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	255072	A. BUILDING _____ B. WING _____	C 03/29/2023

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WINSTON COUNTY NURSING HOME	17560 EAST MAIN STREET LOUISVILLE, MS 39339

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F 000	INITIAL COMMENTS The State Agency (SA) conducted two (2) complaint investigations (CI MS #21037 and CI MS# 21085) at the facility from 3/27/2023 through 3/29/2023. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid Services. The SA identified non-compliance and cited F656 and F689 for CI MS# 21085 for failure to implement care plan and failure to prevent accidents. There were no deficiencies cited for CI MS# 21037 related to pressure ulcers, assessing/monitoring. Based on the facility's implementation of corrective actions on 2/20/23, this was determined to be Past Non Compliance. The census at the time of the survey was 92 with a bed capacity of 120 beds.	F 000	Past noncompliance: no plan of correction required.	
F 656 SS=G	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §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	F 656		

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

Electronically Signed | 04/19/2023

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F 656	Continued From page 1 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. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review and facility policy review the facility failed to implement the care plan related to transfers for one (1) of nine (9) care plans reviewed. Based on implementation of the facility's corrective actions on 2/20/23, this was determined to be Past Non-Compliance. (Resident #1) Findings include:	F 656	Past noncompliance: no plan of correction required.	

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A record review of the facility's policy titled "Care Plan", revealed, "Purpose: To direct resident care from admission to discharge... Procedure: 10.) Customize the care plan to address the resident's individual concerns and needs..."

A record review of the facility's policy titled "Care Plan Kardex for CNA", "Purpose: To ensure that the Certified Nurse Assistants (CNA) identify particular needs of each resident related to activities of daily living ...Procedure: 1.) Certified Nurse Assistants will utilize the Plan of Care Kardex daily to ensure continuity of care to assigned residents ... 2.) The Certified Nurse Assistants will review the Plan of Care Kardex of each assigned resident daily ... 6.) The plan of Care Kardex will identify the Residents' needs to Nurses and Certified Nurse Assistants regarding he is following ADL'S (Activities of Daily Living): Hearing, speech, vision, ambulation, bathing, restraints, bed mobility, and transfer, personal hygiene, dressing, eating, bowel and bladder function, and any adaptive equipment."

A review of the comprehensive care plan with a start date of 2/16/23 titled, "I FALLS"- "I am at risk for falls w(with)/injuries R/T (related to): I have a HX (history) of falls, I am not walking, I have increased weakness. I have a DX (diagnosis) of osteopenia; I am dependent for transfers. Intervention:...Transfers- I am dependent x (times) 2 (two) staff using hoyer lift..."

A record review of the Plan of Care Kardex for February 2023 for Resident #1, revealed under Transfers/ROM(Range of Motion): Mechanical Lift: Hoyer/Ceiling Lift for transfers.

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A review of the findings of the investigation revealed: 1.) On 2/17/23 Certified Nursing Assistant (CNA) # 1 was assigned to resident and approximately 5:30 PM went in to move resident from the recliner to the bed for the night, stepped out into the hall and asked CNA # 2 to assist... 2.) Resident's care plan and instructions for specific resident care are maintained on cards located at the nurse's station and CNAs are instructed to check the card every day for specific instructions or changes in the care plan and initial the card to indicate understanding of the instructions... 3.) Review of the records indicated CNA # 1 did not read the card prior to her shift on 2/17/23. CNA # 1 admitted during an interview that she did not read the care plan which specifically calls for residents to be transferred with a Hoyer lift. 4.) Review of the record indicated CNA # 2 had not previously been assigned and had no knowledge of the resident's specific needs. An interview with CNA # 2 stated she relied on CNA # 1's knowledge of the resident's care plan and assisted CNA # 1 with a two-person manual transfer from the recliner to the bed. 5.) During separate interviews with both CNA's, they indicated they did not observe anything unusual or remarkable about the transfer and the resident did not indicate any pain during or after the transfer... 6.) CNA # 1 and CNA # 2 were suspended pending findings of investigation on 02/18/23.

