STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355040	A. BUILDING _____ B. WING _____	07/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER MEMORIAL HOME	750 MAIN ST E MAYVILLE, ND 58257

(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 07/14/14 and completed on 07/16/14, the sample included five (5) residents for complete review, 12 residents for focused review, and three (3) closed records for review. The sample included two (2) additional residents to verify specific concerns during the survey.	F 000		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a	F 278	F278 1. Corrective action was accomplished by modifying N0410A on the 6/20/14 assessment (See attachment #1). 2. All residents have the potential to be affected by this. 3. The facility put into place a one on one visit with the RN who coded the question wrong. 4. The facility put into place the following QA (See attachment #2). The QA check will be done 1x/week for 4 weeks, then 1x/month x2 months. 5. Corrective action will be accomplished by August 20, 2014.	8-20-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Adm. — (X6) DATE: 8/8/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 278	Continued From page 1 material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), and staff interview, the facility failed to ensure the Minimum Data Set (MDS) accurately reflected the resident's status for 1 of 6 sampled residents (Resident #5) coded for use of antipsychotic medications. Failure to accurately code the MDS for Resident #5 limited the facility's ability to develop and implement an individualized care plan consistent with the resident's needs and may affect the level of care provided to the resident. Findings include: The Long-Term Care Facility RAI User's Manual, October 2013, page N-5 stated, "N0410: Medications Received . . . Steps for Assessment 1. Review the resident's medical record for documentation that any of these medications were received by the resident during the 7-day look-back period . . . Coding Instructions N0410A, Antipsychotic: Record the number of days an antipsychotic medication was received by the resident at any time during the 7-day assessment period . . ." - Review of Resident #5's medical record occurred on July 14-16, 2014. An annual MDS, dated 06/20/2014, identified Resident #5 received an antipsychotic medication all seven days of the look-back period, June 14-20, 2014. The medical record showed the physician discontinued Resident #5's daily antipsychotic medication on	F 278	F278 Addition 1. And meeting with licensed nurses on August 5, 2014 (see attachment #5&6). 3. The facility put into place a one on one visit with the RN who coded the question wrong and met with all licensed nurses and reviewed F278 and the error made in coding August 5, 2014. (See attachment #5&6) 4. Will be done weekly for 12 weeks and monthly x3. Start date was 8-8-14. QA will be completed by the QA Coordinator or a designee per DON on 8/19/14 @ 3:00pm KB	

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F 278	Continued From page 2 04/11/14 and the as needed antipsychotic on 05/21/14 due to lack of use. During an interview on the morning of 07/16/14, an administrative nursing staff member (#6) confirmed Resident #5's annual MDS incorrectly identified the resident received an antipsychotic medication for seven days and the physician discontinued the medication prior to the assessment period for the annual MDS.	F 278		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, professional reference review, and staff interview, the facility failed to follow professional standards of nursing practice for 1 of 1 sampled resident (Resident #11) who received a double dose of medication. Failure to implement a system to document controlled medications when administered resulted in a medication error and has the potential to result in a negative resident outcome and loss or diversion of medications. Findings include: "Geriatric Medication Handbook", 7th edition, Med Pass, Ohio, page 150, states ". . . Controlled drug administration documented on the controlled drug accountability/inventory form or 'count sheet' at the time of administration and not delayed until the end of the medication pass or shift . . ."	F 281	F281 1. Corrective action was accomplished by reviewing policy with CMAs and licensed nurses (See attachments #3,4,5,6). Also met with CMA and employee counseling was done (see attachment #12). 2. All residents receiving controlled substances have the potential to be affected by this. 3. The facility put the following measures into place: a) Mandatory meeting with CMAs on August 4, 2014. (See attachment #3&4). b) Mandatory meeting with licensed nurses August 5, 2014. (See attachment #5&6)	

