STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255303	A. BUILDING _____ B. WING _____	C 01/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR HILL REST HOME	**1201 GUNTER ROAD FLORENCE, MS 39073**

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F 000	INITIAL COMMENTS The State Agency (SA) conducted a complaint investigation (CI) at the facility for CI MS #18285 and CI MS #18459 from 1/27/22 through 1/28/22. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid. The SA substantiated MS #18459 for resident safety and prevention of accidents related to a fall which resulted in a serious injury. The SA cited deficiencies at F689 and F656. CI MS #18285 was not substantiated for physician notification and quality of care. The facility's census at the time of the survey was 53, with a license for 60 beds.	F 000		
F 656 SS=G	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	F 656		3/25/22

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

Electronically Signed | 02/25/2022

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F 656	Continued From page 1 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 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 review and staff interviews, the facility failed to ensure the care plan was followed for a two person mechanical lift transfer resulting in a fall and fracture for one (1) of four (4) care plans reviewed. Resident #2 Findings include: Record review of the facility policy titled "CARE PLANS", undated revealed "POLICY: Each resident will have a plan of care to identify problems, needs and strengths that will identify how the interdisciplinary team will provide care. RESPONSIBILITY: All members of the Interdisciplinary team. Monitored by the MDS (Minimum Data Set) and Director of Nurse's.	F 656	1. Immediate actions taken for the resident(s) found to be affected The DON and the Registered Nurse (RN) supervisor were called to the room immediately following the incident on 1-21-22. The RN supervisor assessed the resident. The resident denoted pain to the left leg and a palpable deformity was noted in the thigh, hip area. The resident was transported via emergency services. Statements were collected from the aide and staff that had direct knowledge of the incident. The aide was placed on suspension pending a completed investigation. The RN on the	

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F 656	Continued From page 2 DEFINATIONS (Definition): Interdisciplinary-all disciplines work together to develop approaches to help residents meet needs or resolve problems. Care Plan- contains resident problems/needs/strengths, resident goals and interdisciplinary approaches..PROCEDURE:...6. Staff approaches are to be developed for each problem/strength/need. Assigned disciplines will be identified to carry out the intervention..." Record review of the 'Care Plan' dated 2/19/18 for Resident #2 revealed "Care Plan Goal" of "Perform ADL's (Activities of Daily Living) as independently as possible with intervention dated 4/06/21, revealed "TOTAL LIFT X (times) 2 (two) FOR ALL TRANSFERS". Record review of the facility 'Lift/Transfer Assessment' dated 11/01/21 thru 1/28/22 for Resident #2 completed by Registered Nurse (RN) #1, revealed "Level of Assistance Required: Dependent". Record review of "Resident Incident Report" dated 1/24/21 revealed the report stated on 1/21/22 at 3:36 PM "CNA (NA #1) stated that she was putting resident back to bed with the lift. Her pants were sliding down, and staff stated that as resident started to slide, she then cradled to the floor". The report stated the immediate response of facility staff was to notify the primary physician who issued an order for the resident to be transferred to the hospital by ambulance for assessment due to a bulge on the resident's leg pain following the fall. The report included a statement by the Administrator which included documentation that the investigation performed by the facility showed the sling was improperly placed to prevent the resident from sliding out of	F 656	evening shift in-serviced the C N A staff on the facility's lift policy, "Total Lift Vanderlift II" 2. Identification of other residents having the potential to be affected. Based on review of the facility's color DOT system utilized for resident requiring the Vanderlift (total), 19 residents were found to have the potential to be affected. 3. Corrective actions(s) / System(s) put in place to reduce the risk of future occurrences. On 2-10-22 a facility wide in-service was conducted by the lift manufacturer on the proper use of the Vera (sit to stand) and the Vanderlift II (total) lift. On 1-24-22 investigative findings revealed that the root cause of the incident was that the aide operated the lift alone and without a second staff person. The aide also failed to correctly position the sling. The root cause was determined. The investigation was completed, and the aide was terminated. Beginning 2-22-22 newly hired staff will be checked off on the "Checkoff for correct use of the Vander II Lift" form by the supervising registered nurse (RN) or the staff development (SD) nurse. The checkoff form emphasizes the requirement for two (2) staff being present when the lift is in operation for resident care. The new hire will have to effectively demonstrate competency in the specific operating steps listed on the form. Checkoffs for new hires will be done	