A review of the conclusion of the investigation revealed, 1.) Both CNAs were immediately placed on leave pending the investigation. 2.) Investigators believe the injury was sustained during the transfer on 2/17/23 and CNAs did not follow the proper protocol by not familiarizing themselves with the care plan instructions on the

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card system. 3.) Investigators did not find intentional abuse or rough handling of resident. 4.) All residents care planned for a Hoyer Lift was reviewed and no deficiencies noted.

An interview via phone with CNA # 1 on 3/28/23 at 11:00 AM, revealed she knew she was supposed to use the Hoyer Lift for Resident #1 and knows she was supposed to review the Kardex every day before caring for residents to make sure there is no changes but verified, she did not review Resident # 1's Kardex on 2/17/23 prior to the transfer. CNA #1 confirmed she was assigned to Resident # 1 and knew she was supposed to use the Hoyer Lift for her. CNA # 1 stated " I got CNA # 2 to help me, we lifted resident gently under her arms and transferred resident to the bed, lifted her legs in the bed and made her comfortable, and the resident never complained." CNA #1 confirmed transferring her incorrectly possibly fractured Resident #1's leg.

An interview with the Quality Assurance (QA)/Nurse Educator on 3/29/23 at 8:45 AM, revealed she was a part of the investigation for Resident #1's fracture and confirmed that the injury Resident # 1 sustained was related to CNA's not following the Kardex care plan for Resident # 1.

An interview with the Director of Nursing (DON) on 3/29/23 at 8:55 AM, she revealed she investigated the fracture on Resident # 1 and confirmed she believed that staff not following the care plan for transfers resulted in the fracture of Resident # 1's leg.

An interview with the Administrator on 3/29/23 at 9:10 AM, he revealed that the CNAs did not follow

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the plan of care resulting in the fracture.

A review of the comprehensive care plan with a start date of 2/16/23 titled, "I desire to have my needs anticipated and met by staff in a timely manner through next review ...Interventions: Transfers- I am dependent x 2 staff using Hoyer lift."

Record review of the Face Sheet revealed that the facility admitted Resident # 1 to the facility on 2/10/23 with diagnoses of Disorder of the Bone density and structure unspecified, Chronic Pain syndrome and Peripheral vascular disease.

Record review of the Minimum Data Set (MDS) Section C with an Assessment Reference Date (ARD) of 2/19/23, revealed that Resident #1 had a Brief Interview of Mental Status (BIMS) score of 06 which indicated that she was severely cognitively impaired. Section GG of the MDS for chair/bed-to chair transfer Resident # 1 was coded Dependent.

A review of CNA # 1's personnel file revealed she was educated on the Kardex (care plan) on 6/27/22 and 7/1/22 on the Lifts.

A review of CNA # 2's personnel file revealed she was educated on the Kardex (care plan) and Lifts on 9/27/22.

The SA validated through record review and staff interview that the following occurred:
1. Investigators believe the injury was sustained during the transfer on 2/17/23 and CNA'S did not follow the proper protocol by not familiarizing themselves with the care plan instructions on the card system.

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F 656	Continued From page 6 2. Both CNAs were immediately placed on leave pending investigation. 3. An Ad Hoc Quality Assurance meeting was held on 2/20/23. 4. Immediate in-person education was conducted 2/20/23 with all staff to reiterate protocols regarding information about care plans, the card system acknowledgement, Resident Rights and abuse and neglect. 5. All Resident's care planned for a Hoyer Lift were reviewed. No additional deficiencies were noted. 6. Investigators did not find intentional abuse or rough handling of resident. 7. Kardex will be checked for completion beginning 2/20/23, three (3) times a week for 3 weeks, then 2 times a week for 3 weeks, then weekly times 3 weeks. Any CNA failing to read and acknowledge Kardex assignments will be subject to disciplinary actions. 8. If either of the two CNA's involved in the incidents are found to be out of compliance within 90 days, immediate dismissal will result. Record review revealed the facility emailed the Investigative summary to the State Agency on 2/23/23 and to the Attorney General's Office on 3/22/23.	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.	F 689		

