STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255108	A. Building B. Wing	10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trend Health & Rehab of Carthage LLC	1101 East Franklin Street Carthage, MS 39051

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21029 Based on record review, observations, interviews, and facility policy review, the facility failed to ensure a resident's right to be free from abuse and neglect as evidenced by: 1) the facility failed to prevent verbal and physical abuse by a Certified Nursing Assistant (CNA) of Resident #2, and 2) failed to prevent neglect of a resident who required transfer via a mechanical lift (Resident #1), for two (2) of three (3) residents reviewed for abuse. Findings Include: Review of the facility policy titled, Abuse Policy and Procedure, dated 04/02/24 and signed by CNA #6, revealed, Each resident of this facility has the right to be free from verbal, sexual, physical and mental abuse . neglect . Review of the facility policy and procedure titled Code of Conduct dated 04/02/24 and signed by CNA #6 revealed, All employees must accept certain responsibilities, adhere to acceptable business practices in matters of conduct and behavior, and exhibit a high degree of personal integrity at all times. Review of the facility policy and procedure titled Reporting Requirements of the Vulnerable Adult Act, dated 04/02/24 and signed by CNA #6 revealed. Who is responsible for reporting? Any person who is employed at a care facility or is a health care professional working in connection with the facility who has knowledge or reasonable cause to believe that a resident of that care facility was the victim of abuse, neglect, or exploitation. Resident #2 (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Interview on 10/22/24 at 2:05 PM with CNA #5 she stated that she knew who CNA # 6 was but she had not really worked directly with her and didn't really know her, but when she saw her in the facility that she had an attitude. CNA #5 stated that about a month ago she was assisting Resident #3 with his bath when he confided in her that CNA #6 had been mean to his roommate (Resident #2). He stated that the privacy curtain had only been pulled halfway and he could see Resident #2 in his bed and he could see CNA #6 attempting to deliver care to the resident. CNA #6 was talking mean to Resident #2 and saying things like Get your hands down and stop moving as she slapped his hands and slapped the side of his face. Resident #3 stated that she mistreated Resident #2 and talked in a mean threatening voice to him. CNA #5 stated that she went to her Unit Manager Registered Nurse (RN) #1 and to the unit nurse Licensed Practical Nurse (LPN) #1 and reported the incidents of verbal and physical abuse. CNA #5 stated that Resident #3 was cognitive and gave good reliable statements to staff and verbalized reliable information and had good consistent memory recall. CNA #5 stated that Resident #3 had never varied with information when recalling the events of the incident of abuse by CNA #6 to his roommate Resident #2. CNA #5 stated that Resident #2 was looked after by the other residents and that he had been living at the facility for a long while and that he was Hispanic and did not speak English but could understand English language. CNA #5 stated that Resident #2 could answer questions by making physical gestures and nodding his head Yes or No. CNA #5 stated that the sister and family of Resident #2 visited him often and he would speak Spanish to his family and didn't really speak to anyone else. CNA #5 stated that they had reported the abuse to the Director of Nursing (DON) and that she had requested that CNA #5 and RN#1 go together and talk to Resident #2 and Resident #3. CNA #5 stated that Resident #3 never changed his recall of the events of verbal and physical abuse of his roommate at the hands of CNA #6. Resident #3 stated that CNA #6 had slapped Resident #2 on the face and on his hands and had talked very rudely and mean to Resident #2. Interview on 10/22/24 at 2:25 PM, with the facility Administrator (ADM) revealed that she had been contacted by someone from outside the facility that CNA #6 had worked at another facility and that she had been terminated from that facility for the same type of abuse to residents. ADM stated that she pulled the employment application of CNA #6 to see if she had documented her employment at the other facility. The application did not contain the other facility as a place of employment, but CNA #6 had admitted during the investigation that she had been terminated at another facility, prior to current employment, for the very same thing. ADM stated that the incident occurred on 09/19/24 and CNA #6 was sent home on suspension on 09/19/24 and was terminated on 09/23/24 for substantiated abuse of Resident #2. ADM stated that the facility staff believed what Resident #3 had reported and that he witnessed abuse of his roommate. Interview on 10/22/23 at 2:45 PM, with the Ombudsman confirmed that she had been given reports of verbal and physical abuse by CNA #6 at another facility prior to this report. Ombudsman stated that when she heard that CNA #6 had a second report of abuse at a second facility, she contacted her supervisor and her supervisor contacted the facility ADM. Ombudsman stated that she had many times spoken with Resident #3 and he was a very reliable witness. Interview on 10/22/24 at 12:05 PM, with CNA #1 stated that Resident #3 was cognitive, and he gave reliable information and he was not confused or demented. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Interview on 10/22/24 at 5:19 PM, with RN #1 revealed that she had been instructed to go with CNA #5 and talk to Resident #3 and to Resident #2. RN #1 stated that Resident #3 told them that CNA #6 had verbally and physically abused Resident #2. Resident #3 stated that he saw CNA #6 slap the resident on the side of his face and on his hands. Resident #3 stated that he witnessed CNA #6 be mean and talk mean to Resident #2. RN #1 stated that they completed a physical assessment and did not find any injury to Resident #2. Resident #2 did not speak English, but he responded by demonstrating a slap to the side of his face. Resident #2 understands English but does not speak English. His sister came to the facility and Resident #2 told the sister that he had been slapped on the face and hands by CNA #6. RN #1 stated that she believed the reports of verbal and physical abuse given by Resident #2 and Resident #3. RN #1 confirmed that to her knowledge CNA #6 had been terminated from the facility for abuse of Resident #2. Interview on 10/22/24 at 5:50 PM, with CNA #6 via telephone revealed that Yes she had been terminated from the facility on 9/23/24 as a result of an alleged event of abuse toward Resident #2. CNA #6 denied the allegations of abuse and stated that she had worked at another facility and that she had left the other facility as a result of not passing the CNA exam in the time frame allotted by the facility. CNA stated that she received her training at another facility, and she obtained her certification after she was terminated from that facility. CNA confirmed that she was placed on suspension on 09/19/24 and was terminated on 09/23/24 and stated that she was terminated for allegedly abusing Resident #2. Observation and interview on 10/22/24 at 6:00 PM, with Resident #3 confirmed that he had told CNA #5 that he witnessed CNA #6 verbally and physically abusing his roommate Resident #2. Resident #3 stated that the situation was now over and that CNA #6 was no longer working at the facility and he did not want to talk about it any more. Resident #3 stated that he had told CNA #6 to her face that she knew she had abused (Resident #2) and it wasn't right. Resident #3 stated that he felt safe at the facility and he was not afraid or felt unsafe. Resident #3 stated that if he could have gotten up and walked over to his roommates bed during the time CNA #6 was abusing him that he would have taken care of things and she wouldn't do that any more. Resident #3 stated that his roommate was in such bad shape and was unable to defend himself. It was observed to be approximately six (6) to eight (8) feet of distance between the bed of Resident #3 and