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	345044	A. BUILDING _____ B. WING _____	C 06/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOSEPH OF THE PINES HEALTH	103 GOSSMAN DRIVE SOUTHERN PINES, NC 28387

(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 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview and record review the facility failed to offer showers to 3 of 3 residents (Resident #348, #337 and #347). The findings included: 1. Resident #348 was admitted 5/22/16 for rehabilitation therapy post a left knee arthroplasty. The Admission Minimum Data Set was not due at the time of the survey. Review of the Hospital Discharge Summary dated 5/22/16 and Admission Orders dated 5/22/16 revealed there were no shower restrictions listed. Review of the Care Plan dated 5/31/16 revealed Resident #348 required assistance with activities of daily living and transfers. There were no shower restrictions indicated. Review of the Shower Schedule for the 150 Hall where Resident #348 ' s room was revealed all rooms on the hall were included on the schedule except for her room. Resident #348 was in room 162B and both 162B and 162A were excluded from the shower schedule. All other rooms on the hall were listed to showers two times a week. The Shower Schedule also indicated " Showers may not apply to all residents D/T (due to) incisions - verify with nurse (complete bed bath if shower restricted). "	F 242	1. Resident #348, #337 and #347 were offered and given showers. Room 162 A & B were added to the shower schedule and NA#6 has been educated on where to find the shower schedule posted. 2. An audit of all residents, to determine if showers have been offered, was completed by nurse supervisor by 6/24. 3. All staff have been re-educated regarding culture change and offering showers to all residents, as well as where to find the shower schedule. 4. Nurse supervisor or designee will audit the schedule weekly and report findings to the DON who will report to QAPI for six months.	6/27/16

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

Electronically Signed | 06/27/2016

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F 242	Continued From page 1 Resident # 348 was interviewed on 6/1/16 at 10:30 AM and was alert and oriented. She stated that she had not been offered a shower since being admitted to the facility and had only been doing bed baths on her own. She stated she would love to have a shower and that she particularly wanted one before being discharged on 6/3/16. Review of the Activities of Daily living task/flow sheet for Resident #348 from 5/22/16 - 6/2/6 revealed that Nursing Assistant #6 was documenting that Resident #348 had a shower each day that NA #6 worked with her since admission (May 24, 25, 28, 29, 30). All other days had been documented as a bed bath or sponge bath. On 6/2/16 at 11:23 AM interview with Nurse #3 revealed that she did not think NA #6 had given Resident #348 a shower each day NA #6 worked with Resident #348 and she thought that NA #6 might have been incorrectly documenting the bathing task. In addition Nurse #3 had not been aware that room 162 was missing from the shower list. She also indicated that some residents did have shower restrictions but she could not see any restrictions for Resident #348 according to the orders. However she said that Occupational Therapy needed to do the first shower with each resident and that was why Resident #348 has not yet been offered a shower by nursing staff. On 6/3/16 at 10:38 AM NA #6 was interviewed she stated that she had not given Resident#348 a shower but thought she had documented Bed Bath correctly - she said that when she reviewed the printed documentation, at this time, she could see that she had documented it incorrectly. She also added that she did not know there was a	F 242		

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F 242	Continued From page 2	F 242		

shower schedule.

On 6/3/16 at 10:46 AM the Rehabilitation Manager and an Occupational Therapist #1 (OT #1) that worked with Resident #348 were interviewed. The Rehabilitation Manager stated that Therapy was not responsible for the first shower for the residents they treated like Resident #348. He also indicated there were no shower restrictions that he was aware of for Resident #348. OT #1 stated that she had worked with Resident #348 a couple of times and that none of the resident ' s OT sessions had included a shower since the time of the resident ' s admission.

2. Resident #337 was admitted 4/26/16 for orthopedic aftercare and had diagnoses including spinal stenosis. The Admission Minimum Data Set dated 5/3/16 indicated the resident was cognitively intact and totally dependent for bathing.

Review of the Hospital Discharge Summary dated 4/26/16 and Admission Orders dated 4/26/16 reveled there were no shower restrictions listed.

