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F 000	INITIAL COMMENTS The State Agency (SA) conducted a Complaint Investigation (CI MS#23773) at the facility from 1/8/24 through 1/10/24. The SA determined the facility was in compliance with the Requirements of Participation in Medicare and Medicaid. Based on the facility's implementation of corrective actions on 12/21/23 taken prior to survey entrance on 1/08/24, related to the complaint CI MS#23773 for Quality of Care/treatment services, this deficient practice was determined to be Past Non-Compliance and the SA cited F600, F656, and F689. However, the facility remains out of compliance due to deficiencies cited on the 12/18/2023 survey. The facility had a census of 56 at the time of the survey and held a license for 60 beds.	F 000		
F 600 SS=G	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:	F 600		

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

Electronically Signed | 01/31/2024

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F 600	Continued From page 1 Based on staff and resident interviews, record review and facility policy review, the facility failed to protect the resident's right to be free from neglect when a resident was transferred utilizing a total lift without two (2) staff members resulting in the lift overturning and the resident falling to the floor. The resident sustained skin tears and a hematoma to her scalp and required transfer to the emergency department. This was for one (1) of seven (7) residents sampled. Resident #1. Findings include: Policy and procedure review of the facility's "Abuse Program" last revised May 23, 2017, revealed "It is the policy of this facility to take all steps necessary to maintain an environment free of abuse and neglect ...Neglect is the failure of the facility, its employees or services providers to provide good and services necessary to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional stress. Neglect occurs when facility staff fail to monitor and/or supervise the delivery of resident care and services to assure that care is provided as needed by residents. Neglect occurs when a facility fails to provide necessary care for residents ..." Record review of the facility investigation "Reportable Incident Form" dated 12/7/23 revealed that CNA (Certified Nurse Aide) #1 attempted to transfer Resident #1 with the total lift without assistance on 12/6/23 at approximately 5:30 PM. CNA #1 admitted that she was trying to transfer Resident #1 to the bed from her wheelchair and did not get assistance from another staff member. The lift fell over when CNA #1 turned toward the bed, and Resident #1	F 600	Past noncompliance: no plan of correction required.	

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F 600	Continued From page 2	F 600		

landed on the floor. When the nurses arrived, the lift was removed from the lower legs of Resident #1. It was noted Resident #1 had multiple skin tears which were cleaned and treated. The Medical Director was in the facility and gave the order to send Resident #1 to the hospital for further evaluation and treatment. She returned that night at 10:43 PM with no new orders. CNA #1 was suspended immediately after the incident and her employment terminated.

Record review of the Emergency Room (ER) visit on 12/6/23 of Resident #1 revealed the "Assessment/Plan 1. Hematoma of scalp, 2. Skin Tear, 3. Back Pain" on page five (5) of 27.

Record review of Resident #1 "Minor Med Care Progress Note" dated 12/7/2023, by the Nurse Practitioner revealed "91 y/o (years old) WF (white female) s/p (status post) fall from Hoyer lift in the facility last night with left temple contusion, left elbow skin tear and right medial ankle skin tear. She denies a headache at this time but she does have tenderness to her right ankle and left elbow from the skin tears."

Record review of Resident #1's "Lift/Transfer Evaluation" dated 10/17/23 revealed she was assessed to require "Sling Size: XXL (extra, extra large) Sling. Required Total Lift. Select assistance required: Total lift with 2 assist. Total Lift: sling size: Total lift with X-Large Sling"

Record review of undated Resident #1's "Resident Summary", which is on the kiosk for CNAs use, revealed "Bed Mobility Extensive Assistance 2 person, Lift Total Lift, Sling Size XXL sling."

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Record review of the binder connected to each lift in the facility revealed a "LONG TERM CARE GUIDE" with Resident #1 required the Total Lift for transfers with 2 staff members and an extra extra large sling.