the bed of Resident #2. Observation and interview with Resident #2 on 10/22/24 at 6:20 PM, revealed that he was sitting alone in the day room in a wheelchair sleeping. Resident #2 quickly opened his eyes when his name was called. The Resident did not attempt to verbalize but followed with his eyes as he was spoken to. He nodded his head yes and no. He nodded no that he was not afraid, and he nodded yes that he was happy at the facility. Record review of a typed statement signed by the Psychiatric Mental Health Nurse Practitioner and dated 09/19/2024 revealed, (Resident #2) sister asked him if someone had hit or slapped him, he indicated with a nod yes and rubbed his check with his hands. His sister asked him if he felt safe, he indicated with a nod no. His sister asked him if anyone had been mean to him he indicted with a nod yes. I spoke with (Resident #3) and he stated that he witnessed (CNA #6) physically hit (Resident #2) on the hand several times, push him over in the bed, and pull on him forcefully almost pulling him out of the bed and he says these types of behaviors have happened several times, however he could not give an approximate number. (Resident #3) states he told her don't be doing him like that and (CNA #6) response was you shut up. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Record review of a hand written statement signed by (CNA #5) dated 9/19/24 read: On 9/19/2024 I (CNA #5) had gave (Resident #3) a shower. After his shower I was making up his bed he told me that his aid was super mean to him. So I asked him who he said the girl and the hallway they call her (name of CNA #6). So he was still telling me that she don't never do anything for him when he ask. Then he got talking about his roommate (Resident #2). He told me that she be hitting and slapping him when giving him a bath and the curtain be open so he see everything. He also said she almost snatched him out of bed one day and also pops his hand. So after leaving out the room I asked (LPN #1) the nursing what to do and (RN#1) was walking down the hall so I talk to both of them. Record review of the hand written statement of Resident #3 written by RN #1 and witnessed by CNA #5 dated 9/19/24 read: (Resident #3) stated The curtain was pulled half way but I could see. She was being rude and telling (Resident #2) , Take your hands off me, don't touch me. (Resident #3) demonstrated to nurse (RN #1) and CNA (CNA #5) how CNA (CNA #6) slapped resident's hand. (Resident #3) stated, she almost jerked him out of the damn bed and I told her not to jerk on him like that and she told me, oh just shut up. She was slapping him on the hip telling (Resident #2) to turn over. If I could have gotten up and walked, I would of gotten a hold of her. Written statement read back to (Resident #3) and he signed the statement that it was correct and his words. The statement was signed and witnessed by CNA #5 and RN#1 on 9/19/24. Record review of the facility's form titled: NOTICE OF TERMINATION documented that (CNA #6) date of hire 04/02/24 Position CNA Effective 9/23/2024 revealed that (CNA #6) had an involuntary termination from the facility for Rule Violation. Supervisor's Comments: In light of the results of investigation into complaint/Grievance r/t (related to) Abuse of (Resident #2) and eyewitness account by his roommate Suspension 9/19/24 Termination 9/23/24 signed by ADM and DON and dated 9/23/24. Rehire NO. Record review of the Minimum Data Set (MDS) for Resident #3 dated 9/5/2024 revealed that he had a Brief Interview of Mental Status (BIMS) score of 14 indicating that he was cognitively intact. The record review of Resident #2's MDS dated [DATE] contained a BIMS score of 3 which indicated that Resident #2 was severely cognitively impaired. Resident #1 Cross reference F610, F656, F689 (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Record review of the Director of Nursing's (DON) investigation report dated October 2, 2024 and signed by the facility DON, stated, Please find attached the investigation of the Right Intertrochanteric femoral fracture identified by CT with contrast on 10/02/24 at (Local Hospital) emergency room (ER). 10/02/24 this resident presented with black vomiting while at the nursing home. In light of the fall and head injury on 10/01/24 the Nurse Practitioner (NP) ordered transfer to (Local Hospital) ER via emergency medical services (EMS) for further evaluation. On 10/02/24 .the DON was notified of a possible Hip fracture noted on the initial abdominal x-ray. A second test, CT without contrast, was done .identifying an acute comminuted and moderately displaced right hip fracture. The DON reported that on 10/02/24, after evaluation at the local ER, Resident #1 was then transferred to (Another Hospital). The DON's investigation report also documented on 10/01/24 this resident, (Resident #1) had a fall from the lift sling during transfer bed to wheelchair in the resident's room at the nursing home. In attendance were 3 CNAs (CNA #4) (CNA #3) and (CNA #2) and a medication LPN, (LPN #1). As per the statements of the nurse and CNAs when they moved the lift to transfer to wheelchair the resident slid out of one side hitting head on the front of the wheelchair causing a skin tear on the forehead, the lift was lowered to the floor, resident was assessed, repositioned and lifted by the total lift back into the bed. The NP and Resident Representative were notified. An order was received to transfer resident to the (Local Hospital) ER for evaluation. (Resident #1) was received back in the facility at 2220. The ER identified only the forehead skin tear. Interview on 10/22/24 at 11:50 AM with Certified Nursing Assistant (CNA) #1 revealed that she trained all the CNA's on the use of all mechanical lifts. She stated that the facility required two (2) person's to assist with the mechanical lifting of all residents. CNA #1 stated that Especially because of the resident's size there would be a necessity to use at least two (2) staff, and maybe more, while using the mechanical lift. CNA #1 confirmed that two staff must assist hands-on when using a mechanical lift for all facility residents. CNA #1 stated that both of the two assisting staff should be holding on to the lift and/or holding on to the resident during the entire mechanical lifting process. She stated that two staff should assist with placing the sling under the resident and two staff were required to hook the sling to the lift and check the accurate attachment of the sling to the lift; and two staff are required to be holding on to the resident and making sure the transfer was steady; by holding on to the resident from the time of sling placement, until the resident is safely and securely transferred would provide safety and assurance of a mechanical lift transfer. CNA #1 stated that never during the mechanical lift process of a resident should there be one (1) staff transferring a resident with a mechanical lift. CNA #1 stated that the use of one (1) staff using a mechanical lift was not in accordance with the facility policy and procedure. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Interview on 10/22/24 at 12:20 PM with Licensed Practical Nurse (LPN) #1 via (by) telephone revealed that she was called to the room of Resident #1 to watch CNA #2 to operate the mechanical lift and transfer Resident #1 from the bed to the wheelchair. LPN #1 stated that she was called there to spot CNA #2 as she used the lift to transfer Resident #1. LPN #1 stated that spot meant to watch her use the mechanical lift, that she did not assist CNA #2 with the operation of the lift for Resident #1 and that she did not have her hands on the lift or her hands on Resident #1 during the transfer with the mechanical lift. LPN #1 stated that when she entered the room she saw CNA #2 operating the mechanical lift and that Resident #1 was up in the air in the sling when the mechanical lift tilted and Resident #1 fell to the floor. LPN #1 stated that CNA #4 was standing behind her near the door of Resident #1's room. LPN #1 stated that there was another CNA assisting CNA #2 with the mechanical lift but she did not know her name and she was unable to recall who the third CNA was that was there to assist. LPN #1 stated that Resident #1 fell from the lift and hit her head and received a skin tear. LPN #1 stated that she assessed Resident #1 while she was on the floor. Three (3) CNA's and LPN #1 assisted to lift Resident #1 back to the bed and LPN #1 stated that she assessed Resident #1 again while she was in the bed. LPN #1 stated that Resident #1 was bleeding from the injury to her forehead and she placed a compression bandage to the bleeding area of Resident #1's head. LPN #1 obtained orders to send Resident #1 to the ER for evaluation. Resident #1 left the facility via ambulance at approximately 9:00 AM on 10/01/24 and was returned to the facility at approximately 3:00 P.M. on 10/01/24 at change of shift. Resident #1 returned from the ER with a diagnosis of a skin tear to her forehead. LPN #1 stated that there was no misuse of the mechanical lift and that there were two (2) CNA's assisting with the mechanical lift of Resident #1. LPN #1 was not able to recall or describe who the second CNA was that assisted CNA #2 to operate the mechanical lift. Interview via telephone on 10/22/24 at 12:30 PM, with CNA #4 revealed that she was asked by LPN #1 to come with her to Resident #1's room. CNA #4 stated that when she entered the room of Resident #1, she saw the resident up in the air in the sling then she turned around to close the room door behind her and when she turned back around Resident #1 had fallen to the floor from the sling. CNA #4 stated that she did not see Resident #1 fall and she does not know who the other CNA was assisting CNA #2 with the mechanical lift, did not know her name and did not pay attention to what she looked like because she was concentrating on the resident. CNA #4 stated that she assisted the LPN #1 and the other two (2) CNAs to lift Resident #1 back to her bed after the fall. CNA #4 stated that Resident #1 obtained a skin tear to her head and was bleeding at her forehead. CNA #4 stated that LPN #1 assessed Resident #1 and placed a bandage on her bleeding head. CNA #4 stated that she did not assist with the operation of the mechanical lift, and she did not have her hands on the lift or on Resident #1 during the bed to wheelchair transfer. CNA #4 stated that she was in the room when Resident #1 fell but she did not see her fall because she was closing the door to the room behind her. She stated that she does not know how the incident occurred. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Interview on 10/22/24 at 12:36 PM, with CNA #2 revealed that she had given Resident #1 a bed bath on the morning of 10/01/24 at approximately 8:30 AM just after the breakfast meal. CNA #2 stated that she was very nervous to give an interview and would probably get things confused because she was so nervous. CNA #2 was tearful and shaky during the entire interview. CNA #2 verbalized that she loved the residents and needed her job and that she would not intentionally do anything to hurt a resident. She repeatedly verbalized it's on me, I should not have started doing the lift before CNA #3 entered the room to help me. CNA #2 stated that she had solely given Resident #1 a bed bath and placed the sling under Resident #1 and had independently attached the sling to the lift and had lifted Resident #1 up above the bed prior to CNA #3 entering the room. CNA #2 stated that CNA #3 did come into the room after she had lifted Resident #1 up above the bed in the mechanical lift. CNA #2 stated she sees now that she should have waited until CNA #3 was present in the room before she started operating the mechanical lift. CNA #2 stated that CNA #3 was standing behind the wheelchair as she was lifting Resident #1. CNA #1 stated that she was driving the lift and when she had Resident #1 up in the air the mechanical lift tilted, and Resident #1 fell out and hit her head. She stated that LPN #1 and CNA #4 were also in the room watching her lift Resident #1. CNA #2 confirmed that there was no staff holding on to Resident #1 while she was lifting Resident #1 from the bed to the wheelchair. CNA #2 stated that Resident #1 fell out of the lift and hit her head and she began to bleed. She stated that LPN #1 told CNA #2 to continue to lower Resident #1 to the floor so they could assess her and treat her bleeding head. LPN #1 assessed Resident #1 while she was on the floor and then all four (4) of the staff (CNA #2, CNA #3, CNA #4 and LPN #1) assisted to transfer Resident #1 from the floor back into the bed, where LPN #1 re-assessed Resident #1 while she was in the bed. Resident #1 was transported to the hospital with a head injury on 10/01/24 at approximately 9:00 A.M. Interview on 10/22/24 at 1:30 PM, with CNA #3 revealed that she was not in the room with CNA #2 when she used the mechanical lift to transfer Resident #1. CNA #3 stated that she was with another resident assisting with her breakfast when (CNA #2) came and got her to help with Resident #1. CNA #2 stated that upon entering Resident #1's room there were no other staff present and Resident #1 was on the floor bleeding from the forehead. CNA #3 stated that CNA #2 had used the mechanical lift alone without a second staff and Resident #1 had fallen and received a head injury. They called LPN #1 and CNA #4 came along with LPN #1 to help get Resident #1 up off of the floor and back into the bed. The four (4) staff together assisted Resident #1 back to her bed where the LPN #1 assessed the resident. CNA #3 confirmed that she had provided a handwritten statement to the facility Director of Nursing (DON) confirming that she was not in the room when Resident #1 fell from the lift. CNA #3 reviewed her handwritten statement with the State Agency (SA) and confirmed that was her statement that was given to the DON. CNA #3 verbalized that Resident #1 was a large lady and that she required at least two (2) persons to assist with her care and to steady the mechanical lift. CNA #3 stated that Resident #1 never moved and was unable to move or wiggle because she was physically disabled. CNA #3 again confirmed that she was not in the room when CNA #2 was utilizing the lift and that she had told the DON that in her statement. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Interview on 10/22/24 at 2:25 PM, with the facility Assistant Director of Nursing (ADON) and the ADM revealed that all mechanical lifts required two (2) persons to assist with the operation of the lift and the resident. Both the ADON and the ADM confirmed that they were not aware that CNA #2 had transferred Resident #1 with the lift by herself. Both the ADON and the ADM expressed that they were under the impression that the DON had thoroughly investigated the incident and had determined that there were three (3) staff assisting CNA #2 with the mechanical lift. Not until today were we made aware that the incident happened another way, stated the ADM. The ADM stated that on 10/02/24 Resident #1 was sent from the local ER for a hip fracture and had never returned to the facility and had been discharged from the facility. The ADM stated that she would talk to the DON when she returned to the facility from medical leave. The ADM confirmed that the incident should have been thoroughly investigated and that she should have known because she is ultimately the one who signs off on allegations of abuse or neglect, but she was unaware. Record review of the hand written statement that was provided to the DON on 10/03/24 by CNA #3 stated, On October 1, 2024 I was walking to feed a resident, as I was alerted to come in (Resident #1's) room. Once I walked into the room she was already laying on the floor. The nurse examined her. Then me, nurse, and another aide proceeded to help get her up off the floor and put back into the bed. The hand written statement was signed by CNA #3 and dated 10/3/2024. Record review of the hand written statement that was provided to the DON on 10/1/24 and signed by (CNA #4) stated, As me, (CNA #3), and (LPN#1) was walking in the room she began to lifted (Resident #1) as she was lifting she slipped out the sling hitted her head on the wheel of the wheel chair the rooms are so cluttered where you can't move around without hitted things in the room. Record review of the hand written statement that was provided to the DON on 10/3/24 by CNA #2 stated, I (CNA #2) gave (Resident #1) a bedbath for shower Day; got her fully dressed to get up. I