STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345217	A. BUILDING _____ B. WING _____	C 08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER NURSING AND REHABILITATION CENTER	225 WHITE STREET JACKSONVILLE, NC 28546

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F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).	F 580		8/15/18

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

Electronically Signed | 08/23/2018

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F 580	Continued From page 1 §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record reviews, family interview and staff interviews, the facility failed to notify the physician of Resident # 37 slipping of a Mechanical lift (sit to stand) and causing the straps to slip around the resident's neck which caused the resident's face to turn purplish blue in color. This was evident in 1 of 5 residents reviewed for accidents. (Resident # 37) The findings included: Resident # 37 was admitted on 11/12/2014 with diagnoses of Alzheimer ' s disease, cerebrovascular disease, dementia, generalized muscle weakness, pain and abnormal posture. The quarterly Minimum Data Set (MDS), dated 5/23/2018, indicated Resident # 37 ' s cognition had been severely impaired and she had required extensive assistance of one person for bed mobility. Resident #37 had been totally dependent with the assistance of 2 staff for transfers, dressing and toileting. The MDS indicated Resident #37 was not steady when moving from a seated position to a standing position and had only able to stabilize with staff assistance.	F 580	Premier Nursing and Rehabilitation Center Acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that this summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Premier Nursing and Rehabilitation Center's response to this Statement of Deficiencies does not denote Agreement with the Statement of Deficiencies nor does it constitute an Admission that any deficiency is accurate. Further, Premier Nursing and Rehabilitation Center reserves the right to Refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal Procedure and/or any other administrative or legal proceeding. F580	

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F 580	Continued From page 2 Resident # 37's care plan, dated 3/18/2018, indicated Resident # 37 required "assistance for mobility due to the aging process, short and long term memory deficits, physical limitations/non-ambulatory, weakness, unsteady balance during transitions." The interventions included the following: monitor for safety awareness, transfers using mechanical lift (sit to stand lift) with aid of 2 persons, report to nurse any decrease in ability to transfer safely and monitor for safety awareness. A review of Resident #37's Care Guide, updated 3/18/2018, and indicated the following: the resident required Activity of Daily Living (ADL) care, may require 2 person assist with toileting. Transfers: mechanical lift (sit to stand lift; vest size - L) with 2 person assist. The resident required non-skid footwear. A review of a nurse's note, dated 6/23/2018, indicated Resident # 37 exhibited difficulty standing with a sit-to-stand lift per staff interview; 3 staff members assisted Resident # 37 onto the toilet when feet slipped off mechanical lift. A review of the facility ' s incident log for Resident # 37 revealed no incident report had been completed after the 6/23/2018 incident. During an interview with Resident #37's Responsible Party (RP) on 7/31/2018 at 2:00 PM, the RP reported on 6/23/2018 he came to visit Resident #37 and found her almost "choked" on the mechanical lift ' s straps. The RP indicated another nursing assistant (NA), NA #3, had been asked to come to Resident #37's room and assisted in getting her safely down to the bathroom floor or toilet seat. The RP reported he	F 580	A 100% review of all residents' progress notes will be completed by the Quality Improvement (QI) nurses, the RN supervisor, was initiated on 8/1/2018, to ensure appropriate documentation, to include when there is an accident, that the resident physician and resident representative (RR) has been notified of any significant change in resident's condition to include when there is an accident, for the last 30 days, 6/23/2018 to 8/1/2018. The resident's physician and/or RR will be notified of any identified areas of concern and the notification will be documented in the resident's electronic medical record by the Quality Improvement (QI) nurses, the Staff Facilitator and/or RN supervisor, and will be completed by 8/2/2018 utilizing a resident census. An in-service was initiated for 100% of all licensed nurses, on 8/1/2018 by the Staff Facilitator regarding notification of physician and/or RR of any significant change in resident's condition to include when there is an accident and that documentation of notification to be entered into the resident's medical record, will be completed by 8/2/2018. When there is any significant change in resident's condition, to include when there is an accident, the license nurse is responsible for notifying the resident physician and/or RR and documenting the notification in the resident's electronic medical records. The Quality	

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F 580	Continued From page 3 had been concerned about Resident #37's safety while being transferred on a mechanical lift. He further indicated the staff did not follow the guidelines as required while using the mechanical lift because he had noticed on the day of the accident she had been transferred by one nurse aide instead of two. The RP further reported Resident #37 had not been wearing shoes or nonskid socks per the care guide and the strap around the lower legs had not been applied. During an interview with NA #1 on 8/1/2018 at 10:00 AM, NA # 1 reported she had been assigned to work with Resident # 37 on 6/23/2018. She indicated before lunch, she had been transferring the resident from the bed to the toilet with the sit-to-stand (mechanical lift) by herself. NA #1 reported Resident #37 started to slip from the lift before getting on the toilet. NA# 1 stated a family member had arrived for a visit and found Resident #37 had slipped from the mechanical lift. NA #1 stated the RP had started to assist to keep her from falling but had been unable to stop the resident from slipping and the strap from getting caught at the resident ' s neck. NA # 1 stated she left Resident # 37 on the lift in the bathroom to get more help from another staff member who had been in another resident ' s room at the end of the hall. NA #1 stated Medication Aide (MA) # 1 also came by the resident ' s bathroom but stood by the resident ' s room waiting for additional assistance to get the resident off the mechanical lift. NA #1 stated prior to the incident she had been in a panic to get Resident # 37 to the bathroom before the family ' s visit. She further added the family of Resident #37 had wanted Resident # 37 up in the mornings and she had no other person to ask for assistance. NA #1 added the day the resident had	F 580	Improvement (QI) nurses, the RN supervisor, Unit Facilitator will review 10% of residents progress notes, daily 3 times a week for 4 weeks then weekly for 4 weeks then monthly for 1 month to ensure appropriate documentation for notification of the physician and/or RR, for any changes in the resident, to include when there is an accident, is recorded in the resident medical record utilizing a MD/RR Notification QI Audit Tool. The Quality Improvement (QI) nurses, the Staff Facilitator and/or RN supervisor, will immediately notify the MD/RR for any identified areas of concern and document in the clinical record and provide retraining with the license nurse. The DON will review and initial the RR/MD notification QI Audit Tool weekly for 8 weeks then monthly for 1 month for completion and to ensure all areas of concern were addressed and documented in the electronic medical records and retraining provided with the responsible staff member. The Executive QI committee will meet monthly and review the MD/RR Notification QI Audit Tool to make changes as needed, to include continued frequency of monitoring for 3 months. The Administrator and the DON will be responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring related to the plan of correction.	

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the accident the facility had been short of staff and she could not find anyone to assist her with transferring Resident # 37 on the mechanical lift. NA #1 stated Resident #37 is always "dancing" (unsteady while standing) while being transferred on the mechanical lift, making it a more difficult transfer.

During an interview with NA #2 on 8/1/2018 at 10:20 AM, NA # 2 stated he came down to Resident # 37's room after he finished giving care to another patient. He had been told he needed to help Resident # 37 who had been left dangling from the mechanical lift. NA #2 indicated once he had arrived at Resident # 37's bathroom, he had noticed the resident ' s face was purplish blue and the lift ' s straps were by the resident's neck. NA # 2 reported he did not recall whether Resident # 37 ' s knees were touching the floor or not because everything had happened so fast. He further indicated the resident head was tilted towards the front of her body. NA # 2 stated after he had assisted the resident to a seated position on the toilet the resident ' s color in her face returned to normal. NA # 2 stated the resident ' s family member had been in the room but had not assisted with getting the resident off the mechanical lift. NA #2 added NA # 1 assisted him with getting Resident # 37 off the lift. He indicated Nurse # 1 assessed Resident # 37 after the resident had been removed from the mechanical lift and had been placed on the toilet.

During an interview with MA #1 on 8/1/2018 at 10: 30 AM, MA # 1 stated NA # 1 had come out of Resident # 37's room and stated she needed help. MA #1 stated she had entered Resident # 37's room and she noticed the resident had been

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on the lift and had slipped down with her feet off the platform of the lift. MA # 1 indicated she had been waiting for NA # 1 to get more help as the patient had been constantly slipping. MA #1 added the resident's face had turned red in color as she slid down the lift. MA # 1 indicated the strap had slipped by the resident's neck.

During an interview with Nurse #1 on 8/1/2018 at 11:10 AM, Nurse # 1 stated she had been assigned to care for Resident #37 on 6/23/2018. Nurse #1 stated NA # 1 reported to her they had difficulty during the transfer of Resident #37 from the bed to the toilet using the mechanical lift. Nurse #1 stated Resident # 37 had slid off the lift because the staff failed to use the leg straps and nonskid socks or shoes which caused the resident to slip some from the lift. Nurse #1 reported NA # 1 had been using the lift with no assistance. She further stated she had expected the NA # 1 to have asked for assistance when using the lift. She indicated the lift required 2 persons. Nurse # 1 stated the use of nonskid socks or shoes had always been required to prevent residents ' feet from slipping off the lift but they had not been used by NA # 1. Nurse #1 stated she had also felt the sit to stand lift was not appropriate for Resident # 37. Nurse # 1 indicated she had assessed Resident #37 after she had been transferred to the toilet by the NA ' s and stated she did not notice any injury to Resident #37. Nurse # 1 indicated she did not report the incident to the physician or the Director of Nursing (DON) because she did not think of Resident # 37 ' s slip on the mechanical lift as an incident or accident. Nurse #1 stated in looking back at what had happened to the resident, she should have reported the incident to the physician, DON and completed an incident

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report.

During an interview with the Physician on 8/1/2018 at 11:30 AM, the Physician indicated he had not been made aware of Resident #37 ' s incident on 6/23/2018. The physician indicated his expectation would have been for the facility staff to have notified him of the incident emphasizing especially if the resident had turned purple blue in color during the incident.

During the interview with the Staff Development Coordinator (SDC) on 8/2/2018 at 11:30 AM, the SDC stated NA # 2 reported to her, during the 08/01/2018 investigation of the incident involving Resident #37, when he had been asked to assist with Resident # 37 on 6/23/2018, she had seen the resident ' s face turned purple blue and the resident ' s veins bulged on her neck while she dangled on the mechanical lift. The SDC indicated she had thought a supervisor had investigated the incident after it happened on 6/23/2018 as she had overheard a conversation about the incident around the time it happened. She added she could not recall the exact date or the name of the supervisor. The SDC stated she had not been the SDC at the time of Resident # 37 ' s mechanical ' s lift accident.

