STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345264	A. BUILDING _____ B. WING _____	C 05/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLEY TOTAL LIVING CENTER	**514 OLD MOUNT HOLLY ROAD STANLEY, NC 28164**

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted 05/28/19 to 05/31/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #BVYR11.	E 000		
F 000	INITIAL COMMENTS No deficiencies cited as a result of the complaint investigation. Event ID # BVYR11.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its	F 656		6/23/19

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

Electronically Signed | 06/14/2019

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F 656	Continued From page 1 rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to implement care plan interventions for transfer assistance for 2 of 3 residents observed for transfers (Resident #73 and #61). Both required 2 persons with gait belt for transfers but were observed to be transferred from bed to wheelchair with 1 person without use of gait belt. Findings included: 1. Resident #73 was admitted to the facility on 3/29/19 with the following diagnoses: displaced femur fracture, dementia, muscle weakness and difficulty walking. Review of a document entitled "Get to Know Me" dated 3/29/19 revealed the type of transfer/staff assistance needed for transfers for Resident #73 was 2 persons with gait belt. Review of Transfer/Lift Assessment dated 3/30/19	F 656	Upon immediate awareness by the Nurse #1 at 6:41am on 5/31/19 that a nursing assistant had transferred Resident #73 and Resident #61 by herself without any assistance as noted in the care plan for each resident, the nursing assistant was terminated from employment following facility personnel and safety policies. Resident #73 and Resident #61 did not experience any adverse effects or harm related to being transferred by one staff member alone. Every Transfer/Lift Assessment was audited and compared to each resident care plan and corresponding Get To Know Me form to ensure accuracy between 6/4/19 – 6/7/19 by Nursing Managers. Any concerns noted between the three forms (assessment form, care plan, and Get To Know Me form) were corrected	

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F 656	Continued From page 2 revealed Resident #73 "meets all requirements for 1-person gait belt transfer but also has had recent hip and/or knee surgery or exhibits behavioral concerns related to care = 2-person gait belt transfer." Review of the Admission Minimum Data Set (MDS) Assessment dated 4/5/19 revealed Resident #73 was moderately cognitively impaired. Resident #73 required extensive physical assistance of two or more persons. Review of Resident #73's care plan dated 4/15/19 revealed the resident required assistance with all Activities of Daily Living (ADL) with the goal of performing ADL as independently as possible. One of the interventions listed was Resident #73 required the assistance of 2 persons with gait belt for transfers. An observation was made on 5/31/19 at 5:48 AM of Resident #73 being transferred by Nurse Aide (NA) #1 from bed to wheelchair. NA #1 had Resident #73 wrap her arms around NA #1's neck while NA #1 stood Resident #73 up while holding on to Resident #73's torso to stand and pivot to the wheelchair. NA #1 did not use a gait belt during the transfer. An interview was conducted with NA #1 on 5/31/19 at 6:15 AM. NA #1 stated she was familiar with Resident #73 and had worked with her before. NA #1 stated she usually got Resident #73 out of bed by herself. NA #1 further stated the transfer information can be found in the "Getting to Know Me" book. During the interview, NA #1 looked up the transfer information from the "Getting to Know Me" book and revealed Resident #73 required 2 persons	F 656	noting each residents' current requirement for transfer (transfer without assistance, transfer with 1 staff using gait belt, transfer with 2 staff using gait belt, or transfer with a mechanical lift) and nursing staff were made aware of any changes made via the 24 hour nurse and CNA reports as well as the communication kiosks. The Staff Development Coordinator will conduct a mandatory in-service with all nursing staff between 6/12/19 – 6/16/19 to review the following details in the current Transfer/Mechanical Lift policy: •requirements to follow the resident care plan and GTKM form as written for all transfers •facility policy and procedures for referring a resident for review of the Transfer Assessment if a resident experiences improvement or decline in status •potential safety concerns for a resident related to failure to follow the Transfer Assessment as it has been written and care planned for each resident •facility policy and procedures for failure to follow the Transfer policy for resident safety Beginning on 6/10/19, each licensed nurse assigned to each unit/hall will observe (2) resident transfers in which either a mechanical lift or a 2-person assist is required every 12 hour shift daily X 2 weeks followed by weekly X 4 weeks, and finally monthly X 3 months to ensure transfers are being done correctly as care planned. Any concerns will be	