On 1/8/24 at 5:00 PM, during an interview with the Administrator on information needed for a facility reported incident regarding Resident #1 falling from a lift and what happened the Administrator stated the Assistant Director of Nursing (ADON) was actually in the facility at the time of the incident working the medication cart. She was Resident #1's assigned nurse that 3-11 shift. CNA #1 was the CNA for Resident #1. CNA #1 attempted to transfer Resident #1 from the wheelchair to bed without getting assistance from another staff member. The CNA turned towards the bed and the lift fell over with Resident #1 in it and she fell onto the floor. CNA #1 admitted she didn't ask for assistance for the Total Lift transfer. She had been recently trained on lift use. She admitted knowing she needed another staff member to assist with the lift but didn't ask anyone. She was suspended that night and terminated after the investigation. He stated, "Thank God (Proper Name) Resident #1 wasn't hurt worse."

Interview with Resident #1 at 5:15 PM on 1/8/24, revealed that one (1) CNA had attempted to put her in bed using a lift. She stated she doesn't know what happened, but she and the lift fell over. She landed between the bedside table and the head of her bed. She revealed that she had a bump and bruise on her left temple area and some skin tears.

Interview with the Assistant Director of Nursing

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(ADON) on 1/8/24 at 5:45 PM, revealed that she was working on the unit as a medication nurse the 3-11 shift on 12/6/23. She stated that when she came into the room, Resident #1 was on the floor with the lift leaning over. Her head was between the bedside table and bed lying on the floor. She stated she did notice the base of the Total Lift was not spread out to prevent the lift from falling over. CNA #1 admitted to not getting another staff member to assist with the transfer of Resident #1 on the Total Lift. The resident had a skin tear to her left inner arm and on her bilateral lower extremities. She was assessed by nursing staff and 911 called for an ambulance to transfer her to the emergency room for further assessment and treatment.

Interview with CNA #1 on 1/9/24 at 1:05 PM, revealed that Resident #1 "had been on the light" and wanted in bed. She stated, "She is a total lift." When asked by the State Agency (SA) if she had asked for help, she stated "No. I didn't ask for help. I poked my head out of the door and didn't see anyone, so I tried to lift her alone." She stated, "I walked away from the lift toward the bed and the lift fell over." She stated she was attempting to use the total lift to transfer Resident #1 from her wheelchair to the bed without assistance. She denied being trained in abuse, neglect, resident rights, the vulnerable adults act and on lift use. She stated that the information for lift use and other ADL's are located on the kiosk on the walls of the resident halls. She said she "thinks there is a folder on the lifts too that have each resident's lift information".

Review of CNA #1's personnel file revealed she was hired 9/6/2023. She signed a "Lift free facility" form and it was dated for 6/9/2023. When

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the SA interviewed CNA #1 on 1/9/24 at 1:05 PM, she stated that her first day at work was 9/6/23 and she must have accidentally switched the numbers of the date. She signed the abuse/neglect policy for the facility on 9/6/23. She completed the facility's "CNAs Skills Check-off" on 11/9/23. This included "Transfer Using Mechanical Lift". She was terminated from employment on 12/7/23.

Record review of the "Face Sheet" of Resident #1 revealed that she was admitted to the facility on 11/23/2020 with her diagnosis' including Chronic Respiratory Failure with Hypercapnia, Morbid (severe) Obesity with Alveolar Hypoventilation, Muscle Weakness, and other Abnormalities of Gait and Mobility."

Record review of the Minimum Data Set (MDS) of Resident #1 with an Assessment Reference Date (ARD) of 10/17/2023, Section C-Cognitive Patterns Brief Interview for Mental Status (BIMS) score of 15 indicated she is able to make daily decisions.

Based on the facility's implementation of corrective actions on 12/7/23, the State Agency (SA) determined the deficiency to be Past Non-Compliance (PNC) and the deficiency was corrected as of 12/7/23, prior to the SA's first entrance on 1/8/24.

Validation of Past non-compliance:

On 12/6/23 the resident was assessed by the Director of Nursing and transferred immediately to the Emergency Room by ambulance. The Survey agency (SA) validated by record review of the nurses notes and Emergency Room

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documentation.

The Certified Nursing Assistant involved in the incident was immediately suspended and terminated 12/7/23. This was validated by the SA by reviewing the facility discipline form that revealed the termination of CNA #1.

The Resident Representative was notified on 12/6/23 and the Survey Agency and Attorney General's office were notified on 12/7/23. This was validated by the SA from record review and interviews.