Review of the Care Plan dated 5/9/16 indicated Resident #337 required assistance of one person for bathing/showering. It also indicated the resident required a mechanical lift for transfers

Review of the Shower Schedule for the 150 Hall where Resident #337 ' s room was revealed resident #337 was to be offered a shower each Wednesday and Saturday between 6:00 AM and 6:00 PM. The Shower Schedule also indicated " Showers may not apply to all residents D/T (due to) incisions - verify with nurse (complete bed

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F 242	Continued From page 3 bath if shower restricted). " Review of the Activities of Daily living task/flow sheet for Resident #337 from 4/26/16 - 6/2/6 revealed that Nursing Assistant #6 was documenting that Resident #337 had a shower each day that NA #6 worked with him since admission (April 30, May 1, 2, 14, 15, 16, 20, 24, 25, 28, 29, 30). All other days had been documented as a bed bath or sponge bath. On 5/31/16 at 4:58 PM resident #337 was interviewed. He stated he had not been offered any showers during his stay at the facility until yesterday (5/30/16). He added that at home he took showers daily and that the " spit baths " he had been taking at the facility " only moved the dirty water around " . On 6/2/16 at 11:23 AM interview with Nurse #3 revealed that she did not think NA #6 had given Resident #337 a shower each day NA #6 worked with Resident #337 and she thought that NA #6 might have been incorrectly documenting the bathing task. She also indicated that some residents did have shower restrictions but she could not see any restrictions for Resident #337 according to the orders. However she said that Occupational Therapy needed to do the first shower with each resident and that was why Resident #337 has not yet been offered a shower by nursing staff. On 6/3/16 at 10:35 AM Nurse #3 stated in interview that Resident #337 required a mechanical transfer until 5/23/16 at which time he transitioned to a two person transfer. She indicated the requirement for a mechanical lift was the reason Resident #337 had not received a shower until recently. She acknowledged that the facility did have a stretcher for showers on another floor of the facility.	F 242		

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F 242	Continued From page 4	F 242		

On 6/3/16 at 10:38 AM NA #6 was interviewed she stated that she had not given Resident#337 a shower until 5/30/16 and all the previous shower documentation entries were incorrect. She added that she thought she had documented Bed Bath correctly - but said that when she reviewed the printed documentation she could see that she had documented it incorrectly. She also added that she did not know there was a shower schedule. In addition NA #6 indicated that she could get the shower stretched from the shower room upstairs in the facility in order to provide showers to residents on 150 hall that required a mechanical lift.

On 6/3/16 at 10:46 AM the Rehabilitation Manager and an Occupational Therapy Assistant #1 (OTA #1) that worked with Resident #337 were interviewed. The Rehabilitation Manager stated that Therapy was not responsible for the first shower for the residents they treated like Resident #337. He also indicated there were no shower restrictions that he was aware of for Resident #337. OTA #1 stated that she had worked with Resident #337 a couple of times and the first shower he had with Occupational Therapy was on 6/2/16.

3. Resident #347 was admitted 5/24/16 for rehabilitation therapy with diagnoses including hypertension, chronic kidney disease and history of falling. The Admission Minimum Data Set was not due at the time of the survey.

Review of the Admission Orders dated 5/24/16 reveled there were no shower restrictions listed.

Review of the Care Plan dated 5/31/16 indicated

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F 242	Continued From page 5	F 242		

Resident #347 required assistance of one person for showers.

Review of the shower schedule for when the resident was in bed 103A (on 100 hall) was that he should have had a shower on each Saturday and Wednesday. There had been two opportunities for the resident to receive a shower between the admission date of 5/24/16 and the date of the initial interview on 5/31/16. The resident was moved to a different room on 6/1/16. The room change resulted in a change in the resident ' s assigned shower days. The new shower days for the new room were Sunday and Thursday evening.
Review of the Activities of Daily living task/flow sheet for Resident #347 from 5/24/16 - 6/2/6 revealed that there was no documentation of showers or bed baths for Resident #37 during that time period.
During interview with Resident #347 on 5/31/16 at 4:43 PM he was alert and oriented and stated that he had taken a " bird bath ' while in the facility but had not been offered a shower. He added that he would have liked to have a shower at least once a week.
On 6/3/16 at 9:45 AM Nursing Assistant #7 and Nurse #4 were interviewed and indicated resident #347 should have been offered showers twice between 5/31/16 and should have been offered one the previous evening on 6/2/16 as well.
On 6/3/16 at 10:00 AM Resident #347 was interviewed and stated he had received a jaccuzi tub bath the night before. He stated that this was the first tub bath/or shower he had received while in the facility. He also said that he was not offered a shower instead of a tub bath but was satisfied with the tub bath. Resident #347 stated that a staff member had told the Nursing

