STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255328	A. Building B. Wing	11/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bedford Care Center of Marion	6434 A Dale Dr Marion, MS 39342

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 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** 43283 Based on observation, staff interview, record review, facility investigation review, and facility policy review, the facility failed to implement comprehensive care plan interventions related to resident transfers when a Certified Nurse Aide (CNA) transferred a resident without assistance, using the incorrect sling size, which resulted in the resident falling during the transfer, receiving a fracture and head laceration for one (1) of four (4) care plans reviewed. Resident #1 Findings include: A record review of the facility's policy Using the are Plan with revised date of 8/2/22 revealed, Policy Statement The care plan shall be used in developing the resident's daily care routines and will be available to staff personnel who have responsibility for providing care or services to the resident . Policy Interpretation and Implementation . 2. uses the care plan to direct care provided by the CNAs and nurses daily . A record review of Resident #1's Comprehensive Care Plan revealed a care plan Focus: The resident has an ADL (Activities of Daily Living) self-care performance deficit .Interventions/Task .Transferring [NAME] total lift x 2, large sling, NON weight bearing. Care plan was initiated on 10/20/22 and revised on 10/25/24 to include non-weight bearing. A record review of Resident #1's Investigative Summary-Final Report, dated 10/21/2024, revealed (Proper name of CNA #1) operated lift alone without verifying resident sling size. She used a small sling which contributed to (Proper name of Resident #1) incident . A record review of written statement from Licensed Practical Nurse (LPN)#1 on 10/20/24, revealed, . CNA was standing in the doorway of room, called out for a nurse, when I entered the room, I saw (proper name) lift with lift pad on it up in the air, resident was lying on her right side face down with blood coming from the right side of her head . CNA stated, I put her on the (proper name) lift by myself, I had no one to help me! . A record review of CNA #1's written statement, dated 10/25/2024, revealed that CNA #1 admitted to transferring Resident #1 without assistance. She stated she used the sling already attached to the lift and did not check the Kardex for the required sling size. She also acknowledged asking another staff member for help, but no one came to help. The witness statement further revealed I (CNA #1) operated the lift and (Proper name of Resident #1) fell -hit her head. (continued on next page)

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

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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	A record review of the Admission Record revealed the facility admitted Resident #1 on 10/20/2022 with diagnoses including Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting the Left Non-Dominant Side. During an observation on 11/25/2024 at 8:15 AM, Resident #1, she recalled only one person was present during the transfer. She stated she kept telling CNA #1, Something's not right. She became emotional while recalling the incident, describing severe pain and a subsequent hospital stay. Resident #1 stated she wanted to stay up in her wheelchair until after lunch and would be assisted back to bed at that time. There was a mechanical lift sling underneath her that had a red trim. On 11/25/24 at 10:30 AM, during an interview with the Licensed Practical Nurse (LPN) #2, she verified Resident #1 required a full body lift prior to after the fall. It is the policy and procedures for the facility, that when a lift is used two staff members must be present at all times. She explained Resident #1's care plan for needing assistance with transfers did not change after the fall. The purpose of the care plan is a guide to go by for residents' care to provide quality care for each resident. She stated she expects all staff to follow the residents' care plans at all times to have the knowledge of how to care for the individual residents. At 12:55 PM on 11/25/24, during an interview with the Administrator, he confirmed Resident #1 was care planned for two-person assistance with transferring with lift. He stated he expects all staff to follow the facility's policies and procedures and residents individual care plans to provide quality care for all the residents at all times. During an observation on 11/25/2024 at 1:25 PM, Resident #1 was transferred by the facility staff via mechanical lift from her wheelchair to the bed. Three (3) CNAs entered the room to assist with the transfer. It was noted that the resident was sitting in a wheelchair with a red lift pad under her, indicating a medium sling, which was not the correct size. CNA #2 confirmed the sling needed