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F 689	Continued From page 7 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 and or hazards during transfer when two (2) staff physically lifted the resident under her arms and transferred her from her chair to the bed without using a mechanical lift resulting in a distal femur fracture for one (1) or six (6) residents reviewed for accidents. Based on implementation of the facility's corrective actions on 2/20/23, this was determined to be Past Non-Compliance. (Resident # 1) Findings include: The facility policy titled "USE OF HYDRAULIC LIFT, HOYER LIFT", revised 9/9/2014, revealed "Purpose: To reduce the risk of injury to residents and or staff related to transfer of dependent or obese residents... Special Considerations: Hydraulic lifts are designed to be operated by one person but, for the safety of residents and staff members, it is this facility's policy for two staff members to be present when hydraulic lift is in use. One to operate the lift and the other to stabilize and support the resident during transfer..." A review of the facility's self-reported investigation of Resident # 1's fracture of unknown cause, revealed, Description of incident: On 2/18/23 family of the resident noted swelling and redness on the right leg and reported to the nurse, upon assessment the Licensed Practical Nurse (LPN) on duty observed the redness and swelling and reported to the Registered Nurse (RN) Supervisor who confirmed the assessment and notified the	F 689	Past noncompliance: no plan of correction required.	

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provider. Resident #1 was sent to Emergency Department (ED) for evaluation and radiology reported a mildly angulated nondisplaced fracture to distal femur and severe tri-compartmental osteoarthritic disease with severe joint space loss. Resident returned from ED with an immobilizer to right leg and medication for pain and to follow up with primary physician as surgery is not an option. The primary physician referred to an orthopedic doctor of choice. The RN Supervisor reported that during the assessment, the family indicated the resident was transferred from the recliner to bed on 2/17/23 in the P.M. without the use of the lift and that her knee was twisted during the transfer. The family indicated they did not witness the transfer but was informed by someone about the incident. The family declined to identify the source of information. Upon notification of the fracture on 2/18/23 the Director of Nursing (DON) reported the incident via phone to Licensure and Certification at approximately 11:30 PM on 2/18/23.

A review of the findings of the investigation revealed: 1.) On 2/17/23 Certified Nursing Assistant (CNA) # 1 was assigned to resident and approximately 5:30 PM went in to move resident from the recliner to the bed for the night, stepped out into the hall and asked CNA # 2 to assist... 2.) Resident's care plan and instructions for specific resident care are maintained on cards located at the nurse's station and CNAs are instructed to check the card every day for specific instructions or changes in the care plan and initial the card to indicate understanding of the instructions... 3.) Review of the records indicated CNA # 1 did not read the card prior to her shift on 2/17/23. CNA # 1 admitted during an interview that she did not read the care plan which specifically calls for

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residents to be transferred with a Hoyer lift. 4.) Review of the record indicated CNA # 2 had not previously been assigned and had no knowledge of the resident's specific needs. An interview with CNA # 2 stated she relied on CNA # 1's knowledge of the resident's care plan and assisted CNA # 1 with a two-person manual transfer from the recliner to the bed. 5.) During separate interviews with both CNA's, they indicated they did not observe anything unusual or remarkable about the transfer and the resident did not indicate any pain during or after the transfer... 6.) CNA # 1 and CNA # 2 were suspended pending findings of investigation on 02/18/23.

A review of the conclusion of the investigation revealed, 1.) Both CNAs were placed on leave pending the investigation. 2.) Investigators believe the injury was sustained during the transfer on 2/17/23 and CNAs did not follow the proper protocol by not familiarizing themselves with the care plan instructions on the card system. 3.) Investigators did not find intentional abuse or rough handling of resident. 4.) All residents care planned for a Hoyer Lift was reviewed and no deficiencies noted.

An observation of Resident # 1 on 3/27/23 at 3:00 PM, revealed resident lying in bed facing the door, eyes closed with no nonverbal signs of pain observed.

An interview and observation on 3/28/23 at 10:00 AM, revealed Resident # 1 lying in bed watching the television, State Agency (SA) spoke to the resident and asked if she was hurting, and Resident # 1 smiled and shook her head no.