All CNA's and Nurses were in serviced/retrained starting on 12/7/23 on following the individual care plan related to lift use, the facility policies on Total Lift Use, Abuse and Neglect, Care Plans. This was validated by the SA from sampled staff being interviewed to confirm their attendance, knowledge of the training, observation of lift use and record review of the signed documents of the attendance by the staff. As part of the facility monitoring, inservices will continue on the Total Lift use monthly for CNAs and quarterly for nurses throughout 2024. All nursing new hires will be in-serviced upon hire.

All residents care plans, lift instructions, resident summary's (information with access for the CNAs in the Kiosk with guidance for individual lift use), and the binders on all the lifts that contained the individual resident information for specific lift use were audited to ensure correct and consistent information. Sampled residents care plans, lift instructions, resident summary's and binders on the lifts were audited by the Survey Agency to confirm they had consistent and correct information.

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F 600	Continued From page 7 The SA validated through record review and interview that the facility held a Quality Assurance and Performance Improvement meeting on 12/7/23 to discuss the incident with the fall from the Total Lift. On 12/7/23, the Administrator, DON and ADON began monitoring resident halls daily reminding CNAs and nurses of the requirement of always having two staff members when using the Total Lift. The SA was able to validate the actions the facility took after the incident involving Resident #1 and CNA #1 through record review, interviews and observations.	F 600		
F 656 SS=G	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §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).	F 656		

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F 656	Continued From page 8 (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 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. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review, policy procedure review and interviews, the facility failed to implement a comprehensive person-centered care plan for one (1) of seven (7) residents sampled, Resident #1, as evidenced by on 12/6/23, Certified Nurse Aide (CNA) #1 failed to follow the "Resident Care Summary" and "ADL's (activities of daily living)" Care Plan for Resident #1 when she attempted to transfer Resident #1 using the total lift without the assistance of another staff member. Findings include:	F 656	Past noncompliance: no plan of correction required.	

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Policy and procedure review of the facility's "Care Plans" policy last updated 2/03/2023 revealed, "Policy: Each resident will have a person centered plan of care to identify problems, needs and strengths that will identify how the interdisciplinary team will provide care ...DEFINITIONS: Resident Care Summary-part of the Comprehensive Care Plan and used as the tool to make staff aware of the resident's daily care needs; serves as ADL care plan ..."

Record review of Resident #1's care plan revealed "Requires assistance for all ADL's related to impaired mobility and incontinence" with a "Start Date 11/24/2020...Intervention: TOTAL LIFT X (times) 2 person assist with XXL (extra extra large) sling".

Record review of the facility investigation "Reportable Incident Form" dated 12/7/23 revealed that CNA #1 attempted to transfer Resident #1 with the total lift without assistance on 12/6/23 at approximately 5:30 PM. CNA #1 admitted that she was trying to transfer Resident #1 to the bed from her wheelchair and did not get assistance from another staff member. The lift fell over when CNA #1 turned toward the bed, and Resident #1 landed on the floor. When the nurses arrived, the lift was removed from the lower legs of Resident #`1. It was noted resident #1 had multiple skin tears which were cleaned and treated. The Medical Director was in the facility and gave the order to send Resident #1 to the hospital for further evaluation and treatment. She returned that night at 10:43 PM with no new orders. CNA #1 was suspended immediately after the incident and her employment terminated.

Record review of undated Resident #1's

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"Resident Summary", which is the care guidance located on the kiosk for CNA use, revealed "Bed Mobility Extensive Assistance 2 person, Lift: Total Lift, Sling Size XXL sling."

Record review of the binder connected to each lift in the facility revealed a "LONG TERM CARE GUIDE" with Resident #1 required the Total Lift with 2 person assistance and the 2XL sling.

During an interview with Resident #1 on 1/8/24 at 5:15 PM, she stated that one Certified Nurse Aide (CNA) had attempted to put her in bed using a lift. She stated she doesn't know what happened, but she and the lift fell over. She landed between the bedside table and the head of her bed. She revealed that she had a bump and bruise on her left temple area and some skin tears.

