STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345335	A. BUILDING ______ B. WING ______	12/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN OAKS NURSING AND REHABILITATION CENTER	**1704 NC HIGHWAY 39 N LOUISBURG, NC 27549**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to ensure that staff members were following the care plan for 1 of 8 sampled residents (Resident #87) whose care plans were reviewed. Findings included: Resident #87 was re-admitted to the facility on 11/11/14. Cumulative diagnoses included depression, reflux, psychosis, anxiety, and dementia. According to the electronic chart, Resident #87's resident care guide indicated she required 2 staff persons when using the mechanical life device. The Annual Minimum Data Set (MDS) assessment of 03/03/14 noted that Resident #87 needed extensive assistance with transfers. The Care Area Assessment (CAA) summary indicated she triggered for falls but it was not to be addressed in her care plan. The most recent Quarterly MDS of 10/11/14 noted she required total assistance from staff for transfers. An interdisciplinary care plan progress note of 11/21/14 noted that a mechanical lift device was to be used for functional transfers for Resident	F 282	F282 1) NA #5 is no longer employed at the facility. Resident #87 will continue to receive a 2 person mechanical lift transfer per the Resident Care guide. 2) 100% of nursing staff re-education on the facility Safe Movement Policy was initiated on 12/3/14 by the Staff Facilitator to include reading the resident care guide prior to all transfers. A return demonstration by all nursing staff was completed by the Assistant Director of Nursing, the Staff Facilitator, and 7AM I 3PM RN Supervisor beginning 12/3/14 to assure the Nursing Assistants were performing transfers per the Resident Care guide. A QI Resident Care Audit Tool for transfer observations was utilized for monitoring. Staff was retrained by the Assistant Director of Nursing, Staff Facilitator, or RN Supervisor for all identified areas of concern. All newly hired staff will receive the education in orientation on Safe Handling and Movement Policy to include reading the resident care guide prior to all transfers by the Staff Facilitator. 3) Monitoring of resident transfers will be	12/24/14

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

Electronically Signed | | 12/22/2014

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.

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F 282	Continued From page 1 #87. Resident #87's most current care plan, dated 12/02/14, indicated that she required assistance with transferring from one position to another related to cognitive deficit, physical limitations and a fracture of the right femur. Transfer with a mechanical lift device utilizing 2 persons for constant supervision and physical assist was included in the interventions. Resident #87 was observed sitting in a wheelchair in her room on 12/03/14 at 2:00 PM. During an observation of care for Resident #87 on 12/03/14 at 2:10 PM, Nurse Aide #5 (NA #5) rolled a mechanical lift device into the resident's room and began to prepare her for transfer to the bed. She placed the green lift sling pad behind Resident #87 but was unable to slide the pad totally underneath her buttocks. She manipulated the pad several times in an effort to place it correctly but still was not able to position it underneath her buttocks so she criss-crossed the end pieces of the pad underneath her legs and attached them to the lift device bar. As she began to lift Resident #87, she commented that the pad needed to be adjusted so she lowered her back onto the seat of the wheelchair. She attempted to reposition the pad once again and began lifting her from the wheelchair. As she lifted Resident #87, it was noted that her entire buttocks area was hanging out of the pad. She continued to move her over to the bed and lowered her onto the bed. She removed the green sling pad and began to provide personal care. During an interview on 12/03/14 at 3:00 PM with	F 282	completed for 2 residents each shift daily x 2 weeks by the Assistant Director of Nursing, Staff Facilitator, and RN Supervisor, then each shift 5 times a week x 2 weeks, then twice weekly x 2 weeks, then weekly x 2 weeks, then once weekly x 2 weeks, then monthly x 1 utilizing a resident transfer audit tool. Resident #87 will be included in the audit. All staff will be immediately retrained for any identified areas of concern by the Assistant Director of Nursing, Staff Facilitator, and RN Supervisor. The Director of Nursing will initial and review the results of the resident transfer audit tool weekly and evaluate the need for additional staff education. 4) The Director of Nursing will present the results of the monitoring to the Executive Quality Assurance Committee Meetings x 3 months for trends and the need for continued monitoring.	

