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
	25BN	A. BUILDING: _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELHAVEN SENIOR CARE, LLC	1004 NORTH ST JACKSON, MS 39202

(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 The State Agency (SA) conducted a complaint survey, MS #15875, at the facility on 5/9/19. During the survey the SA determined the complaint was substantiated for accidents, when Certified Nursing Assistant (CNA) failed to use a mechanical lift to transfer Resident #1, and to have two (2) person assistance, as required by assessment and care plan for Resident #1. This resulted in a fall, with subsequent harm to Resident #1, who sustained a Right Tibia Fracture on 4/19/19, and was transferred to the hospital for treatment. During the investigation, the SA determined a Past Non-Compliant (PNC) harm level (Level III) existed at: Accidents-M640 Based on the facility's corrective measures, initiated on 4/19/19, and completed on 5/5/19, prior to the SA entrance of 5/9/19, the SA determined the Past Non-Compliance at a scope and severity of "Level III" at M640-Accidents. Due to the implementation of all corrective actions as of 5/5/19, prior to the SA entrance on 5/9/19, M640 was determined corrected as of 5/6/19, and the facility remained in substantial compliance with the Mississippi Regulations for Minimum Standards for Institutions for Aged or Infirm licensure requirements.	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	M 640		5/9/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25BN	A. BUILDING: _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELHAVEN SENIOR CARE, LLC	1004 NORTH ST JACKSON, MS 39202

(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 640	Continued From page 1 appropriate state agencies. This Statute is not met as evidenced by: Level III Based on observations, interviews, record review, policy review, and facility investigation review, the facility failed to prevent an accident by staff's failure to use a mechanical lift and assistance of another staff member for transferring Resident #1, as assessed and care planned. That action resulted in the resident's fall with a subsequent Right Tibia Plateau fracture on 4/19/19, with hospitalization until 4/21/19. This affected one (1) of four (4) residents reviewed for accidents and incidents, Resident #1. During the investigation, the SA determined a Past Non-Compliant (PNC) harm level (Level III) existed. Due to the facility's implementation of all corrective measures as of 5/5/19, prior to the SA entrance on 5/9/19, M640 was determined corrected as of 5/6/19. Findings include: Review of an "Accident/Incident Reporting" policy, updated 10/2016, revealed all accidents/incidents including residents, employees, or visitors will be reported to the Charge Nurse and to the appropriate department heads immediately when it occurs. Accident/Incident is defined as an unexpected happening, which may or may not have caused injury..(ie Resident falls). A document, "Responsibility For Accident/Incident Reports Policy", dated 7/2016, revealed all incident and accidents involving a resident will be	M 640	Per letter, no POC required for past non-compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25BN	A. BUILDING: _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELHAVEN SENIOR CARE, LLC	1004 NORTH ST JACKSON, MS 39202

(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 640	Continued From page 2	M 640		

investigated immediately upon knowledge of the incident.

In a review of the facility's policy, "Modified Lifting Policy, (Mechanical Lift)", undated, noted it is the policy of this facility to help lift residents who are unable to be lifted manually and to promote comfort and to maintain proper body alignment while the resident is being moved. The need for the use of a lift, lift type, sling type, and sling size will be determined by the facility Mechanical Lift Assessment. This assessment will be done upon admission and updated quarterly with the Minimum Data Set (MDS) as well as when needed. The policy also noted staff will follow the documented lifting protocol deemed appropriate for each resident.

Review of an incident report, "Fall", dated 4/19/19 at 10:38 AM, revealed, "Writer notified per CNA that res (resident) legs got weak et CNA lowered res to the floor. Body audit obtained no injury noted @ (at) this time". Location was in the resident's room.