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F 281	Continued From page 3 The facility failed to provide a policy/procedure for administration of narcotic/controlled medications when requested. Review of Resident #11's record occurred on July 14-16, 2014. Medical diagnoses included nephritis [inflamed kidneys] and nephropathy [kidney damage]. Review of Nurse's Notes identified the following: *01/26/14, 2:13 p.m. - "Medication: Alerted by CMA [certified medication aide] that 2 Hydrocodone 5-500 Hydrocodone-Acetaminophen] were administered at 1:20 p [p.m.] and 2 were administered at 1:50 p. Call to [physician's name] on call provider, awaiting call back. VSS [vital signs stable] Resident informed medication she received and advised it may cause her to be drowsy. . ." *01/26/14, 4:12 p.m. - "Physician order: Reviewed administered Hydrocodone doses with [physician's name]. Order to hold 8 p.m. dose today and monitor VS [vital signs] at 4 p.m. and 8 p.m. today." Review of the Incident Report for the medication error revealed the following: ". . . Description of medication error by staff: thought I had missed the dose at 1:20 p.m. so I gave another dose at 1:50 p.m. Had not missed the dose. . . . THIS ERROR WILL BE AVOIDED BY . . . Entering meds [medications] in narcotic log when punched from card. . . ." During an interview on 07/16/14 at 10:00 a.m., an administrative nurse (#1) stated the staff member who administered the medication incorrectly reviewed the narcotic log and thought she had	F 281	4. The facility is monitoring by using the following QA tool. (See attachment #2). This will be done on random checks 3x/week x1 month then weekly x1 month. 5. Corrective action will be accomplished by August 20, 2014. F281 Addition 4. This random check will be done 3x/week x3 months then weekly x3 months. Start date was 7-28-14. Will continue with yearly med administration audit on all licensed staff administering medications. QA will be completed by the QA coordinator or a designee. Re DCD on 8/19/14 @ 3:00pm LB	8-20-14

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F 281	Continued From page 4 not given the medication, administered a dose, entered the electronic medication administration record to sign off the medication, and realized she had administered a second dose. During an interview on 07/16/14 at 8:55 a.m. regarding controlled/narcotic medication administration, an administrative nurse (#2) confirmed staff members should sign out the medications as they administer them and not at the end of shift. - Observation of the medication cart on the C/D unit occurred on 07/16/14 at 11:15 a.m. with a nursing staff member (#7). During reconciliation of the controlled medications the count sheet identified the following: * Ativan 0.5 mg (1/2 tablet) 6 tablets left - observation showed 5 (1/2 tablets) in the medication punch card * Tramodol 15 tablets left - observation showed 14 tablets in the medication punch card The certified medication assistant (CMA) (#8) stated she had not signed out the 8:00 a.m. controlled medications she had administered. During an interview on 07/16/14 at 11:45 a.m., an administrative nurse (#1)confirmed she expected staff to sign out controlled medications at the time the medications were administered.	F 281		
F 323 SS=E	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 adequate supervision and assistance devices to prevent accidents.	F 323	F323 1. Corrective action will be accomplished by updating gait belt policy (See attachment #7). All care plans and assignment sheets were compared to make sure	