During an interview with the DON on 8/2/2018 at 12:30 PM, the DON reported she had not been aware of Resident #37's incident of 6/23/2018 when the resident had slipped off the lift. The DON indicated her expectation of nursing staff would have been to have completed an incident report so she could have started an in-service training on the proper use of a mechanical lift. She further indicated her expectation was for the Physician to have been notified about the

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F 580	Continued From page 7 accident. During an interview with the Administrator on 8/2/2018 at 12:40 PM, the Administrator reported he had just learned about the incident of Resident #37's slip off the mechanical lift. The Administrator stated his expectation would have been for the staff to have reported the accident to the DON immediately so they could have begun an in-service on the proper use of the mechanical lift. Administrator also reported his expectation was for the Physician to have been notified about the accident.	F 580		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, family interview and staff interviews, the facility neglected to follow manufacturer's guidelines by failing to attach and tighten the leg straps of the facility's mechanical lift around the resident's	F 600	F600 Free From Abuse and Neglect CFR(s): 483.12(a)(1) On 6/23/18 on 7-3 shift Nursing Assistant (NA) #1 was transferring resident #37 with	8/15/18

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lower legs and failed to implement care plan and care guide interventions indicating use of 2 person assistance while transferring with the use of mechanical lift(sit to stand) and failed to ensure the resident had on non-skid footwear for 1 of 5 sampled residents reviewed for accidents. Resident #37 slipped during a transfer from the mechanical lift which allowed the lift's straps to slip around the resident ' s neck which caused the resident's face to turn purplish blue in color. Resident #37 was assessed at the facility and found to have no physical injuries.

Immediate Jeopardy for Resident # 37 began on 6/23/2018 when the resident slipped while only one staff member was transferring her using a mechanical lift and staff failed to properly secure her to the lift and ensure she was wearing non-skid foot and the lift's straps slipped around the resident's neck causing the resident's face to turn purplish blue. Immediate Jeopardy was remove on 8/2/2018 when the facility provided an acceptable credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a scope and severity of D (not actual harm with potential for more than minimal harm that is not Immediate Jeopardy) to allow for ongoing in- servicing or monitoring to be accomplished.

The findings included:

A review of the manufacturer's manual instructions for the mechanical lift used at the facility, dated April 2013, included the following instructions: "Position the mechanical lift and adjust the width of the base, so that the patient's feet can be centered on the footrest. The lower

the sit to stand lift with one person assist from the chair to the bathroom. Resident #37 started to slip while in the sit to stand lift. NA #1 retrieved assistance from NA #2 and NA #3 to transfer resident #37 due to slipping while in the sit to stand lift. Resident #37 was noted purplish blue in the face during transfer.
Nurse #1 assessed resident #37 while in the bathroom with no injuries noted.
A thorough investigation was initiated on 8/1/2018 by the Administrator and Director of Nursing to identify the root cause of the failure of prevention of accident related to resident #37. During the investigation it was found that the Director of Nursing failed to appropriately investigate the incident after reading the documentation of the incident note in the clinical record on 6/25/18 due to failure to flag the incident for follow up. The Director of Nursing failed to assure re-assessment of resident #37 for a different method of lift transfer to prevent accident since being unable to stand on 6/23/18. It was also determined by the Administrator that the Nursing assistant failed to follow the resident care guide for 2 person assist related to rushing to get the resident dressed and out of bed before the family came to the room. Per interview with the nursing assistant on 8/2/18, nursing assistant #1 stated she failed to pull the call bell cord and left the resident in a compromising position in an attempt to get assistance faster. The Administrator determined that the Nursing Assistant failed to adhere to education that was provided regarding emergency lift

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F 600	Continued From page 9 legs (below the knees) should be parallel to the lower-leg on the lift. Adjust the horizontal and vertical position of the pad for comfortable resistance just below the kneecaps. Attach and tighten the strap around the lower legs." Resident # 37 was admitted on 11/12/2014 with diagnoses of Alzheimer ' s disease, cerebrovascular disease, dementia, generalized muscle weakness, pain and abnormal posture. The quarterly Minimum Data Set (MDS), dated 5/23/2018, indicated Resident # 37' s cognition had been severely impaired and she had required extensive assistance of one person for bed mobility. Resident #37 had been totally dependent with the assistance of 2 staff for transfers, dressing and toileting. The MDS indicated Resident #37 was not steady when moving from a seated position to a standing position and was only able to stabilize with staff assistance. The MDS indicated Resident #37 was not steady when moving on and off the toilet and had only been able to stabilize with staff assistance. The MDS indicated Resident #37 had no trial of a toileting program and she had been frequently incontinent of her bowels and bladder. Resident # 37's care plan, dated 5/23/2018 indicated Resident # 37 required "assistance for mobility due to the aging process, short and long term memory deficits, physical limitations/non-ambulatory, weakness, unsteady balance during transitions." The interventions included the following: monitor for safety awareness, transfers using mechanical lift (sit to stand lift) with aid of 2 persons, report to nurse any decrease in ability to transfer safely and	F 600	procedures on 4/9/18. Nursing Assistant #1 was removed from the schedule on 8/1/18 by the Director of Nursing pending an investigation of resident #37 incident. A 24 hour report was completed and sent to the Health Care Personnel Registry by the Administrator on 8/2/18. Corrective Actions On 8/01/18, interviews were initiated by the Social Workers with all alert and oriented residents with questions in regards to: 1. Has the facility failed to provide care? 2. If yes please explain? The resident concern process was followed by the social worker and Administrator for all identified areas of concern by 8/2/18. On 8/1/18, a transfer observation of 100% of all residents to include resident #37 utilizing mechanical lifts was initiated by the Minimum Data Set (MDS) coordinator, MDS nurses and therapy manager. The purpose of the observation is to ensure that the resident's current mechanical lift use was the safest method of transfer. The audit was completed by 8/2/18. The MDS coordinator re-evaluated the resident transfer method, updated the resident care plan and care guide, and completed a therapy referral by 8/2/18 for any identified areas of safety concerns observed during the audit. On 8/1/18, a questionnaire was initiated with 100% of all nurses and nursing	

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F 600	Continued From page 10 monitor for safety awareness A review of Resident #37's current Care Guide dated 5/23/2018 indicated the following: the resident required Activity of Daily Living (ADL) care, may require 2 person assist with toileting. Transfers: mechanical lift (sit to stand lift; vest size - L) with 2 person assist. The resident required non-skid footwear. A review of a nurse's note, dated 6/23/2018 and written by Nurse # 1, indicated Resident # 37 exhibited difficulty standing with a sit-to-stand lift per staff interview; 3 staff members assisted Resident # 37 onto the toilet when her feet slipped off mechanical lift. A review of the facility's incident log for Resident # 37 revealed no incident report had been completed after the 6/23/2018 incident. During an interview with Resident #37's Responsible Party (RP) on 7/31/2018 at 2:00 PM, the RP reported on 6/23/2018 he came to visit Resident #37 and found her almost "choked" on the mechanical lift ' s straps. The RP indicated another nursing assistant (NA), NA #3, had been asked to come to Resident #37's room and assisted in getting her safely down to the bathroom floor or toilet seat. The RP reported he had been concerned about Resident #37's safety while being transferred on a mechanical lift. He further indicated the staff did not follow the guidelines as required while using the mechanical lift because he had noticed on the day of the accident she had been transferred by one nurse aide instead of two. The RP further reported Resident #37 had not been wearing shoes or nonskid socks per the care guide and the strap around the lower legs had not been applied.	F 600	assistants by the Quality Improvement (QI) nurse with questions regarding: 1. Do you feel any resident transfer method, to include type of mechanical lift, needs to be changed? 2. If yes, what resident and reason why? This questionnaire was completed by 8/2/18. The MDS coordinator re-evaluated the resident transfer method, updated the resident care plan and care guide, and completed a therapy referral by 8/2/18 for any identified areas of safety concerns expressed during the questionnaire. After 8/2/18, all nurses and nursing assistants that have not completed the questionnaire will not be allowed to work until the questionnaire is completed. On 8/1/18, return demonstrations of mechanical lift transfer was initiated with 100% of all nurses and nursing assistants by the Staff Facilitator. The purpose of the return demonstrations are to ensure that staff are checking the resident care guide for the correct number of person to utilize for transfers and that the mechanical lift is being utilized per manufacture specifications during the transfer. After, 8/2/18, all nurses and nursing assistants that have not completed the return demonstration will not be allowed to work until the return demonstration is completed. On 8/1/18 an audit of all resident's incident reports to include resident #37 from 6/23/18 to 8/1/18 was initiated by the MDS nurses and the treatment nurse to ensure all incidents have been thoroughly investigated to determine the root cause and appropriate interventions initiated to	