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F 242	Continued From page 6 Assistant that helped him with the bath that the in room showers were no longer being used. Resident #347 said he was not told what days were his scheduled shower days. On 6/3/16 at 10:46 AM the Rehabilitation Manager and an Occupational Therapy Assistant #2 (OTA #1) that worked with Resident #347 were interviewed. The Rehabilitation Manager stated that Therapy was not responsible for the first shower for the residents they treated like Resident #347. He also indicated there were no shower restrictions that he was aware of for Resident #347. OTA #2 stated that she had worked with Resident #347 and they had worked on sponge baths and dressing in Occupational Therapy but not showers.	F 242		
F 252 SS=D	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and resident interview, the facility failed to provide an environment without persistent odor in one of six resident rooms (room #804) observed on 800 hall. Findings included: On 06/01/2016 at 9:14 AM, a urine odor was noted while talking with Resident #114 in room #804. When Resident #114 was asked if the	F 252	1. The chair was removed from the resident□s room prior to exit. 2. All residents' rooms that are independent for toileting were checked for odor, including furniture. On 6-9-16, every room in the facility was checked for odor by 2 admissions nurses, 1 RN and one LPN. 3. All of the staff doing direct patient	6/27/16

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F 252	Continued From page 7 building was clean, she said, " Yes " , and added that they are very particular. On 6/1/2016 at 3:29 PM, Resident #114 was just waking up. A urine odor was smelled in her room. On 6/2/2016 at ~ 2:30 PM, the resident was not in her room. The bed was made and had a homemade afghan folded on the end of the bed. A towel was laying on the end of the bed. A urine odor was present in the room. Nurse Aide (NA) #1 was interviewed and said Resident #114 goes to the bathroom on her own. There was not an odor in the bathroom. NA #1 said she would strip the bed and was observed to follow through. A used wash cloth was found in the resident ' s closet. On 6/3/2016 at 9:15 AM an odor was smelled in the room. On 6/3/2016 at 9:25 AM the resident and the room was observed with the Director of Nurses (DON). Two towels were observed in the resident's room, one on the chair and one on bed. The DON said the chair had a strong urine odor. On 6/3/2016 at 10:30 AM interview with the Administrator revealed arrangements had been made for the chair to be changed out.	F 252	care, RN's, LPN's, CNA's, on all shifts including the evening, nights, and weekends and PRN as well have been in serviced by the Staff Development/Infection Control Nurse on proper grooming for residents and reporting any issues with odor to nurse supervisor. This was completed on 6-9-16 and again on 6-20-16. 4. Audits of odors in rooms will include 1 room on each unit for a total of 7 rooms each week. Grooming audits also include in checking for odors. Housekeeping supervisor will round weekly and check for odor in rooms. He will report findings to QAPI for six months	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate	F 278		6/27/16

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F 278	Continued From page 8 each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to accurately code the Minimum Data (MDS) assessment on Preadmission Screening and Resident Review (PASRR) for 2 (Residents #165 & #355) of 3 sampled residents reviewed for PASRR. Findings included: 1. Resident #165 was admitted to the facility on 5/3/16 with multiple diagnoses including Bipolar Disorder. The admission MDS assessment dated 5/10/16	F 278	1. The MDS Coordinator corrected the assessment for residents #165 & #355 the PASSR II on 6-3-16. 2. An audit of all Level II PASRR by Medicare Case Manager was completed 6 -3-16 and 6-6-16 and were found to be coded correctly on the MDS assessment. 3. The Director of Nursing re-educated all 4 MDS Coordinators on process of including PASSR II's on MDS assessment on 6-3-16. All 4 MDS Coordinators were RN's that would be responsible for this	

