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BEDFORD CARE CENTER OF MENDENH	925 WEST MANGUM AVENUE MENDENHALL, MS 39114

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F 000	INITIAL COMMENTS On 12/13/2023, the State Agency (SA) conducted an onsite complaint investigation, CI MS #23522, for a Facility Self -Reported Incident (FRI) related to an improper transfer resulting in fractures of Resident #1's left tibia and fibula and left nondisplaced intertrochanteric femur fracture. The SA determined that the facility was in compliance with the requirements for participation in Medicare and Medicaid and deficiencies were cited at F656 and F689. Based on the facility's implementation of corrective actions on 11/09/23 through 11/12/23, this was determined to be Past Non Compliance. The facility was licensed for 60 beds and the resident census was 57 on 12/13/23.	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 under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights	F 656		

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

Electronically Signed | 12/29/2023

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F 656	Continued From page 1 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: CI MS #23522 Based on staff interviews, record reviews, and facility policy and procedure reviews, the facility failed to implement the care plan for a two (2) person transfer using a full body lift, resulting in an injury to Resident #1 for one (1) of three (3) care plans reviewed for transfers. Based on implementation of the facility's corrective actions initiated on 11/09/23-11/12/23, this was determined to be Past Non-Compliance (PNC).	F 656	Past noncompliance: no plan of correction required.	

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Findings Include:

The facility policy and procedure titled "Using the Care Plan" dated revised 8/2/22 revealed: "The care plan shall be used in developing the resident's daily care routines and will be available to staff personnel who have responsibility for providing care or services to the resident.."

The facility policy and procedure titled "Comprehensive Care Plans" dated revised 8/24/22 revealed: "Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident ... to meet a resident's medical, nursing needs. Policy Explanation and Compliance Guidelines ...f. Resident specific interventions ...reflect the resident's needs and preferences ..."

Record review of the Care Plan Detail for Res #1 revealed "Focus: The resident has an ADL (Activities of Daily Living) self-care deficit ... Interventions/Task ...ADL Transferring-Total assist x 2 staff using total lift with medium sling ..."

Record review of the Task List Report revealed " ... ADL - Total Assist x 2 staff using total lift with medium sling ...." Date Initiated 02/06/2023.

Record review of the review of the facility's investigation dated 11/14/23 and signed by the Nursing Home Administrator revealed "On 11-9-2023 at approximately 9:15 A.M. it was discovered that (Proper Name of Res #1) had a hematoma on her lower left extremity on the anterior of her leg. After the discovery, she was sent to Proper name of the local hospital) for

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examination and subsequent treatment. At that point, an investigation was begun to determine the cause of the injury. In questioning Certified Nursing Assistants (CNA's) that had been assigned to her on 11-8-2023, it was discovered that she was transferred improperly, she was care planned for a total lift. She had a history of Osteopenia .... They discovered fractures of the left fibula and tibia. Due to this diagnosis (Proper Name of Res #1) was scheduled with an orthopedic doctor the following day ...He determined that she (Res #1) had a fracture of the left tibia and fibula fracture and left non-displaced intertrochanteric femur fracture ... Additional pain medication was ordered ... Certified Nursing Assistant (Proper Name of CNA #1) was interviewed and gave a written statement that indicated that she inappropriately pivoted (Proper Name of Res #1) instead of using the lift she performed a one person pivot...Based on the interviews and the timeline it appeared that (Proper Name of Res #1's) CNA inappropriately transferred her using a one person assist pivot causing injury. The CNA #1 was terminated..."

Interview via telephone on 12/13/23 at 2:00 PM, with CNA #1 she stated transferred Res #1 from her bed to her wheelchair without a full body lift or the assistance of another staff. CNA #1 confirmed that she did not use a lift to transfer Res #1 and did not utilize another staff to assist with the transfer.

Interview on 12/13/23 at 2:30 PM, with Licensed Practical Nurse (LPN) #1 she confirmed that she was the Care Plan and Minimum Data Set (MDS) nurse. LPN#1 confirmed that Res #1 was care planned since 02/06/23 for a full body lift with two (2) person (s) to assist for all transfers. LPN #1

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stated that all staff had been educated on the care plan of Res #1 and that CNA #1 knew that Res #1 was to be transferred via a full body lift with two (2) person (s) to assist. LPN #1 stated that the CNA 's had access to the CNA care plan that was available in the Kiosk under Point of Care.