made sure she was pulled up in bed before stepping out. Went to shower room and grab the total lift and brought into room, had her chair by bed being prepared to get her up. I went to door to ask someone to spot me with lift So (LPN #1) (the nurse) and two CNA came behind her as I was proceeding to transfer her to put in chair. The total lift tilted over and (Resident #1) fell and Hit her head on the edge of her chair leg. The hand written statement was signed by CNA #2 and dated 10/3/24. Record review of the undated hand written statement provided to the DON by LPN #1 stated, I was asked to step in the room to assist with a total transfer, along with 2 other staff. Once I stepped into the room. Staff began to lift her off the bed. Once lifted she steered the lift to get her over the wheelchair. As she began to steer the lift, resident slipped out of sling hitting her head on the front of wheelchair. Record review of After Visit Summary, dated 10/01/24, from the hospital stated, Tylenol only for pain. Monitor wound for any development of infection. Return for vomiting, weakness, lethargy. Reason for visit: Fall . Laceration of forehead . Record review of Hospital ER report dated 10/02/24 and titled, CT Abdomen Pelvis with contrast, revealed Reason for visit n/v (nausea and vomiting) Results: Acute appearing right femoral intertrochanteric fracture. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255108	A. Building B. Wing	10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trend Health & Rehab of Carthage LLC	1101 East Franklin Street Carthage, MS 39051

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	The record review of the investigation completed by the facility's DON was not consistent with the handwritten statements of the CNAs nor the LPN's handwritten statement. On 10/25/24, after the SA had exited the survey, the facility's ADON notified via email and confirmed that they had re-interviewed and the CNA's and LPN involved with the incident of Resident #1's fall from the mechanical lift and that CNA #2 CNA #4 and LPN #1 confessed that they had not been truthful and had lied on their original statements that they gave to the DON on 10/1/24-10/3/24. CNA #2 confessed that she used the mechanical lift alone and improperly and that the other three (3) CNA's were not in the room when the fall of Resident #1 occurred. LPN #1 and CNA #4 both gave new statements that they were not present in the room with CNA #2 when Resident #1 fell and received serious injury and that they had falsified their statements and had not been truthful during the investigation of the suspected neglect. The record review of the Admission Record of Resident #1 revealed that she was admitted to the facility on [DATE] with diagnosis of Cerebral Infarction Due to Embolism of left middle cerebral artery; among many other diagnoses. Record review of the Section C of the Minimum Data Set (MDS) dated [DATE] for Resident #1 revealed she was severely cognitively impaired.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21029 Based on interviews, record reviews, and facility policy and procedure reviews, the facility failed to thoroughly investigate the incident of a fall from a mechanical lift for Resident #1 who sustained an injury to her forehead and a fracture requiring surgical repair for one (1) of three (3) residents reviewed. Cross reference F600, F656, F689 Findings Include: The facility's undated policy titled Abuse Policy Responsibility stated, The facility will identify and INVESTIGATE all suspicious or allegations of abuse (such as suspicious bruising of residents, neglect or misappropriation of resident property). The facility will review the occurrence, pattern, and trend that may constitute abuse. The facility will thoroughly INVESTIGATE all alleged violations under the direct supervision of the Administrator. The facility will take all necessary steps to prevent further potential abuse while the investigation is in progress. Any employee of the facility suspected of abuse or neglect will be suspended pending investigation until the facility investigation is complete. Record review of the DON's investigation report dated October 2, 2024 and signed by the facility Director of Nursing (DON), stated, Please find attached the investigation of the Right Intertrochanteric femoral fracture identified by Computed Tomography (CT) with contrast on 10/02/24 at (Local Hospital) emergency room (ER). 10/02/24 this resident presented with black vomiting while at the nursing home. In light of the fall and head injury on 10/01/24 the NP ordered transfer to (Local Hospital) ER via EMS for further evaluation. The DON reported that on 10/02/24, after evaluation at the local ER, Resident #1 was then transferred to (Another Hospital). The DON's investigation report also documented on 10/01/24 this resident, (Resident #1) had a fall from the lift sling during transfer bed to wheelchair in the resident's room at the nursing home. In attendance were three (3) Certified Nursing Assistants (CNA) #4, CNA #3, and CNA #2 and a medication Licensed Practical Nurse (LPN) #1. As per the statements of the nurse and CNAs when they moved the lift to transfer to wheelchair the resident slid out of one side hitting head on the front of the wheelchair causing a skin tear on the forehead, the lift was lowered to the floor, resident was assessed, repositioned and lifted by the total lift back into the bed. The NP and Resident Representative were notified. An order was received to transfer resident to the (Local Hospital) ER for evaluation. (Resident #1) was received back in the facility at 2220. The ER identified only the forehead skin tear (on 10/1/24). Record review of Hospital ER report dated 10/02/24 and titled, CT Abdomen Pelvis with contrast, revealed Reason for visit n/v (nausea and vomiting) Results: Acute appearing right femoral Intertrochanteric fracture. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0610 Level of Harm - Actual harm Residents Affected - Few	During an nterview on 10/22/24 at 12:20 PM with Licensed Practical Nurse (LPN) #1 via (by) telephone revealed that she was called to the room of Resident #1 to watch CNA #2 to operate the mechanical lift and transfer Resident #1 from the bed to the wheelchair. LPN #1 stated that she was called there to spot CNA #2 as she used the lift to transfer Resident #1. LPN #1 stated that spot meant to watch her use the mechanical lift, that she did not assist CNA #2 with the operation of the lift for Resident #1 and that she did not have her hands on the lift or her hands on Resident #1 during the transfer with the mechanical lift. LPN #1 stated that when she entered the room she saw CNA #2 operating the mechanical lift and that Resident #1 was up in the air in the sling when the mechanical lift tilted and Resident #1 fell to the floor. LPN #1 stated that there was another CNA assisting CNA #2 with the mechanical lift but she did not know her name and she was unable to recall who the third CNA was that was there to assist. LPN #1 stated that Resident #1 fell from the lift and hit her head and received a skin tear. During an interview via telephone on 10/22/24 at 12:30 PM with CNA #4 revealed that she was asked by LPN #1 to come with her to Resident #1's room. CNA #4 stated that when she entered the room of Resident #1 she saw the resident up in the air in the sling then she turned around to close the room door behind her and when she turned back around Resident #1 had fallen to the floor from the sling. CNA #4 stated that she did not see Resident #1 fall and she does not know who the other CNA was assisting CNA #2 with the mechanical lift. CNA #4 was unable to describe or to recall the name of the CNA that was assisting CNA #2 with the mechanical lift of Resident #1, and stated that she does not know how the incident occurred. During an interview on 10/22/24 at 12:36 PM with CNA #2 revealed that she had given Resident #1 a bed bath on the morning of 10/01/24 at approximately 8:30 AM. CNA #2 stated that she was very nervous to give an interview and would probably get things confused because she was so nervous. CNA #2 was tearful and shaky during the entire interview. CNA #2 verbalized that she loved the residents and needed her job and that she would not intentionally do anything to hurt a resident. She repeatedly verbalized it's on me, I should not have started doing the lift before CNA #3 entered the room to help me. CNA #2 stated that she had solely given Resident #1 a bed bath and had placed the sling under Resident #1 and had independently attached the sling to the lift and had lifted Resident up above the bed prior to CNA #3 entering the room. CNA #2 stated that CNA #3 did come into the room after she had lifted Resident #1 up above the bed in the mechanical lift. CNA #2 stated she sees now that she should have waited until CNA #3 was present in the room before she started operating the mechanical lift. CNA #2 repeated numerous times It's on me, I don't want to get anyone in trouble it's on me. CNA #2 stated that CNA #3 was standing behind the wheelchair as she was lifting Resident #1. CNA #2 stated that there was not enough room at the beside to have CNA #3 holding on to the lift and holding on to Resident #1. CNA #1 stated that she was driving the lift and when she had Resident #1 up in the air the mechanical lift tilted and Resident #1 fell out and hit her head. She stated that LPN #1 and CNA #4 were also in the room watching her lift Resident #1. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Actual harm Residents Affected - Few	During an interview on 10/22/24 at 1:30 PM with CNA #3 revealed that she was not in the room with CNA #2 when she used the mechanical lift to transfer Resident #1. CNA #3 stated that she was with another resident assisting with her breakfast when (CNA #2) came and got her to help with Resident #1. CNA #2 stated that upon entering Resident #1's room there were no other staff present and Resident #1 was on the floor bleeding from the forehead. CNA #3 stated that CNA #2 had used the mechanical lift alone without a second staff and Resident #1 had fallen and received a head injury. They called LPN #1 and CNA #4 came along with LPN #1 to help get Resident #1 up off of the floor and back into the bed. The four (4) staff together assisted Resident #1 back to her bed where the LPN #1 assessed the resident. CNA #3 confirmed that she had provided a hand written statement to the facility Director of Nursing (DON) confirming that she was not in the room when Resident #1 fell from the lift. CNA #3 reviewed her hand written statement with the State Agency (SA) and confirmed that was her statement that was given to the DON. CNA #3 again confirmed that she was not in the room when CNA #2 was utilizing the lift and that she had told the DON that in her statement. Record review of the hand written statement that was provided to the DON on 10/03/24 by CNA #3 stated, On October 1, 2024 I was walking to feed a resident, as I was alerted to come in (Resident #1's) room. Once I walked into the room she was already laying on the floor. The nurse examined her. Then me, nurse, and another aide proceeded to help get her up off the floor and put back into the bed. The hand written statement was signed by CNA #3 and dated 10/3/2024. During an interview on 10/22/24 at 2:25 PM, with the facility Assistant Director of Nursing (ADON) and the Administrator (ADM) both the confirmed that they were not aware that CNA #2 had transferred Resident #1 with the lift by herself. Both the ADON and the ADM expressed that they were under the impression that the DON had thoroughly investigated the incident and had determined that there was three (3) staff assisting CNA #2 with the mechanical lift. Not until today were we made aware that the incident happened another way, stated the ADM. The ADM stated that on 10/02/24 Resident #1 was sent from the local ER for a hip fracture and had never returned to the facility and had been discharged from the facility. The ADM confirmed that the incident should have been thoroughly investigated and that she should have known because she is ultimately the one who signs off on allegations of abuse or neglect, but she was unaware. The ADM stated that she would talk to the DON when she returned to the facility from medical leave. The record review of the investigation completed by the facility's DON was not consistent with the hand written statements of the CNAs nor the LPN's hand written statement. The DON did not investigate the incident in accordance with the facility's policies and procedures for the operation and use of mechanical lifts and for Abuse. The facility did not suspend the staff during the investigation that were involved with the mechanical lift incident of Resident #1, as outlined in the facility's policy and procedure. On 10/25/24, after the SA had exited the survey, the facility's ADON notified via email and confirmed that they had re-interviewed and the CNAs and LPN involved with the incident of Resident #1's fall from the mechanical lift and that CNA #2 CNA #4 and LPN #1 confessed that they had not been truthful with their original statements that they gave to the DON on 10/1/24-10/3/24. CNA #2 confessed that she used the mechanical lift alone and improperly and that the other CNAs were not in the room when the fall of Resident #1 occurred. LPN #1 and CNA #4 both gave new statements that they were not present in the room with CNA #2 when Resident #1 fell and received serious injury. (continued on next page)

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F 0610 Level of Harm - Actual harm Residents Affected - Few	Record review of the hand written statement that was provided to the DON on 10/1/24 and signed by (CNA #4) stated, As me, (CNA #3), and (LPN#1) was walking in the room she began to lifted (Resident #1) as she was lifting she slipped out the sling hitted her head on the wheel of the wheel chair the rooms are so cluttered where you can't move around without hitted things in the room. Record review of the hand written statement that was provided to the DON on 10/3/24 by CNA #2 stated, I (CNA #2) gave (Resident #1) a bedbath for shower Day; got her fully dressed to get up. I made sure she was pulled up in bed before stepping out. Went to shower room and grab the total lift and brought into room, had her chair by bed being prepared to get her up. I went to door to ask someone to spot me with lift So (LPN #1) (the nurse) and two CNA came behind her as I was proceeding to transfer her to put in chair. The total lift tilted over and (Resident #1) fell and Hit her head on the edge of her chair leg. The hand written statement was signed by CNA #2 and dated 10/3/24. Record review of the undated hand written statement provided to the DON by LPN #1 stated, I was asked to step in the room to assist with a total transfer, along with 2 other staff. Once I stepped into the room. Staff began to lift her off the bed. Once lifted she steered the lift to get her over the wheelchair. As she began to steer the lift, resident slipped out of sling hitting her head of the front of w/c. Record review of the Section C of the Minimum Data Set (MDS) dated [DATE] for Resident #1 revealed she was severely cognitively impaired. The record review of the Admission Record of Resident #1 revealed that she was admitted to the facility on [DATE] with diagnosis of Cerebral Infarction Due to Embolism of left middle cerebral artery; among many other diagnoses.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21029 Based on interviews, record reviews, and facility policy and procedure reviews, the facility failed to implement the care plan for transfer with a mechanical lift. During the transfer, Resident #1 fell from the lift and sustained a head injury and hip fracture requiring surgical repair. Resident #1 was one (1) of three (3) residents reviewed for care plans. Findings Included: Review of the facility policy titled Following the Care Plan Policy dated 2011, revealed, It is the Policy of this facility to follow a written and approved care plan for each resident. All employee will be trained upon hire and be required to follow the care plan. All employees will follow the written care plan that is developed in order to assure the residents needs are met . Review of the facility policy dated revised 6/13 titled Nurse Aide Information Policy revealed: It is the policy of this facility to initiate and maintain an individualized Nurse Aide Information (electronic health record) Kardex upon admission and complete within 7 (seven) days of the residents stay . 