Review of the facility's investigation report, dated 4/23/19, revealed upon interview with CNA #1, the CNA lifted Resident #1 alone during a transfer and the resident's "legs gave out". The CNA stated she didn't notify the nurse at the time because the resident didn't hit the floor. Resident #1 was assessed, due to report of pain prior to going to Dialysis, without noted injury. Resident #1 went to Dialysis and was transferred to the emergency room from Dialysis on 4/19/19, after complaint of continued pain, where X-rays were obtained, with a fracture diagnosis. It was determined during the investigation that Resident #1 fell during the transfer by CNA #1, and this fall resulted in a Right Tibia Fracture for Resident #1.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25BN	A. BUILDING: _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELHAVEN SENIOR CARE, LLC	1004 NORTH ST JACKSON, MS 39202

(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 640	Continued From page 3 CNA #1 transferred the resident without another staff member, and did not use a lift, per assessment and care plan, which resulted in the resident's fall and subsequent fracture. The report documented that Resident #1 was hospitalized from 4/19/19, until 4/21/19, when she returned to the facility with a leg immobilizer and an order for non-weight bearing to the right lower extremity. The report documented that CNA #1 was terminated for improper transfer of Resident #1. A review of the hospital admission history and physical, noted on 4/20/19 at 2:36 AM, Resident #1 was admitted with the complaint of right shoulder pain and right leg pain after a fall at the nursing home. Resident #1 was diagnosed with a fracture of the right tibia plateau (right leg fracture) and contusion to the right shoulder. In a review of Resident #1's Kardex (CNA care plan), from the electronic Kiosk, Resident #1 required the use of the Vander Total Lift, with two (2) person assist for all transfers, related to weakness, with the onset date 5/15/18, on admission. In an interview with Resident #1's Responsible Party (RP) on 5/9/19 at 1:40 PM, the RP reported he was notified on 4/19/19, that his mother had fallen and had been transferred to the hospital. The RP stated the next day the facility notified him there had been an investigation, which determined that his mother had been lifted by a CNA alone and that she had not used the lift like she was supposed to. Resident #1's RP also stated he was notified at that time that the nurse (CNA) had been terminated and the other staff had been trained to make sure this did not happen again.	M 640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25BN	A. BUILDING: _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELHAVEN SENIOR CARE, LLC	1004 NORTH ST JACKSON, MS 39202

(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 640	Continued From page 4 In an interview with Resident #1's roommate, (Unsampled Resident #B), on 5/9/19 at 4:15 PM, she stated CNA #1 dropped Resident #1 while transferring her from the bed to the chair and did not use a lift. The roommate stated another staff member came and assisted the CNA in getting the resident off the floor. Resident #1's roommate stated she was yelling out loud in pain at the time of the fall. She stated a nurse did come in and check the resident. Review of Unsampled Resident #B's most recent MDS, with an Assessment Reference Date (ARD) of 2/21/19, revealed a BIMS score of 15, which indicated no cognitive impairment. In an interview on 5/9/19 at 9:55 AM, the Facility Administrator revealed Resident #1 was at the dialysis unit when they called and said Resident #1 was complaining of pain and was being transferred to the Emergency Room (ER) for an evaluation. The Administrator stated that the facility investigation revealed CNA #1 transferred Resident #1 from the bed to the chair alone and without the use of a lift on 4/19/19. The Administrator stated during the investigation, CNA #1 confirmed she lifted Resident #1 without assistance and the resident's legs gave way and she slid Resident #1 to the floor. The Administrator stated that CNA #1 was terminated for not using the lift and not having two (2) people present, as per Resident #1's plan of care and the facility's policy for using the lift. The Administrator stated CNA #1 stated that she knew better, but she did it anyway. The facility Administrator confirmed the facility had a Quality Assurance (QA) meeting and no policies were changed for use of the lift or following the care plan. The Administrator stated that all staff had been in-serviced again on the use of the lift and following the care plan. The Administrator stated	M 640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25BN	A. BUILDING: _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELHAVEN SENIOR CARE, LLC	1004 NORTH ST JACKSON, MS 39202

(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 640	Continued From page 5	M 640		

that no other incidents regarding improper use of the lift have been identified and audits have been initiated. The Administrator confirmed the Responsible Party (RP) for Resident #1 was notified and the resident's physician, the Medical Director, and the incident was reported to the Mississippi State Department of Health and the Attorney General's office.

