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	355046	A. BUILDING _____ B. WING _____	03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN ACRES MANOR	1 E MAIN ST CARRINGTON, ND 58421

(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 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey, started on 02/29/16 and completed on 03/03/16, the sample included 4 residents for complete review, 9 residents for focused review, and 2 closed records for review. The sample included 6 additional residents to verify specific concerns during the survey.	F 000		
F 164 SS=E	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.	F 164		4/1/16

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

Electronically Signed | 03/15/2016

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F 164	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and group and staff interviews, facility staff failed to provide privacy during insulin administration for 4 of 4 supplemental residents (Resident #17, #19, #20, and #21) receiving insulin in the dining room. Failure to provide privacy is an infringement of residents' rights. Findings include: Review of the facility policy "Insulin Pen Injections" occurred on 03/01/16. The policy, revised 05/25/15, stated, ". . . Steps in the Procedure . . .6. Insulin may be administered in the dining area per resident preference and will be care planned accordingly. 7. Select appropriate injection site. 8. Assist resident to a comfortable position and ask him/her to relax arm, leg, or abdomen depending on the site chosen for the injection. . . ." Observations of insulin administration identified the following: * 02/29/16 at 5:12 p.m.: Resident #20 seated at a table in the dining room with another resident seated at the same table and 4 additional residents seated in the area. A licensed nurse (#3) prepared a NovoLog insulin pen and brought it to the dining table. The nurse then unbuttoned the resident's shirt, pulled the sleeve partially off his left upper arm, and administered the insulin, in the view of the other residents seated in the area. * 02/29/16 at 5:16 p.m.: Resident #19 seated at a	F 164	1. Residents # 17, 19, 20, & 21 will be given their insulin in a discrete area. 2. All residents who receive insulin have the potential to be affected by this practice. 3. The policy related to Insulin Pen Injections has been updated with the deletion of #6 in section titled Steps on the Procedure. This policy, as well as the policy Quality of Life - Dignity will be reviewed. All staff will be in-serviced on both policies. A video titled Sensitizing our Desensitized Sensitive staff by Cat Selman will be viewed at in-service on 3/30/2016. See attachment 1 and 2. 4. QA coordinator and committee will monitor for insulin administration in the dining room weekly times one month, monthly times two months and quarterly times three.	

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F 164	Continued From page 2 table in the dining room with another resident seated at the same table directly across from Resident #19 and 4 additional residents seated in the area. A licensed nurse prepared a NovoLog insulin pen and brought it to the dining table. The nurse administered the insulin in the resident's right arm, in the view of the other residents seated in the area. * 03/01/16 at 8:06 a.m.: Resident #17 seated at a table in the dining room with three other residents seated at the same table. The nurse prepared the NovoLog insulin pen and brought it to the table. The nurse administered the insulin in the resident's right arm, as the other three residents watched. * 03/01/16 at 8:10 a.m.: Resident #21 seated at a table in the dining room with two other residents seated at the same table. The nurse prepared a NovoLog insulin pen and brought it to the dining table. The nurse administered the insulin in the resident's left arm, in the view of the other residents seated at the table. During an an interview on the afternoon of 03/02/16, an administrative nurse (#1) reported the facility brought the issue of insulin administration to the attention of the Resident Council members (approximately 10 of the 64 residents currently residing in the facility). It was unclear how many of these members were diabetic and receiving insulin. It was also unclear how/if the facility determined the non-diabetic residents were comfortable viewing insulin injections in the dining room as they ate.	F 164		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a	F 241		4/1/16

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F 241	Continued From page 3 manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility staff failed to provide care in a manner to enhance the dignity of 3 of 15 sampled residents (Resident #7, #8, and #9). Failure to assist residents in the dining room and knock on doors prior to entering rooms does not promote residents' dignity or enhance their quality of life. Findings include: DINING ROOM Review of the facility policy titled "Assistance with Meals" occurred on 03/04/16. This policy, revised February 2016, stated, ". . . Level of assistance will be defined as: . . . Prompt - able to eat per self but may need encouragement to keep eating, does not need to have someone sit next to them, Supervised with aspiration risk - Must have someone at the table who is able to observe the resident at all times. May need to assist with some portion of the meal. Supervised with weight loss risk - Must have someone at the table who is able to observe the resident but is able to leave fluids with resident while unattended. . . ." - Review of Resident #7's medical record occurred on February 29-March 3, 2016. Diagnoses included current and history of	F 241	1. Residents # 7 will have supervised dining to provide assist as needed related to motor control. See attachment 3. All staff will be instructed to knock on the door and wait for a response prior to entering the rooms of residents 8 & 9. 2. All residents have the potential to be affected by these practices. 3. Policy Quality of Life □ Dignity will be reviewed and staff will be in-serviced. A video titled Sensitizing our Desensitized Sensitive staff by Cat Selman will be viewed at in-service on 3/30/2016. Attachment 2 4. QA coordinator and committee will monitor resident dignity related to dining and knocking on door prior to entering weekly times one month, monthly times two months and quarterly times three.	