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F 600	Continued From page 11 During an interview with NA #1 on 8/1/2018 at 10:00 AM, NA # 1 reported she had been assigned to work with Resident # 37 on 6/23/2018. She indicated before lunch, she had been transferring the resident from the bed to the toilet with the sit-to-stand (mechanical lift) by herself. NA #1 reported Resident #37 started to slip from the lift before getting on the toilet. NA# 1 stated a family member had arrived for a visit and found Resident #37 had slipped from the mechanical lift. NA #1 stated the RP had started to assist to keep her from falling but had been unable to stop the resident from slipping and the strap from getting caught at the resident ' s neck. NA # 1 stated she left Resident # 37 on the lift in the bathroom to get more help from another staff member who had been in another resident ' s room at the end of the hall. NA #1 stated Medication Aide (MA) # 1 also came by the resident ' s bathroom but stood by the resident ' s room waiting for additional assistance to get the resident off the mechanical lift. NA #1 stated prior to the incident she had been in a panic to get Resident # 37 to the bathroom before the family ' s visit. She further added the family of Resident #37 had wanted Resident # 37 up in the mornings and she had no other person to ask for assistance. NA #1 added the day the resident had the accident the facility had been short of staff and she could not find anyone to assist her with transferring Resident # 37 on the mechanical lift. NA #1 stated Resident #37 is always "dancing" (unsteady while standing) while being transferred on the mechanical lift, making it a more difficult transfer. During an interview with NA #2 on 8/1/2018 at 10:20 AM, NA # 2 stated he came down to	F 600	prevent further incidents. This audit was completed by 8/2/18. The QI nurse investigated the incident, implement interventions, and updated the resident care plan and care guide by 8/2/18 for all identified areas of concern. On 8/1/18 an audit of all resident's progress notes to include resident #37 from 6/23/18 to 8/1/18 was initiated by the QI nurse and the Registered Nurse (RN) supervisor to ensure that all documented incidents have an incident report, was investigated to determine the root cause and appropriate interventions were implemented to prevent further incidents. This audit was completed by 8/2/18. The QI nurse investigated the incident, implement interventions, and updated the resident care plan and care guide by 8/2/18 for all identified areas of concern. On 8/01/18, an in-service was initiated for 100% of all staff to include nurses, nursing assistants, housekeeping, dietary, therapy, maintenance, payroll, book keeper, social workers, was initiated by the Staff Facilitator regarding Neglect to include examples of neglect and prevention of neglect. This inservice was completed by 8/02/18. After 8/2/18, all staff to include nurses, nursing assistants, housekeeping, dietary, therapy, maintenance, payroll, book keeper, social workers that have not worked and/or not received the in-services was mailed the in-service via certified mail by the Payroll Bookkeeper. Instructions included in the inservice packet to read, sign the inservice, call the Staff Facilitator or Director of Nursing with any questions,	

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F 600	Continued From page 12 Resident # 37's room after he finished giving care to another patient. He had been told he needed to help Resident # 37 who had been left dangling from the mechanical lift. NA #2 indicated once he had arrived at Resident # 37's bathroom, he had noticed the resident ' s face was purplish blue and the lift ' s straps were by the resident ' s neck. NA # 2 reported he did not recall whether Resident # 37 ' s knees were touching the floor or not because everything had happened so fast. He further indicated the resident head was tilted towards the front of her body. NA # 2 stated after he had assisted the resident to a seated position on the toilet the resident ' s color in her face returned to normal. NA # 2 stated the resident ' s family member had been in the room but had not assisted with getting the resident off the mechanical lift. NA #2 added NA # 1 assisted him with getting Resident # 37 off the lift. He indicated Nurse # 1 assessed Resident # 37 after the resident had been removed from the mechanical lift and had been placed on the toilet. During an interview with MA #1 on 8/1/2018 at 10: 30 AM, MA # 1 stated NA # 1 had come out of Resident # 37's room and stated she needed help. MA #1 stated she had entered Resident # 37's room and she noticed the resident had been on the lift and had slipped down with her feet off the platform of the lift. MA # 1 indicated she had been waiting for NA # 1 to get more help as the patient had been constantly slipping. MA #1 added the resident ' s face had turned red in color as she slid down the lift. MA # 1 indicated the strap had slipped by the resident ' s neck. During an interview with Nurse #1 on 8/1/2018 at 11:10 AM, Nurse # 1 stated she had been	F 600	and return the signed inservice to the Staff Facilitator or Director of Nursing prior to next schedule shift. Staff were not be permitted to work until the signed inservices were received. On 8/1/18 an in-service was initiated by the Staff Facilitator with 100% of all nurses and nursing assistants regarding the safe handling and movement policy. This in-service included reading the resident care guide to identify the number of person required for resident transfer, reporting to the nurse when a transfer method is no longer safe, lowering the resident and not leaving the resident when sliding in the lift and how to safely strap and transfer resident in the mechanical lift per the manufacture specifications. The manufacture specification was printed by the Staff Facilitator and reviewed with staff during the inservice. This in-service was completed by 8/2/18. After 8/2/18, all nurses and nursing assistants that have not worked and/or not received the in-services were mailed via certified mail by the Payroll Bookkeeper. Instructions included in the inservice packet to read, sign the inservice, call the Staff Facilitator or Director of Nursing with any questions, and return the signed inservice to the Staff Facilitator or Director of Nursing prior to next schedule shift. Staff were not permitted to work until the signed inservices were received. The Administrator, Director of Nursing, and Quality Improvement nurse was in serviced on the process of investigating incidents on 8/1/18 by the Facility Nurse Consultant. The in-service included to	

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F 600	Continued From page 13 assigned to care for Resident #37 on 6/23/2018. Nurse #1 stated NA # 1 reported to her they had difficulty during the transfer of Resident #37 from the bed to the toilet using the mechanical lift. Nurse #1 stated Resident # 37 had slid off the lift because the staff failed to use the leg straps and nonskid socks or shoes which caused the resident to slip some from the lift. Nurse #1 reported NA # 1 had been using the lift with no assistance. She further stated she had expected the NA # 1 to have asked for assistance when using the lift. She indicated the lift required 2 persons. Nurse # 1 stated the use of nonskid socks or shoes had always been required to prevent residents ' feet from slipping off the lift but they had not been used by NA # 1. Nurse #1 stated she had also felt the sit to stand lift was not appropriate for Resident # 37. Nurse # 1 indicated she had assessed Resident #37 after she had been transferred to the toilet by the NA's and stated she did not notice any injury to Resident #37. Nurse # 1 indicated she did not report the incident to the physician or the Director of Nursing (DON) because she did not think of Resident # 37's slip on the mechanical lift as an incident or accident. Nurse #1 stated in looking back at what had happened to the resident, she should have reported the incident to the physician, DON and completed an incident report. During an interview with the Physician on 8/1/2018 at 11:30 AM, the Physician indicated he had not been made aware of Resident #37's incident on 6/23/2018. The physician indicated his expectation would have been for the facility staff to have notified him of the incident emphasizing especially if the resident had turned purple blue during the incident.	F 600	review the incident reports 5 days per week, how to pull a report from the risk management portal in the electronic records to identify incidents that have been documented by the nurses, printing the incident reports from the electronic records, flagging the incident for follow up, reading progress notes to identify all incidents, discussing incidents in the clinical morning meetings, determining the root cause of the incident, completion of incident reports, and implementing and monitoring interventions. An inservice was completed with the Director of Nursing on 8/2/18 regarding requirements for re -evaluating residents for change in transfer methods by the Facility Nurse Consultant. On 8/1/18 an in-service was initiated by the Staff Facilitator with 100% of all nurses regarding completion of incident reports and collecting witness statements. After 8/2/18, all nurses that have not worked and/or not received the in-service will be mailed the in-service via certified mail by the Payroll Bookkeeper. Instructions will be included in the inservice packet to read, sign the inservice, call the Staff Facilitator or Director of Nursing with any questions, and return the signed inservice to the Staff Facilitator or Director of Nursing prior to next schedule shift. Staff will not be permitted to work until the signed inservices are received. The decision to monitor the system for prevention of accidents was made on 8/1/2018 by the Administrator and Director of Nursing. The RN Supervisor, the Staff	

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F 600	Continued From page 14 During an interview with the MDS nurse on 8/2/2018 at 9:30 AM, the MDS nurse reported Resident #37 had history of being unstable while being transferred on a sit to stand lift because her legs had been buckling (both of knees give out). The MDS nurse stated the family had insisted on the use of the sit to stand lift even though the staff at the facility had been aware it had not been appropriate for Resident # 37. During an observation of a mechanical lift transfer made on 8/2/2018 at 10:30 AM, Resident # 37's appeared confused with the instructions given her by NA # 4 to grasp the mechanical lift ' s sling bar. Resident # 37 had been noticed to be unsteady while standing on the lift. During an interview with NA #4 on 8/2/2018 at 10:40 AM, NA# 4 reported Resident #37 had been unstable while on the lift but she had been transferred using the sit to stand lift for a long time. NA #4 indicated Resident # 37 had usually been assisted to the toilet before breakfast and lunch. During the interview with the Staff Development Coordinator (SDC) on 8/2/2018 at 11:30 AM, the SDC stated NA # 2 reported to her, during the 08/01/2018 investigation of the incident involving Resident #37, when he had been asked to assist with Resident # 37 on 6/23/2018, she had seen the resident's face turned purple blue and the resident ' s veins bulged on her neck while she dangled on the mechanical lift. The SDC indicated she had thought a supervisor had investigated the incident after it happened on 6/23/2018 as she had overheard a conversation about the incident around the time it happened. She added she could not recall the exact date or	F 600	Facilitator, Treatment nurse, Unit Facilitator and/or the QI nurses, will audit 10% of all residents requiring mechanical lifts for transfers to include resident #37 to ensure staff are checking the resident care guide and utilizing the number of person identified on the care guide, staff are utilizing the mechanical lift per manufacture specification during the transfer, and ensure the current lift is the safest method of transfer 3 x a week for four weeks, then weekly for x 4 weeks, then monthly x 1 month utilizing a Lift Transfer Audit Tool. Any areas of concern will be immediately addressed by the RN Supervisor, the Staff Facilitator, the Unit Facilitator and/or the QI nurses to include staff retraining. The Director of Nursing will review and initial the Lift Transfer Audit Tools weekly x 8 weeks then monthly x 1 month. The RN Supervisor, the Staff Facilitator, Treatment nurse, Unit Facilitator and/or the QI nurses will review all incidents reports and progress notes 3 x a week for 4 weeks, then weekly for x 4 weeks, then monthly x 1 month utilizing the Incident Audit Tool to ensure all identified incidents have been thoroughly investigated, incidents reports completed, and appropriate interventions implemented to prevent further accidents. The RN Supervisor, the Staff Facilitator, Treatment nurse, Unit Facilitator and/or the QI nurses will investigate the incident, implement interventions, and provide retraining for all identified areas of concern during the audit. The Director of Nursing will review and initial the Incident	