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F 282	Continued From page 2 the former staff development coordinator (MDS nurse), it was reported that the facility's policy for transferring residents with a mechanical lift device was based on the premise that residents were transferred according to their assessments and per the resident care guide. He stated Resident #87 was assessed as a 2 person transfer. Staff were expected to have 2 staff members when using the lift to transfer her. An interview was attempted with NA #5 but she had left the building and was not available for interview according to the Administrator at 3:30 PM on 12/03/14. The Administrator also reported that she had been made aware of the use of the mechanical lift device without utilizing 2 staff persons and she had asked NA #5 about the transfer. She stated NA #5 told her she was aware of what the policy was but there was no one available to assist her when she needed to transfer Resident #87 so she transferred her without assistance. The Administrator also stated that the resident care guide clearly indicated she was to have the assistance of 2 staff persons when being transferred via the lift device. She also remarked that if NA #5 needed assistance there were administrative nurses available to assist her and all she needed to do was ask for help	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312		12/24/14

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F 312	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff and resident interviews, the facility failed to provide thorough personal hygiene care for 2 of 3 sampled residents (Resident #124 and Resident #133) whose care was observed. Findings included: 1. Resident #124 was admitted to the facility on 07/09/14 with cumulative diagnoses of Multiple Sclerosis (MS), muscle weakness and congestive heart failure (CHF). Resident #124's Quarterly Minimum Data Set (MDS) dated 09/25/14 showed Resident #124 needed the extensive assistance of one person for hygiene and toileting. In an observation on 12/03/14 at 11:35 AM resident #124 was lying in bed. Two Nursing Assistants (NA #1 and NA #2) entered the room to provide incontinent care. The aides positioned Resident #124 onto her right side. The brief was removed and stool was wiped from Resident #124's buttocks with wipes using a front to back motion by NA #2. Resident #124 was then rolled to the left side and NA # 1 used wipes to remove more stool from Resident #124's buttocks. Resident #124 was repositioned and a clean brief was placed on Resident #124 and taped in place. The aides were asked to check Resident #124's perineal area for stool. NA #2 used a wipe in a front to back motion to cleanse Resident #124's perineal area. When the wipe was placed in the trash, stool was seen on the wipe. In an interview on 12/03/14 at 2:40 PM, NA #1 stated she had recently been through orientation at the facility. She indicated when cleansing a	F 312	F312 1) Resident #124 was provided a second, thorough incontinent care by NA#1 and #2 which was observed by the Staff Facilitator. NA#1 and #2 received re-education by the Staff Facilitator on 12/3/14 on thorough perineal care after each incontinent episode on 12/3/14. Resident #133 was offered a shower on 12/3/14 by NA#1 and refused. The resident was offered and further refused additional incontinent care on 12/3/2014. 2) 100% of nursing staff were re-educated on thorough incontinent care by the Staff Facilitator to include washing the area with soap and water if resident has stool, rinsing the resident after bathing with regular soap and providing timely incontinence care. This was initiated on 12/3/14 to include NA #1 and NA #2. A 100% return demonstration on proper technique for incontinent care was initiated on 12/3/14 and proper technique for bathing was initiated on 12/16/14 for all Nursing Assistants by the Assistant Director of Nursing, the Staff Facilitator, and shift Supervisor utilizing a Resident Care Audit. NAs were immediately retrained by the Assistant Director of Nursing, the Staff Facilitator, and shift Supervisor for all identified areas of concern. All newly hired staff will receive the education regarding thorough incontinent care and bathing to include washing the area with soap and water if	

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F 312	Continued From page 4 resident who had stool she should remove the stool with wipes and then wash the area with soap and water. She stated if the resident was female the perineal area should be opened and washed to remove any stool that may be there. NA #1 indicated if this step was not done the resident could get a urinary tract infection (UTI) or irritation. She stated when the brief was removed and Resident #124's perineal area was cleansed there had been stool present on the wipe. In an interview on 12/03/14 at 2:52 PM, NA #2 indicated when incontinent care was provided the perineal area should be cleansed first to remove any stool that may be there. She stated the resident should then be turned and the buttocks cleansed. NA #2 indicated when Resident #124's perineal area was cleansed, stool was noted on the wipe. She stated if stool was left in the perineal area it could cause the resident to get an infection. In an interview on 12/04/14 at 11:09 AM Staff Development Coordinator stated when incontinent care was provided she expected the aides to follow the procedure which was taught during orientation. This included using soap and water to cleanse the area after wiping stool off with wipes. It was also her expectation that the aides clean the perineal area to remove any stool that may be there. She indicated not removing stool from the perineal area could cause a UTI. 2. A review of the quarterly Minimum Data Set (MDS) Assessment dated 11/04/2014 revealed that Resident #133 was admitted to the facility on 10/21/13 with diagnoses of hypertension, dementia, and seizure disorder. The same assessment indicated the resident required	F 312	resident has stool, rinsing the resident after bathing with soap that is not a no-rinse soap, and providing timely incontinence care during orientation by the Staff Facilitator. 3) Peri-care and bathing audits will be conducted to ensure staff are washing the area with soap and water if resident has stool, rinsing the resident after bathing with regular soap and providing timely incontinence care for 2 residents each shift daily x 2 weeks by the Assistant Director of Nursing, the RN Supervisor, and the Staff Facilitator, then 5 days weekly for 2 weeks, then twice weekly x 2 weeks, then weekly x 2, then monthly x 1. These audits will be completed utilizing an incontinent care audit tool, will include resident #124 and resident # 133, and will include nights and weekends. The Director of Nursing will review results of the incontinent care audit tools to identify and re-education needs. 4) The Director of Nursing will present the results of the resident care audit to the Executive Quality Assurance Committee monthly x 3 for trends and the need for continued monitoring.	