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F 241	Continued From page 4	F 241		

aspiration pneumonia, gastro-esphageal reflux disease, and right shoulder rotater cuff tear and elbow lateral epicondylitis. The quarterly Minimum Data Set (MDS), dated 01/19/16, identified moderately impaired cognition, limited assistance of one person required for eating, and a mechanically altered diet. The current care plan identified, ". . . Independent with dining, setup assist as needed. . . ." The resident's current care plan contradicted the MDS.

Observation showed the following:
* 03/01/16 at 8:56 a.m., a certified nursing assistant (CNA) (#9) offered Resident #7 a glass of thickened liquids. After Resident #7 took sips from the glass, the CNA (#9) transferred him from his recliner to the bathroom using the stand lift. Resident #7 had residue on his lips throughout the transfer. The CNA (#9) failed to wipe the resident's face with a kleenex/napkin prior to/after the transfer.
* On 03/01/16 at 12:37 p.m., Resident #7 sat at an assisted table in the dining room. An unidentified CNA fed two of his peers, who were seated across the table. Resident #7 attempted to feed himself following tray set-up. Resident #7 dripped/spilled food/juice on his lips/chin, right hand/forearm, clothing protector, and table. The unidentified CNA watched as Resident #7 stabbed and then ate one slice of a beet that landed on the table top and another that landed on his right wrist. She then asked one of the other CNAs sitting at a nearby table what type of assistance Resident #7 required. The CNA replied, "Supervision." (The CNA's response contradicted both the current care plan and the MDS.) The unidentified CNA continued to watch as Resident #7 stabbed and then ate various

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food items from his clothing protector. Resident #7 had food residue/juice running down his right hand/forearm in several places. The CNA (#9) failed to assist Resident #7 as he struggled to feed himself and failed to wipe his hand/forearm with a napkin.
* On 03/02/16 at 12:33 p.m., Resident #7 sat at an assisted table in the dining room. An unidentified CNA fed two of his peers, who were seated across the table. Resident #7 attempted to feed himself following tray set-up. Resident #7 dripped/spilled food/gravy on his right hand/forearm and clothing protector. The unidentified CNA watched as Resident #7 scooped and then ate three bites of mashed potatoes/gravy from his clothing protector. Resident #7 had food residue/gravy on his lips and running down his right hand/forearm in several places. The CNA (#9) failed to assist him as he struggled to feed himself and failed to wipe his mouth and hand/forearm with a napkin.

During an interview on the afternoon of 03/03/16, a managerial nurse (#8) confirmed staff are expected to assist residents who stuggle to feed themselves and are expected to wipe any residue present with a napkin.

RESIDENT ROOMS

- Review of the facility policy "Quality of Life-Dignity" occurred on 03/01/16. The policy, revised 03/24/14, stated, ". . . Residents' private space and property shall be respected at all times. . . . Staff will knock and request permission before entering residents' rooms. . . ."

During the initial tour on 02/29/16 at 10:30 a.m.,

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F 241	Continued From page 6 an unidentified certified nursing assistant (CNA) knocked and entered Resident #9's room without announcing him/herself and/or waiting for a response. During the group interview on 02/29/16 at 3:30 p.m., three residents indicated staff knock and walk into their rooms without waiting for a response. Observation on 03/01/16 at 10:12 a.m., showed a CNA (#6) enter Resident #8's room without knocking, announcing herself, and/or waiting for a response. Observation on 03/01/16 at 1:04 p.m., showed a CNA (#7) enter Resident #7's room without knocking, announcing herself, and/or waiting for a response. During an interview on 03/03/16 at 11:15 a.m., a managerial nurse (#8) confirmed staff are expected to knock and wait for a response prior to entering a resident's room.	F 241		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by:	F 309		4/1/16