Interview on 12/13/23 at 3:35 PM with Registered Nurse (RN #1) revealed that she was the Quality Assurance (QA) nurse and immediately on 11/09/23 at approximately 12:00 noon an emergency QA meeting was held. The QA committee assisted with the completion of the facility's investigation and they determined that CNA #1 did not transfer Res #1 in accordance to the care plan and because of not using the lift for transferring with a two (2) person (s) assist, Res #1 was injured.

Record review of the facility's investigations dated 11/9/23 and signed by the DON revealed, " Interview with resident (Proper name of Res #1) Spoke with resident to inquire about injury to LLE (left lower extremity). Resident confirmed being transferred without lift but denied being dropped, bumped or falling..."

Record review of the facility's investigation report revealed an unsigned typed note dated 11-9-2023 (no time documented) revealed "It appears that three CNA's broke policy and assisted resident (Proper Name of Res #1) to stand. Interviews with the CNA's indicated that they had stood her in lieu of following her care plan..."

Record review of the Admission Record revealed Resident #1 was admitted to the facility on 2/6/23 with diagnoses that included Unspecified

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Dementia and Other specified disorders of done density and structure.

The State Agency (SA) validated the facility's Past Non-Compliance (PNC) Corrective Action on 12/13/23:

The SA validated through interviews and record review that on 11/10/2023 the facility held an Emergency Quality Assurance (QA) meeting with the Medical Director and the Interdisciplinary Team.

The SA validated through interviews and record review that on 11/10/2023 through 11/12/2023 the facility completed a 100% body audit completed by the DON with involvement by the Administrator.

The SA validated through interviews and record review that on 11/09/2023 the facility began in-services for all direct care staff on proper lift techniques by the staff development nurse.

The SA validated through interviews and record review that a 100% audit of all residents was completed to ensure that they had a *BCARE Lifts/Transfer Assistance Evaluation completed appropriately, and that the facility compared the Lift Evaluation, Care Plan and Kardex of all residents to ensure that they match and were correct.

The SA validated through interviews and record review that in-services for all nursing staff, including agency staff on using the Transfer and Kardex Training was performed by the Staff Development nurse.

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F 656	Continued From page 6 The SA validated through interviews and record review that an ongoing processes to ensure that the correct lift and procedures are and will be used included: Skill observations for the Stand Lift and Total Lift for all nursing staff and CNA's and agency staff was completed. This was performed by the Staff Development nurse and audited by the Director of Nursing. The SA validated through interviews and record review that the facility will use the QA Transfer Audit when completing transfer audits and the Nurse Supervisor will visualize a transfer and verify that CNA's are using the appropriate lift and technique. This will be used through 12/31/23. The SA validated through interviews and record review that transfer audits will be completed by a cart nurse 2 x per shift per day. The DON will visualize one (1) transfer on each shift every week. The other audits for the week may be delegated. This will be completed through 12/31/23. The SA validated through interviews and record review that the facility's investigation determined that CNA #1 was responsible for the injuries to Res #1. CNA #1 was terminated for not following the care plan for the proper transfer of Res #1 and not using the full body lift with a (2) person assist.	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	F 689		

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F 689	Continued From page 7 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: CI MS 23522 Based on record reviews, interviews, and facility policy and procedure review the facility failed to ensure a resident was free of accidents and/or hazards during transfer when staff physically lifted and transferred Resident #1 from her bed to her wheelchair without using the required full body lift with two (2) person (s) to assist, resulting in a fracture of the left tibia and fibula and a left non-displaced intertrochanteric femur fracture for one (1) of three (3) residents reviewed for accident/hazards. Resident #1. Based on implementation of the facility's corrective actions on 11/09/23 through 11/12/23, this was determined to be Past Non-Compliance. Findings include: Record review of the facility policy and procedure titled "Resident Lift/Transfer Policy and Procedure Acknowledgement for Nurses and Certified Nursing Assistants" dated 01/01/2019 revealed "It is the Policy of (Proper Name of Facility)this facility) to provide a safe environment for...Residents by providing mechanical lift equipment for Resident lifts/transfers. Mechanical lifts are available on each Nursing Unit for Resident lifts/transfers. Procedures for Mechanical Lifts/Transfers 1. Only trained and authorized employees are allowed to lift/transfer Residents ...according to each Resident's Care Plan ..."	F 689	Past noncompliance: no plan of correction required.	

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Record review of the facility policy and procedure titled "Safe Transfer and Lifting of Residents" dated revised 8/2/22 revealed: 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... VI. Procedure for transferring resident with full body lift: ... c.identifies resident/ensures proper transfer is followed per care plan...Ensures 2nd person is assisting..."