4. CNA's (Certified Nursing Assistant) will review their assigned residents Kardex per the kiosk electronic health record at the beginning of their shift and as needed throughout their shift . Record review of the Care Plan for Resident #1, date initiated 11/22/2022, revealed, I require assistance with ADL's (Activities of Daily Living) related to self-care impairment due to cerebrovascular accident (CVA) with intervention: Use total lift for transfers times two (2) person assist. Record review of the Care Plan contained in the CNA's Kiosk read: Monitor resident for side effects of oversedation, increased confusion, dizziness, blurred vision, or nausea. Safety: Provide assistance as needed for transfers. Use total mechanical lift x 2 person assist. CNA #1 revealed during an interview on 10/22/24 at 11:50 AM, that she trained all the CNAs on the use of all mechanical lifts. She stated that the facility required two (2) person's to assist with the mechanical lifting of all residents. CNA #2 revealed in an interview on 10/22/24 at 12:36 PM, that she had given Resident #1 a bed bath on the morning of 10/01/24 at approximately 8:30 AM. CNA #2 stated that she was very nervous to give an interview and would probably get things confused because she was so nervous. She was tearful and shaky during the entire interview. She repeatedly verbalized it's on me, I should not have started doing the lift before CNA #3 entered the room to help me. CNA #2 stated that she had placed the sling under Resident #1 and had independently attached the sling to the lift and had lifted the resident above the bed. CNA #1 stated that she was driving the lift when she had Resident #1 up in the air the mechanical lift tilted and Resident #1 fell out and hit her head. The CNA confirmed that Resident #1 was transported to the hospital with a head injury on 10/01/24 at approximately 9:00 AM. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Actual harm Residents Affected - Few	CNA #3 revealed in an interview on 10/22/24 at 1:30 PM, that she was not in the room with CNA #2 when she used the mechanical lift to transfer Resident #1. CNA #3 stated that she was with another resident assisting with her breakfast when (CNA #2) came and got her to help with Resident #1. CNA #3 stated that upon entering Resident #1's room there were no other staff present and Resident #1 was on the floor bleeding from the forehead. CNA #3 stated that CNA #2 had used the mechanical lift alone without a second staff and Resident #1 had fallen and received a head injury. They called Licensed Practical Nurse (LPN) #1 and CNA #4 came along with LPN #1 to help get Resident #1 up off of the floor and back into the bed. The four (4) staff together assisted Resident #1 back to her bed where the LPN #1 assessed the resident. CNA #3 confirmed that she had provided a hand written statement to the facility Director of Nursing (DON) confirming that she was not in the room when Resident #1 fell from the lift. The facility Assistant Director of Nursing (ADON) and the Administrator (ADM) revealed during an interview on 10/22/24 at 2:25 PM, that the CNA's used the care plan guides located in the CNA's kiosk on the units prior to each shift for reference on how to care for the residents that they are assigned to care for that shift. Both the ADON and the ADM confirmed that the mechanical lift's were care planned on each resident that required a mechanical lift and that all mechanical lifts required two (2) persons to assist with the operation of the lift and the resident. Both the ADM and the ADON confirmed that Resident #1 was care planned as a two (2) person assist with a total body mechanical lift. Both the ADM and the ADON confirmed that the two (2) person assist method required that two (2) staff would both assist with the operation of the lift and with the proper attachment of the proper size sling. Both the ADON and the ADM confirmed that they were not aware that CNA #2 had transferred Resident #1 with the lift by herself. Both the ADON and the ADM expressed that they were under the impression that the DON had thoroughly investigated the incident and had determined that there was three (3) staff assisting CNA #2 with the mechanical lift. Not until today were we made aware that the incident happened another way, stated the ADM. The ADM stated that on 10/02/24 Resident #1 was sent from the local ER for a hip fracture and had never returned to the facility and had been discharged from the facility. The ADM stated that she would talk to the DON when she returned to the facility from medical leave. Record review of the DON's investigation report dated October 2, 2024 and signed by the facility DON, stated, Please find attached the investigation of the Right Intertrochanteric femoral fracture identified by Computer Tomography (CT) with contrast on 10/02/24 at (Local Hospital) ER. 10/02/24 this resident presented with black vomiting while at the nursing home. In light of the fall and head injury on 10/01/24 the Nurse Practitioner (NP) ordered transfer to (Local Hospital) ER via EMS (emergency medical services) for further evaluation. The DON reported that on 10/02/24, after evaluation at the local ER, Resident #1 was then transferred to (Another Hospital). The DON's investigation report also documented on 10/01/24 this resident, (Resident #1) had a fall from the lift sling during transfer bed to wheelchair in the resident's room at the nursing home. In attendance were 3 CNAs (CNA #4) (CNA #3) and (CNA #2) and a medication LPN, (LPN #1). As per the statements of the nurse and CNAs when they moved the lift to transfer to wheelchair the resident slid out of one side hitting head on the front of the wheelchair causing a skin tear on the forehead, the lift was lowered to the floor, resident was assessed, repositioned and lifted by the total lift back into the bed. The NP and Resident Representative were notified. An order was received to transfer resident to the (Local Hospital) ER for evaluation. (Resident #1) was received back in the facility at 2220. The ER identified only the forehead skin tear. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0656 Level of Harm - Actual harm Residents Affected - Few	Record review of the hand written statement that was provided to the DON on 10/03/24 by CNA #3 stated, On October 1, 2024 I was walking to feed a resident, as I was alerted to come in (Resident #1's) room. Once I walked into the room she was already laying on the floor. The nurse examined her. Then me, nurse, and another aide proceeded to help get her up off the floor and put back into the bed. The hand written statement was signed by CNA #3 and dated 10/3/2024. Record review of After Visit Summary, dated 10/01/24, from the hospital stated, Tylenol only for pain. Monitor wound for any development of infection. Return for vomiting, weakness, lethargy. Reason for visit: Fall. Record review of Hospital ER report dated 10/02/24 and titled, CT Abdomen Pelvis with contrast, revealed Reason for visit N/V (nausea and vomiting) Results: Acute appearing right femoral intertrochanteric fracture. The record review of the Admission Record of Resident #1 revealed that she was admitted to the facility on [DATE] with diagnosis of Cerebral Infarction Due to Embolism of left middle cerebral artery; among many other diagnoses. Record review of the Section C of the Minimum Data Set (MDS) dated [DATE] for Resident #1 revealed she was severely cognitively impaired. On 10/25/24, three (3) days after the State Agency (SA) had exited the survey, the facility's ADON notified via email and confirmed that they had re-interviewed the CNA's and Licensed Practical Nurse (LPN) involved with the incident of Resident #1's fall from the mechanical lift, and CNA #2, CNA #4 and LPN #1 confessed that they had not been truthful and had lied in their original statements that they gave to the DON on 10/1/24-10/3/24. CNA #2 confessed that she used the mechanical lift alone and improperly and that the other three (3) CNA's were not in the room when the fall of Resident #1 occurred. LPN #1 and CNA #4 both gave new statements that they were not present in the room with CNA #2 when Resident #1 fell and received serious injury.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255108	A. Building B. Wing	10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trend Health & Rehab of Carthage LLC	1101 East Franklin Street Carthage, MS 39051