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F 656	Continued From page 3 the sling. According to the report, the Staff Development Nurse's interview of NA #1 confirmed she had not properly placed the sling according to manufacturer's instructions, or facility training, policy, or procedures. It was determined the root cause of the fall was failure of NA #1 to ensure there was two (2) staff members involved in the use of the mechanical lift before initiating Resident #2's transfer and failure to position the sling according to the manufacturers recommendations or Resident #2's needs and care plan or the facility training, policies, and procedures. Review of a written statement dated 1/21/22 and signed by NA #1 revealed, "I started to operate the two-person lift on alone...While holding her, her left leg was caught bent which made me lay her completely flat on the floor ...her left leg was in pain". On 1/27/22 at 10:30 AM, an interview with the Administrator revealed he had reported the fall and injury to the State Agency (SA) by telephone on 1/21/22 and submitted further information following an investigation on 1/25/21. The Administrator stated NA #1 was immediately suspended pending the conclusion of the investigation and following the investigation NA #1 was terminated. The Administrator stated NA #1 admitted to attempting to perform the mechanical lift transfer alone, which he confirmed was not in agreement with the care plan for Resident #2. He said during the investigation NA #1 confirmed she had not crossed the lower straps according to facility training and policies and procedures. The Administrator stated "Our investigation determined the fall resulted because the CNA didn't have another person assisting her	F 656	weekly for the first 4 weeks of employment. After the fourth check off is completed, the new staff will be in-serviced on Vanderlift II operation as part of the facility's monthly in-services. The in-servicing nurse will address any missed steps or incorrectly performed steps immediately. Beginning 2-22-22, the SD nurse or supervising RN will check off current staff on the use of the Vanederlift II, using the "Skills Observation Assessment" form. These check offs will be completed on 3-4-22. Enhanced lift care training will be part of the in-servicing from 2-22-22 to 3-4-22 and become part of the routine, monthly training beginning 4-1-22. The enhancement will be adding training on the eCare system, where staff will demonstrate competency in finding and reviewing the resident's lift care guide and identifying the correct lift ordered for the resident and routine review of the color DOT system. 4. How the corrective action will be monitored to ensure the practice will not recur. Beginning 2-28-22, the minimum data sets nurse (MDS) will review resident care plans weekly and ensure updates as needed. On 2-28-22 the director of nursing (DON) will audit lift care plans weekly for 6 consecutive weeks and ensure that the eCare system is updated for residents needing lifts. After facility wide checkoffs and in-servicing of current staff is completed	

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F 656	Continued From page 4 and she didn't cross the straps to prevent the resident from sliding out of the sling." On 1/27/22 at 11:40 AM, during an interview with the Staff Development Nurse revealed all NAs had access to resident records on a computer kiosk mounted to the wall in the hallway to access residents' care plans. On 1/27/22 at 2:40 PM, an interview with the Staff Development Nurse revealed NA #1 was hired on 1/5/21 and he had provided orientation in-services and training which included training on the use of the mechanical lifts; he confirmed this training included a video provided by the manufacturer on the safe operation of the lifts. He stated she had completed Nurse's Aide training but had not yet taken her state certification exam (the exam was scheduled for February 2022). He reported she was working on her own. The Staff Development Nurse explained that the total lift used a four (4) point system of straps which required the straps under the lower extremities (legs) to be "crossed" and then attached to the lift "hooks". He stated NA #1 had admitted to him she had failed to cross the straps under the legs of Resident #2 and she attempted to perform the bed to wheelchair transfer alone. He stated she told him during the investigation she knew she was "supposed to have two (2) people for using the lift". The Staff Development Nurse stated he was not aware why NA#1 did not follow the proper procedure for using the lift, and NA #1 was unable to explain her actions at the time of the investigation. He stated the NA #1 was immediately suspended during the investigation and terminated upon the conclusion of the investigation. He said the "Task List" on the kiosk communicated care instruction to the CNAs and	F 656	on 3-4-22, routine, monthly in-services will resume 4-1-22. These in-services will include finding and following each resident's lift care plan, identifying the correct lift, and following the care planned procedure. DON will observe transfers performed on 5 residents per week x 4 weeks, beginning the week of 3-7-22. Then the DON will observe 5 transfers on 5 residents per month x 3 months. Observations will be reviewed by Admin for compliance to the plan of care. Any deviations from care plan or policy noted during observation will be addressed and corrected immediately to ensure safety and compliance for all residents during the transfer process. Findings will be presented to the Quality Assuance, Performance Improvement (QAPI) committee monthly x 4 months beginning 3-25-22. The MDS nurse and DON will present audit findings to the QAPI committee monthly. The next scheduled QAPI meeting is 3-25-22. The committee will also review the department head round sheets.	