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F 600	Continued From page 15 the name of the supervisor. The SDC stated she had not been the SDC at the time of Resident # 37 ' s mechanical ' s lift accident. During an interview with the DON on 8/2/2018 at 12:30 PM, the DON reported she had not been aware of Resident #37's incident of 6/23/2018 when the resident had slipped off the lift. The DON indicated her expectation of nursing staff would have been to have completed an incident report so she could have started an in-service training on the proper use of a mechanical lift. During an interview with the Administrator on 8/2/2018 at 12:40 PM, the Administrator reported he had just learned about the incident of Resident #37's slip off the mechanical lift. The Administrator stated his expectation would have been for the staff to have reported the accident to the DON immediately so they could have begun an in-service on the proper use of the mechanical lift. The Administrator, Director of Nursing and Facility ' s nurse consultant were notified of the Immediate Jeopardy on 8/1/2018 at 4:30 pm. On 8/2/2018 the facility provided an acceptable credible allegation for immediate jeopardy removal that included the following: Corrective Actions On 8/1/18, interviews were initiated by the Social Workers with all alert and oriented residents. The resident concern process will be followed by the social worker and Administrator for all identified areas of concern by 8/2/18. On 8/1/18, a transfer observation of 100% of all	F 600	Audit Tool weekly x 8 weeks then monthly x 1 month. The Quality Improvement Organization was contacted by the Director of Nursing on 8/02/18 for assistance in evaluation of specific steps to be taken to address neglect and prevention of accidents and training, staff position/title designated to be responsible for the steps, timeline for accomplishment of the steps, specific methodology to be used to evaluate the plan's success, and frequency of monitoring the effects of the plan initiation. The DON will present the findings of the Lift Transfer Audit Tools and the Incident Audit Tools to the Executive Quality Assurance (QA) committee monthly for 3 months. The Executive QA Committee will meet monthly for 3 months and review the Lift Transfer Audit Tools and the Incident Audit Tools to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring. The decision to review the monitoring of prevention of accidents during the quality assurance committee meeting was made by the Administrator and Director of Nursing on 8/01/2018. The Administrator and DON was responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring related to the plan of correction.	

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residents to include resident # 37 utilizing mechanical lifts was initiated by the Minimum Data Set (MDS) coordinator, MDS nurses and therapy manager. The purpose of the observation is to ensure that the resident ' s current mechanical lift use is the safest method of transfer. The audit will be completed by 8/2/18. The MDS coordinator will re-evaluate the resident transfer method, update the resident care plan and care guide, and complete a therapy referral by 8/2/18 for any identified areas of safety concerns observed during the audit.

On 8/1/18, a questionnaire was initiated with 100% of all nurses and nursing assistants by the Quality Improvement (QI) nurse. This questionnaire will be completed by 8/2/18. The MDS coordinator will re-evaluate the resident transfer method, update the resident care plan and care guide, and complete a therapy referral by 8/2/18 for any identified areas of safety concerns expressed during the questionnaire. After 8/2/18, all nurses and nursing assistants that have not completed the questionnaire will not be allowed to work until the questionnaire is completed.

On 8/1/18, return demonstrations of mechanical lift transfer was initiated with 100% of all nurses and nursing assistants by the Staff Facilitator. The purpose of the return demonstrations are to ensure that staff are checking the resident care guide for the correct number of person to utilize for transfers and that the mechanical lift is being utilized per manufacture specifications during the transfer. After, 8/2/18, all nurses and nursing assistants that have not completed the return demonstration will not be allowed to work until the return demonstration is completed.

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On 8/1/18 an audit of all resident ' s incident reports to include resident # 37 from 6/23/18 to 8/1/18 was initiated by the MDS nurses and the treatment nurse to ensure all incidents have been thoroughly investigated to determine the root cause and appropriate interventions initiated to prevent further incidents. This audit will be completed by 8/2/18. The QI nurse will investigate the incident, implement interventions, and update the resident care plan and care guide by 8/2/18 for all identified areas of concern.

On 8/1/18 an audit of all resident ' s progress notes to include resident # 37 from 6/23/18 to 8/1/18 was initiated by the QI nurse and the Registered Nurse (RN) supervisor to ensure that all documented incidents have an incident report, was investigated to determine the root cause and appropriate interventions were implemented to prevent further incidents. This audit will be completed by 8/2/18. The QI nurse will investigate the incident, implement interventions, and update the resident care plan and care guide by 8/2/18 for all identified areas of concern.

On 8/01/18, an in-service was initiated for 100% of all staff to include nurses, nursing assistants, housekeeping, dietary, therapy, maintenance, pay roll, book keeper, social workers, was initiated by the Staff Facilitator regarding Neglect to include examples of neglect and prevention of neglect. This in-service was completed by 8/02/18. After 8/2/18, all staff to include nurses, nursing assistants, housekeeping, dietary, therapy, maintenance, pay roll, book keeper, social workers that have not worked and/or not received the in-services will be mailed the in-service via certified mail by the Payroll Bookkeeper.

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Instructions will be included in the in-service packet to read, sign the in-service, call the Staff Facilitator or Director of Nursing with any questions, and return the signed in-service to the Staff Facilitator or Director of Nursing prior to next schedule shift. Staff will not be permitted to work until the signed in services are received.

On 8/1/18 an in-service was initiated by the Staff Facilitator with 100% of all nurses and nursing assistants regarding the safe handling and movement policy. This in-service included reading the resident care guide to identify the number of person required for resident transfer, reporting to the nurse when a transfer method is no longer safe, lowering the resident and not leaving the resident when sliding in the lift and how to safely strap and transfer resident in the mechanical lift per the manufacture specifications. The manufacture specification will be printed by the Staff Facilitator and reviewed with staff during the in-service. This in-service will be completed by 8/2/18. After 8/2/18, all nurses and nursing assistants that have not worked and/or not received the in-services will be mailed via certified mail by the Payroll Bookkeeper. Instructions will be included in the in-service packet to read, sign the in-service, call the Staff Facilitator or Director of Nursing with any questions, and return the signed in-service to the Staff Facilitator or Director of Nursing prior to next schedule shift. Staff will not be permitted to work until the signed in services are received.

The Administrator, Director of Nursing, and Quality Improvement nurse was in serviced on the process of investigating incidents on 8/1/18 by the Facility Nurse Consultant. The in-service included to review the incident reports 5 days per

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week, how to pull a report from the risk management portal in the electronic records to identify incidents that have been documented by the nurses, printing the incident reports from the electronic records, flagging the incident for follow up, reading progress notes to identify all incidents, discussing incidents in the clinical morning meetings, determining the root cause of the incident, completion of incident reports, and implementing and monitoring interventions.

An in-service was completed with the Director of Nursing on 8/2/18 regarding requirements for re -evaluating residents for change in transfer methods by the Facility Nurse Consultant.

On 8/1/18 an in-service was initiated by the Staff Facilitator with 100% of all nurses regarding completion of incident reports and collecting witness statements. After 8/2/18, all nurses that has not worked and/or not received the in-service will be mailed the in-service via certified mail by the Payroll Bookkeeper. Instructions will be included in the in-service packet to read, sign the in-service, call the Staff Facilitator or Director of Nursing with any questions, and return the signed in-service to the Staff Facilitator or Director of Nursing prior to next schedule shift. Staff will not be permitted to work until the signed in services are received.

The decision to monitor the system for prevention of accidents was made on 8/1/2018 by the Administrator and Director of Nursing. The RN Supervisor, the Staff Facilitator, Treatment nurse, Unit Facilitator and/or the QI nurses, will audit 10% of all residents requiring mechanical lifts for transfers to include resident # 37 to ensure staff are checking the resident care guide and utilizing

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the number of person identified on the care guide, staff are utilizing the mechanical lift per manufacture specification during the transfer, and ensure the current lift is the safest method of transfer 3 x a week for four weeks, then weekly for x 4 weeks, then monthly x 1 month utilizing a Lift Transfer Audit Tool. Any areas of concern will be immediately addressed by the RN Supervisor, the Staff Facilitator, the Unit Facilitator and/or the QI nurses to include staff retraining. The Director of Nursing will review and initial the Lift Transfer Audit Tools weekly x 8 weeks then monthly x 1 month.

The Registered Nurse (RN) Supervisor, the Staff Facilitator, Treatment nurse, Unit Facilitator and/or the QI nurses will review all incidents reports and progress notes 3 x a week for 4 weeks, then weekly for x 4 weeks, then monthly x 1 month utilizing the Incident Audit Tool to ensure all identified incidents have been thoroughly investigated, incidents reports completed, and appropriate interventions implemented to prevent further accidents. The RN Supervisor, the Staff Facilitator, Treatment nurse, Unit Facilitator and/or the QI nurses will investigate the incident, implement interventions, and provide retraining for all identified areas of concern during the audit. The Director of Nursing will review and initial the Incident Audit Tool weekly x 8 weeks then monthly x 1 month.

The Quality Improvement Organization will be contacted by the Director of Nursing on 8/02/18 for assistance in evaluation of specific steps to be taken to address neglect and prevention of accidents and training, staff position/title designated to be responsible for the steps, timeline for accomplishment of the steps, specific

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methodology to be used to evaluate the plan ' s success, and frequency of monitoring the effects of the plan initiation.

The DON will present the findings of the Lift Transfer Audit Tools and the Incident Audit Tools to the Executive Quality Assurance (QA) committee monthly for 3 months. The Executive QA Committee will meet monthly for 3 months and review the Lift Transfer Audit Tools and the Incident Audit Tools to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring. The decision to review the monitoring of prevention of accidents during the quality assurance committee meeting was made by the Administrator and Director of Nursing on 8/01/2018.

Final date of compliance is 8/02/2018.

The Administrator and DON will be responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring related to the plan of correction.

The Credible Allegation for Immediate Jeopardy removal was validated on 8/2/2018, which removed the Immediate Jeopardy on 8/2/2018. During the Immediate Jeopardy removal validation process interviews were conducted with nursing staff present in the facility on 8/2/2018. The staff confirmed the recent in- services and training of the proper use of Mechanical lift. Reviews of the in-service records, audit tools, audits performed and facility assessments were made. Observations of residents' transfers were completed.