Record review of the facility's investigation report revealed an unsigned typed note dated 11-9-2023 (no time documented) revealed "It appears that three CNA's broke policy and assisted resident (Proper Name of Res #1) to stand. (Res #1) has a condition where her bones are extremely brittle. On the morning of 11-9-2023, (Res #1) was noted to have a hematoma on her lower leg. There were no breaks in the skin, and she denied being dropped. Interviews with the CNA's indicated that they had stood her in lieu of following her care plan. This is preliminary and the investigation continues..."

Record review of the review of the facility's investigation dated 11/14/23 and signed by the Nursing Home Administrator revealed "On 11-9-2023 at approximately 9:15 A.M. it was discovered that (Proper Name of Res #1) had a hematoma on her lower left extremity on the anterior of her leg. After the discovery, she was sent to Proper name of the local hospital) for examination and subsequent treatment. At that point, an investigation was begun to determine the cause of the injury. In questioning Certified Nursing Assistants (CNA's) that had been assigned to her on 11-8-2023, it was discovered

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that she was transferred improperly, she was care planned for a total lift. She had a history of Osteopenia .... They discovered fractures of the left fibula and tibia. Due to this diagnosis (Proper Name of Res #1) was scheduled with an orthopedic doctor the following day ...He determined that she (Res #1) had a fracture of the left tibia and fibula fracture and left non-displaced intertrochanteric femur fracture ... Additional pain medication was ordered ... Certified Nursing Assistant (Proper Name of CNA #1) was interviewed and gave a written statement that indicated that she inappropriately pivoted (Proper Name of Res #1) instead of using the lift she performed a one person pivot...Based on the interviews and the timeline it appeared that (Proper Name of Res #1's) CNA inappropriately transferred her using a one person assist pivot causing injury. CNA #1 was terminated..."

Interview on 12/13/23 at 11:30 AM, with the facility Administrator (ADM) he stated that they completed the facility investigation on 11/10/23 and determined that Res #1 was injured by CNA #1 due to her not using the proper technique for a total full body lift with a two (2) person transfer assistance. CNA #1 was terminated as a result of not following the policies and procedures for transfers of Res #1. The ADM stated that Res #1 received fractures to her tibia and fibula and a left non-displaced intertrochanteric femur fracture .

Record review of the facility's investigations dated 11/9/23 and signed by the DON revealed, " Interview with resident (Proper name of Res #1) Spoke with resident to inquire about injury to LLE (left lower extremity). Resident confirmed being transferred without lift but denied being dropped, bumped or falling. Resident stated she did not

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recall having anything bump into her. Resident stated she did not remember being injured in any way. Resident denied being mistreated or hurt in any way."

Interview on 12/13/23 at 12:00 PM with the Director of Nursing (DON) revealed she had determined that Res #1 was injured as a result of being improperly transferred by three (3) CNA's.

Interview on 12/13/23 at 1:15 PM, with the Social Services Director (SSD) revealed that Res #1 had been interviewed by staff on 11/09/23 and on 11/10/23 concerning the injuries that she received on 11/08/23 and Res #1 denied any abuse and denied being dropped. Res #1 did confirm to staff that she had been transferred without the use of the total body lift. Res #1 stated that she did not want to be transferred by the total body lift. SSD stated that on 11/10/23 that she assessed Res #1 and found her to issue no complaints.

Record review of the handwritten statement signed by CNA #1 (undated) revealed " ...I raised her (Res #1's) bed just a little bit to make transfer easier. (Proper Name Res #1) wrapped her arms around my shoulders and I wrapped around her, under her shoulders but around ribs/under breast, one hand flat on her back and one hand holding her waist band. I easily and slowly lifted her and pivoted her. I turned her around towards sink put legs of chair on and put my hands on bottom of her feet and sat them down, one by one at a time on her foot rests ... "I checked on her on and off throughout the day and when I left at the end of my shift she was asleep at the front."

