

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  255229	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/09/2024
NAME OF PROVIDER OR SUPPLIER  Holly Springs Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1315 Highway 4 East Holly Springs, MS 38635	

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)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45598</b></p> <p>Based on staff interview, record review, and facility policy review the facility failed implement the care plan to provide two-person assistance when providing care for a dependent resident for one (1) of three (3) sampled residents. Resident #1.</p> <p>Findings Include:</p> <p>Review of the facility policy, Care Plans, Comprehensive Person-Centered with reviewed date of 01/2023, revealed, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.</p> <p>Record review of Resident #1's Care Plan revealed that she had a self-care deficit with interventions that included, toileting/incontinent care. The resident requires TOTAL assistance by two (2) FOR INCONTINENT CARE</p> <p>On 09/09/24 at 11:10 AM, an interview with Registered Nurse (RN) Supervisor revealed that Assistant Director of Nursing (ADON) reported to her on Monday morning, July 22, 2024, that Resident #1 fell out of the bed the day before. She revealed that ADON reported that Certified Nursing Assistant (CNA) #1 went into Resident #1's room by herself to provide care. She confirmed that Resident #1 had contractures and was care planned to have two-person assistance with any care provided to prevent any accidents.</p> <p>On 09/09/24 at 11:30 AM a phone interview with Assistant Director of Nursing (ADON) revealed that on 07/21/24, CNA #1 went into Resident #1's room by herself to provide care and Resident #1 rolled out of the bed. She confirmed that Resident #1's was care planned for two-person assistance.</p> <p>On 09/09/24 at 11:57 AM, an interview with CNA #2 revealed that Resident #1 was very contracted, had no interaction and was unable to grab on to the side rails or hold the CNA's arm to help hold herself. CNA #2 revealed that Resident #1 required two-person assistance with all care. CNA #2 revealed that if they weren't familiar with a resident and didn't know what type of assistance was required, they were supposed to look the care plan up in their computer system.</p> <p>(continued on next page)</p>

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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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 09/09/24 at 12:45 PM, a phone interview with CNA #1 revealed that she was working on 07/21/24 when the accident with Resident #1 happened. She revealed that she was in Resident #1's room by herself changing her brief when she fell out of the bed. CNA #1 confirmed that if she had followed the care plan for two-person assistance and had another person helping her, that Resident #1 probably would not have fallen out of the bed.</p> <p>On 09/09/24 at 2:15 PM, an interview with Minimum Data Set (MDS) Coordinator revealed that care plans were developed so staff knew how to provide for the individualized needs of the residents. She revealed that the care plans were resident-driven and patient specific. MDS Coordinator confirmed that Resident #1's Care Plan included an intervention to provide two-person assistance with personal care and confirmed that CNA #1 did not follow the care plan when she provided Resident #1's care without assistance.</p> <p>Record review of Resident #1's Admission Record revealed an admitted [DATE] and that she had diagnoses that included Unspecified Dementia, Need for Assistance with Personal Care, and Contractures to Right Knee, Left Knee, Right Hand, and Left Hand.</p> <p>Record review of Resident #1's MDS with Assessment Reference Date (ARD) of 07/09/2024 under Section C revealed that a Brief Interview for Mental Status (BIMS) should not be completed because resident was rarely or never understood.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45598</p> <p>Based on interviews, record review and facility policy review the facility failed to provide two-person assistance with incontinent care for a dependent resident in a manner to prevent a fall for one (1) of three (3) sampled residents. Resident #1.</p> <p>Findings Include:</p> <p>Review of the facility policy titled, Fall Prevention Program with reviewed date of 06/10/2024 revealed, All residents will be assessed for the risk for falls at the time of admission, on a quarterly basis, and upon significant change in condition thereafter. Based on the results of this assessment, specific interventions will be implemented to minimize falls, avoid repeat falls and minimize falls resulting in significant injury.</p> <p>Record review of Resident #1's Incident Report dated 07/21/24 at 14:42 revealed, Was notified by Certified Nursing Assistant (CNA Proper Name) that Resident (proper name) was on the floor. CNA (proper name) stated as she was changing her, Resident's (proper name) body was turned to the left. CNA (proper name) was using her hands to hold up the weight of Resident's (proper name) legs as she was getting her brief changed. While changing her, her legs slipped over the side of the bed and Resident (proper name) proceeded to fall on floor. Resident was unable to give description. There were no injuries observed at time of incident. Record review revealed that the resident did not suffer an injury with the fall.</p> <p>An interview with Registered Nurse (RN) Supervisor on 09/09/24 at 11:10 AM, revealed the Assistant Director of Nursing (ADON) reported to her on Monday morning, July 22, 2024, that Resident #1 fell out of the bed the day before. She revealed the ADON reported that (CNA) #1, went into Resident #1's room to change her and she rolled out of the bed. She revealed that Resident #1 had contractures and was supposed to have two-person assistance to prevent any accidents. RN Supervisor revealed that CNA #1 went in by herself to provide care, positioned Resident #1 too close to the edge of the bed and she fell off the bed onto the floor. She confirmed that there should have been two people in the room, one to assist with holding the resident and the other to provide care. RN Supervisor revealed that residents with contractures were supposed to have two- person assistance to prevent falls or injuries.</p> <p>A phone interview with Assistant Director of Nursing (ADON) on 09/09/24 at 11:30 AM revealed that on 07/21/24, CNA #1 was in the room changing Resident #1's brief and doing peri-care, Resident #1 was over too close to the edge of the bed and fell on to the floor. She revealed that Resident #1 was supposed to have two people to assist with her care but CNA #1 went into her room by herself. ADON revealed that she didn't know if CNA #1 was unaware that Resident #1 was a two person assist or if she just got caught up, got busy and forgot. ADON revealed that they educated their staff to look at residents' care plans or ask the nurse to protect the residents and to protect themselves.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A phone interview with CNA #1 on 09/09/24 at 12:45 PM, revealed that she was working on 07/21/24 when the accident with Resident #1 happened. She revealed that she was in Resident #1's room by herself changing her brief when she fell out of bed. CNA #1 revealed that she was standing on the right side of the Resident #1's bed and pulled the resident's legs over to the right side against her abdomen for support, she then reached over the resident to the left of the bed to get her clean brief, and Resident #1 fell out of the bed. CNA #1 revealed that she didn't pay attention to the position of Resident #1's upper body and didn't realize that she was positioned near the edge of the bed. CNA #1 revealed that she tried to catch Resident #1 before she hit the floor, and she did prevent her head from hitting the floor. She revealed that she called for help, looked her over, the nurse and ADON, assessed Resident #1 and there were no injuries identified. CNA #1 revealed that she was supposed to have another person in the room with her because Resident #1 required 2-person assistance. CNA #1 revealed that she should have pulled her towards the middle of the bed and made sure her body was not on the edge of the bed. She confirmed that since this incident she has made sure that she had two people in the room with her to prevent any other accidents like this.</p> <p>Record review of Resident #1's Admission Record revealed an admitted [DATE] and had diagnoses that included Unspecified Dementia, Need for Assistance with Personal Care, and Contractures to Right Knee, Left Knee, Right Hand, and Left Hand.</p> <p>Record review of Resident #1's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 07/09/2024 under Section C revealed that a Brief Interview for Mental Status (BIMS) should not be completed because resident was rarely or never understood.</p>		