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F 323	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure appropriate use of assistive devices to prevent accidents for 9 of 14 sampled residents (Resident #1, #2, #3, #4, #7, #9, #11, #12, and #13) and 2 supplemental residents (Resident #21 and #22) who required staff assistance for transfers. Failure to properly use an E-Z stand (sit-to-stand mechanical lift) (Resident #12) and gait belt (Resident #1, #2, #4, #7, and #11), failure to clearly identify how staff are expected to transfer residents (Resident #3, #7, #9, and #12), and failure to transport residents with foot pedals (Resident #1, #2, #3, #13, #21, and #22) increased the risk for falls, pain, and injury to residents. Findings include: Review of the facility policy titled "Gait Belts" occurred on 07/16/14. This undated policy stated, ". . . All CNAs [certified nursing assistants] and TAs [transport aides] should use a gait belt if deemed unsafe to transfer the resident either from bed to wheelchair, recliner or chair to wheelchair or any other transfer assisted by staff . . . All CNAs and TAs were instructed on the proper use of a gait belt during their certification process and yearly during skills blitz if needed." Review of the facility policy titled "Mechanical E-Z standing Lift" occurred on 07/16/14. This policy, revised July 2005, stated, "Purpose: To provide a	F 323	each matched. A new update is coming soon in our computerized Matrix medical record which will allow assignment sheets to pull directly from the care plan. (Everything will auto-matically match). Mandatory inservices were held. (See attachments #3-6,8&9). Assignment sheets were updated with gait belts and foot rests. (See attachment #10). New mesh bags are on order and will be placed on back of wheelchair for foot rests when they arrive (See attachment #11). 2. All residents using gait belts, standing lifts and foot rests have the potential to be affected by it. 3. The measures put into place are as follows: a) All care plans and assignment sheets were compared to make sure they match. b) Mandatory RN/LPN meeting. (See attachment #5&6). c) Mandatory CMA meeting (See attachment #3&4). d) Mandatory CNA meeting (See attachment #8&9). e)	

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F 323	Continued From page 6 safe means of transferring to prevent injury to residents and staff. . . ." - Review of Resident #1's medical record occurred on July 14-15, 2014 and diagnoses included chronic obstructive pulmonary disease (COPD) and osteoarthritis. The quarterly Minimum Data Set (MDS), dated 06/20/14, identified extensive assistance of two or more staff members for transfers. The current care plan stated, "Problem: Impaired Mobility/Ambulation R/T [related to] SOB [shortness of breath] with exertion from COPD . . . Approach: . . . Transfers: extensive assist of 1-2 . . ." Observation on 07/14/14 at 5:00 p.m. identified two certified nursing assistants (CNAs) (#12 and #14) transferred Resident #1 from her wheelchair to the toilet using a gait belt. One CNA (#14) held the gait belt with one hand and lifted under Resident #1's arms with his other hand. Observation on 07/15/14 at 2:10 p.m. identified two CNAs (#15 and #16) transferred Resident #1 from a recliner to her wheelchair using a gait belt. During the transfer, one CNA (#16) lifted under Resident #1's left arm. Observation on 07/15/14 at 2:14 p.m. showed a staff member (#15) transported Resident #1 from the television room to the activity room without utilizing foot rests. Observation showed Resident #1's feet brushing the floor. Observation on 07/15/14 at 3:20 p.m. identified two CNAs (#14 and #25) transferred Resident #1 onto the toilet. While assisting her onto the toilet and back to her wheelchair, one CNA (#14) lifted	F 323	Mesh bags ordered for foot rests and are on order (Attachment #11). f) Gait belts and foot rests added to assignment sheets (Attachment #2). g) Gait belts, transfers and foot rests updated on resident care audits done yearly on CNAs. (See attachment #13). 4. The facility will monitor by using the following QA tool. (See attachment #2). This will be done 3x/week for 1 month then weekly x1 month. Annual QA resident care audits will be done yearly on CNAs. (See attachment #13). 5. Corrective action will be accomplished by August 20, 2014.	8-20-14

