance videos, and reviewed all staff that were assigned to Resident #1. The Interim Administrator confirmed the facility is unclear on how the resident received the fractures but discovered that several employees did not use the sit-stand-lift while transferring the resident. On 3/13/23 at 11:20 AM, an interview with the Director of Nurses (DON) revealed that on 3/3/23, Resident #1 sustained bilateral fractures of the tibia and fibula. During the investigation, the facility discovered that several Certified Nurse Assistants (CNAs) transferred the resident without using the sit-to-stand mechanical lift and conducted pivot transfers instead. The DON expressed it was "strange" that Resident #1 had fractures on both legs in the same area, and she thought it could have been caused by the sit-to-stand lift, but she was not sure. On 3/13/23 at 12:00 PM, during an interview with the Nurse Practitioner (NP), she said that a nurse notified her on 3/3/23 that Resident #1 had bruising and pain in both legs. She assessed Resident #1 and confirmed that both her lower extremities had swelling, erythema, and bruising and the injuries were in the same area on both legs. She stated that she ordered bilateral x-rays, which showed Resident #1 had left and right tibia/fibula fractures. She then requested that the resident be sent to the local ER. The NP confirmed there were no injuries or falls reported	M 640		

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to her regarding Resident #1 and she was unclear how the accident occurred.

On 3/14/23 at 9:44 AM, in an interview with Certified Nurse Assistant (CNA) #1, she stated that on 2/27/23 around 5:00 AM, she did not use the sit-to-stand lift when transferring the Resident #1, but instead got another CNA to help pivot transfer her from the bed to her wheelchair. CNA #1 said that she normally used the lift, but she "did it the easy way".

On 3/14/23 at 10:00 AM, in an interview with CNA #2, she confirmed that she assisted CNA #1 with a pivot transfer on Resident #1 on 2/27/23 and they did not use the sit-to-stand lift.

On 3/28/23 at 11:05 AM, an interview with CNA #4 revealed that on 3/1/23, after lunch, she transferred Resident #1 back to her bed. She stated she did a pivot transfer by herself and did not use the sit-to-stand lift. She explained that Resident #1 was weight-bearing and was able to help with the transfer. CNA #4 expressed she was aware Resident #1 required a sit-to-stand lift with transfers, but Resident #1 was an easy pivot transfer and the resident assist with the transfer. CNA #4 stated she conducted a pivot transfer by herself.

On 3/28/23 at 1:22 PM, in an interview with CNA #3, she stated that she broke protocol and did not use the sit to stand lift during the transfer of Resident #1 on 2/28/23. She said that she used a pivot transfer to transfer Resident #1 from her wheelchair to her bed and did not have assistance with the transfer. CNA #3 revealed she was aware that Resident #1 required a lift for transfers, but she performed the transfer alone because Resident #1 was not a big person and

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was easy to transfer.

On 3/27/23 at 4:21 PM, an interview with CNA #5 revealed that on 3/2/23 at 3:00 PM, she assisted with transferring Resident #1 from her wheelchair to her bed using the sit-to-stand mechanical lift. She explained that during the transfer, Resident #1 began "hollering" in pain. Another CNA assisted with the transfer and they both noticed that Resident #1's legs were bruised. They notified Licensed Practical Nurse (LPN) #1 and she came and looked at her legs. CNA #5 said that Resident #1 was in tears around 10:15 PM that night and complained of pain in her legs. CNA #5 stated, "This was different for her" and they reported it to the nurse.

On 3/28/23 at 8:29 AM, in an interview with CNA #6, she stated that Resident #1 was up, dressed, and in her wheelchair on 3/2/23 during the day shift. She said Resident #1 often requested pain medication for pain to her legs and hip, and often requested to have her "peri-pad" changed throughout the day. However, on 3/2/23, Resident #1 complained of pain but did not request her peri-pad to be changed, which was unusual for her. On 3/2/23 at 3:00 PM, CNA #6 confirmed that she assisted other CNAs with transferring Resident #1 back to bed with the lift and Resident #1 complained of pain during the transfer. CNA #6 said that they noticed the resident's legs were blue and swollen and went to get the nurse.

On 3/28/23 at 8:36 AM, an interview with CNA #7, she confirmed that on 3/2/23 in the afternoon about 3:00 PM before getting off that day, Resident #1 complained that her legs were hurting, and was "hollering out loud" when she was transferred with the sit-to-stand lift from her

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wheelchair to the bed, which was not normal for her. CNA #7 confirmed that the resident's legs had bruising and that it was reported to LPN #1.

On 3/28/23 at 3:30 PM, an interview Interim Administrator revealed she expected the staff to follow the recommended transfer evaluation and if the evaluation indicated resident should be transferred with a sit-to-stand lift, then the staff should perform the transfer using the lift.

The facility submitted the following acceptable Removal Plan on 3/30/23:

On 3/28/23 at 4:25 PM the State Survey Agency notified the Interim Administrator that the facility failed to ensure 1.) Resident #1 was transferred with the sit-to-stand mechanical lift as determined necessary by the comprehensive care plan 2.) Evaluate and provide pain management for Resident #1. 3.) To implement care plan interventions for Resident #1 when the facility did not transfer her using the sit-to-stand mechanical lift and did not provide pain management for her when she experienced pain.
On 3/28/23 at 4:25 PM the Immediate Jeopardy Templates for F656, F689 and F697 were provided to the Interim Administrator.
At approximately 11:10 AM on Friday, March 3, 2023, the Nurse Practitioner reported that Resident #1 was experiencing bilateral leg pain. X-ray reports revealed bilateral fractures of the Tibia/Fibula. Resident #1 was sent to a local hospital Emergency Room for orthopedic evaluation.