Interview via telephone on 12/13/23 at 2:00 PM,

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with CNA #1 she stated that Res #1 did not complain of pain did not call out in pain and did not make any complaints of pain or injury when CNA #1 transferred Res #1 from her bed to her wheelchair without a full body lift or the assistance of another staff. CNA #1 confirmed that she did not use a lift to transfer Res #1 and did not utilize another staff to assist with the transfer. CNA #1 stated that Res #1 was not injured during the "improper" transfer. CNA #1 stated that she placed Res #1 in her wheelchair and then assisted to dress her and provide personal grooming. CNA #1 pushed Res #1 from her room to the nursing station at approximately 10:00 AM on 11/08/23. CNA #1 stated that Res #1 was cognitive and was able to communicate her needs and wants and she wanted CNA #1 to manually transfer her from her bed to the wheelchair without the use of the full body lift. CNA #1 confirmed that she was terminated on 11/10/23 as a result of the improper transfer of Res #1. CNA #1 denied that Res #1 received any injuries as a result of not using the lift for transferring Res #1 on 11/08/23 at approximately 10:00 AM.

Record review of the handwritten statement dated 11/10/23 and signed by CNA #2 revealed "I was working as shower aide on 11/8/23 when resident came into shower room saying the back of her left leg under where the knee bend was hurting her. At the time whoever her aide was did not have total sling under her, so me and other shower aide did 2 person assist with her. I asked was she ok was her leg ok before removing clothes, resident said yes. Removed clothes and put clothes back on, resident did not complain about anything hurting her. Proceeded to take her back to nurse station where she was sitting

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before shower. (Res #1) was never stood on her feet when doing 2 person assist. One staff was under arms another staff under legs and transfer her from wheelchair to shower chair."

Interview on 12/13/23 at 2:45 PM, with CNA #2 revealed that she and CNA #3 were giving baths as a team on 11/08/23. She confirmed that they transferred Res #1 from her wheelchair to the shower area without using a full body lift. CNA #2 stated that they did not drop or injure Res #1 and that Res #1 did not complain of pain or injury. CNA #2 assisted with Res #1's bath on 11/08/23 at approximately 2:30 PM or 3:00 PM. CNA #2 stated that Res #1 was placed in her wheelchair without a sling underneath her when she was brought to the shower area. CNA #2 stated that because Res #1 had no sling underneath her they were unable to use the lift and there were no lifts in the shower area to use. CNA #2 stated that she and CNA #3 used 2 person assistance to transfer Res #1 from her wheelchair to the shower chair and back in to her wheelchair. After the shower was completed the CNA's returned Res #1 to her room per her request.

Record review of the handwritten statement signed by CNA #3 (undated) read: "On November 8th 2023 It was (Res #1's) bath day. We asked (Res #1) was she going to take a bath and she replied yes. We took Res #1's in the shower room and asked her again was she sure she wanted a shower. She replied yes again. Res #1 was complaining of her left leg hurting before the shower and during the shower. We didn't notice any spots or bruises during her shower. Res #1 didn't have a sling under her when brought into the shower room. We did a 2 assist with her since their was no sling under her

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to transfer. Her feet did not hit the floor when we transferred her. When we got finished with her shower we put her back into her chair from the shower chair and still noticed anything wrong with Res #1. When doing the 2 person assist we put our arms under her arm pits to secure her. We then lifted her up out of her wheelchair holding on to her and put her in the shower chair, making sure her feet didn't hit the floor."

Record review of a written investigation report signed by the RN #1/ Quality Assurance (QA)/Infection Control Nurse dated 11-10-23 (no documented time) revealed "On 11-9-23 ...resident's anterior lower leg was bruised with a knot and was painful to the touch ...NP was notified and gave orders for resident to be sent out for Doppler and XRAY ...sent out via ambulance ...to be transported via ambulance. Orders placed to monitor left lower extremity for discoloration and to monitor pedal pulses. After resident returned resident was interviewed again by DON. While DON interviewed resident I went to get resident her pain medication. Pain medication was administered by the cart nurse. Nurse Practitioner (NP) notified the oncoming NP for 11-10-23 to evaluate resident. Resident was evaluated by NP on 11-10-23 and is placing order for resident to receive something else for pain."

Interview on 12/13/23 at 3:35 PM with Registered Nurse (RN #1) revealed that she was the Quality Assurance (QA) nurse and immediately on 11/09/23 at approximately 12:00 noon an emergency QA meeting was held. The QA committee assisted with the completion of the facility's investigation and they determined that CNA #1 did not transfer Res #1 in accordance to the care plan and because of not using the lift for

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transferring with a two (2) person (s) assist, Res #1 was injured.