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F 312	Continued From page 5 extensive assistance with 2 staff members for bathing, personal hygiene, and toileting, and that the resident was always incontinent of bladder and bowel, and was not on a bladder or bowel training regimen. In addition, the MDS assessment revealed the resident rejected care 1 to 3 days during a 7 day period. The Nursing Care Plan which was last updated in September 2014 included interventions to address the resident's urinary incontinence related to cognitive impairment such as encouraging fluid intake, encouraging the resident to call for assistance if needed for toileting, monitoring for urinary tract infections such as frequency, urgency, malaise, foul smelling urine, and providing perineal care after each incontinent episode. During the first observation on 12/01/2014 at 1:07 PM, Resident #133 was lying on his right side on the bed, fully clothed, and the lunch tray was sitting uneaten on his bedside table. A strong odor of urine was noted. In the second observation on 12/02/2014 at 10:30 AM, Resident #133 was alert and sitting in his wheelchair in his room with the strong odor of urine noted. Wetness was also observed along the front area of his pants between his legs. During the third observation on 12/03/14 at 9:20 AM, Resident #133 was sitting on the bedside eating breakfast, and there was a very strong odor of urine noted. During the final observation on 12/03/2014 at 10:50 AM, the odor of urine was still very strong as the resident was sitting in his wheelchair in his	F 312		

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F 312	Continued From page 6 room. An observation of incontinent care and bathing for the resident was made on 12/03/2014 at 11:35 AM as the resident was seated in his wheelchair. Upon entry to Resident #133's room, the strong odor of urine remained present. Nursing Assistant (NA) #1 was assisted by NA #2 and gathered supplies, washed their hands, and donned clean disposable gloves. NA #1 drew a basin of warm water, then added soap to the water and encouraged the resident to participate in the bathing activity. The resident complied and washed his own face. NA #1 then washed the resident's chest, back, and under his arms with warm, soapy water using a washcloth and dried the washed area with a towel. NA #2 applied lotion to the areas where Resident #133 had been bathed and also stated the soap used for the resident was not a "no-rinse soap." NA #1 then emptied the basin of water and drew another basin full of warm water. NA #1 assisted the resident to a standing position and then removed the resident's disposable brief which was malodorous, saturated with urine and soft stool. As NA #1 cleaned the stool, she used multiple disposable wipes, dipped them in the basin of water, and wiped the stool from back to front. NA #1 used more disposable wipes to clean the scrotal area and then the penis. NA #1 disposed of the wipes and then used a washcloth to finishing bathing the resident's scrotal and rectal area. As the resident was standing, some stool was visible on the towel which was on the seat of the wheelchair. After the resident received the incontinent care, he was assisted to sitting position in the wheelchair, on top of the towel which had some stool visible on it. NA #1 emptied the basin of soapy water and drew a third	F 312		

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F 312	Continued From page 7 basin of warm water, adding soap again to the water while NA #2 got a clean towel, assisted the resident to a standing position again, then replaced the soiled towel in the seat of the wheelchair with the clean towel. NA #1 then noted more stool around the rectal area and continued to use a washcloth to finish cleaning the stool. In an interview with NA #1 after the observation on 12/03/2014 at 12:00 PM, she stated that the resident had at times refused incontinent care and bathing. She explained that the resident would respond to her request to provide incontinent care by saying, "A man has to do for himself." In addition, she stated she did not rinse off the soap during his bath and that she probably should have done so. NA #1 stated that she routinely provided incontinent care for her residents after breakfast, before lunch, and before leaving her 7:00 to 3:00 PM shift. She added that she had not provided incontinent care for Resident #133 on the morning of 12/03/2014 before breakfast, and that she had waited until 11:35 AM to provide incontinent care that day. An interview was conducted with the Director of Nursing (DON) and the Minimum Data Set (MDS) Nurse on 12/03/2014 at 12:20 PM. During the interview, the DON stated there were no set times for providing incontinent care or bathing. The MDS Nurse stated that it was the facility's expectation that day shift NAs provide incontinent care for their assigned residents at the beginning of their shifts before breakfast, after breakfast, before lunch, and after lunch. The MDS nurse also added that it would be his expectation that a resident be cleaned of incontinence prior to breakfast. The DON stated that it was her	F 312		