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F 309	Continued From page 7 Based on observation, record review, review of professional literature, and staff interview, the facility failed to ensure 2 of 4 sampled resident (Resident #7 and #8) identified by the facility as having difficulties swallowing received the care and services necessary to attain the highest degree of safety possible while eating. Failure to ensure residents with a known risk of aspiration were positioned properly prior to providing food/liquid resulted in one of the residents aspirating (#7). Findings include: Nancy B. Swigert, "The Source for Dysphagia: Third Edition", LinguiSystems, Inc, 2007, pages 15, 125, 128 and the educational handouts identified, ". . . Signs and Symptoms of Dysphagia . . . Pneumonia - If a patient has aspirated, he may develop pneumonia within several hours . . . Late Regurgitation . . . If the patient is vomiting hours after a meal, it probably indicates an esophageal disorder . . . an esophageal disorder in which food backs up in the esophagus . . . Signs of oral phase dysphagia include pocketing of food in the cheeks . . . losing food or liquid out the front of the mouth . . . Signs of pharyngeal dysphagia are coughing or choking during a meal . . . During the oral intake of . . . foods and/or liquids, it is optimal for a patient to be seated at a 90 degree angle, whether in a bed or in a chair. . . . Even a slightly reclined position while eating greatly increases the risk of premature loss of food over the back of the tongue . . . As long as the bolus size is controlled to a small amount . . . the bolus can rest in the valleculae and pyriforms [parts of the throat] without aspiration during a delayed swallowing	F 309	1. Resident # 7 & 8 will be in an upright position as close to 90 degrees as possible when eating or drinking and assist if coughing present during eating or drinking. 2. All resident who have difficulties swallowing have the potential to be affected by this practice. 3. The policies related to Preparing the Resident for a meal, Assisting the resident In-Room meals, and Assisting the Impaired Resident with In-Room Meals, and Signs and Symptoms of Aspiration have been reviewed. See attachments 4-5-6 & 7. The Nurses and CNA□s will be reeducated on these policies. An in-service to all Nurses and CNA's will be presented on March 30, 2016 titled Dysphagia by Rachael Jordaan, SLP with these objectives: Following this in-service you will be able to: a. Define dysphagia and related terminology b. Identify signs and symptoms of aspiration c. Identify who is at risk for aspiration d. Explain what you can do to help those with dysphagia e. Identify and describe appropriate diet consistency levels 4. QA coordinator and committee will monitor positioning and coughing while	

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F 309	Continued From page 8 response . . . It's . . . difficult . . . to determine if pneumonia is due to aspiration unless the pneumonia developed soon after an observable episode of aspiration . . ." - Review of Resident #7's medical record occurred on February 29-March 3, 2016. Diagnoses included current and history of aspiration pneumonia, gastro-esophageal reflux disease, and right shoulder rotator cuff tear and elbow lateral epicondylitis. The quarterly Minimum Data Set (MDS), dated 01/19/16, identified moderately impaired cognition, limited assistance of one person required for eating, and a mechanically altered diet. The current care plan identified, ". . . potential for aspiration. . . . Independent with dining, setup assist as needed. (The resident's current care plan contradicted the MDS.) . . . Monitor for increased cough or symptoms of aspiration." Observation showed the following: * 02/29/16 at 4:21 p.m., a certified nursing assistant (CNA) (#7) provided Resident #7's toileting cares. She stated, "He is very, very warm." She went on to explain the nurse had told her Resident #7 had an emesis containing pieces of food earlier in the day. * 03/01/16 at 7:52 a.m., Resident #7 sat (at an approximate 90 degree angle) at an independent table in the dining room, and attempted to feed himself following tray set-up. He coughed throughout the meal. * 03/01/16 at 8:56 a.m., a CNA (#9) offered Resident #7 a glass of thickened liquids as he sat in his recliner at an approximate 60 degree angle. Resident #7 took one-to-two sips of thickened liquid, had residue on his lips, and	F 309	eating or drinking weekly times one month, monthly times two months and quarterly times three.	

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demonstrated a delayed cough.
* 03/01/16 at 9:07 a.m., a CNA (#9) offered Resident #7 a glass of thickened liquids as he lay in his recliner at an apporximate 35 degree angle. Resident #7 took two sips of thickened liquid and immediately began coughing. (No further observations were made of staff feeding Resident #7 in a reclined position.)

During an interview on 03/01/16 at 8:45 a.m., an unidentified dietary staff member reported Resident #7 sat at an independent table in the dining room for breakfast and ate following tray set-up.