On 1/8/24 at 5:45 PM, an interview with the Assistant Director of Nursing (ADON) revealed that when she went into Resident#1's room, CNA #1 stated she did not get help to use the Total Lift from another staff member. She stated, "No, she did not follow the Resident Summary or the ADL care plan. Both the Resident Summary and the ADL care plan state to have 2 staff members to use the Total Lift. We are a lift free facility which means that staff do not physically lift residents. We use 2 staff always with the Total Lift."

During an interview with CNA #1 on 1/9/24 at 1:05 PM, she stated that Resident #1 "had been on the light" and wanted in bed. "She is a total lift." When asked by the State Agency (SA) if she had asked for help, she stated "No. I didn't ask for help. I poked my head out of the door and didn't see anyone, so I tried to lift her alone." She stated, "I walked away from the lift toward the bed

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and the lift fell over." She stated she was attempting to use the total lift to transfer Resident #1 from her wheelchair to the bed without assistance. She stated that the information for lift use and other Activities of Daily Living (ADL) are located on the kiosk on the walls of the resident halls. She said she "thinks there is a folder on the lifts too that have each resident's lift".

During an interview with the Director of Nurses (DON) and Assistant Director of Nurses (ADON) on 1/9/24 at 1:55 PM revealed that information used to determine the lift use for a resident is by the residents care and mobility in the hospital, facility therapy department will assess residents for safety reasons and the nurses on admission will also evaluate the resident for lift use and mobility. The evaluation/assessment is done every 90 days and as needed by the Minimum Data Set (MDS) nurse. If there are changes on the care plans, it is made in the computer and automatically updates in the kiosk.

Record review of the "Face Sheet" of Resident #1 revealed that she admitted to the facility on 11/23/2020 with her diagnosis' including Chronic respiratory failure with hypercapnia, Morbid (severe) obesity with alveolar hypoventilation, Muscle weakness, other abnormalities of gait and mobility."

Review of the "Minimum Data Set (MDS)-Version 3.0" of Resident #1 with an Assessment Reference Date (ARD) of 10/17/2023, "Section C-Cognitive Patterns Brief Interview for Mental Status (BIMS) score of "15". She is able to make daily decisions.

Based on the facility's implementation of

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corrective actions on 12/7/23, the State Agency (SA) determined the deficiency to be Past Non-Compliance (PNC) and the deficiency was corrected as of 12/7/23, prior to the SA's first entrance on 1/8/24.

Validation of Past non-compliance:

On 12/6/23 the resident was assessed by the Director of Nursing and transferred immediately to the Emergency Room by ambulance. The Survey agency (SA) validated by record review of the nurses notes and Emergency Room documentation.

The Certified Nursing Assistant involved in the incident was immediately suspended and terminated 12/7/23. This was validated by the SA by reviewing the facility discipline form that revealed the termination of CNA #1.

The Resident Representative was notified on 12/6/23 and the Survey Agency and Attorney General's office were notified on 12/7/23. This was validated by the SA from record review and interviews.

All CNA's and Nurses were in serviced/retrained starting on 12/7/23 on following the individual care plan related to lift use, the facility policies on Total Lift Use, Abuse and Neglect, Care Plans. This was validated by the SA from sampled staff being interviewed to confirm their attendance, knowledge of the training, observation of lift use and record review of the signed documents of the attendance by the staff. As part of the facility monitoring, inservices will continue on the Total Lift use monthly for CNAs and quarterly for nurses throughout 2024. All nursing new hires will

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F 656	Continued From page 13 be in-serviced upon hire. All residents care plans, lift instructions, resident summary's (information with access for the CNAs in the Kiosk with guidance for individual lift use), and the binders on all the lifts that contained the individual resident information for specific lift use were audited to ensure correct and consistent information. Sampled residents care plans, lift instructions, resident summary's and binders on the lifts were audited by the Survey Agency to confirm they had consistent and correct information. The SA validated through record review and interview that the facility held a Quality Assurance and Performance Improvement meeting on 12/7/23 to discuss the incident with the fall from the Total Lift. On 12/7/23, the Administrator, DON and ADON began monitoring resident halls daily reminding CNAs and nurses of the requirement of always having two staff members when using the Total Lift. The SA was able to validate the actions the facility took after the incident involving Resident #1 and CNA #1 through record review, interviews and observations.	F 656		
F 689 SS=G	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	F 689		