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F 656	Continued From page 22	F 656		
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 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	F 656		8/15/18

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F 656	Continued From page 23 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 record reviews, family interview and staff interviews, the facility failed to implement care plan and care guide interventions indicating use of 2 person assistance while transferring with the use of mechanical lift (sit to stand) and the use of nonskid footwear for 1 of 5 sampled residents (Resident # 37) The findings Included: Resident # 37 was admitted on 11/12/2014 with diagnoses of Alzheimer's disease, cerebrovascular disease, dementia, generalized muscle weakness, pain and abnormal posture. The quarterly Minimum Data Set (MDS), dated 5/23/2018, indicated Resident # 37's cognition had been severely impaired and she had required extensive assistance of one person for bed mobility. Resident #37 had been totally dependent with the assistance of 2 staff for transfers, dressing and toileting. The MDS indicated Resident #37 was not steady when moving from a seated position to a standing position and had only able to stabilize with staff assistance. The MDS indicated Resident #37 was not steady when moving on and off the toilet and had only been able to stabilize with staff assistance Resident # 37's care plan, dated 3/18/2018, indicated Resident # 37 required "assistance for mobility due to the aging process, short and long	F 656	F656 100% audit was initiated on 8/1/2018 of all residents to include resident #37 on observation for method of transfers, to include mechanical lifts, will be reviewed to ensure the care plan is followed to include the number of required staff needed to transfer the resident, by the Director of Therapy and three Minimum Data Set Nurses . Retraining will be conducted during the audit by the Director of Therapy and three Minimum Data Set Nurses with assigned nursing assistant and licensed nurse for any identified areas of concern. An in-service for 100% of all license nurses and nursing assistants (NA) was initiated on 7/31/2018 by the Staff Facilitator regarding following the care plan/care guide to include the number of required staff needed to transfer the resident. All newly hired licensed nurses and nursing assistants will be in-serviced during orientation by the Staff Facilitator regarding following the care plan/care guide to include the number of required staff needed to transfer the resident, and will be completed by 8/2/2018. 10% of residents to include resident #37 on observation for method of transfers, to include mechanical lifts, will be reviewed to ensure the care plan is followed to	

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F 656	Continued From page 24 term memory deficits, physical limitations/non-ambulatory, weakness, unsteady balance during transitions." The interventions included the following: monitor for safety awareness, transfers using mechanical lift (sit to stand lift) with aid of 2 persons, report to nurse any decrease in ability to transfer safely and monitor for safety awareness. A review of Resident #37's Care Guide, updated 3/18/2018, and indicated the following: the resident required Activity of Daily Living (ADL) care, may require 2 person assist with toileting. Transfers: mechanical lift (sit to stand lift; vest size - L) with 2 person assist. The resident required non-skid footwear. A review of a nurse's note, dated 6/23/2018, indicated Resident # 37 exhibited difficulty standing with a sit-to-stand lift per staff interview; 3 staff members assisted Resident # 37 onto the toilet when feet slipped off mechanical lift. During an interview with Resident #37's Responsible Party (RP) on 7/31/2018 at 2:00 PM, the RP reported on 6/23/2018 he came to visit Resident #37 and found her almost "choked" on the mechanical lift ' s straps. The RP indicated another nursing assistant (NA), NA #3, had been asked to come to Resident #37's room and assisted in getting her safely down to the bathroom floor or toilet seat. The RP reported he had been concerned about Resident #37's safety while being transferred on a mechanical lift. He further indicated the staff did not follow the guidelines as required while using the mechanical lift because he had noticed on the day of the accident she had been transferred by one nurse aide instead of two. The RP further reported	F 656	include the number of required staff needed to transfer the resident utilizing a care plan audit tool by the RN Supervisor, the Staff Facilitator and/or QI nurses weekly times 8 weeks then monthly times 1 month. The nursing assistant and licensed nurse will be reeducated by the RN Supervisor, the Staff Facilitator and/or QI nurses for any identified areas of concern during the audit. The Director of Nursing will review and initial the Care plan audit tool weekly for 8 weeks then monthly for 1 month for completion and to ensure all areas of concern were addressed. The Executive QI committee will meet monthly and review the Care plan audit tool and address any issues, concerns and\or trends and to make changes as needed, to include continued frequency of monitoring for 3 months. The Administrator and the DON will be responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring related to the plan of correction.	

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Resident #37 had not been wearing shoes or nonskid socks per the care guide and the strap around the lower legs had not been applied.

During an interview with NA #1 on 8/1/2018 at 10:00 AM, NA # 1 reported she had been assigned to work with Resident # 37 on 6/23/2018. She indicated before lunch, she had been transferring the resident from the bed to the toilet with the sit-to-stand (mechanical lift) by herself. NA #1 reported Resident #37 started to slip from the lift before getting on the toilet. NA# 1 stated a family member had arrived for a visit and found Resident #37 had slipped from the mechanical lift. NA #1 stated the RP had started to assist to keep her from falling but had been unable to stop the resident from slipping and the strap from getting caught at the resident ' s neck. NA # 1 stated she left Resident # 37 on the lift in the bathroom to get more help from another staff member who had been in another resident ' s room at the end of the hall. NA #1 stated

Medication Aide (MA) # 1 also came by the resident's bathroom but stood by the resident ' s room waiting for additional assistance to get the resident off the mechanical lift. NA #1 stated prior to the incident she had been in a panic to get Resident # 37 to the bathroom before the family's visit. She further added the family of Resident #37 had wanted Resident # 37 up in the mornings and she had no other person to ask for assistance. NA #1 added the day the resident had the accident the facility had been short of staff and she could not find anyone to assist her with transferring Resident # 37 on the mechanical lift. NA #1 stated Resident #37 is always "dancing" (unsteady while standing) while being transferred on the mechanical lift, making it a more difficult

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transfer.

During an interview with NA #2 on 8/1/2018 at 10:20 AM, NA # 2 stated he came down to Resident # 37's room after he finished giving care to another patient. He had been told he needed to help Resident # 37 who had been left dangling from the mechanical lift. NA #2 indicated once he had arrived at Resident # 37's bathroom, he had noticed the resident ' s face was purplish blue and the lift's straps were by the resident ' s neck. NA # 2 reported he did not recall whether Resident # 37's knees were touching the floor or not because everything had happened so fast. He further indicated the resident head was tilted towards the front of her body. NA # 2 stated after he had assisted the resident to a seated position on the toilet the resident ' s color in her face returned to normal. NA # 2 stated the resident ' s family member had been in the room but had not assisted with getting the resident off the mechanical lift. NA #2 added NA # 1 assisted him with getting Resident # 37 off the lift. He indicated Nurse # 1 assessed Resident # 37 after the resident had been removed from the mechanical lift and had been placed on the toilet.

During an interview with Nurse #1 on 8/1/2018 at 11:10 AM, Nurse # 1 stated she had been assigned to care for Resident #37 on 6/23/2018. Nurse #1 stated NA # 1 reported to her they had difficulty during the transfer of Resident #37 from the bed to the toilet using the mechanical lift. Nurse #1 stated Resident # 37 had slid off the lift because the staff failed to use the leg straps and nonskid socks or shoes which caused the resident to slip some from the lift. Nurse #1 reported NA # 1 had been using the lift with no

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assistance. She further stated she had expected the NA # 1 to have asked for assistance when using the lift. She indicated the lift required 2 persons. Nurse # 1 stated the use of nonskid socks or shoes had always been required to prevent residents ' feet from slipping off the lift but they had not been used by NA # 1. Nurse #1 stated she had also felt the sit to stand lift was not appropriate for Resident # 37. Nurse # 1 indicated she had assessed Resident #37 after she had been transferred to the toilet by the NA's and stated she did not notice any injury to Resident #37. Nurse # 1 indicated she did not report the incident to the physician or the Director of Nursing (DON) because she did not think of Resident # 37 ' s slip on the mechanical lift as an incident or accident. Nurse #1 stated in looking back at what had happened to the resident, she should have reported the incident to the physician, DON and completed an incident report.

During an interview with the DON on 8/2/2018 at 12:30 PM, the DON reported she had not been aware of Resident #37's incident of 6/23/2018 when the resident had slipped off the lift. The DON indicated her expectation of nursing staff would have been to have completed an incident report so she could have started an in-service training on the proper use of a mechanical lift. She also stated her expectation was for the staff to follow the care plan.

During an interview with the Administrator on 8/2/2018 at 12:40 PM, the Administrator reported he had just learned about the incident of Resident #37's slip off the mechanical lift. The Administrator stated his expectation would have been for the staff to have reported the accident to

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F 656	Continued From page 28 the DON immediately so they could have begun an in-service on the proper use of the mechanical lift. He indicated his expectation was for the staff to follow the care plan.	F 656		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, family interview, physician interview and staff interviews, the facility failed to attach and tighten the mechanical lift's leg straps around the lower legs per manufacturer's guidelines and failed to implement care plan and care guide interventions indicating use of 2 person assistance while transferring with the use of mechanical lift (sit to stand) and failed to ensure the resident had on non-skid footwear for 1 of 5 sampled residents reviewed for accidents. Resident #37 slipped during a transfer from the mechanical lift which allowed the lift's straps to slip around the resident's neck which caused the resident's face to turn purplish blue in color. Resident #37 was assessed at the facility and found to have no physical injuries. Immediate Jeopardy for Resident # 37 began on 6/23/2018 when the resident slipped while only one staff member was transferring her using a	F 689	F689 Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) On 6/23/18 on 7-3 shift Nursing Assistant (NA) #1 was transferring resident #37 with the sit to stand lift with one person assist from the chair to the bathroom. Resident #37 started to slip while in the sit to stand lift. NA #1 retrieved assistance from NA #2 and NA #3 to transfer resident #37 due to slipping while in the sit to stand lift. Resident #37 was noted purplish blue in the face during transfer. Nurse #1 assessed resident #37 while in the bathroom with no injuries noted. A thorough investigation was initiated on 8/1/2018 by the Administrator and Director of Nursing to identify the root cause of the failure of prevention of accident related to resident #37. During the investigation it	8/15/18

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mechanical lift and staff failed to properly secure her to the lift and ensure she was wearing non-skid foot and the lift ' s straps slipped around the resident ' s neck causing the resident ' s face to turn purplish blue. Immediate Jeopardy was remove on 8/2/2018 when the facility provided an acceptable credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a scope and severity of D (not actual harm with potential for more than minimal harm that is not Immediate Jeopardy) to allow for ongoing in- servicing or monitoring to be accomplished.