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On 3/28/23 at 11:00 AM, during an interview via phone with CNA # 1, revealed she was assigned to Resident # 1 on 2/17/23, and knew she was supposed to use the Hoyer Lift for Resident #1. She was supposed to review the Kardex every day before caring for residents to make sure there is no changes but verified, she did not review Resident # 1's Kardex on 2/17/23 prior to the transfer. CNA # 1 stated she got CNA # 2 to help her, we lifted the resident gently under her arms and transferred her to the bed, lifted her legs in the bed and made her comfortable. The resident never complained. CNA #1 confirmed transferring her incorrectly possibly fractured Resident #1's leg.

A phone interview with CNA # 2 on 3/28/23 at 3:00 PM, revealed she did assist with the two-person transfer for Resident # 1 but she was not assigned to the resident just assisted, and trusted that CNA #1 who was assigned to her knew the care she needed.

On 3/29/23 at 8:45 AM, during an interview with the Quality Assurance (QA)/Nurse Educator, she stated she was a part of the investigation for Resident #1's fracture. She confirmed that the fracture was most likely sustained during the improper transfer of Resident # 1.

An interview with the Director of Nursing (DON) on 3/29/23 at 8:55 AM, revealed she investigated the fracture for Resident # 1 and confirmed she believed that Resident # 1 being transferred incorrectly resulted in the fracture of her leg and confirmed that other possible concerns from an incorrect transfer are falls, and further injuries.

An interview with the Administrator on 3/29/23 at

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9:10 AM, revealed that the investigation of Resident # 1 is clear, the resident had no other incidents or injuries until she was transferred incorrectly on 2/17/23 by CNA #1 and CNA #2.

A record review of the Progress notes dated 2/18/2023, revealed family of Resident # 1 was visiting and reported Resident # 1 was complaining of knee pain, that Resident # 1 was assessed by the LPN and RN Supervisor on duty and assessment revealed the right knee swelling, redness, and warm to touch. The provider was notified and ordered to be sent to the Emergency Room for an outpatient x-ray. Review of the x-ray report revealed Impression: "Acute nondisplaced distal femoral condyle fracture extending from lateral to medial."

A review of the Transfer Assessment dated 2/10/23 revealed under Mode of Transfer: Lift mechanically.

A review of CNA # 1's personnel file revealed she was educated on the Kardex (care plan) on 6/27/22 and 7/1/22 on the Lifts.

A review of CNA # 2's personnel file revealed she was educated on the Kardex (care plan) and Lifts on 9/27/22.

Record review of the Face Sheet revealed that the facility admitted Resident #1 on 2/10/23 with diagnoses of Disorder of the Bone density and structure unspecified, Chronic Pain syndrome and Peripheral vascular disease.

Record review of the Minimum Data Set (MDS) Section C with an Assessment Reference Date (ARD) of 2/19/23, revealed that Resident #1 had

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a Brief Interview of Mental Status (BIMS) score of 06 which indicated that she was severely cognitively impaired. Section GG of the MDS for chair/bed-to chair transfer Resident # 1 was coded Dependent.

The SA validated through record review and staff interview that the following occurred:
1. Investigators believe the injury was sustained during the transfer on 2/17/23 and CNA'S did not follow the proper protocol by not familiarizing themselves with the care plan instructions on the card system.
2. Both CNAs were immediately placed on leave pending investigation.
3. An Ad Hoc Quality Assurance meeting was held on 2/20/23.
4. Immediate in-person education was conducted 2/20/23 with all staff to reiterate protocols regarding information about care plans, the card system acknowledgement, Resident Rights and abuse and neglect.
5. All Resident's care planned for a Hoyer Lift were reviewed. No additional deficiencies were noted.
6. Investigators did not find intentional abuse or rough handling of resident.
7. Kardex will be checked for completion beginning 2/20/23, three (3) times a week for 3 weeks, then 2 times a week for 3 weeks, then weekly times 3 weeks. Any CNA failing to read and acknowledge Kardex assignments will be subject to disciplinary actions.
8. If either of the two CNA's involved in the incidents are found to be out of compliance within 90 days, immediate dismissal will result.
Record review revealed the facility emailed the Investigative summary to the State Agency on 2/23/23 and to the Attorney General's Office on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255072	A. BUILDING _____ B. WING _____	C 03/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINSTON COUNTY NURSING HOME	**17560 EAST MAIN STREET LOUISVILLE, MS 39339**

(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 689	Continued From page 13 3/22/23.	F 689		