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F 689	Continued From page 14 accidents. This REQUIREMENT is not met as evidenced by: Based on record review, interview and facility policy/procedure review, the facility failed to ensure an environment that is free from accident hazards and provide the necessary supervision to prevent injury for one (1) of seven (7) sampled residents, Resident #1. Findings include: Policy and procedure review of the facility's "Total Lift Vanderlift II", last "Updated 2/3/2023" revealed the "Responsibility: All Licensed Nursing Personnel and All Other Staff Providing Care to Resident or Lifting. Two people are required to operate the Total Lift." Record review of the facility investigation "Reportable Incident Form" dated 12/7/23 revealed that CNA (Certified Nurse Aide) #1 attempted to transfer Resident #1 with the total lift without assistance on 12/6/23 at approximately 5:30 PM. CNA #1 admitted that she was trying to transfer Resident #1 to the bed from her wheelchair and did not get assistance from another staff member. The lift fell over when CNA #1 turned toward the bed, and Resident #1 landed on the floor. When the nurses arrived, the lift was removed from the lower legs of Resident #1. It was noted Resident #1 had multiple skin tears which were cleaned and treated. The Medical Director was in the facility and gave the order to send Resident #1 to the hospital for further evaluation and treatment. She returned that night at 10:43 PM with no new orders. CNA #1 was suspended immediately after the incident and her employment terminated.	F 689	Past noncompliance: no plan of correction required.	

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Record review of Resident #1's the Emergency Room (ER) visit on 12/6/23 revealed the "Assessment/Plan 1. Hematoma of scalp, 2. Skin Tear, 3. Back Pain" on page five (5) of 27.

Record review of Resident #1 "Minor Med Care Progress Note" dated 12/7/2023, by the Nurse Practitioner revealed "91 y/o (years old) WF (white female) s/p (status post) fall from Hoyer lift in the facility last night with left temple contusion left elbow skin tear and right medial ankle skin tear. She denies a headache at this time but she does have tenderness to her right ankle and left elbow from the skin tears."

Record review of Resident #1's "Lift/Transfer Evaluation" dated 10/17/23 revealed she was assessed to require an XXL (extra extra large) Sling with the Total lift with the assistance of 2 staff members.

Record review of undated Resident #1's "Resident Summary", which is on the kiosk for CNA use, revealed "Bed Mobility Extensive Assistance 2 person, Lift Total Lift, Sling Size XXL sling."

Record review of the binder connected to each lift in the facility revealed a "LONG TERM CARE GUIDE" with Resident #1 required the Total Lift with 2 person assistance and the XXL sling.

Interview with the Administrator on 1/8/24 at 5:00 PM, reviewing information needed for a facility reported incident regarding Resident #1 falling from a lift and what happened the Administrator stated the Assistant Director of Nursing (ADON) was actually in the facility at the time of the

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incident working the medication cart. She was Resident #1's assigned nurse that 3-11 shift. CNA #1 was the CNA for Resident #1. CNA #1 attempted to transfer Resident #1 from the wheelchair to bed without getting assistance from another staff member. The CNA turned towards the bed and the lift fell over with Resident #1 in it and she fell onto the floor. CNA #1 admitted she didn't ask for assistance for the Total Lift transfer. She had been recently trained on lift use. She admitted knowing she needed another staff member to assist with the lift but didn't ask anyone. She was suspended that night and terminated after the investigation. He stated, "Thank God (Proper Name) Resident #1 wasn't hurt worse."

On 1/8/24 at 5:15 PM, an interview with Resident #1 revealed her saying that one Certified Nurse Aide (CNA) had attempted to put her in bed using a lift. She stated she doesn't know what happened, but she and the lift fell over. She landed between the bedside table and the head of her bed. She revealed that she had a bump and bruise on her left temple area and some skin tears.