The findings included:

A review of the manufacturer' s manual instructions for the mechanical lift used at the facility, dated April 2013, included the following instructions: "Position the mechanical lift and adjust the width of the base, so that the patient's feet can be centered on the footrest. The lower legs (below the knees) should be parallel to the lower-leg on the lift. Adjust the horizontal and vertical position of the pad for comfortable resistance just below the kneecaps. Attach and tighten the strap around the lower legs."

Resident # 37 was admitted on 11/12/2014 with diagnoses of Alzheimer's disease, cerebrovascular disease, dementia, generalized muscle weakness, pain and abnormal posture.

The quarterly Minimum Data Set (MDS), dated 5/23/2018, indicated Resident # 37's cognition had been severely impaired and she had required extensive assistance of one person for bed mobility. Resident #37 had been totally dependent with the assistance of 2 staff for

was found that the Director of Nursing failed to appropriately investigate the incident after reading the documentation of the incident note in the clinical record on 6/25/18 due to failure to flag the incident for follow up. The Director of Nursing failed to assure re-assessment of resident #37 for a different method of lift transfer to prevent accident since being unable to stand on 6/23/18. It was also determined by the Administrator that the Nursing assistant failed to follow the resident care guide for 2 person assist related to rushing to get the resident dressed and out of bed before the family came to the room. Per interview with the nursing assistant on 8/2/18, nursing assistant #1 stated she failed to pull the call bell cord and left the resident in a compromising position in an attempt to get assistance faster. The Administrator determined that the Nursing Assistant failed to adhere to education that was provided regarding emergency lift procedures on 4/9/18.
Nursing Assistant #1 was removed from the schedule on 8/1/18 by the Director of Nursing pending an investigation of resident #37 incident. A 24 hour report was completed and sent to the Health Care Personnel Registry by the Administrator on 8/2/18.
Corrective Actions
On 8/01/18, interviews were initiated by the Social Workers with all alert and oriented residents with questions in regards to:

1. Has the facility failed to provide care?

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F 689	Continued From page 30 transfers, dressing and toileting. The MDS indicated Resident #37 was not steady when moving from a seated position to a standing position and was only able to stabilize with staff assistance. The MDS indicated Resident #37 was not steady when moving on and off the toilet and had only been able to stabilize with staff assistance. The MDS indicated Resident #37 had no trial of a toileting program and she had been frequently incontinent of her bowels and bladder. Resident # 37's care plan, dated 5/23/2018 indicated Resident # 37 required "assistance for mobility due to the aging process, short and long term memory deficits, physical limitations/non-ambulatory, weakness, unsteady balance during transitions." The interventions included the following: monitor for safety awareness, transfers using mechanical lift (sit to stand lift) with aid of 2 persons, report to nurse any decrease in ability to transfer safely and monitor for safety awareness A review of Resident #37's current Care Guide dated 5/23/2018 indicated the following: the resident required Activity of Daily Living (ADL) care, may require 2 person assist with toileting. Transfers: mechanical lift (sit to stand lift; vest size - L) with 2 person assist. The resident required non-skid footwear. A review of a nurse's note, dated 6/23/2018 and written by Nurse # 1, indicated Resident # 37 exhibited difficulty standing with a sit-to-stand lift per staff interview; 3 staff members assisted Resident # 37 onto the toilet when her feet slipped off mechanical lift.	F 689	2. If yes please explain? The resident concern process was followed by the social worker and Administrator for all identified areas of concern by 8/2/18. On 8/1/18, a transfer observation of 100% of all residents to include resident #37 utilizing mechanical lifts was initiated by the Minimum Data Set (MDS) coordinator, MDS nurses and therapy manager. The purpose of the observation is to ensure that the resident's current mechanical lift use was the safest method of transfer. The audit was completed by 8/2/18. The MDS coordinator re-evaluated the resident transfer method, updated the resident care plan and care guide, and completed a therapy referral by 8/2/18 for any identified areas of safety concerns observed during the audit. On 8/1/18, a questionnaire was initiated with 100% of all nurses and nursing assistants by the Quality Improvement (QI) nurse with questions regarding: 1. Do you feel any resident transfer method, to include type of mechanical lift, needs to be changed? 2. If yes, what resident and reason why? This questionnaire was completed by 8/2/18. The MDS coordinator re-evaluated the resident transfer method, updated the resident care plan and care guide, and completed a therapy referral by 8/2/18 for any identified areas of safety concerns expressed during the questionnaire. After 8/2/18, all nurses and nursing assistants that have not completed the questionnaire	

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F 689	Continued From page 31 A review of the facility ' s incident log for Resident # 37 revealed no incident report had been completed after the 6/23/2018 incident. During an interview with Resident #37 ' s Responsible Party (RP) on 7/31/2018 at 2:00 PM, the RP reported on 6/23/2018 he came to visit Resident #37 and found her almost "choked" on the mechanical lift's straps. The RP indicated another nursing assistant (NA), NA #3, had been asked to come to Resident #37's room and assisted in getting her safely down to the bathroom floor or toilet seat. The RP reported he had been concerned about Resident #37 ' s safety while being transferred on a mechanical lift. He further indicated the staff did not follow the guidelines as required while using the mechanical lift because he had noticed on the day of the accident she had been transferred by one nurse aide instead of two. The RP further reported Resident #37 had not been wearing shoes or nonskid socks per the care guide and the strap around the lower legs had not been applied. During an interview with NA #1 on 8/1/2018 at 10:00 AM, NA # 1 reported she had been assigned to work with Resident # 37 on 6/23/2018. She indicated before lunch, she had been transferring the resident from the bed to the toilet with the sit-to-stand (mechanical lift) by herself. NA #1 reported Resident #37 started to slip from the lift before getting on the toilet. NA# 1 stated a family member had arrived for a visit and found Resident #37 had slipped from the mechanical lift. NA #1 stated the RP had started to assist to keep her from falling but had been unable to stop the resident from slipping and the strap from getting caught at the resident's neck. NA # 1 stated she left Resident # 37 on the lift in	F 689	will not be allowed to work until the questionnaire is completed. On 8/1/18, return demonstrations of mechanical lift transfer was initiated with 100% of all nurses and nursing assistants by the Staff Facilitator. The purpose of the return demonstrations are to ensure that staff are checking the resident care guide for the correct number of person to utilize for transfers and that the mechanical lift is being utilized per manufacture specifications during the transfer. After, 8/2/18, all nurses and nursing assistants that have not completed the return demonstration will not be allowed to work until the return demonstration is completed. On 8/1/18 an audit of all resident's incident reports to include resident #37 from 6/23/18 to 8/1/18 was initiated by the MDS nurses and the treatment nurse to ensure all incidents have been thoroughly investigated to determine the root cause and appropriate interventions initiated to prevent further incidents. This audit was completed by 8/2/18. The QI nurse investigated the incident, implement interventions, and updated the resident care plan and care guide by 8/2/18 for all identified areas of concern. On 8/1/18 an audit of all resident's progress notes to include resident #37 from 6/23/18 to 8/1/18 was initiated by the QI nurse and the Registered Nurse (RN) supervisor to ensure that all documented incidents have an incident report, was investigated to determine the root cause and appropriate interventions were implemented to prevent further incidents.	

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F 689	Continued From page 32 the bathroom to get more help from another staff member who had been in another resident's room at the end of the hall. NA #1 stated Medication Aide (MA) # 1 also came by the resident's bathroom but stood by the resident ' s room waiting for additional assistance to get the resident off the mechanical lift. NA #1 stated prior to the incident she had been in a panic to get Resident # 37 to the bathroom before the family ' s visit. She further added the family of Resident #37 had wanted Resident # 37 up in the mornings and she had no other person to ask for assistance. NA #1 added the day the resident had the accident the facility had been short of staff and she could not find anyone to assist her with transferring Resident # 37 on the mechanical lift. NA #1 stated Resident #37 is always "dancing" (unsteady while standing) while being transferred on the mechanical lift, making it a more difficult transfer. During an interview with NA #2 on 8/1/2018 at 10:20 AM, NA # 2 stated he came down to Resident # 37's room after he finished giving care to another patient. He had been told he needed to help Resident # 37 who had been left dangling from the mechanical lift. NA #2 indicated once he had arrived at Resident # 37 ' s bathroom, he had noticed the resident ' s face was purplish blue and the lift ' s straps were by the resident ' s neck. NA # 2 reported he did not recall whether Resident # 37 ' s knees were touching the floor or not because everything had happened so fast. He further indicated the resident head was tilted towards the front of her body. NA # 2 stated after he had assisted the resident to a seated position on the toilet the resident ' s color in her face returned to normal. NA # 2 stated the resident ' s family member had	F 689	This audit was completed by 8/2/18. The QI nurse investigated the incident, implement interventions, and updated the resident care plan and care guide by 8/2/18 for all identified areas of concern. On 8/01/18, an in-service was initiated for 100% of all staff to include nurses, nursing assistants, housekeeping, dietary, therapy, maintenance, payroll, book keeper, social workers, was initiated by the Staff Facilitator regarding Neglect to include examples of neglect and prevention of neglect. This inservice was completed by 8/02/18. After 8/2/18, all staff to include nurses, nursing assistants, housekeeping, dietary, therapy, maintenance, payroll, book keeper, social workers that have not worked and/or not received the in-services was mailed the in-service via certified mail by the Payroll Bookkeeper. Instructions included in the inservice packet to read, sign the inservice, call the Staff Facilitator or Director of Nursing with any questions, and return the signed inservice to the Staff Facilitator or Director of Nursing prior to next schedule shift. Staff were not be permitted to work until the signed inservices were received. On 8/1/18 an in-service was initiated by the Staff Facilitator with 100% of all nurses and nursing assistants regarding the safe handling and movement policy. This in-service included reading the resident care guide to identify the number of person required for resident transfer, reporting to the nurse when a transfer method is no longer safe, lowering the resident and not leaving the resident when	

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been in the room but had not assisted with getting the resident off the mechanical lift. NA #2 added NA # 1 assisted him with getting Resident # 37 off the lift. He indicated Nurse # 1 assessed Resident # 37 after the resident had been removed from the mechanical lift and had been placed on the toilet.