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F 323	Continued From page 7 under the resident's left arm. After toileting Resident #1, the CNAs (#14 and #25) transferred the resident from her wheelchair to her bed. During the transfer, both CNAs (#14 and #25) held onto the gait belt with one hand and lifted under Resident #1's arms with their other hand. - Review of Resident #2's medical record occurred on July 14-15, 2014 and diagnoses included muscle weakness, joint contractures, osteoarthritis, and history of a femur fracture (May 2014). The significant change MDS, dated 05/15/14, identified the Resident #2 transferred with extensive assistance of two or more staff members. The current CNA ADL (activities of daily living) resident care guide regarding transferring Resident #2 stated, "walks w/ [with] walker & 2 assist. Pivot." Observation on 07/14/14 at 4:30 p.m. showed a CNA (#12) transported Resident #2 from the television room to the resident's room without utilizing foot rests. Observation showed Resident #2's feet brushing the floor. Observation on 07/15/14 at 8:50 a.m. identified a CNA (#16) transferred Resident #2 from her wheelchair to the toilet without using a gait belt. The CNA (#16) lifted under Resident #2's left arm to assist her to a standing position. Observation on 07/15/14 at 3:05 p.m. identified two CNAs (#14 and #25) transferred Resident #2 from her wheelchair to the toilet using a gait belt. One CNA (#14) lifted under Resident #2's left arm to assist her to transfer onto the toilet and again when assisting her back to her wheelchair. During an interview on 07/16/14 at 11:15 a.m., an	F 323	Addition F323 Resident #1 care plan and assignment sheet updated with gait belt. Care plan updated with foot rests. Resident #2 care plan updated for refusal of leg rests due to making her more anxious. The gait belt was added to her care plan. Resident #3 assignment sheet updated with foot rests. Care plan and assignment sheets address resident can be transferred with 1 to 2 assist with gait belt or may use standing lift prn. Resident #13 refuses foot rests, and this is in the care plan per his request. Resident #9 care plan updated with gait belt and updated to match assignment sheet. Resident #11, the brace was on the care plan and is now on the assignment sheet. Assignment sheet was updated with gait belt. Resident #21 had a foot buddy ordered and placed to prevent foot drop with transfers. Resident #22 had foot rests added to care plan.	

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F 323	Continued From page 8 administrative nurse (#2) stated staff should use a gait belt when providing hands-on assistance to residents and should avoid lifting/pulling on residents' arms during transfers. - Review of Resident #3's medical record occurred on July 14-15, 2014 and diagnoses included dementia with aggressive behaviors. The admission MDS, dated 05/25/14, identified the resident transferred with extensive assistance of two or more staff members. The current CNA ADL resident care guide identified Resident #3 transferred with assistance of one or two staff members or the sit-to-stand mechanical lift at times. Observation on 07/14/14 at 5:10 p.m. showed two CNAs (#12 and #14) transported Resident #3 from the dining room to his room without utilizing foot rests. Observation showed Resident #3's feet firmly planted on the floor, resulting in resistance during the transport. Observation on 07/15/14 at 2:20 p.m. showed two CNAs (#16 and #23) transported Resident #3 from a table in the television room to a recliner in the same room without utilizing foot rests. Observation showed the resident's feet firmly planted on the floor, resulting in resistance during the transport. Observations during the survey identified the facility staff transferred Resident #3 using a sit-to-stand mechanical lift. During all transfers, the facility staff failed to involve the charge nurse to assess whether Resident #3 required the use of the sit-to-stand lift or could be transferred with the assistance of one or two staff members.	F 323	Resident #4 had gait belt added to assignment sheets. The care plan and assignment sheets were updated to match according to transfers. Resident #7 had gait belt added to assignment sheets. Resident #12 care plan and assignment sheets were updated during survey and currently match. QA will be completed by the QA Coordinator or a designee Per DON on 8/19/14 @ 3:00pm KB	

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During an interview on 07/15/14 at 10:05 a.m., two CNAs (#21 and #22) stated the CNAs decide at the time of the transfer if they will use a sit-to-stand mechanical lift or pivot transfer for Resident #3, depending on his alertness and cooperation.

- Review of Resident #13's medical record occurred on 07/16/14 and diagnoses included osteoarthritis. The quarterly MDS, dated 05/25/14, identified extensive assistance of one staff member for locomotion off the unit.

Observation on 07/15/14 at 2:04 p.m. showed a transport aide (#15) transported Resident #13 from the lobby to the dining room without utilizing foot rests. Observation showed Resident #13's feet brushing the floor.