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F 656	Continued From page 5	F 656		

the "Task List" was updated by the MDS nurses if a resident's care plan changed.

Record review of the "Diagnostic Radiology" report dated 1/21/22 revealed, "Reason for Exam left upper leg pain swelling. Report EXAM: XR (X-ray) Femur 2 (two) V (view) LT (left) ...Indication: left upper leg pain swelling ...Findings: There is an angulated complete fracture of the mid diaphysis of the femur. Intramedullary rod is seen in the mid and distal femur with a total knee arthroplasty. Osteopenia..."

Record review of the "Skills Checkoff for Vander and Vander II" dated 1/05/22, signed by the Staff Development Nurse, revealed NA #1 had performed a skills checkoff on the competent use of the total lift. Review of the "Skills Checkoff" revealed the instructions included "Note ...Follow any specific lift/transfer instructions for the individual. Use number of staff required for the procedure.". Step 5 revealed "Extend leg straps alongside the individual, carefully working forward and under his hips.". Step 6 revealed "Lift one thigh and place leg strap under, carefully bringing up and around inner thigh between knees. Repeat with other leg. Cross one leg strap through the other at the loop closest the sling.".

Record review of the 'Face Sheet' for Resident #2 revealed she had been admitted by the facility on 12/17/10 with diagnoses including Lack of Coordination, Generalized Muscle Weakness, and Osteoarthritis.

Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/12/22 revealed her Brief Interview of

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F 656	Continued From page 6 Mental Status (BIMS) score was nine (9) which indicated she had moderate cognitive impairment. Further review of the MDS revealed she required extensive two-person assistance for surface-to-surface transfers. She was not able to ambulate (walk) and used a wheelchair for mobility.	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 accidents. This REQUIREMENT is not met as evidenced by: Based on staff and resident representative interviews, record review, and facility policy review, the facility failed to ensure that two (2) staff members were involved in a mechanical lift transfer for a resident who required 2 person assistance and failed to secure the resident in a mechanical lift correctly for one (1) of four (4) sampled residents reviewed for supervision to prevent accidents during transfers. Resident #2 fell from the total mechanical lift, onto the floor and sustained a femur fracture. Findings included: Record review of the "VANCARE Vanderlift Operating Manual" dated "November 2017" page 8 "Patient Assessment Criteria for Transfers ...WARNING Although one person can perform	F 689	1. Immediate actions taken for the resident(s) found to be affected The DON and the Registered Nurse (RN) supervisor were called to the room immediately following the incident on 1-21-22. The RN supervisor assessed the resident. The resident denoted pain to the left leg and a palpable deformity was noted in the thigh, hip area. The resident was transported via emergency services. Statements were collected from the aide and staff that had direct knowledge of the incident. The aide was placed on suspension pending a completed investigation. The RN on the evening shift in-serviced the C N A staff on the facility's lift policy, "Total Lift	3/25/22

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F 689	Continued From page 7 patient transfers, certain patients or situations may require the help of one or more additional staff members. For example, patients with unpredictable behavior due to dementia may require additional help". Page 15 revealed "Transfer from a Bed or Stretcher ...3) ...Make sure the required number of staff members are present". Record review of the facility "Modified Lifting Policy", no date, revealed the copy was signed by Nurse Aide (NA) #1 on 1/05/22, indicating "I have read and fully understand the modified lifting policy for (Proper Name of Facility). The policy revealed, "will provide a safe work environment for patient care areas by providing and requiring the use of safety materials, equipment and training designed to prevent personnel and patient injury,,, It is crucial that health care professionals practice safe lifting...at all times" ...Procedures 1. Staff will follow the documented lifting protocol deemed appropriate for each resident. This information is documented in the resident's chart and via a sticker system which is located on lift at Nurses' Station for reference to each resident. This information should be referred to prior to lifting/transferring or assisting each resident. This documentation will also include which sling(s) is appropriate for each resident. 2. Staff will utilize proper transfer/lifting/assistance procedures for each resident to include use of mechanical transfer devices ..." Record review of "Resident Incident Report" dated 1/24/21 revealed on 1/21/22 at 3:36 PM "CNA (NA #1) stated that she was putting resident back to bed with the lift. Her pants were sliding down, and staff stated that as resident started to	F 689	Vanderlift II" 2. Identification of other residents having the potential to be affected. Based on review of the facility's color DOT system utilized for resident requiring the Vanderlift (total), 19 residents were found to have the potential to be affected. 3. Corrective actions(s) / System(s) put in place to reduce the risk of future occurrences. On 2-10-22 a facility wide in-service was conducted by the lift manufacturer on the proper use of the Vera (sit to stand) and the Vanderlift II (total) lift. On 1-24-22 investigative findings revealed that the root cause of the incident was that the aide operated the lift alone and without a second staff person. The aide also failed to correctly position the sling. The root cause was determined. The investigation was completed, and the aide was terminated. Beginning 2-22-22 newly hired staff will be checked off on the "Checkoff for correct use of the Vander II Lift" form by the supervising registered nurse (RN) or the staff development (SD) nurse. The checkoff form emphasizes the requirement for two (2) staff being present when the lift is in operation for resident care. The new hire will have to effectively demonstrate competency in the specific operating steps listed on the form. Checkoffs for new hires will be done weekly for the first 4 weeks of employment. After the fourth check off is	