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F 312	Continued From page 8 expectation that regular soap should be rinsed off the resident. In addition, the DON stated that it was her expectation that all residents, both male and female, be wiped from front to back, and added that Resident #133 had a history of a UTI. The DON also stated that the facility was aware of the chronic foul odor of urine in the resident's room. She added that there were times when the resident had rejected care. During an interview with the DON and the MDS, on 12/03/14 at 12:20 PM, the MDS nurse and the DON provided in-service education for two nursing assistants which included the following: 1) When providing incontinent care, always wipe from front to back, including male residents, as males are as capable of getting urinary tract infections from improper care as female resident, 2) When cleaning residents during incontinent care, it is the expectation that regular soap be rinsed off unless using a no-rinse soap, 3) If a resident has an incontinent episode while sitting up in a chair, it is the expectation that the chair be cleansed thoroughly and sanitized prior to placing the resident back in the chair, and 4) The nursing assistant must notify the nurse when a resident refuses a bath/shower and document in the plan of care, and the nurse must document the refusal in the electronic chart and notify the responsible party and document. The MDS nurse provided a copy of the basic perineal care guidelines from the Nursing Procedure Manual, version dated April 2013. He stated that it was the expectation that all residents, male and female, be wiped from front to back, even though the procedure was not described in detail on the policy. He added that wiping from front to back was based upon good nursing practice.	F 312		

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F 315	Continued From page 9	F 315		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff and resident interviews, the facility failed to assess 1 of 1 residents (Resident #133) for a toileting program. Findings included: A review of the quarterly Minimum Data Set (MDS) Assessment dated 11/04/2014 revealed that Resident #133 was admitted to the facility on 10/21/13 with diagnoses which included hypertension, dementia, and seizure disorder. The same assessment indicated the resident required extensive assistance with 2 staff members for bathing, personal hygiene, and toileting, and that the resident was always incontinent of bladder and bowel, and was not on a bladder or bowel training regimen. In addition, the MDS assessment revealed the resident rejected care 1 to 3 days during a 7 day period. The Nursing Care Plan which was last updated in September 2014 included interventions to address the resident's urinary incontinence	F 315	F315 1) Resident #133 was evaluated by the Restorative Nurse on 12/3/14 and a Restorative Toileting Program was initiated on 12/3/14 for scheduled toileting. 2) All residents have the potential to be affected. A 100% audit was completed by the MDS nurses x 2 on 12/17/14 utilizing the most recent MDS assessment of all residents to determine residents that have had a decline in continence. The Restorative Nurse evaluated and completed a restorative nursing program for those residents with decline in continence on 12/17/14. A monitoring tool was developed by the former Staff Development Coordinator (MDS nurse) on 12/16/14 to review MDS assessments for a decline in the residentsl urinary continence and submit referrals to the Restorative Nurse for a restorative	12/24/14