Observation on 03/01/16 at 12:37 p.m., showed Resident #7 sat (at an approximate 90 degree angle) at an assisted table in the dining room and attempted to feed himself following tray set-up. An unidentified CNA fed two of his peers, who were seated across the table. The unidentified CNA watched as Resident #7 struggled to feed himself, had residue on his lips/chin, and coughed throughout the meal. She asked one of the other CNAs sitting at a nearby table what type of assistance Resident #7 required. The CNA replied, "Supervision." (The CNA's response contradicted both the current care plan and the MDS.)

During an interview on 03/01/16 at 2:37 p.m., an unidentified nurse reported Resident #7 was "first diagnosed with aspiration pneumonia in 2014, and again on 02/29/16 [the first day of survey]." She described him as having "a non-productive cough following swallowing of food or drink and fine crackles in the base of his lungs." (This was the first notification the survey team received that

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F 309	Continued From page 10 Resident #7 had recently been diagnosed with aspiration pneumonia.) The unidentified nurse also stated, "[Resident #7] did eat breakfast . . . independently after having his plate set up for him without complications." (This conflicts with the observation at 7:52 a.m., as Resident #7 coughed throughout the meal.) A bedside swallowing assessment, dated 03/01/16, identified, ". . . [Resident #7] was referred for a swallowing evaluation by his physician and nursing due to recent event of aspiration pneumonia. . . . Co-morbidities include: pneumonia (2/29/16) . . . pt. [patient] demonstrated mostly non-productive delayed cough throughout meal. . . . It has also been reported to this therapist that pt. has been noted to struggle with non-cohesive and slippery foods . . . It was also reported to this therapist that pt. occasionally received intake at a recline, which may result in increased chances for aspiration. . . . supervision needed for all meals; provide assistance as needed . . . upright at 90 degrees for all intake . . ." Observation on 03/02/16 at 12:33 p.m., showed Resident #7 sat (at an approximate 90 degree angle) at an assisted table in the dining room, and attempted to feed himself following tray set-up. An unidentified CNA fed two of his peers, who were seated across the table. The unidentified CNA watched as Resident #7 struggled to feed himself, had residue on his lips, a piece of meat pocketed in his cheek, and coughed throughout the meal. - Review of Resident #8's medical record occurred on February 29-March 3, 2016.	F 309		

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Diagnoses included dementia and gastro-esophageal reflux disease. The quarterly MDS, dated 12/04/16, identified moderately impaired cognition and supervision required for eating. The current care plan identified, ". . . history of choking . . . Monitor for further choking/coughing episodes. . . . Encourage to remain upright . . . after meals."

Observation showed the following:
* 03/01/16 at 8:56 a.m. and 2:15 p.m., a CNA (#10) offered Resident #8 a glass of water as she laid flat on her back in bed. Resident #8 declined both offers.
* 03/01/16 at 10:36 a.m., Resident #8 ate her snack as she laid in bed. Her bed was elevated to an approximate 40 degree angle.
* 03/02/16 at 10:10 a.m., a CNA (#10) again offered Resident #8 a glass of water after providing cares. An unidentified restorative aide cued the CNA (#10) to raise the head of the bed. The CNA (#10) raised the bed to an approximate 25 degree angle and handed the glass to Resident #8. Resident #8 sipped from the glass, and stated, "You want me to drink more?"

During an interview on the afternoon of 03/03/16, a managerial nurse (#8) confirmed staff are expected to position residents appropriately, assist residents who struggle to feed themselves, and are required to monitor and/or report symptoms of dysphagia/aspiration.

The facility failed to 1) position Resident #7 and #8 as close to 90 degrees as possible prior to giving him/her liquids, 2) provide the limited assistance of one person Resident #7 required for eating, 3) and recognize and/or report

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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 309	Continued From page 12 Resident #7's symptoms of dysphagia/aspiration (drooling, pocketing, delayed swallow, coughing, and emesis). Failure to implement the above interventions placed Resident #7 and #8 at an increased risk of aspiration.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide the necessary treatment and services to prevent the development of pressure ulcers for 1 of 2 sampled resident (Resident #8). Failure to implement preventative measures may result in the development of pressure ulcers to the heels. Findings include: Review of the facility policy titled "Repositioning" occurred on 03/04/16. This policy, revised 05/25/13, stated, ". . . Check the care plan . . . to determine resident's specific positioning needs . . ." - Review of Resident #8's medical record	F 314	1. Resident # 8 will have pressure relieving devices placed so heels will be floating when in bed as stated in Plan of Care. 2. Any resident who is care planned to have a pressure relieving device placed has the potential for this practice. 3. The policy related to Prevention of Pressure Ulcers will be reviewed. The Restorative Nurse will reeducate the Nurses and CNA's on the proper use of pressure relieving devices and the importance of following the plan of care. See attachment 8	4/1/16