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F 689	Continued From page 8 slide, she then cradled to the floor". The report revealed the immediate response of facility staff was to notify the primary physician who issued an order for the resident to be transferred to the hospital by ambulance for assessment due to a bulge on the resident's leg pain following the fall. The report included a statement by the Administrator which included documentation that the investigation performed by the facility showed the sling was improperly placed to prevent the resident from sliding out of the sling. According to the report, the Staff Development Nurse's interview of NA #1 confirmed she had not properly placed the sling according to manufacturer's instructions, or facility training, policy, or procedures. It was determined the root cause of the fall was failure of NA #1 to ensure there was two (2) staff members involved in the use of the mechanical lift before initiating Resident #2's transfer and failure to position the sling according to the manufacturers recommendations or Resident #2's needs and care plan or the facility training, policies, and procedures. Record review of the "Diagnostic Radiology" report dated 1/21/22 revealed, "Reason for Exam left upper leg pain swelling. Report EXAM: XR (X-ray) Femur 2 (two) V (view) LT (left) ...Indication: left upper leg pain swelling ...Findings: There is an angulated complete fracture of the mid diaphysis of the femur. Intramedullary rod is seen in the mid and distal femur with a total knee arthroplasty. Osteopenia..." Record review of the 'Care Plan' dated 2/19/18 for Resident #2 revealed "Care Plan Goal" of "Perform ADL's (Activities of Daily Living) as	F 689	completed, the new staff will be in-serviced on Vanderlift II operation as part of the facility's monthly in-services. The in-servicing nurse will address any missed steps or incorrectly performed steps immediately. Beginning 2-22-22, the SD nurse or supervising RN will check off current staff on the use of the Vanederlift II, using the "Skills Observation Assessment" form. These check offs will be completed on 3-4-22. Enhanced lift care training will be part of the in-servicing from 2-22-22 to 3-4-22 and become part of the routine, monthly training beginning 4-1-22. The enhancement will be adding training on the eCare system, where staff will demonstrate competency in finding and reviewing the resident's lift care guide and identifying the correct lift ordered for the resident and routine review of the color DOT system. 4. How the corrective action will be monitored to ensure the practice will not recur. Beginning 2-28-22, the minimum data sets nurse (MDS) will review resident care plans weekly and ensure updates as needed. On 2-28-22 the director of nursing (DON) will audit lift care plans weekly for 6 consecutive weeks and ensure that the eCare system is updated for residents needing lifts. After facility wide checkoffs and in-servicing of current staff is completed on 3-4-22, routine, monthly in-services will resume 4-1-22. These in-services will	

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F 689	Continued From page 9 independently as possible with intervention dated 4/06/21, revealed "TOTAL LIFT X (times) 2 (two) FOR ALL TRANSFERS". Record review of the facility 'Lift/Transfer Assessment' dated 11/01/21 thru 1/28/22 for Resident #2 revealed on 1/11/22 she was assessed as "TOTAL lift for transfers to and from: bed to chair, chair to toilet, chair to chair" Level of Assistance Required: Dependent". The assessment was documented as "Reported by" Registered Nurse (RN) #1. Review of a written statement dated 1/21/22 and signed by NA #1 revealed, "I started to operate the two-person lift on alone...While holding her, her left leg was caught bent which made me lay her completely flat on the floor ...her left leg was in pain". On 1/27/22 at 10:30 AM, an interview with the Administrator revealed he had reported the fall and injury to SA by telephone on 1/21/22 and submitted further information following an investigation on 1/25/21. The Administrator stated NA #1 was immediately suspended pending the conclusion of the investigation and following the investigation NA #1 was terminated. The Administrator stated NA #1 admitted to attempting to perform the mechanical lift transfer alone, which he confirmed was not in agreement with the care plan for Resident #2. He said during the investigation NA #1 confirmed she had not crossed the lower straps according to facility training and policies and procedures. The Administrator stated "Our investigation determined the fall resulted because the CNA (NA#1) didn't have another person assisting her and she didn't cross the straps to prevent the	F 689	include finding and following each resident's lift care plan, identifying the correct lift, and following the care planned procedure. DON will observe transfers performed on 5 residents per week x 4 weeks, beginning the week of 3-7-22. Then the DON will observe 5 transfers on 5 residents per month x 3 months. Observations will be reviewed by Admin for compliance to the plan of care. Any deviations from care plan or policy noted during observation will be addressed and corrected immediately to ensure safety and compliance for all residents during the transfer process. Findings will be presented to the Quality Assuance, Performance Improvement (QAPI) committee monthly x 4 months beginning 3-25-22. The MDS nurse and DON will present audit findings to the QAPI committee monthly. The next scheduled QAPI meeting is 3-25-22. The committee will also review the department head round sheets.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 10	F 689		