On 1/8/24 at 5:45 PM an interview with the ADON revealed that she was working on the unit as a medication nurse on the 3-11 shift on 12/6/23. She stated that when she came into the room, Resident #1 was on the floor with the lift leaning over. Her head was between the bedside table and bed lying on the floor. She stated she did notice the base of the Total Lift was not spread out to prevent the lift from falling over. CNA #1 admitted to not getting another staff member to assist with the transfer of Resident #1 on the Total Lift. The resident had a skin tear to her left

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inner arm and on her bilateral lower extremities. She was assessed by nursing staff and 911 called for an ambulance to transfer her to the emergency room for further assessment and treatment.

On 1/9/24 at 1:05 PM an interview with CNA #1 revealed that Resident #1 "had been on the light" and wanted in bed. "She is a total lift." When asked by the State Agency (SA) if she had asked for help, she stated "No. I didn't ask for help. I poked my head out of the door and didn't see anyone, so I tried to lift her alone." She stated, "I walked away from the lift toward the bed and the lift fell over." She stated she was attempting to use the total lift to transfer Resident #1 from her wheelchair to the bed without assist. She denied being trained in abuse, neglect, resident rights, the vulnerable act and on lift use.

Record review of CNA #1's personnel file revealed she was hired 9/6/2023. She signed a "Lift free facility" form and it was dated for 6/9/2023. When the State Agency (SA) interviewed CNA #1 on 1/9/24 at 1:05 PM, she stated that her first day at work was 9/6/23 and she must have accidentally switched the numbers. She signed the abuse/neglect policy for the facility on 9/6/23. She completed the facility's "CNAs Skills Check-off" on 11/9/23. This included "Transfer Using Mechanical Lift". She was terminated from employment on 12/7/23.

Record review of the "Face Sheet" of Resident #1 revealed that she admitted to the facility on 11/23/2020 with her diagnosis' including Chronic respiratory failure with hypercapnia, Morbid (severe) obesity with alveolar hypoventilation, Muscle weakness, other abnormalities of gait and

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mobility.

Review of the "Minimum Data Set (MDS)-Version 3.0" of Resident #1 with an Assessment Reference Date (ARD) of "10/17/2023", "Section C-Cognitive Patterns Brief Interview for Mental Status (BIMS)" of "15". She is able to make daily decisions.

Based on the facility's implementation of corrective actions on 12/7/23, the State Agency (SA) determined the deficiency to be Past Non-Compliance (PNC) and the deficiency was corrected as of 12/7/23, prior to the SA's first entrance on 1/8/24.

Validation of Past non-compliance:

On 12/6/23 the resident was assessed by the Director of Nursing and transferred immediately to the Emergency Room by ambulance. The Survey agency (SA) validated by record review of the nurses notes and Emergency Room documentation.

The Certified Nursing Assistant involved in the incident was immediately suspended and terminated 12/7/23. This was validated by the SA by reviewing the facility discipline form that revealed the termination of CNA #1.

The Resident Representative was notified on 12/6/23 and the Survey Agency and Attorney General's office were notified on 12/7/23. This was validated by the SA from record review and interviews.

All CNA's and Nurses were in serviced/retrained starting on 12/7/23 on following the individual

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care plan related to lift use, the facility policies on Total Lift Use, Abuse and Neglect, Care Plans. This was validated by the SA from sampled staff being interviewed to confirm their attendance, knowledge of the training, observation of lift use and record review of the signed documents of the attendance by the staff. As part of the facility monitoring, inservices will continue on the Total Lift use monthly for CNAs and quarterly for nurses throughout 2024. All nursing new hires will be in-serviced upon hire.

All residents care plans, lift instructions, resident summary's (information with access for the CNAs in the Kiosk with guidance for individual lift use), and the binders on all the lifts that contained the individual resident information for specific lift use were audited to ensure correct and consistent information. Sampled residents care plans, lift instructions, resident summary's and binders on the lifts were audited by the Survey Agency to confirm they had consistent and correct information.

The SA validated through record review and interview that the facility held a Quality Assurance and Performance Improvement meeting on 12/7/23 to discuss the incident with the fall from the Total Lift. On 12/7/23, the Administrator, Director of Nursing and ADON began monitoring resident halls daily reminding CNAs and nurses of the requirement of always having two staff members when using the Total Lift.

The SA was able to validate the actions the facility took after the incident involving Resident #1 and CNA #1 through record review, interviews and observations.