These findings were reported 3/3/23 to the State Survey Agency at 1:03 PM and the State Attorney General at 1:21 PM.

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M 640	Continued From page 9 On March 3, 2023, at approximately 11:30 the facility initiated an investigation including staff interviews, obtaining statements and reviewing video. Because the facility could not determine the date, time or cause of the injury the facility requested that the Attorney General's office assign an investigator to assist in this investigation. The investigator arrived on site on 3/13/23 to initiate their investigation. As of 3/29/23 a specific incident that caused the injury to Resident #1 has not been identified. Training for ALL nursing staff, prior to working their next scheduled shift: Beginning on 3/3/23, no nursing staff was allowed to work until completion of training, provided by the Director of Nursing (DON), on the following topics, Falls and Accidents Care Plans Mandatory Lift training video located in the Bedford Care Centers Education Library Additional training started on 3/28/23, for ALL staff and no staff was allowed to work until trained on the following topics, Pain Assessment and Management Accidents Care Plan Implementation All training was provided by DON and Staff Development Nurse. Lift assessments have been completed/updated on all residents due to the fact that all residents who require the use of mechanical lifts have the potential to be affected by use of incorrect lifts. Lift Assessments were completed by Registered Nurse (RN) #1 starting on 3/3/23 and completed on 3/4/23. Care plans have been reviewed for all residents	M 640		

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who require the use of mechanical lifts. Review was completed by Minimum Data Set (MDS) Nurse #1, started on 3/4/23 and completed on 3/6/23. Review indicated all residents were care planned for the correct lift.
Monitoring for use of appropriate lift, sling/belt is being carried out by the DON. The Lift/Transfer Monitoring Tool is being used to document monitoring and was initiated on 3/28/23.

All residents have been assessed for pain using the Pain Evaluation which includes the pain scale. Assessments were completed on 3/29/23 by the DON and RN #2. The Pain Alert Monitoring log is being used to monitor and audit for pain management and was initiated on 3/28/23. The DON and RCC/IP are responsible for conducting pain management audits.

Care Plans for all residents have been reviewed regarding pain management. The review was completed by MDS Nurse #1 and MDS Nurse #2 on 3/29/23. No resident's care plans required updating.

Audit has been performed for all Resident Kardex. The audit was completed by the assisting Interim Administrator, on 3/3/23. No discrepancies were noted.

Facility lifts have been inspected for proper use and function. Environmentalist/Maintenance Director completed the inspections on 3/10/23. Five (5) sit to stand lifts were inspected. One was removed from service to replace a part related to the switch. Four (4) total/full body lifts were inspected with no maintenance required.

Emergency Quality Assurance meetings were conducted on 3/7/23 and 3/29/23. Attending the

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meetings were Interim Administrator, assisting Interim Administrator, Corporate Nurse, Medical Director, Director of Nursing, Resident Care Coordinator/Infection Preventionist, MDS Nurses, and Social Services. Discussed in the meeting were:
Review of Resident #1 injury identified on 3/3/23
Results/status of investigation
Actions taken including training, monitoring and audits of care plans and assessments of pain and transfer status/lift utilization
Review of policies related to care plans, accidents and injuries, lift utilization and transfer. No changes to policies were recommended or made.

The facility alleges that the Immediate Jeopardy has been removed as of March 30, 2023.

The SA validated the facility's removal plan on 3/31/23:

On 3/31/23, the SA validated through record review of the meeting sign in sheet and through staff interviews that the facility held a Quality Assurance Performance Improvement (QAPI) Committee meeting on 3/7/23 and 3/29/23.

On 3/31/23, the SA validated through record review of the meeting sign-in sheet and through staff interviews that the facility held a QAPI meeting on 3/7/23 and 3/29/23 regarding care plans, assessments of pain, and transfer status/lift utilization. Review policies related to care plans, accidents, injuries, lift utilization, and transfer.

On 3/31/23, the SA validated through staff interview and record review that the facility provided education beginning on 3/3/23 for falls,

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M 640	Continued From page 12 accidents, care plans, and mandatory lift training. The staff attended additional training beginning on 3/28/23 pain assessment and management, accidents and care plan implementation. On 3/31/23, the SA validated through staff interviews and record reviews that the facility performed lift assessments and updated all residents who require the use of mechanical lifts. On 3/31/23, the SA validated through staff interviews and record reviews that the facility reviewed care plans for all residents who require the use of mechanical lifts. On 3/31/23, the SA validated through staff interviews and record reviews that the facility monitored the use of the appropriate lift, sling/belt for all residents. On 3/31/23, the SA validated through staff interviews and record reviews that the facility assesses all residents for pain using the Pain Evaluation, which includes the pain scale. On 3/31/23, the SA validated through staff interviews and record reviews that the facility all resident care plans have been reviewed regarding pain management. On 3/31/23, the SA validated through staff interviews and record reviews that the facility audited all resident Kardex. On 3/31/23, the SA validated through staff interviews and record reviews that the facility lifts have been inspected for proper use and function.	M 640		