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F 315	Continued From page 10 related to cognitive impairment such as encouraging fluid intake, encouraging the resident to call for assistance if needed for toileting, monitoring for urinary tract infections such as frequency, urgency, malaise, foul smelling urine, and providing perineal care after each incontinent episode. The care plan also included a focus for the problem of resistance to care related to cognitive impairment (will not allow staff to cut nails or to be shaven.) One of the interventions related to this problem was, "If resident refuses care, leave and return in 5-10 minutes." In addition, the care plan stated goals that the resident would be clean, neat, and odor free with regards to bathing and personal hygiene. Interventions for this goal were to provided assistance and supervision with bathing, hygiene, and grooming. There were no interventions in place for a toileting progran for the resident. A review of the documentation on the daily intervention sheets for the month of November 2014 revealed the resident was independent with toilet use on day shift (7:00 AM to 3:00 PM) on 11/07/2014, 11/10/2014, 11/12/2014, 11/14/2014, 11/26/2014, 11/28/2014, and on evening shift (3:00 PM to 11:00 PM) on 11/04/2014, 11/10/2014, 11/14/2014, and 11/17/2014. In addition, the resident was independent for toilet use on the night shift (11:00 PM to 7:00 AM) on 11/09/2014 and 11/23/2014. Also, the personal hygiene activity did not occur at all on day shifts on 11/04/2014, 11/11/2014, 11/17/2014, and 11/28/2014, or on night shift 23 out of 30 days of November 2014. During an observation on 12/01/2014 at 1:07 PM, Resident #133 was lying on his right side on the	F 315	toileting program. Monitoring will follow the MDS assessment schedule. 3) Monitoring of the scheduled resident assessments will occur weekly x 4 weeks by the MDS nurses x2 to determine a decline in urinary status. Then monitoring will occur biweekly x 2, then monthly x 1. The Director of Nursing will review the monitoring tools weekly to assure residents with decline in urinary continence have been referred to the Restorative Program. 4) The Director of Nursing will present the results of the monitoring to the Executive Quality Assurance Committee meeting monthly x 3 for trends and the need for continued monitoring.	

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	345335	A. BUILDING ______ B. WING ______	12/04/2014

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F 315	Continued From page 11	F 315		

bed, fully clothed, and the lunch tray was sitting uneaten on his bedside table. A strong odor of urine was noted.

In the second observation on 12/02/2014 at 10:30 AM, Resident #133 was alert and sitting in his wheelchair in his room. The strong odor of urine noted and wetness was also observed along the front area of his pants between his legs.

During the third observation on 12/03/14 at 9:20 AM, Resident #133 was sitting on the bedside eating breakfast, and there was a very strong odor of urine noted.

During an observation and an interview with Resident #133 on 12/02/2014 at 10:30 AM, there was a strong odor of urine. The resident stated that he would go to the toilet whenever he felt he needed to go. He also stated that sometimes he might just forget to toilet himself and the nursing assistants would have to clean him up. He stated that he could do some things, such as using the toilet, for himself.

In an interview with NA #1 on 12/03/2014 at 12:00 PM, she explained that the resident would respond to her request to provide care by stating, "A man has to do for himself." She added that sometimes, the resident would independently go the toilet in his room without asking for assistance.

An interview was conducted with the Director of Nursing (DON) and the Minimum Data Set (MDS) Nurse on 12/03/2014 at 12:20 PM. The DON stated the facility was well-aware of the odor of urine and incontinence issues with the resident, and that the facility had tried many different

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F 315	Continued From page 12 interventions to improve the odor and incontinence problems. During the interview the MDS Nurse stated the resident would be a good candidate for a toileting program, as there were times when he had been toileting himself. He explained the process for initiating a toileting program involved making a referral to the restorative nursing department, who would then evaluate the resident for the toileting program. On 12/03/2014 at 2:00 PM, the MDS nurse stated that he had initiated a nursing care plan intervention for restorative nursing to evaluate Resident #133 for the toileting program. A copy of the addition to the nursing care plan was provided with the following update under the focus for urinary incontinence: 1) Restorative Scheduled Toileting Program: Toilet before meals, after meals, every night at bedtime, and as needed. 2) If resident does not participate in Restorative Scheduled Toileting Program, document reason. In an interview with NA #2 on 12/04/2014 at 11:35 AM, she stated that a nursing assistant or nurse could recommend a resident for the toileting program if they felt the resident might be able to follow a toileting routine.	F 315		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		12/24/14