During an interview with MA #1 on 8/1/2018 at 10: 30 AM, MA # 1 stated NA # 1 had come out of Resident # 37's room and stated she needed help. MA #1 stated she had entered Resident # 37's room and she noticed the resident had been on the lift and had slipped down with her feet off the platform of the lift. MA # 1 indicated she had been waiting for NA # 1 to get more help as the patient had been constantly slipping. MA #1 added the resident ' s face had turned red in color as she slid down the lift. MA # 1 indicated the strap had slipped by the resident ' s neck.

During an interview with Nurse #1 on 8/1/2018 at 11:10 AM, Nurse # 1 stated she had been assigned to care for Resident #37 on 6/23/2018. Nurse #1 stated NA # 1 reported to her they had difficulty during the transfer of Resident #37 from the bed to the toilet using the mechanical lift. Nurse #1 stated Resident # 37 had slid off the lift because the staff failed to use the leg straps and nonskid socks or shoes which caused the resident to slip some from the lift. Nurse #1 reported NA # 1 had been using the lift with no assistance. She further stated she had expected the NA # 1 to have asked for assistance when using the lift. She indicated the lift required 2 persons. Nurse # 1 stated the use of nonskid socks or shoes had always been required to prevent residents' feet from slipping off the lift but they had not been used by NA # 1. Nurse #1

sliding in the lift and how to safely strap and transfer resident in the mechanical lift per the manufacture specifications. The manufacture specification was printed by the Staff Facilitator and reviewed with staff during the inservice. This in-service was completed by 8/2/18. After 8/2/18, all nurses and nursing assistants that have not worked and/or not received the in-services were mailed via certified mail by the Payroll Bookkeeper. Instructions included in the inservice packet to read, sign the inservice, call the Staff Facilitator or Director of Nursing with any questions, and return the signed inservice to the Staff Facilitator or Director of Nursing prior to next schedule shift. Staff were not permitted to work until the signed inservices were received.
The Administrator, Director of Nursing, and Quality Improvement nurse was in serviced on the process of investigating incidents on 8/1/18 by the Facility Nurse Consultant. The in-service included to review the incident reports 5 days per week, how to pull a report from the risk management portal in the electronic records to identify incidents that have been documented by the nurses, printing the incident reports from the electronic records, flagging the incident for follow up, reading progress notes to identify all incidents, discussing incidents in the clinical morning meetings, determining the root cause of the incident, completion of incident reports, and implementing and monitoring interventions.
An inservice was completed with the Director of Nursing on 8/2/18 regarding

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stated she had also felt the sit to stand lift was not appropriate for Resident # 37. Nurse # 1 indicated she had assessed Resident #37 after she had been transferred to the toilet by the NA's and stated she did not notice any injury to Resident #37. Nurse # 1 indicated she did not report the incident to the physician or the Director of Nursing (DON) because she did not think of Resident # 37 ' s slip on the mechanical lift as an incident or accident. Nurse #1 stated in looking back at what had happened to the resident, she should have reported the incident to the physician, DON and completed an incident report.

During an interview with the Physician on 8/1/2018 at 11:30 AM, the Physician indicated he had not been made aware of Resident #37's incident on 6/23/2018. The physician indicated his expectation would have been for the facility staff to have notified him of the incident emphasizing especially if the resident had turned purple blue during the incident.

During an interview with the MDS nurse on 8/2/2018 at 9:30 AM, the MDS nurse reported Resident #37 had history of being unstable while being transferred on a sit to stand lift because her legs had been buckling (both of knees give out). The MDS nurse stated the family had insisted on the use of the sit to stand lift even though the staff at the facility had been aware it had not been appropriate for Resident # 37.

During an observation of a mechanical lift transfer made on 8/2/2018 at 10:30 AM, Resident # 37's appeared confused with the instructions given her by NA # 4 to grasp the mechanical lift' s sling bar. Resident # 37 had been noticed to be unsteady while standing on the lift.

requirements for re -evaluating residents for change in transfer methods by the Facility Nurse Consultant.
On 8/1/18 an in-service was initiated by the Staff Facilitator with 100% of all nurses regarding completion of incident reports and collecting witness statements. After 8/2/18, all nurses that have not worked and/or not received the in-service will be mailed the in-service via certified mail by the Payroll Bookkeeper. Instructions will be included in the inservice packet to read, sign the inservice, call the Staff Facilitator or Director of Nursing with any questions, and return the signed inservice to the Staff Facilitator or Director of Nursing prior to next schedule shift. Staff will not be permitted to work until the signed inservices are received.
The decision to monitor the system for prevention of accidents was made on 8/1/2018 by the Administrator and Director of Nursing. The RN Supervisor, the Staff Facilitator, Treatment nurse, Unit Facilitator and/or the QI nurses, will audit 10% of all residents requiring mechanical lifts for transfers to include resident #37 to ensure staff are checking the resident care guide and utilizing the number of person identified on the care guide, staff are utilizing the mechanical lift per manufacture specification during the transfer, and ensure the current lift is the safest method of transfer 3 x a week for four weeks, then weekly for x 4 weeks, then monthly x 1 month utilizing a Lift Transfer Audit Tool. Any areas of concern will be immediately addressed by the RN

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F 689	Continued From page 35 During an interview with NA #4 on 8/2/2018 at 10:40 AM, NA# 4 reported Resident #37 had been unstable while on the lift but she had been transferred using the sit to stand lift for a long time. NA #4 indicated Resident # 37 had usually been assisted to the toilet before breakfast and lunch. During the interview with the Staff Development Coordinator (SDC) on 8/2/2018 at 11:30 AM, the SDC stated NA # 2 reported to her, during the 08/01/2018 investigation of the incident involving Resident #37, when he had been asked to assist with Resident # 37 on 6/23/2018, she had seen the resident ' s face turned purple blue and the resident ' s veins bulged on her neck while she dangled on the mechanical lift. The SDC indicated she had thought a supervisor had investigated the incident after it happened on 6/23/2018 as she had overheard a conversation about the incident around the time it happened. She added she could not recall the exact date or the name of the supervisor. The SDC stated she had not been the SDC at the time of Resident # 37's mechanical ' s lift accident. During an interview with the DON on 8/2/2018 at 12:30 PM, the DON reported she had not been aware of Resident #37 ' s incident of 6/23/2018 when the resident had slipped off the lift. The DON indicated her expectation of nursing staff would have been to have completed an incident report so she could have started an in-service training on the proper use of a mechanical lift. During an interview with the Administrator on 8/2/2018 at 12:40 PM, the Administrator reported he had just learned about the incident of Resident	F 689	Supervisor, the Staff Facilitator, the Unit Facilitator and/or the QI nurses to include staff retraining. The Director of Nursing will review and initial the Lift Transfer Audit Tools weekly x 8 weeks then monthly x 1 month. The RN Supervisor, the Staff Facilitator, Treatment nurse, Unit Facilitator and/or the QI nurses will review all incidents reports and progress notes 3 x a week for 4 weeks, then weekly for x 4 weeks, then monthly x 1 month utilizing the Incident Audit Tool to ensure all identified incidents have been thoroughly investigated, incidents reports completed, and appropriate interventions implemented to prevent further accidents. The RN Supervisor, the Staff Facilitator, Treatment nurse, Unit Facilitator and/or the QI nurses will investigate the incident, implement interventions, and provide retraining for all identified areas of concern during the audit. The Director of Nursing will review and initial the Incident Audit Tool weekly x 8 weeks then monthly x 1 month. The Quality Improvement Organization was contacted by the Director of Nursing on 8/02/18 for assistance in evaluation of specific steps to be taken to address neglect and prevention of accidents and training, staff position/title designated to be responsible for the steps, timeline for accomplishment of the steps, specific methodology to be used to evaluate the plan's success, and frequency of monitoring the effects of the plan initiation. The DON will present the findings of the Lift Transfer Audit Tools and the Incident	

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F 689	Continued From page 36 #37's slip off the mechanical lift. The Administrator stated his expectation would have been for the staff to have reported the accident to the DON immediately so they could have begun an in-service on the proper use of the mechanical lift. The Administrator, Director of Nursing and Facility's nurse consultant were notified of the Immediate Jeopardy on 8/1/2018 at 4:30 pm. On 8/2/2018 the facility provided an acceptable credible allegation for immediate jeopardy removal that included the following: Corrective Actions: On 8/01/18, interviews were initiated by the Social Workers with all alert and oriented residents. The resident concern process will be followed by the social worker and Administrator for all identified areas of concern by 8/2/18. On 8/1/18, a transfer observation of 100% of all residents to include resident # 37 utilizing mechanical lifts was initiated by the Minimum Data Set (MDS) coordinator, MDS nurses and therapy manager. The purpose of the observation is to ensure that the resident ' s current mechanical lift use is the safest method of transfer. The audit will be completed by 8/2/18. The MDS coordinator will re-evaluate the resident transfer method, update the resident care plan and care guide, and complete a therapy referral by 8/2/18 for any identified areas of safety concerns observed during the audit. On 8/1/18, a questionnaire was initiated with 100% of all nurses and nursing assistants by the	F 689	Audit Tools to the Executive Quality Assurance (QA) committee monthly for 3 months. The Executive QA Committee will meet monthly for 3 months and review the Lift Transfer Audit Tools and the Incident Audit Tools to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring. The decision to review the monitoring of prevention of accidents during the quality assurance committee meeting was made by the Administrator and Director of Nursing on 8/01/2018. The Administrator and DON was responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring related to the plan of correction.	

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Quality Improvement (QI) nurse. This questionnaire will be completed by 8/2/18. The MDS coordinator will re-evaluate the resident transfer method, update the resident care plan and care guide, and complete a therapy referral by 8/2/18 for any identified areas of safety concerns expressed during the questionnaire. After 8/2/18, all nurses and nursing assistants that have not completed the questionnaire will not be allowed to work until the questionnaire is completed.

On 8/1/18, return demonstrations of mechanical lift transfer was initiated with 100% of all nurses and nursing assistants by the Staff Facilitator. The purpose of the return demonstrations are to ensure that staff are checking the resident care guide for the correct number of person to utilize for transfers and that the mechanical lift is being utilized per manufacture specifications during the transfer. After, 8/2/18, all nurses and nursing assistants that have not completed the return demonstration will not be allowed to work until the return demonstration is completed.