Attempts were made to contact Certified Nursing Assistant (CNA) #1 by phone on 5/9/19, twice with no answer. The Surveyor left messages on voicemail, with no return call.

Review of the statement, documented by CNA #1, received during the investigation by the facility on 4/19/19, revealed she transferred Resident #1 by herself and without a lift. She stated during the transfer that the resident's legs broke (gave out) and she lowered the resident to the ground.

Record review of CNA #1's training for the "Modified Lifting Policy for the "Zero Back Injury Program" was signed by CNA #1 on 2/7/19, when hired. This policy indicated that she was aware she was to use the lift and utilize a second person during a transfer of a dependent resident.

Review of CNA #1's "Personnel Action", dated 4/19/19, revealed the CNA was separated from employment due to failure to follow the care plan for using the lift and two (2) person assistance; the resident's strength gave out during a transfer and the CNA lowered her to the floor (considered a fall), causing injury to the resident.

Observation of Resident #1 on 5/9/19 at 2:05 PM, revealed the resident lying in bed with the head of the bed elevated, side rails up x two (2) and the call light in reach. Resident #1 was not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25BN	A. BUILDING: _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELHAVEN SENIOR CARE, LLC	1004 NORTH ST JACKSON, MS 39202

(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 640	Continued From page 6 interviewable. The facility admitted Resident #1 on 4/12/18, with the diagnoses of Congestive Heart Failure, End Stage Renal Disease with Dialysis, High Blood Pressure, Type II Diabetes Mellitus, Major Depression and Hemiplegia. The Annual MDS on 415/19, revealed Resident #1 had a BIMS score of 4, which indicated Resident #1 had severe cognitive impairment. The SA determined the facility had identified the incident of Resident #1's fall and fracture as a result of CNA #1 improperly transferring the resident without the use of a lift and assistance of another staff, as required by the assessment and care plan. The facility implemented the following corrective measures prior to the State Agency's entrance on 5/9/19, and alleged corrections were completed as of 5/5/19: An investigation was initiated on 4/19/2019, related to Resident #1 having an unreported fall with injury on 4/19/2019 at 10:38 AM. CNA #1 transferred Resident #1 via stand and pivot transfer by herself, however Resident #1 was care planned for a total lift times two (2) staff members. Resident #1 was transferred from dialysis and was admitted to an area Hospital on 4/19/2019. She returned to the facility on 4/21/2019, with a diagnosis of a Tibia Plateau Fracture. Corrective measures were as follows: 1. CNA #1 was terminated on 4/19/2019, for failure to follow Resident #1's care plan to provide assistance with transfers.	M 640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25BN	A. BUILDING: _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELHAVEN SENIOR CARE, LLC	1004 NORTH ST JACKSON, MS 39202

(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 640	Continued From page 7 2. In-Service related to following the lift protocol was initiated on 4/19/2019, by the Administrator, to nursing staff. 3. In-Services related to Abuse and Neglect, Accidents/Incidents, timely reporting of Accidents/Incidents, and Proper Use of Lifts for Each Resident was initiated by RN Supervisor #1 on 4/22/2019, to nursing staff. 4. In-Services related to Abuse and Neglect, Lift Protocol, and following care plan/kardex were initiated/continued on 4/25/2019, by the Administrator and Director of Nursing (DON), to nursing staff. 5. A Quality Assurance (QA) Meeting, related to the incident, was held on 4/26/2019, with QA members: Medical Director, Administrator, Director of Nursing (DON), Social Services Director, Dietary Manager, Therapy Director, Medical Records, MDS Coordinator, Business Office Manager, Maintenance Director, and RN Supervisor #1. The QA team reviewed the incident, the policy/procedures (without changes) and actions taken with education. 6. The DON/RN Supervisor initiated lift competency check offs beginning the week of 4/29/2019, with nursing staff (for the lift protocol.) 7. The DON/RN Supervisor began monitoring transfer/lift protocol during four (4) random patient care observations beginning the week of 4/29/2019. 8. An audit of care plans was completed by RN Supervisor #2 on 5/5/2019, to ensure that care plans included the lift type, sling size, and that two	M 640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25BN	A. BUILDING: _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELHAVEN SENIOR CARE, LLC	1004 NORTH ST JACKSON, MS 39202