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	355046	A. BUILDING _____ B. WING _____	03/03/2016

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F 314	Continued From page 13 occurred on February 29-March 3, 2016. Diagnoses included dementia, impaired skin integrity, and decreased mobility. The quarterly Minimum Data Set (MDS), dated 12/04/15, identified moderately impaired cognition and extensive assistance of two or more persons required for bed mobility. The current care plan identified, ". . . Prone to impaired skin integrity related to . . . decreased mobility. . . . Extensive assist to . . . reposition . . . Keep heels free from pressure when in bed. . . ." Observation showed the following: * 02/29/16 at 2:42 p.m., 03/01/16 at 10:36 a.m. and 11:25 a.m., and 03/02/16 at 10:10 a.m., Resident #8 laid in bed with her heels resting directly on the mattress. * 03/01/16 at 2:15 p.m., Resident #8 laid in bed with a pillow under her knees and her heels resting directly on the mattress. Staff failed to float Resident #8's heels as care planned. During an interview on the afternoon of 03/03/16, a managerial nurse (#8)confirmed staff are expected to float Resident #8's heels as care planned. Failure to consistently implement pressure ulcer prevention measures as care planned for Resident #8 may result in the development of pressure ulcers.	F 314	4. QA coordinator and committee will monitor placement of pressure relieving devices weekly times one month, monthly times two months and quarterly times three.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives	F 323		4/1/16

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F 323	Continued From page 14 adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide adequate supervision and assistive devices for 3 of 8 sampled residents (Resident #7, #8, and #9) during transfers. Failure of the staff to ensure proper use of assistive devices (gait belts and stand lifts) has the potential to cause residents unnecessary pain and places them at risk for possible accident and/or injury. Findings include: Review of the facility policy titled "Safe Transfer of Residents" occurred on 03/04/16. This policy, revised 02/25/13, stated, ". . . Staff will document resident transferring and lifting needs in the care plan. Such assessment shall include . . . Resident's mobility (degree of dependency) . . . Weight-bearing ability . . . Cognitive status . . . Any transfers that are completed without the use of a mechanical lift will be completed with one or two staff with the use of a gait belt unless resident refuses and documentation of education is completed. . . ." STAND LIFTS - Review of Resident #7's medical record occurred on February 29-March 3, 2016. Diagnoses included right shoulder rotator cuff	F 323	1. Residents # 7, 8, will be evaluated for proper use of the stand lift and Resident # 9 for gait belt use . 2. Any resident in need of stand lift or assist with transfer or ambulation has the potential to be affected by this practice. 3. The policy related to Safe Transfer of Residents has been reviewed. Nurses and CNA□s will be reeducated on this policy. See attachment 9. Nurses and CNA□s will be in-serviced with the use of videos Hoyer Pro Journey and on proper use of the stand lift. They will be reeducated on what and when to report to the nurse if there are changes in the resident condition. 4. QA coordinator and committee will monitor the proper use of the stand lift and gait belt use weekly times one month, monthly times two months and quarterly times three.	

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F 323	Continued From page 15	F 323		

tear and elbow lateral epicondylitis, osteoarthritis, and pain. The quarterly Minimum Data Set (MDS), dated 01/19/16, identified moderately impaired cognition and extensive assistance of one person required for transfers.

The current care plan identified, ". . . Impaired mobility . . . Extensive assist with transfers, 1 assist with EZ stand [lift] . . ."

Observations showed the following:
* 02/29/16 at 4:21 p.m., a certified nursing assistant (CNA) (#7) attempted to transfer Resident #7 from his recliner to the bathroom utilizing a sit-to-stand lift. Resident #7 refused to use the toilet. The CNA (#7) then checked his brief and changed him as he hung from the lift. The resident's head hung forward at an approximate 125 degree angle. He was unable to hold onto the right handle, let his (functional) left arm drop to his side, and was unable to bear his weight. He was in a seated position with the harness straps pulling upward into his axillae (armpits) raising his shoulders to ear level. The CNA (#7) failed to ensure Resident #7 was able to hold onto the lift handle and/or bear weight prior to providing pericares and while being transferred in the lift, and failed to report his inability to bear weight to the nurse.
* 03/01/16 at 9:07 a.m., a CNA (#9) attempted to transfer Resident #7 from the bathroom to his recliner utilizing a sit-to-stand lift. After providing pericares, the CNA (#7) asked Resident #7 if he was "okay." He responded, "No." She then stated, "Hang in there." The resident's head hung forward at an approximate 130 degree angle. He was unable to hold onto the right handle, let his left arm drop to his side unless given repetitive