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F 323	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to ensure that a resident who was assessed as needing a 2 person transfer when using a mechanical lift device (Resident #87) was transferred utilizing 2 staff members when being observed. Findings included: The purpose of the facility's Safe Resident Handling & Movement Policy, last revised 08/22/14, was to ensure that residents were cared for safely. The POLICY noted that "Staff will follow the movement and handling safety interventions/procedures for each resident as individually determined through the admission/re-entry admission process and the RAI process." The DISCIPLINE section of this policy noted that "All employees are required to follow the movement and handling interventions and procedures for each individual resident as specified on their Resident Care Guide in the resident's room. " Resident #87 was re-admitted to the facility on 11/11/14. Cumulative diagnoses included depression, reflux, psychosis, anxiety, and dementia. According to the electronic chart, Resident #87's resident care guide indicated she required 2 staff persons when using the mechanical life device. The Annual Minimum Data Set (MDS) assessment of 03/03/14 noted that Resident #87 needed extensive assistance with transfers. The	F 323	F323 1) NA #5 is no longer employed at the facility. Resident #87 will continue to receive a 2 person mechanical lift transfer per the Resident Care guide. 2) 100% of nursing staff re-education on the facility Safe Movement Policy was initiated on 12/3/14 by the Staff Facilitator to include reading the resident care guide prior to all transfers. A return demonstration by all nursing staff was completed by the Assistant Director of Nursing, the Staff Facilitator, and 7AM I 3PM RN Supervisor beginning 12/3/14 to assure the Nursing Assistants were performing transfers per the Resident Care guide. A QI Resident Care Audit Tool for transfer observations was utilized for monitoring. Staff was retrained by the Assistant Director of Nursing, Staff Facilitator, or RN Supervisor for all identified areas of concern. All newly hired staff will receive the education in orientation on Safe Handling and Movement Policy to include reading the resident care guide prior to all transfers by the Staff Facilitator. 3) Monitoring of resident transfers will be completed for 2 residents each shift daily x 2 weeks by the Assistant Director of Nursing, Staff Facilitator, and RN Supervisor, then each shift 5 times a week x 2 weeks, then twice weekly x 2 weeks, then weekly x 2 weeks, then once	

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F 323	Continued From page 14 Care Area Assessment (CAA) summary indicated she triggered for falls but it was not to be addressed in her care plan. The most recent Quarterly MDS of 10/11/14 noted she required total assistance from staff for transfers. An interdisciplinary care plan progress note of 11/21/14 noted that a mechanical lift device was to be used for functional transfers for Resident #87. Resident #87's most current care plan, dated 12/02/14, indicated that she required assistance with transferring from one position to another related to cognitive deficit, physical limitations and a fracture of the right femur. Transfer with a mechanical lift device utilizing 2 persons for constant supervision and physical assist was included in the interventions. Resident #87 was observed sitting in a wheelchair in her room on 12/03/14 at 2:00 PM. During an observation of care for Resident #87 on 12/03/14 at 2:10 PM, Nurse Aide #5 (NA #5) rolled a mechanical lift device into the resident's room and began to prepare her for transfer to the bed. Resdient #87 was sitting in her wheelchair. She placed the green lift sling pad behind Resident #87 but was unable to slide the pad totally underneath her buttocks. She manipulated the pad several times in an effort to place it correctly but still was not able to position it underneath her buttocks so she overlapped the end pieces of the pad and placed them underneath her legs. She then attached the ends of the sling pad to the lift device bar. As she	F 323	weekly x 2 weeks, then monthly x 1 utilizing a resident transfer audit tool. Resident #87 will be included in the audit. All staff will be immediately retrained for any identified areas of concern by the Assistant Director of Nursing, Staff Facilitator, and RN Supervisor. The Director of Nursing will initial and review the results of the resident transfer audit tool weekly and evaluate the need for additional staff education. 4) The Director of Nursing will present the results of the monitoring to the Executive Quality Assurance Committee Meetings x 3 months for trends and the need for continued monitoring.	

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F 323	Continued From page 15 began to lift Resident #87, she commented that the pad needed to be adjusted so she lowered her back onto the seat of the wheelchair. She attempted to reposition the pad once again and began lifting her from the wheelchair. As she lifted Resident #87, it was noted that her entire buttocks area was hanging out of the pad. She continued to move her over to the bed and lowered her onto the bed. She removed the green sling pad and began to provide personal care. During an interview on 12/03/14 at 3:00 PM with the former staff development coordinator (MDS nurse), it was reported that the facility's policy for transferring residents with a mechanical lift device was based on the premise that residents were transferred according to their assessments and per the resident care guide. He stated Resident #87 was assessed as a 2 person transfer. Staff were expected to have 2 staff members when using the lift to transfer her. An interview was attempted with NA #5 but she had left the building and was not available for interview according to the Administrator at 3:30 PM on 12/03/14. The Administrator also reported that she had been made aware of the use of the mechanical lift device without utilizing 2 staff persons and she had asked NA #5 about the transfer. She stated NA #5 told her she was aware of what the policy was but there was no one available to assist her when she needed to transfer Resident #87 so she transferred her without assistance. The Administrator also stated that the resident care guide clearly indicated she was to have the assistance of 2 staff persons when being transferred via the lift device. She also remarked that if NA #5 needed assistance	F 323		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 323	Continued From page 16 there were administrative nurses available to assist her and all she needed to do was ask for help.	F 323		