Interview on 12/13/23 at 4:00 PM, with the DON she confirmed that Res #1 was found to have injuries of bruises and a hematoma to her lower left leg on 11/09/23 at approximately 9:15 AM and was transferred via ambulance to the local hospital emergency room on 11/09/23 at approximately 10:00 AM and was found to have fractures of her lower left leg. The DON confirmed that on 11/10/23 Res #1 was transported via ambulance to a doctor's orthopedic clinic in another nearby town approximately 50 miles away. The DON stated that on 11/10/23 at approximately 8:30 PM, Resident #1 was pronounced dead at the facility.

Record review of the local hospital Emergency Department report dated 11/09/23 at 10:27 revealed a discharge note that read: "The patient was discharged to Home or Self Care. Instructions given to the patient: Fracture, tibia and Fibula (Both Bones) and the patient was advised to return if worsening or increasing symptoms or return as needed.

Record review of the (Proper Name) Ortho dated 11/10/23 revealed " ...she was at the emergency room yesterday ...she was found to have a fracture and referred here ...Pain is severe with a rating 10/10 ...The problem started after an injury ...Left Lower Leg Examination: There is swelling and ecchymosis (bruising) in the lower leg. She is very tender to palpation (touch) over the distal fibula ...Hip/Pelvis Xrays: ...looks like there is a nondisplaced fracture in the intertrochanteric region ...Tibia Xrays: There is an oblique midshaft tibia fracture with mild displacement and a

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nondisplaced distal fibula fracture ..."

Record review of the Progress Notes dated 11/10/2023 at 17:35 (5:35 PM) and signed by RN #1 revealed "Resident was evaluated by (Proper Name of Nurse Practitioner). Ordered Tramadol 2 x a day for pain."

Record review of the progress notes dated 11/10/2023 at 20:38 (8:38 PM) revealed: "Resident was heard by roommate making gurgling sounds and immediate attention was provided by increasing o2% rate of delivery and suctioning excess secretions. After about half an hour, her nurse found the said resident not moving. Assessment by this writer found resident pulseless without signs of breathing, and pupils not reactive to light. Notifications made to Administrator, RP, Coroner, and Funeral Home. Resident was cleaned and dressed. Death protocol implemented."

Record review of the Admission Record revealed Resident #1 was admitted to the facility on 2/6/23 with diagnoses that included Unspecified Dementia and Other specified disorders of done density and structure.

Record review of the Minimum Data Set (MDS) dated 11/05/2023 contained a Brief Interview of Mental Status (BIMS) score of 13 which indicated that Res #1 was cognitively intact.

Record review of the Death Certificate of Res #1 dated 11/10/23 at 8:38 P.M. listed the cause of death for Res #1 as Failure to Thrive and Dementia.

The State Agency (SA) validated the facility's Past

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Non-Compliance (PNC) Corrective Action on 12/13/23:

The SA validated through interviews and record review that on 11/10/2023 the facility held an Emergency QA meeting with the Medical Director and the Inter-Disciplinary Team.

The SA validated through interviews and record review that on 11/10/2023 through 11/12/2023 the facility completed a 100% body audit completed by the DON with involvement by the Administrator.

The SA validated through interviews and record review that on 11/09/2023 the facility began in-services for all direct care staff on proper lift techniques by the staff development nurse.

The SA validated through interviews and record review that a 100% audit of all residents was completed to ensure that they had a *BCARE Lifts/Transfer Assistance Evaluation completed appropriately, and that the facility compared the Lift Evaluation, Care Plan and Kardex of all residents to ensure that they match and were correct.

The SA validated through interviews and record review that in-services for all nursing staff, including agency staff on using the Transfer and Kardex Training was performed by the Staff Development nurse.

The SA validated through interviews and record review that an ongoing processes to ensure that the correct lift and procedures are and will be used included: Skill observations for the Stand Lift and Total Lift for all nursing staff and CNA's

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and agency staff was completed. This was performed by the Staff Development nurse and audited by the Director of Nursing.

The SA validated through interviews and record review that the facility will use the QA Transfer Audit when completing transfer audits and the Nurse Supervisor will visualize a transfer and verify that CNA's are using the appropriate lift and technique. This will be used through 12/31/23.

The SA validated through interviews and record review that transfer audits will be completed by a cart nurse 2 x per shift per day. The DON will visualize one (1) transfer on each shift every week. The other audits for the week may be delegated. This will be completed through 12/31/23.

The SA validated through interviews and record review that the facility's investigation determined that CNA #1 was responsible for the injuries to Res #1.CNA #1 was terminated for not following the care plan for the proper transfer of Res #1 and not using the full body lift with a (2) person assist.