(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 640	Continued From page 8 (2) staff members were required for all transfers using lifts. Revisions were made at that time. 9. Notifications were made to the MS State Department of Health, the Attorney General's Office, the Physician and the Resident Representative were made by the administrative staff, of Resident #1's fall with fracture and CNA #1's inappropriate transfer of the resident. The State Agency validated the facility's corrective measures by record review, interview with staff, in-service documentation review and QA document review: During record review the State Agency validated the facility conducted an investigation, that was initiated on 4/19/2019, related to Resident #1 having an unreported fall with injury on 4/19/2019 at 10:38 AM. CNA #1 transferred Resident #1 via stand and pivot transfer times one (1) staff, however Resident #1 was care planned for a total lift times two (2) staff members. Resident #1 was transferred from dialysis and was admitted to an area Hospital on 4/19/2019. She returned to the facility on 4/21/2019, with diagnosis of a Tibia Plateau Fracture, an immobilizer and non-weight bearing to the right lower extremity. The SA validated the facility's documented corrective measures and determined the corrective measures were completed as of 5/5/19, and the were as follows: 1. Review of the personnel action documentation and interview with administration revealed that CNA #1 was terminated on 4/19/2019, for the incident of Resident #1's fall/fracture. 2. Review of in-Service sign-in sheets and interview with staff revealed the Administrator	M 640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25BN	A. BUILDING: _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELHAVEN SENIOR CARE, LLC	1004 NORTH ST JACKSON, MS 39202

(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 640	Continued From page 9 initiated education related to following lift protocol, on 4/19/2019. 3. Interview with nursing staff and review of the In-Service sign-in sheets, revealed RN #1 initiated education related to Abuse and Neglect, Accidents/Incidents, timely reporting of Accidents/Incidents, and Proper Use of Lifts for Each Resident, on 4/22/2019. 4. Interview with nursing staff and administrative staff and review of the In-Service sign-in sheets, revealed education was initiated related to Abuse and Neglect, Lift Protocol, and following care plan/kardex were initiated/continued on 4/25/2019, by the Administrator and Director of Nursing (DON). The SA validated that all nursing staff had completed education prior to working. 5. Review of sign-in sheets and interview with attending staff as well as the Medical Director, revealed a QA Meeting was held, related to the incident of Resident #1's fracture, on 4/26/2019, and attended by QA members: Medical Director, Administrator, DON, Social Services Director, Dietary Manager, Therapy Director, Medical Records, MDS Coordinator, Business Office Manager, Maintenance Director, and RN Supervisor #1. 6. Review of documentation and interview with the DON/RN Supervisor, revealed lift competency check offs beginning the week of 4/29/2019, were completed with all nursing staff. 7. Interview with the DON, and documentation review, revealed the DON/RN Supervisor began monitoring transfer/lift protocol during four (4) random patient care observations beginning the week of 4/29/2019.	M 640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25BN	A. BUILDING: _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELHAVEN SENIOR CARE, LLC	1004 NORTH ST JACKSON, MS 39202

(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 640	Continued From page 10 8. Interview with RN #2 and review of the care plans revealed an audit of care plans was completed by RN Supervisor #2 on 5/5/2019, to ensure that care plans included the lift type, sling size, and that two (2) staff members were required for all transfers using lifts. 9. Review of documents and interview with administrative staff revealed that notifications were made to the RP and Medical Director on 4/19/19, and the SA and Attorney General's office on 4/22/19, of the incident with Resident #1's fall and subsequent fracture.	M 640		