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F 656	Continued From page 3 assistance with gait belt for transfers. NA #1 stated she forgot to look at the "Getting to Know Me book" before she transferred the resident because she had always transferred Resident #73 by herself. NA #1 stated she should not have transferred the resident by herself and that a gait belt should have been used. An interview conducted with Nurse #1 on 5/31/19 at 6:41 AM revealed Resident #73 required 2 persons assistance with gait belt for transfers. Nurse #1 stated NA #1 should not have transferred Resident #73 by herself. Nurse #1 said NA #1 should have gotten another staff member to help her, and that they should have used a gait belt to transfer the resident. An interview conducted with the House Supervisor on 5/31/19 at 9:35 AM revealed that it was her expectation that the nurse aides follow the transfer/lift status indicated in the "Get to Know Me" book. The House Supervisor stated NA #1 should have gotten another staff member to help her with the transfer of Resident #73 from bed to wheelchair. An interview was conducted with the Director of Nursing (DON) on 5/31/19 at 10:00 AM. The DON stated she expected the nurse aides to follow the care plan as to what had been deemed the safest assistance for transfers. The DON further stated it was the facility's policy that disciplinary action and re-education be given to any staff member observed not following the lift status because they considered this a serious issue. An interview conducted with the Administrator on 5/31/19 at 10:16 AM revealed it was her	F 656	immediately corrected through the disciplinary process up to and including termination for failure to follow the care plan as written. All findings from the transfer observations conducted by the licensed nurses including any corrections/disciplinary actions related to transfers will be reviewed by Director of Nursing upon completion of each. The DON will then report findings and any corrective actions taken to the QAPI Committee monthly for any further recommendations or actions.	

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F 656	Continued From page 4	F 656		

expectation that staff follow the care plan and the transfer/lift policy.

2. Resident #61 was admitted to the facility on 1/4/19 with the following diagnoses: Alzheimer's disease, dementia, anxiety disorder and pressure ulcer of left heel.

Review of Resident #61's care plan dated 4/1/19 revealed the resident required assistance for all Activities of Daily Living (ADL) with the goal of performing ADL as independently as possible. One of the interventions listed was Resident #61 required extensive assistance of 2 persons with gait belt for transfers.

Review of the Quarterly Minimum Data Set (MDS) Assessment dated 4/4/19 revealed Resident #61 was severely cognitively impaired. Resident #61 required extensive physical assistance of two or more persons.

Review of a document entitled "Get to Know Me" dated 4/4/19 revealed the type of transfer/staff assistance needed for transfers for Resident #61 was 2 persons with gait belt.

Review of Transfer/Lift Assessment dated 4/10/19 revealed Resident #61 "meets all requirements for 1-person gait belt transfer but also has had recent hip and/or knee surgery or exhibits behavioral concerns related to care = 2-person gait belt transfer."

An observation was made on 5/31/19 at 6:02 AM of Resident #61 being transferred by Nurse Aide (NA) #1 from bed to wheelchair. NA #1 had Resident #61 wrap her arms around NA #1's neck while NA #1 stood Resident #61 up while holding

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F 656	Continued From page 5	F 656		

on to Resident #61's torso to stand and pivot to the wheelchair. During the transfer, Resident #61 was observed to have difficulty standing up and bearing weight. NA #1 did not use a gait belt during the transfer.

An interview was conducted with NA #1 on 5/31/19 at 6:15 AM. NA #1 stated she thought she might be in trouble after noting Resident #61 had some difficulty standing up during the transfer. NA #1 stated she thought Resident #61 required 1-person assistance with transfers, but she was not sure. NA #1 said she was familiar with Resident #61, but she did not usually get her up out of the bed. NA #1 got Resident #61 out of the bed at that time because Resident #61 was requesting to be gotten out of the bed. NA #1 further stated the transfer information can be found in the "Getting to Know Me" book. During the interview, NA #1 looked up the transfer information from the "Getting to Know Me" book and revealed Resident #61 required 2 persons assistance with gait belt for transfers. NA #1 stated she should not have transferred the resident by herself and that a gait belt should have been used. NA #1 stated she should have looked at the "Getting to Know Me" book before she transferred the resident, which she forgot to do.

An interview conducted with Nurse #1 on 5/31/19 at 6:41 AM revealed Resident #61 required 2 persons assistance with gait belt for transfers. Nurse #1 stated NA #1 should not have transferred Resident #61 by herself. Nurse #1 said NA #1 should have gotten another staff member to help her, and that they should have used a gait belt to transfer the resident.

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F 656	Continued From page 6 An interview conducted with the House Supervisor on 5/31/19 at 9:35 AM revealed that it was her expectation that the nurse aides follow the transfer/lift status indicated in the "Get to Know Me" book. The House Supervisor stated NA #1 should have gotten another staff member to help her with the transfer of Resident #61 from bed to wheelchair. An interview was conducted with the Director of Nursing (DON) on 5/31/19 at 10:00 AM. The DON stated she expected the nurse aides to follow the care plan as to what had been deemed the safest assistance for transfers. The DON further stated it was the facility's policy that disciplinary action and re-education be given to any staff member observed not following the lift status because they considered this a serious issue. An interview conducted with the Administrator on 5/31/19 at 10:16 AM revealed it was her expectation that staff follow the care plan and the transfer/lift policy.	F 656		