On 8/1/18 an audit of all resident's incident reports to include resident # 37 from 6/23/18 to 8/1/18 was initiated by the MDS nurses and the treatment nurse to ensure all incidents have been thoroughly investigated to determine the root cause and appropriate interventions initiated to prevent further incidents. This audit will be completed by 8/2/18. The QI nurse will investigate the incident, implement interventions, and update the resident care plan and care guide by 8/2/18 for all identified areas of concern.

On 8/1/18 an audit of all resident's progress notes to include resident # 37 from 6/23/18 to 8/1/18

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was initiated by the QI nurse and the Registered Nurse (RN) supervisor to ensure that all documented incidents have an incident report, was investigated to determine the root cause and appropriate interventions were implemented to prevent further incidents. This audit will be completed by 8/2/18. The QI nurse will investigate the incident, implement interventions, and update the resident care plan and care guide by 8/2/18 for all identified areas of concern.

On 8/01/18, an in-service was initiated for 100% of all staff to include nurses, nursing assistants, housekeeping, dietary, therapy, maintenance, pay roll, book keeper, social workers, was initiated by the Staff Facilitator regarding Neglect to include examples of neglect and prevention of neglect. This in-service was completed by 8/02/18. After 8/2/18, all staff to include nurses, nursing assistants, housekeeping, dietary, therapy, maintenance, pay roll, book keeper, social workers that have not worked and/or not received the in-services will be mailed the in-service via certified mail by the Payroll Bookkeeper. Instructions will be included in the in-service packet to read, sign the in-service, call the Staff Facilitator or Director of Nursing with any questions, and return the signed in-service to the Staff Facilitator or Director of Nursing prior to next schedule shift. Staff will not be permitted to work until the signed in services are received.
On 8/1/18 an in-service was initiated by the Staff Facilitator with 100% of all nurses and nursing assistants regarding the safe handling and movement policy. This in-service included reading the resident care guide to identify the number of person required for resident transfer, reporting to the nurse when a transfer method is no longer safe, lowering the resident and not

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leaving the resident when sliding in the lift and how to safely strap and transfer resident in the mechanical lift per the manufacture specifications. The manufacture specification will be printed by the Staff Facilitator and reviewed with staff during the in-service. This in-service will be completed by 8/2/18. After 8/2/18, all nurses and nursing assistants that have not worked and/or not received the in-services will be mailed via certified mail by the Payroll Bookkeeper. Instructions will be included in the in-service packet to read, sign the in-service, call the Staff Facilitator or Director of Nursing with any questions, and return the signed in-service to the Staff Facilitator or Director of Nursing prior to next schedule shift. Staff will not be permitted to work until the signed in services are received.

The Administrator, Director of Nursing, and Quality Improvement nurse was in serviced on the process of investigating incidents on 8/1/18 by the Facility Nurse Consultant. The in-service included to review the incident reports 5 days per week, how to pull a report from the risk management portal in the electronic records to identify incidents that have been documented by the nurses, printing the incident reports from the electronic records, flagging the incident for follow up, reading progress notes to identify all incidents, discussing incidents in the clinical morning meetings, determining the root cause of the incident, completion of incident reports, and implementing and monitoring interventions.

An in-service was completed with the Director of Nursing on 8/2/18 regarding requirements for re-evaluating residents for change in transfer methods by the Facility Nurse Consultant.

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On 8/1/18 an in-service was initiated by the Staff Facilitator with 100% of all nurses regarding completion of incident reports and collecting witness statements. After 8/2/18, all nurses that has not worked and/or not received the in-service will be mailed the in-service via certified mail by the Payroll Bookkeeper. Instructions will be included in the in-service packet to read, sign the in-service, call the Staff Facilitator or Director of Nursing with any questions, and return the signed in-service to the Staff Facilitator or Director of Nursing prior to next schedule shift. Staff will not be permitted to work until the signed in services are received.

The decision to monitor the system for prevention of accidents was made on 8/1/2018 by the Administrator and Director of Nursing. The RN Supervisor, the Staff Facilitator, Treatment nurse, Unit Facilitator and/or the QI nurses, will audit 10% of all residents requiring mechanical lifts for transfers to include resident # 37 to ensure staff are checking the resident care guide and utilizing the number of person identified on the care guide, staff are utilizing the mechanical lift per manufacture specification during the transfer, and ensure the current lift is the safest method of transfer 3 x a week for four weeks, then weekly for x 4 weeks, then monthly x 1 month utilizing a Lift Transfer Audit Tool. Any areas of concern will be immediately addressed by the RN Supervisor, the Staff Facilitator, the Unit Facilitator and/or the QI nurses to include staff retraining. The Director of Nursing will review and initial the Lift Transfer Audit Tools weekly x 8 weeks then monthly x 1 month.

The Registered Nurse (RN) Supervisor, the Staff Facilitator, Treatment nurse, Unit Facilitator

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F 689	Continued From page 41	F 689		

and/or the QI nurses will review all incidents reports and progress notes 3 x a week for 4 weeks, then weekly for x 4 weeks, then monthly x 1 month utilizing the Incident Audit Tool to ensure all identified incidents have been thoroughly investigated, incidents reports completed, and appropriate interventions implemented to prevent further accidents. The RN Supervisor, the Staff Facilitator, Treatment nurse, Unit Facilitator and/or the QI nurses will investigate the incident, implement interventions, and provide retraining for all identified areas of concern during the audit. The Director of Nursing will review and initial the Incident Audit Tool weekly x 8 weeks then monthly x 1 month.

The Quality Improvement Organization will be contacted by the Director of Nursing on 8/02/18 for assistance in evaluation of specific steps to be taken to address neglect and prevention of accidents and training, staff position/title designated to be responsible for the steps, timeline for accomplishment of the steps, specific methodology to be used to evaluate the plan ' s success, and frequency of monitoring the effects of the plan initiation.

The DON will present the findings of the Lift Transfer Audit Tools and the Incident Audit Tools to the Executive Quality Assurance (QA) committee monthly for 3 months. The Executive QA Committee will meet monthly for 3 months and review the Lift Transfer Audit Tools and the Incident Audit Tools to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring. The decision to review the monitoring of prevention of accidents during the quality assurance committee meeting was

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F 689	Continued From page 42 made by the Administrator and Director of Nursing on 8/01/2018. Final date of compliance is 8/02/2018. The Administrator and DON will be responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring related to the plan of correction. The Credible Allegation for Immediate Jeopardy removal was validated on 8/2/2018, which removed the Immediate Jeopardy on 8/2/2018. During the Immediate Jeopardy removal validation process interviews were conducted with nursing staff present in the facility on 8/2/2018. The staff confirmed the recent in- services and training of the proper use of Mechanical lift. Reviews of the in-service records, audit tools, audits performed and facility assessments were made. Observations of residents' transfers were completed.	F 689		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper	F 761		8/15/18

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F 761	Continued From page 43 temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to dispose/discard expired medications in 1 of 3 medication storage rooms (Front Medication Room) and in 1 of 4 medication carts observed (300/400 Hall Medication Aide Cart). The findings included: During an observation of the medication refrigerator in the Front Medication Room on 07/30/18 at 5:10 p.m., the refrigerator contained 124 pre-filled syringes of Fluvirin (influenza vaccine) with an expiration date of May 2018. During an observation of the nurse aide medication cart for the 300/400 hall on 08/02/18 at 11:30 a.m., a plastic storage bag was found to contain three expired bottles of medications: Woman's Laxative expired February 2013, Gas Relief May 2018 and Omega XL expired July 2018. During an interview with Nurse #1 on 07/30/18 at 5:15 p.m., Nurse #1 stated it was the	F 761	F761 Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) 100% audit was completed on 8/15/2018 of 100, 200, 300, and 400 halls medication rooms and four medication carts, 800 hall medication room and two medication carts, and 700 hall medication room and medication cart, to ensure all medication rooms and medication carts, do not have any expired medications that are utilized by the licensed nurse and/or medication aide by the RN supervisor, Unit Facilitator, and the Quality Improvement (QI) nurses on 8/15/2018. Any areas of concerns were addressed at that time. 100% inservice to all licensed nurses and medication aides on checking medication rooms and medication carts for expired meds, and discarding expired medications appropriately, was initiated on 8/14/2018 by the Staff Facilitator and will be	

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F 761	Continued From page 44 responsibility of the hall nurses to keep the medication rooms free of expired medications. During an interview with Medication Aide (MA) #1 on 08/02/18 at 11:30 a.m., MA #1 stated she did not know how the expired medication got into her medication cart. During an interview with the Director of Nursing (DON) on 07/30/18 at 5:40 p.m., the DON stated it had been a joint effort of the nursing supervisors and the hall nurses to keep the medication rooms and medication carts free of expired medications. The DON stated it was her expectation nursing staff remove expired medication from the medication rooms and carts as soon as it is noticed.	F 761	completed on 8/15/2018. Any licensed nurse or medication aide that is not available for in-service will be in-serviced over the telephone and a copy of the in-service will be sent via certified mail on 8/15/2018 with return receipt requested. No licensed nurse or medication aide will be allowed to work until in-service is complete. All newly hired licensed nurses and medication aides will be inserviced on checking medication rooms and medication carts for expired meds, and discarding expired medications appropriately during orientation. A list of Medication Discard dates from the Pharmacy will be placed in front of every Medication Administration Record on all medication carts in the facility and every medication room as a reference to be utilized by the licensed nurses and medication aides, by the Director of Nursing and completed on 8/15/2018. Medication Carts will be monitored using a Medication carts and Med rooms/Expired medications QI Tool to ensure all medication rooms and medication carts do not have expired medications, by the RN supervisor, Unit Facilitator, Staff Facilitator and the QI nurses, 3 times a week for 4 weeks, then weekly for 4 weeks then monthly for 1 month. The licensed nurse and medication aides will be immediately re-trained by the auditor, RN supervisor, Unit Facilitator, Staff Facilitator and the QI nurses, for any identified areas of concern. The Director of Nursing will review and initial the Medication cart/Expired medications QI	

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F 761	Continued From page 45	F 761	Tool for completion and to ensure all areas of concerns were addressed weekly for 8 weeks and monthly for 1 month. The Executive QI committee will meet to review the Medication cart and medication rooms/expired medications QI tool monthly for 3 months to determine issues and trend to include continued monitoring frequency.	