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F 278	Continued From page 9 indicated that Resident #165 was not evaluated by level II PASRR and determined to have serious illness and or mental retardation or a related condition. The PASRR form for Resident #165 was reviewed. The form indicated that Resident #165 was evaluated as PASRR level II with #XXXXXXXXXX F (30-60 day limited stay) and would expire on 8/2/16. On 6/2/16 at 4:40 PM, MDS Nurse #2 was interviewed. MDS Nurse #2 stated that she was aware that Resident #165 was a level II PASRR but missed to code it correctly on the MDS. She added that she would correct the MDS to reflect the level II PASRR. On 6/3/16 at 11:05 AM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the MDS Nurse to code the MDS assessment accurately. 2. Resident # 355 was admitted to the facility on 5/19/16 with multiple diagnoses including Post Traumatic Stress Disorder. The admission MDS assessment dated 5/26/16 indicated that Resident #355 was not evaluated by level II PASRR and determined to have serious illness and or mental retardation or a related condition. The PASRR form for Resident #355 was reviewed. The form indicated that Resident #355 was evaluated as PASRR level II with	F 278	assessment and coding. A systemic change was discussed on 6-3-16 with the Admission Coordinator to notify all MDS Coordinators and the Director of Nursing of any PASRR II's being admitted so these will be placed on the audit sheet and audited by the 4. Assistant Director of Nursing will audit Level II PASRR's every 2 weeks and report the findings of the audit to QAPI for at least 6 months.	

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F 278	Continued From page 10 #XXXXXXXXXX F (30-60 day limited stay) and would expire on 8/16/16. On 6/2/16 at 5:20 PM, MDS Nurse #2 was interviewed. MDS Nurse #2 stated that she was aware that Resident #355 was a level II PASRR but missed to code it correctly on the MDS. She added that she would correct the MDS to reflect the level II PASRR. On 6/3/16 at 11:05 AM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the MDS Nurse to code the MDS assessment accurately.	F 278		
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 record review, observation and staff interview, the facility failed to follow the care plan for 1 (Resident # 37) of 1 sampled resident observed during transfer using a mechanical lift. Finding included: Resident #37 was admitted to the facility on 4/6/05 and was re-admitted on 3/15/16 with multiple diagnoses including Alzheimer's disease and Morbid Obesity. The significant change in status Minimum Data Set (MDS) assessment dated 3/22/16 indicated that Resident #37 had memory and decision making problems and	F 282	1. NA#4 was corrected and educated by Director of Nursing prior to survey exit on 6-3-16. 2. All residents with change of status for transfers were audited by each MDS Coordinator and completed on 6-20-16 to assure that staff is following updated care plan. The care plans are updated. 3. The Staff Development nurse re-educated all the nurse aides, that work each shift including days, evenings, nights, weekends and PRN. All nurse aides were re-educated on reading care	6/27/16

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F 282	Continued From page 11 needed extensive with 2 person assist with transfers. The assessment also indicated that the resident was not steady during transfer between bed and chair or wheelchair, she was only able to stabilize with human assistance. The care area assessments (CAAs) for Resident #37 dated 3/22/16 indicated that the resident had significantly declined in mental and functional status since return from recent hospitalization. The assessment indicated that the resident needed a Hoyer lift with transfers with 2 person assist. The care plan dated 3/16/16 was reviewed. The care plan for activities of daily living (ADL) had a goal to adhere to the ADL record and the approaches included to transfer with 2 persons using a Hoyer lift. On 5/31/16 at 2:15 PM, Resident #37 was observed during transfer using a mechanical lift. NA #1 was using a sit to stand lift instead of a Hoyer lift to transfer Resident #37 from the wheelchair to the bed by herself. On 5/31/16 at 2:30 PM, NA #4 was interviewed. NA #4 stated that she was assigned to Resident #37 and this hall was not her normal assignment. She indicated that the resident had been using a sit to stand lift with 1 person assist. She added that the resident was not able to sit up without help. On 6/3/16 at 11:05 AM, the Director of Nursing (DON) was interviewed. The DON indicated that she expected the NA to follow the care plan for transfers by using a Hoyer lift for Resident #37.	F 282	plans and follow care plans for accurate transfer of residents by 6-9-16 and again on 6-20-16 by the staff development nurse. All were re-educated starting 5-27-16 as we noted a this area needed to be reviewed again. 4. Staff development will randomly observe at least 7 NA□s per week to include different shifts and the weekends to assure care plan being followed and report results of audit to QAPI for six months.	
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS	F 311		6/27/16