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F 323	Continued From page 16	F 323		

cues to "hold on," and was unable to bear his weight. He was in a seated position with the harness straps pulling upward into his axillae raising his shoulders to ear level. The CNA (#9) failed to ensure Resident #7 was able to hold onto the lift handle and/or bear weight while being transferred in the lift, and failed to report his inability to bear weight to the nurse.
* 03/02/16 at 9:35 a.m., a CNA (#11) attempted to transfer Resident #7 from his recliner into the bathroom utilizing a sit-to-stand lift. He was unable to hold onto the right handle and repetitively let go of the left handle in order to grab a strap that was hanging from the sling. He was in a semi-seated position with the harness straps pulling upward into his axillae (armpits) raising his shoulders. The CNA (#11) cued him to "hold on." After unsuccessfully cuing him three times, she placed his left hand on the handle and placed her hand over his. The CNA (#9) failed to ensure Resident #7 was able to hold onto the lift handle while being transferred in the lift and failed to report his inability to the nurse.

- Review of Resident #8's medical record occurred on February 29-March 3, 2016. Diagnoses included dementia, poor balance, and pain. The quarterly MDS, dated 12/04/15, identified moderately impaired cognition and extensive assistance of two or more persons required for transfers.

The current care plan identified, ". . . Impaired mobility . . . Extensive assist of 1 assist with EZ stand [lift] . . ." (The resident's current care plan contradicted the MDS.)

Observations showed the following:

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F 323	Continued From page 17 * 02/29/16 at 4:21 p.m., a CNA (#10) attempted to transfer Resident #8 from the toilet to her wheelchair utilizing a sit-to-stand lift. The CNA (#10) raised the lift just high enough to place Resident #8 in a semi-squat position. The resident stated, "I'm tired." The CNA (#10) responded, "I'll get you right away." She then provided Resident #8's pericares as Resident #8 hung from the lift. She was in a semi-seated position with the harness straps pulling upward into her axillae raising her shoulders to ear level, with her elbows extended out horizontally. The CNA (#10) failed to ensure Resident #8 was in a full standing position and able to bear weight prior to providing pericares in the lift. * 03/01/16 at 2:15 p.m., a CNA (#10) attempted to transfer Resident #8 from the toilet to her wheelchair utilizing a sit-to-stand lift. The CNA (#10) provided Resident #8's pericares as the resident hung from the lift. Resident #8 was leaning heavily to her right side and unable to bear her weight. She was in a seated position with the harness straps pulling upward into her axillae raising her shoulders to ear level, with her elbows extended out horizontally. The CNA (#10) failed to ensure Resident #8 was able to bear weight prior to providing toileting cares in the lift, and failed to report her inability to bear weight to the nurse. During an interview on the afternoon of 03/03/16, a managerial nurse (#8) confirmed residents are expected to be able to bear weight and hold onto the handles of the lift while being transferred with the EZ stand from one location to another. GAIT BELTS	F 323		

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F 323	Continued From page 18 - Review of Resident #9's medical record occurred on February 29-March 3, 2016. Diagnoses included transient ischemic attach (TIA) (mini stroke), orthostatic blood pressure changes, dementia, osteoarthritis, pain, weakness, and difficulty walking. The quarterly MDS, dated 01/01/16, identified moderately impaired cognition and supervision of one person required while walking in her room or in the corridor. The current care plan identified, ". . . Impaired mobility, potential for falls related to unsteady gait . . . History of dizziness, weakness [added 02/15/16] . . . assist of one with ambulation with FWW [front-wheeled walker] Assist as needed. [added 10/02/14] . . ." Observation on 03/01/16 at 9:21 a.m. and 11:13 a.m. showed a CNA (#10) cued Resident #9 to walk from the bathroom to her recliner using her FWW. The CNA (#10) failed to apply a gait belt prior to and/or assist Resident #9 as she ambulated to her recliner. The CNA (#10) stated staff "use the gait belt whenever Resident #10 is weak." During an interview on the afternoon of 03/03/16, a managerial nurse (#8) confirmed staff are expected to utilize a gait belt whenever assisting residents with ambulation.	F 323		