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21029 Based on observation, interviews, record reviews, and facility policy and procedures review the facility failed to avoid a preventable accident when Resident #1 was transferred with a mechanical lift without the required two (2) person transfer assistance. This resulted in Resident #1 sustaining an injury to her forehead and a right intertrochanteric femoral fracture requiring surgery. Resident #1 was transported to the hospital emergency room (ER) two times related to the accident. This was for one (1) of three (3) residents reviewed. Resident #1 Findings Included: Review of the facility policy, undated, titled: Modified Lifting Policy read: PROCEDURE: 1. Use of a mechanical lift requires two (2) nursing assistants to perform the procedure each time that it is used. 2. Staff will follow the documented lifting protocol deemed appropriate for each resident. This information is documented in the resident's chart and via a sticker system in a designated area of the facility for reference to each resident. This information should be referred to prior to lifting/transferring or assisting each resident. This documentation will also include type of lift and sling determined to be appropriate for each resident . The facility provided a notice that was posted in the facility that read: WARNING! Nursing Staff Never Use a Lift Alone! It is ABUSE! THE FACILITY POLICY IN REGARDS TO LIFTING WITH A MECHANICAL LIFT IS 1. Two Person Assist Every Time a Lift is Used 2. Properly apply the Sling 3. Always Assure you are using the correct lift. Record review of the DON's investigation report dated October 2, 2024 and signed by the facility DON, stated, Please find attached the investigation of the Right Intertrochanteric femoral fracture identified by CT with contrast on 10/02/24 at (Local Hospital) ER. 10/02/24 this resident presented with black vomiting while at the nursing home. In light of the fall and head injury on 10/01/24 the Nurse Practitioner (NP) ordered transfer to (Local Hospital) ER via EMS for further evaluation. On 10/02/24 .the DON was notified of a possible Hip fracture noted on the initial abdominal x-ray. A second test, CT without contrast, was done . identifying an acute comminuted and moderately displaced right hip fracture. The DON reported that on 10/02/24, after evaluation at the local ER, Resident #1 was then transferred to (Another Hospital). The DON's investigation report also documented on 10/01/24 this resident, (Resident #1) had a fall from the lift sling during transfer bed to wheelchair in the resident's room at the nursing home. In attendance were 3 CNAs (CNA #4) (CNA #3) and (CNA #2) and a medication LPN, (Licensed Practical Nurse #1). As per the statements of the nurse and CNAs when they moved the lift to transfer to wheelchair the resident slid out of one side hitting head on the front of the wheelchair causing a skin tear on the forehead, the lift was lowered to the floor, resident was assessed, repositioned and lifted by the total lift back into the bed. The NP and Resident Representative were notified. An order was received to transfer resident to the (Local Hospital) ER for evaluation. (Resident #1) was received back in the facility at 2220. The ER identified only the forehead skin tear. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 10/22/24 at 11:50 AM, in an interview with Certified Nursing Assistant (CNA) #1 revealed that she trained all the CNA's on the use of all mechanical lifts. She stated that the facility required two (2) person's to assist with the mechanical lifting of all residents. CNA #1 stated that the only way that a resident could possibly fall from a mechanical lift would be due to improper use of the lift or by placing the wrong size sling to the lift to move a resident. CNA #1 stated that she did not witness the fall of Resident #1, but stated that she had in past times assisted with the transfer of the resident and that she never moved about while in the lift because of her severely compromised physical and mental condition and was incapable of movement. CNA #1 stated that Resident #1 was non verbal and was dependent upon staff for all of her needs. CNA #1 stated that Especially because of the resident's size there would be a necessity to use at least two (2) staff, and maybe more, while using the mechanical lift. CNA #1 confirmed that two staff must assist hands-on when using a mechanical lift for all facility residents. CNA #1 stated that never during the mechanical lift process of a resident should there be one (1) staff transferring a resident with a mechanical lift. CNA #1 stated that the use of one (1) staff using a mechanical lift was not in accordance with the facility policy and procedure. On 10/22/24 at 12:20 PM, interview with Licensed Practical Nurse (LPN) #1 via (by) telephone revealed that she was called to the room of Resident #1 to watch CNA #2 to operate the mechanical lift and transfer Resident #1 from the bed to the wheelchair. LPN #1 stated that she was called there to spot CNA #2 as she used the lift to transfer Resident #1. LPN #1 stated that spot meant to watch her use the mechanical lift, that she did not assist CNA #2 with the operation of the lift for Resident #1 and that she did not have her hands on the lift or her hands on Resident #1 during the transfer with the mechanical lift. LPN #1 stated that when she entered the room she saw CNA #2 operating the mechanical lift and that Resident #1 was up in the air in the sling when the mechanical lift tilted and Resident #1 fell to the floor. LPN #1 stated that CNA #4 was standing behind her near the door of Resident #1's room. LPN #1 stated that there was another CNA assisting CNA #2 with the mechanical lift but she did not know her name and she was unable to recall who the third CNA was that was there to assist. LPN #1 stated that Resident #1 fell from the lift and hit her head and received a skin tear. LPN #1 stated that she assessed Resident #1 while she was on the floor. Three (3) CNA's and LPN #1 assisted to lift Resident #1 back to the bed. LPN #1 stated that she assessed Resident #1 again while she was in the bed. LPN #1 stated that Resident #1 was bleeding from the injury to her forehead and she placed a compression bandage to the bleeding area of Resident #1's head. LPN #1 obtained orders to send Resident #1 to the ER for evaluation. Resident #1 returned from the ER with a diagnosis of a skin tear to her forehead. LPN #1 stated that there was no misuse of the mechanical lift and that there were two (2) CNA's assisting with the mechanical lift of Resident #1. LPN #1 was not able to recall or describe who the second CNA was that assisted CNA #2 to operate the mechanical lift. On 10/22/24 at 12:30 PM, during a telephone interview with CNA #4 revealed that she was asked by LPN #1 to come with her to Resident #1's room. CNA #4 stated that when she entered the room of Resident #1 she saw the resident up in the air in the sling then she turned around to close the room door behind her and when she turned back around Resident #1 had fallen to the floor from the sling. CNA #4 stated that she did not see Resident #1 fall. CNA #4 stated that she did not know the name of the CNA that was assisting CNA #2 and did not pay attention to what she looked like because she was concentrating on the resident. CNA #4 stated that she assisted LPN #1 and the other two (2) CNA's to lift Resident #1 back to her bed after the fall. CNA #4 stated that Resident #1 obtained a skin tear to her head and was bleeding at her forehead. CNA #4 stated that LPN #1 assessed Resident #1 and placed a bandage on her bleeding head. She stated that she does not know how the incident occurred. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 10/22/24 at 12:36 PM, during an interview with CNA #2 revealed that she had given Resident #1 a bed bath on the morning of 10/01/24. CNA #2 stated that she was very nervous to give an interview and would probably get things confused because she was so nervous. CNA #2 was tearful and shaky during the entire interview. CNA #2 verbalized that she loved the residents and needed her job and that she would not intentionally do anything to hurt a resident. She repeatedly verbalized numerous times it's on me, I should not have started doing the lift before CNA #3 entered the room to help me. CNA #2 stated that she had solely given Resident #1 a bed bath and had placed the sling under Resident #1 and had independently attached the sling to the lift and had lifted Resident up above the bed prior to CNA #3 entering the room. CNA #2 stated she sees now that she should have waited until CNA #3 was present in the room before she started operating the mechanical lift. CNA #2 stated that CNA #3 was standing behind the wheelchair as she was lifting Resident #1. CNA #1 stated that she was driving the lift and when she had Resident #1 up in the air the mechanical lift tilted and Resident #1 fell out and hit her head. She stated that LPN #1 and CNA #4 were also in the room watching her lift Resident #1. CNA #2 confirmed that there was no staff holding on to Resident #1 while she was lifting Resident #1 from the bed to the wheelchair. CNA #2 stated that Resident #1 fell out of the lift and hit her head and she began to bleed. She stated that LPN #1 told CNA #2 to continue to lower Resident #1 to the floor so they could assess her and treat her bleeding head. LPN #1 assessed Resident #1 while she was on the floor and then all four (4) of the staff (CNA #2, CNA #3, CNA #4 and LPN #1) assisted to transfer Resident #1 from the floor back into the bed, where LPN #1 re-assessed Resident #1 while she was in the bed. Resident #1 was transported to the hospital with a head injury on 10/01/24 at approximately 9:00 A.M. On 10/22/24 at 1:30 PM, during an interview with CNA #3 revealed that she was not in the room with CNA #2 when she used the mechanical lift to transfer Resident #1. CNA #3 stated that she was with another resident assisting with her breakfast when (CNA #2) came and got her to help with Resident #1. CNA #2 stated that upon entering Resident #1's room there were no other staff present and Resident #1 was on the floor bleeding from the forehead. CNA #3 stated that CNA #2 had used the mechanical lift alone without a second staff and Resident #1 had fallen and received a head injury. They called LPN #1 and CNA #4 came along with LPN #1 to help get Resident #1 up off of the floor and back into the bed. The four (4) staff together assisted Resident #1 back to her bed where LPN #1 assessed the resident. CNA #3 confirmed that she had provided a hand written statement to the facility Director of Nursing (DON) confirming that she was not in the room when Resident #1 fell from the lift. CNA #3 reviewed her hand written statement with the State Agency (SA) and confirmed that was her statement that was given to the DON. CNA #3 stated that she had in past times assisted with the transfer of Resident #1 with a mechanical lift and there had never been any issues with Resident #1 resisting care or moving about while in the sling of the mechanical lift. CNA #3 verbalized that Resident #1 was a large lady and that she required at least two (2) persons to assist with her care and to steady the mechanical lift. CNA #3 stated that Resident #1 never moved and was unable to move or wiggle. CNA #3 again confirmed that she was not in the room when CNA #2 was utilizing the lift and that she had told the DON that in her statement. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 10/22/24 at 2:25 PM, an interview with the Assistant Director of Nursing (ADON) and the Administrator (ADM) confirmed that the two (2) person assist method required that two (2) staff would both assist with the operation of the lift and with the proper attachment of the sling. Both the ADON and the ADM confirmed that they were not aware that CNA #2 had transferred Resident #1 with the lift by herself. Both the ADON and the ADM expressed that they were under the impression that the DON had thoroughly investigated the incident and had determined that there was three (3) staff assisting CNA #2 with the mechanical lift. Not until today were we made aware that the incident happened another way, stated the ADM. The ADM stated that on 10/02/24 Resident #1 was sent from the local ER for a hip fracture and had never returned to the facility and had been discharged from the facility. The ADM stated that she would talk to the DON when she returned to the facility from medical leave. The record review of the investigation completed by the facility's DON was not consistent with the hand written statements of the CNAs nor the LPN's hand written statement. The DON did not investigate the incident in accordance with the facility's policies and procedures for the operation and use of mechanical lifts and for Abuse and Neglect. On 10/25/24, after the SA had exited the survey, the facility's ADON notified via email and confirmed that they had re-interviewed and the CNAs and LPN involved with the incident of Resident #1's fall from the mechanical lift and that CNA #2, CNA #4 and LPN #1 confessed that they had not been truthful and had lied on their original statements that they gave to the DON on 10/1/24-10/3/24. CNA #2 confessed that she used the mechanical lift alone and improperly and that the other CNAs were not in the room when the fall of Resident #1 occurred. LPN #1 and CNA #4 both gave new statements that they were not present in the room with CNA #2 when Resident #1 fell and received serious injury and that they had falsified their statements and had not been truthful during the investigation. Record review of the hand written statement that was provided to the DON on 10/03/24 by CNA #3 revealed, On October 1, 2024 I was walking to feed a resident, as I was alerted to come in (Resident #1's) room. Once I walked into the room she was already laying on the floor. The nurse examined her. Then me, nurse, and another aide proceeded to help get her up off the floor and put back into the bed. The hand written statement was signed by CNA #3 and dated 10/3/2024. Record review of the hand written statement that was provided to the DON on 10/1/24 and signed by (CNA #4) revealed, As me, (CNA #3), and (LPN#1) was walking in the room she began to lifted (Resident #1) as she was lifting she slipped out the sling hitted her head on the wheel of the wheel chair . Record review of the hand written statement that was provided to the DON on 10/3/24 by CNA #2 revealed, I (CNA #2) gave (Resident #1) a bedbath for shower Day; got her fully dressed to get up. I made sure she was pulled up in bed before stepping out. Went to shower room and grab the total lift and brought into room, had her chair by bed being prepared to get her up. I went to door to ask someone to spot me with lift So (LPN #1) (the nurse) and two CNA came behind her as I was proceeding to transfer her to put in chair. The total lift tilted over and (Resident #1) fell and Hit her head on the edge of her chair leg. The hand written statement was signed by CNA #2 and dated 10/3/24. Record review of the undated hand written statement provided to the DON by LPN #1 stated, I was asked to step in the room to assist with a total transfer, along with 2 other staff. Once I stepped into the room. Staff began to lift her off the bed. Once lifted she steered the lift to get her over the wheelchair. As she began to steer the lift, resident slipped out of sling hitting her head on the front of wheelchair. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Record review of After Visit Summary, dated 10/01/24, from the hospital stated, Tylenol only for pain. Monitor wound for any development of infection. Return for vomiting, weakness, lethargy. Reason for visit: Fall. Record review of Hospital ER report dated 10/02/24 and titled, CT Abdomen Pelvis with contrast, revealed Reason for visit n/v (nausea and vomiting) Results: Acute appearing right femoral intertrochanteric fracture. Record review of the Section C of the Minimum Data Set (MDS) dated [DATE] for Resident #1 revealed she was severely cognitively impaired. The record review of the Admission Record of Resident #1 revealed that she was admitted to the facility on [DATE] with diagnosis of Cerebral Infarction Due to Embolism of left middle cerebral artery; among many other diagnoses.