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ST JOSEPH OF THE PINES HEALTH	103 GOSSMAN DRIVE SOUTHERN PINES, NC 28387

(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 311	Continued From page 12 A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview and record review, the facility failed to provide supervision and assistance in the form of oversight, encouragement or cuing with personal cleanliness to maintain good hygiene for 1 of 4 sampled residents reviewed for urinary incontinence (Resident #114). Findings included: According to the medical record, Resident #114 had diagnoses including dementia without behavioral disturbance, essential hypertension, atrial fibrillation, convulsions, coagulation defect, hypo-osmolality and hyponatremia, glaucoma, hearing loss, muscle weakness, and, histories of falling, urinary tract infection, venous thrombosis and embolism. She was admitted on 8/1/2011. The annual Minimum Data Set (MDS) assessment dated 12/2/2015 indicated Resident #114 was independent with set up help for transfer and walking in room, required supervision from one personal assistant for toilet use, personal hygiene and bathing and she was interviewable. There were no rejection of care behaviors. The Care Area Assessment indicated a decision not to care plan urinary incontinence, but to address activities of daily living (ADL) in the care plan. The care plan revised on 12/15/2015 and 6/2/2016 included ADL Flow Record interventions	F 311	1. The care plan and ADL book for resident #114 were updated on 6-3-16 by the MDS Coordinator and audit was done by Director of Nursing prior to survey exit. 2. All charts for residents with continent and incontinent status were audited by 2 admission nurses, an LPN and RN for updated care plan and compliance with ADL book on 6-9-16. Each MDS Coordinator audited behind the admission nurses to ensure the care plan and ADL were corrected by 6-13-16. 3. The Staff Development Nurse re-educated all the nurse aides on every shift including mornings, evenings, nights, weekends and PRN on following the care plan on assisting residents with ADL care according to care plan on 6-9-16 and again on 6-20-16. 4. The nurse supervisor will audit at least seven care plans for residents with urinary incontinence to ensure that they match the ADL book weekly. The audit findings will be reported to QAPI for six months to ensure ongoing compliance.	

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including, " I need the assistance of one with encouragement " for bathing/showering. " I am occasional[ly] incontinent " for bladder function. " I wear pads for dignity and protection. " " I require supervision " for toilet use.

The Quarterly Review Minimum Data Set assessment dated 3/1/2016 indicated Resident #114 required supervision from one assistant for personal hygiene. For toilet use she needed supervision and set up help. She was independent with transfer and needed supervision with walking in room. For bathing she was totally dependent on one personal assistant. She was steady moving on and off a toilet, used a walker, was occasionally incontinent of bladder and was not on a toileting program. She did not exhibit rejection of care behaviors.

Resident #114 was initially observed in her room on 06/01/2016 at 9:14 AM. When she was asked, " Do you get the help you need getting dressed, toileting, and cleaning your teeth? " She said, she does it herself. A urine odor was noted while talking with the resident.

On 6/1/2016 at 3:29 PM, Resident #114 was just waking up. A urine odor was smelled. Nurse Aide (NA) #1 said we give her showers. She does for herself. She goes to the bathroom herself. She does not wear any incontinent products. She dresses herself.

On 6/2/2016 at ~ 2:30 PM, Resident #114 was not in her room. A urine odor was present. NA #1 was interviewed and said Resident #114 does not wear pull-ups. She wears panties. She goes to the bathroom on her own. NA #1 said she would strip the bed and was observed to follow

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F 311	Continued From page 14 through. On 6/02/2016 at 4:03 PM, the MDS Coordinator was interviewed. She said she uses the information nurse aides enter from the kiosk for activities of daily living. The Interventions and Tasks Documentation Survey Report for June 2016 indicated that Bathing/Showering was marked as given to Resident #114 at 8:59 AM on 6/3/16. On 6/3/2016 at 9:15 AM an odor was smelled in the room and around the resident. On 6/3/2016 at 9:25 AM the resident and the room was observed with the Director of Nursing (DON). The resident said, " I did not take a shower this morning. " Two towels were observed in resident's room, one on the chair and one on the bed. The DON said the chair had a strong urine odor. Nurse #1 said she charted that the resident had shower today. NA #2 and NA #3 said Resident #114 did not have a shower. She refused because she says " she may get pneumonia " . These aides confirmed the resident wore panties only. She did use pull ups or pads. 6/3/2016 10:17 AM observation with the MDS Nurse revealed pads were not found in room or bathroom. 6/3/2016 10:30 with the Administrator revealed it was her expectation that aides should be helping the resident. She added that the chair had been changed out.	F 311		
F 312	483.25(a)(3) ADL CARE PROVIDED FOR	F 312		6/27/16