to be replaced with a blue (large) sling. The CNAs were able to remove the medium sling and place the large sling while the resident was in the wheelchair and then transferred her using the correct large sling size. During an interview on 11/25/2024 at 1:45 PM, CNA #2 confirmed the wrong size of lift pad was under the resident, indicating that the incorrect lift pad was used earlier that morning during a transfer from bed to wheelchair. He stated he did not assist with the resident's transfer that morning because the transfer occurred on the previous shift. On 11/25/2024 at 3:00 PM, during an interview with the Administrator, he stated he was unaware that Resident #1 had been transferred this morning with the wrong size lift pad. He explained that all staff had been educated on proper lift pad identification and the need to check the Kardex before using the lift. He reiterated that sufficient lift pads were available and expected staff to follow policies. He stated that CNA #4 had been assigned to Resident #1 this morning. During an interview, on 11/25/2024 at 3:40 PM, CNA #4 admitted she was assigned to care for Resident #1 during the night shift last night. She reported transferring Resident #1 using a mechanical lift and a red-trimmed/medium size sling pad. She stated she did not check the Kardex that morning, assuming the resident required a large sling. She also noted that only medium sling pads were available at the time. (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	During a post survey interview on 11/26/2024 at 9:30 AM, CNA #1 stated that on the morning of 10/21/24, she had asked the nurse for assistance with the mechanical lift transfer of Resident #1, but no one came to help. She admitted not checking the Kardex for the correct sling size and using the sling already attached to the lift.

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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. 43283 Based on observation, interviews, record review, facility investigation review, and facility policy reviews the facility failed to ensure a resident was transferred safely while using a mechanical lift when a Certified Nurse Aide (CNA) performed the transfer without assistance and used the incorrect sling size, which caused the resident to fall, resulting in a fracture and head laceration for one (1) of four (4) sampled residents. (Resident #1) Findings include: A review of the facility's policy, Safe Transfer and Lifting of Residents, revised 08/02/2022, revealed, .In order to protect the safety and well-being of staff and residents, and to promote quality care, this facility uses appropriate techniques and devices to lift and move residents . General Guidelines .6. Enough slings in sizes required by residents should be available at all times . VI. Procedure for transferring resident with full body lift .c. Ensures proper transfer is followed per care plan .e. Ensures resident is within weight requirements of lift f. Ensures a 2nd person is assisting . A record review of Resident #1's Progress Notes, dated 10/21/2024 at 7:10 AM, revealed the resident was found crying loudly on the floor with a large laceration on the right side of her forehead and a hematoma on her right forearm. CNA #1 stated the resident slid out of the sling during a transfer using a mechanical lift. A record review of Resident #1's Kardex revealed the resident required a total lift with two (2) staff and a large sling. The record indicated the resident was non-weight-bearing. A record review of Resident #1's Investigative Summary-Final Report, dated 10/21/2024, revealed (Proper name of the CNA) operated lift alone without verifying resident sling size. She used a small sling which contributed to (Proper name of Resident #1) incident . A record review of CNA #1's written statement, dated 10/25/2024, revealed that CNA #1 admitted to transferring Resident #1 without assistance. She stated she used the sling already attached to the lift and did not check the Kardex for the required sling size. She also acknowledged asking another staff member for help, but no one came to help. The witness statement further revealed I (CNA #1) operated the lift and (Proper name of Resident #1) fell -hit her head. A record review of the Fall During Assist report, dated 10/21/2024, revealed that CNA #1 attempted to transfer Resident #1 using a mechanical lift without the assistance of a second staff member. The report noted that CNA #1 used a medium sling instead of the required large sling, which resulted in the resident sliding out of the sling and falling to the floor. The report documented that the resident sustained a laceration to the right side of the forehead and a hematoma on the right arm and was sent to the emergency room for further evaluation. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A record review of Resident #1's Emergency Department History and Physical, dated 10/21/2024, revealed the resident sustained a displaced femur fracture and a laceration requiring sutures. She also complained of left hip and knee pain. A record review of the X-ray Femur, dated 10/21/2024, revealed Resident #1 had an acute displaced, obliquely oriented fracture through the distal femoral shaft. A record review of the Discharge Summary, dated 10/25/2024, revealed Resident #1 underwent Open Reduction and Internal Fixation (ORIF) surgery for the femur fracture and was discharged back to the facility with a non-weight-bearing status. A record review of the Admission Record revealed the facility admitted Resident #1 on 10/20/2022 with diagnoses including Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting the Left Non-Dominant Side. A record review of the Comprehensive Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/01/2024 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of eight (8), which indicated the resident's cognition was moderately impaired. On 11/25/2024 at 8:15 AM, during an observation and interview with Resident #1, she recalled only one person was present during the transfer. She stated she kept telling CNA #1, Something's not right. She became emotional while recalling the incident, describing she had some pain and a subsequent hospital stay. Resident #1 stated she wanted to stay up in her wheelchair until after lunch and would be assisted back to bed at that time. There was a mechanical lift sling underneath her that had a red trim. On 11/25/2024 at 10:55 AM, during an interview, the Administrator confirmed CNA #1 admitted to transferring the resident alone using the sling already attached to the lift without verifying its size. The fall occurred at the end of the shift as the staff were assisting residents up for the day. On 11/25/2024 at 11:20 AM, during an interview with Resident #1's family member, she explained that the nurse informed her that her sister fell out of the lift and sustained a gash on her forehead, which would not stop bleeding, necessitating emergency medical care. She stated that Resident #1 required four (4) stitches to her forehead and added that hospital tests revealed her sister had a fractured femur requiring surgery, and a plate was subsequently inserted. On 11/25/2024 at 1:20 PM, during an observation and interview with CNA #2, he confirmed the resident required a large sling for transfers and stated two staff members are always required when using a lift. He reviewed the resident's Kardex and identified the correct sling size for the resident was a large. On 11/25/2024 at 1:25 PM, during an observation of Resident #1 being transferred by facility staff via the mechanical lift from her wheelchair to the bed, three (3) CNAs entered the room to assist with the transfer. It was noted that the resident was sitting in a wheelchair with a red lift pad under her, indicating a medium sling, which was not the correct size. CNA #2 confirmed the sling needed to be replaced with a blue (large) sling. The CNAs were able to remove the medium sling and place the large sling while the resident was in the wheelchair and then transferred her using the correct large sling size. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 11/25/2024 at 1:45 PM, during an interview with CNA #2, he confirmed the wrong size of lift pad was under the resident, indicating that the incorrect lift pad was used earlier that morning during a transfer from bed to wheelchair. He stated he did not assist with the resident's transfer that morning because the transfer occurred on the previous shift. On 11/25/24 at 2:00 PM, during an interview, CNA #3 confirmed Resident #1 had a medium lift pad underneath her while in the wheelchair and stated Resident #1 was already up in her chair when she arrived to work. CNA #3 confirmed a medium sling was incorrect according to the residents Kardex. During an interview on 11/25/2024 at 3:00 PM, the Administrator stated he was unaware that Resident #1 had been transferred this morning with the wrong size lift pad. He explained that all staff had been educated on proper lift pad identification and the need to check the Kardex before using the lift. He reiterated that sufficient lift pads were available and expected staff to follow policies. He stated that CNA #4 had been assigned to Resident #1 this morning. On 11/25/2024 at 3:40 PM, during an interview with CNA #4, she admitted she was assigned to care for Resident #1 during the night shift last night. She reported transferring Resident #1 using a mechanical lift and a red-trimmed/medium size sling pad. She stated she did not check the Kardex that morning, assuming the resident required a large sling. She also noted that only medium sling pads were available at the time. On 11/26/2024 at 9:30 AM, during a post survey interview, CNA #1 stated that on the morning of 10/21/24, she had asked the nurse for assistance with the mechanical lift transfer of Resident #1, but no one came to help. She admitted not checking the Kardex for the correct sling size and using the sling already attached to the lift.