resident from sliding out of the sling.".

On 1/27/22 at 11:40 AM, during an interview with the Staff Development Nurse revealed all NAs had access to resident records on a computer kiosk mounted to the wall in the hallway to access residents' care plans.

On 1/27/22 at 2:40 PM, an interview with the Staff Development Nurse revealed NA #1 was hired on 1/5/21, and he had provided orientation in-services and training which included training on the use of the mechanical lifts. He confirmed this training included a video provided by the manufacturer on the safe operation of the lifts. He stated she had completed Nurse's Aide training but had not yet taken her state certification exam (the exam was scheduled for February 2022). He reported she was working on her own. The Staff Development Nurse explained that the total lift used a four (4) point system of straps which required the straps under the lower extremities (legs) to be "crossed" and then attached to the lift "hooks". He stated NA#1 had admitted to him she had failed to cross the straps under the legs of Resident #2 and she attempted to perform the bed to wheelchair transfer alone. He stated she told him during the investigation she knew she was "supposed to have two (2) people for using the lift". The Staff Development Nurse stated he was not aware why NA#1 did not follow the proper procedure for using the lift, and the NA was unable to explain her actions at the time of the investigation. He stated NA#1 was immediately suspended during the investigation and terminated upon the conclusion of the investigation. He said the "Task List" on the kiosk communicated care instruction to the CNAs and the "Task List" was updated by the MDS nurses if

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255303	A. BUILDING _____ B. WING _____	C 01/28/2022

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a resident's care plan changed.

On 1/27/22 at 4:54 PM, a telephone interview with the Resident Representative (RR) (daughter) revealed she was notified immediately following the fall of Resident #2 on 1/25/22. She stated that her mother was currently in traction in a hospital waiting for transfer to another hospital for surgery. She stated, "It shouldn't have happened". She stated she had been told that her mother had "slipped out of the canvas sling during a transfer". She said "They said it was a new CNA". She stated the hospitalization of her mother had been "quite an ordeal". The RP for Resident #2 stated that her mother is eighty-nine (89) years old and has been living at the nursing home for "almost thirteen (13) years". The RR stated "The CNA should have had someone with her that was experienced with taking care of these fragile, elderly patients". She stated "I'm one hundred percent (100%) sure it was not intentional, but there is no excuse for what happened. They need people trained with use of these lifts".

Record review of the "Skills Checkoff for Vander and Vander II" dated 1/05/22, signed by the Staff Development Nurse, revealed NA#1 had performed a skills checkoff on the competent use of the total lift. Review of the "Skills Checkoff" revealed the instructions included "Note ...Follow any specific lift/transfer instructions for the individual. Use number of staff required for the procedure.". Step 5 stated "Extend leg straps along side the individual, carefully working forward and under his hips.". Step 6 stated "Lift one thigh and place leg strap under, carefully bringing up and around inner thigh between knees. Repeat with other leg. Cross one leg strap through the other at the loop closest the sling.".

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F 689	Continued From page 12 Record review of the 'Face Sheet' for Resident #2 revealed she had been admitted by the facility on 12/17/10 with diagnoses including Lack of Coordination, Generalized Muscle Weakness, Presence of Left Artificial Hip Joint, and Osteoarthritis. Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/12/22 revealed her Brief Interview for Mental Status (BIMS) score was 9 out of 15 which revealed she was moderately cognitively impaired. Section G revealed she required extensive two-person assistance for surface-to-surface transfers. She was not able to ambulate (walk) and used a wheelchair for mobility.	F 689		