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F 312 SS=D	Continued From page 15 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. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to transfer a resident as care planned for 1 (Resident # 37) of 1 sampled resident observed during transfer using a mechanical lift. Finding included: Resident #37 was admitted to the facility on 4/6/05 and was re-admitted on 3/15/16 with multiple diagnoses including Alzheimer's disease and Morbid Obesity. The significant change in status Minimum Data Set (MDS) assessment dated 3/22/16 indicated that Resident #37 had memory and decision making problems and needed extensive with 2 person assist with transfers. The assessment also indicated that the resident was not steady during transfer between bed and chair or wheelchair, she was only able to stabilize with human assistance. The care area assessments (CAAs) for Resident #37 dated 3/22/16 indicated that the resident had significantly declined in mental and functional status since return from recent hospitalization. The assessment indicated that the resident needed a Hoyer lift with transfers with 2 person assist. The care plan dated 3/16/16 was reviewed. The care plan for activities of daily living (ADL) had a goal to adhere to the ADL record and the	F 312	1. NA #4 educated by Director of Nursing on 6-3-16 on following the care plan and checking for updates each shift prior to survey exit. 2. All residents with change of status for transfers were audited by each MDS Coordinator to ensure that staff are following updated care plan on 6-20-16. 3. The staff development nurse re-educated all nurse aides on each shift; morning, evening, nights, weekends and PRN on how to read and follow care plan on 6-9-16 and again on 6-20-16. Education started on 5-27-16 as it was noted a need for this area to be reviewed for education. 4. Staff Development coordinator and each Clinical supervisor will randomly observe 7 NA□s per week on each unit, on each shift, and weekends for proper transfer with Hoyer lift and report findings to QAPI for six months.	

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approaches included to transfer with 2 persons using a Hoyer lift.

On 5/31/16 at 2:15 PM, Resident #37 was observed during transfer using a mechanical lift. NA #4 was using a sit to stand lift instead of a Hoyer lift to transfer Resident #37 from the wheelchair to the bed by herself. NA #4 maneuvered the lift to the bed, lowered the lift to let the resident sit at the edge of the bed. After the straps were removed from the resident, the resident was lying across the bed with her head hanging down and her legs were still on the lift. NA #4 was trying to remove the lift away from the bed but the lift was stuck under the bed. The NA was unable to hold the resident's head because she was on the other side of the bed. With the resident's head hanging down and the lift stuck under the bed, NA #4 decided to request for help. Another NA came to help and lifted resident's upper body to sitting position and instructed NA #4 to raise the bed in order to remove the lift away from the bed. After the lift was moved away from the bed, the resident was positioned in bed by the 2 nurse's aides.

On 5/31/16 at 2:30 PM, NA #4 was interviewed. NA #4 stated that she was assigned to Resident #37 and this hall was not her normal assignment. She indicated that the resident had been using a sit to stand lift with 1 person assist. She added that the resident was not able to sit up without help.

On 6/3/16 at 9:05 AM, interview with NA #5 was conducted. NA #5 was assigned to Resident #37 and was normally assigned to the hall where the resident resided. NA #5 indicated that Resident

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F 312	Continued From page 17 #37 was using a Hoyer lift with 2 person assist with transfers. She stated that the resident was unable to sit up without help. She revealed that the kardex for the resident indicated Hoyer lift with 2 person assist with transfers. NA #5 added that in the past, the resident was using a sit to stand lift but after the hospitalization in March 2016, it was changed to a Hoyer lift. On 6/3/16 at 9:08 AM, the kardex for Resident #37 was reviewed. The kardex revealed that the resident needed a Hoyer lift with 2 person assist with transfers. On 6/3/16 at 11:05 AM, the Director of Nursing (DON) was interviewed. The DON indicated that she expected the NA to follow the care plan for transfers by using the Hoyer lift for Resident #37.	F 312		