- Review of Resident #9's medical record occurred on July 14-15, 2014. Medical diagnoses included osteoarthritis, chronic back pain, Parkinsonism, and legal blindness. The resident's quarterly MDS, dated 06/15/14, identified extensive assistance of one person for transfers.

The current certified nursing assistant's (CNA) POC (point of care) sheet (resident care guide) identified Resident #9 required assistance of one staff member with a wheeled walker for transfers.

Resident #9's current care plan stated ". . . Impaired Mobility/Ambulation . . . Transfers: Standing lift for transfers, assist of 1 to 2. . . ."

Observation on 07/14/14 at 9:00 a.m. showed two CNAs (#3 and #4) transferred Resident #9 from his wheelchair to the bathroom using a stand lift.

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F 323	Continued From page 10	F 323		

During an interview on 07/14/14 at 11:30 a.m., a CNA (#3) stated her and another staff member transferred Resident #9 from bed to his wheelchair by pivoting him "that time." The CNA (#3) stated, Resident "doesn't pivot to the bathroom because everybody (all CNAs) don't like him in the bathroom without a stand lift. We usually pivot him when he gets out of bed on the day shift. I do not know if the p.m. shift does it differently."

During an interview on 07/14/14 at 1:30 p.m., a CNA (#3) stated her and another staff CNA (#4) member transferred Resident #9 from his wheelchair to the bathroom then to bed using a stand lift.

Observation on 07/14/14 at 4:15 p.m. showed a CNA (#5) transferred Resident #9 from bed to his wheelchair by pivoting him. During an interview on 07/14/14 at 4:15 p.m., the CNA (#5) stated "pivot [resident] to toilet from wheelchair in the bathroom. Resident doesn't walk to the bathroom." The CNA stated resident "pivots since came here as unsteady walking but does very well with pivoting. Occasionally his legs get weak. Resident is care planned that he cannot walk and to use stand lift as needed."

During an interview on 07/16/14 at 9:35 a.m., an administrative nursing staff member (#6) stated Resident #9's care plan identified staff members should use a stand lift at all times and confirmed the careplan and POC sheet should match.

- Review of Resident #11's medical record occurred on July 14-15, 2014. Medical diagnoses included Parkinson's disease, muscle spasms, paralysis, contracture joint, lumbago (low back

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	355040	A. BUILDING _____ B. WING _____	07/16/2014

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LUTHER MEMORIAL HOME	750 MAIN ST E MAYVILLE, ND 58257

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pain), malaise, fatigue, debility, and knee joint replacement. The resident's annual MDS, dated 06/27/14, identified extensive assistance of one person for transfers.

Resident #11's Activities of Daily Living CAA (Care Area Assessment) identified double vision and jerky movements.

A physician's order, dated 09/20/07, stated "Side to Side Knee Brace (Rt) [right] - wear during day and especially when walking and during transfers. WB [weight bearing] as tolerated in brace."

Resident #11's current care plan stated . . . Impaired Mobility/Ambulation . . . Transfers: Extensive assist of 2 . . . Pivot transfers . . ." Resident's current POC [point of care] sheet or care plan lacked use of a brace during transfers.

Observation on 07/14/14 at 4:50 p.m. showed a CNA (#9) transferred Resident #11 from the toilet to her wheelchair. The CNA failed to apply a gait belt and pulled on the back of the resident's pants to guide her into her chair.

During an interview on 07/14/14 at 4:50 p.m., the CNA (#9) stated Resident #11 pivots to her chair after standing up and turns by herself. The CNA grabs her pants to make sure she pivots.

Observation on 07/15/14 at 9:50 a.m. showed two CNAs (#10 and #11) transferred Resident #11 from a recliner to her wheelchair. The CNAs failed to apply or offer the resident's right knee brace. Observation showed the resident leaning forward at the waist and unsteady during the transfer.

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Observation on 07/15/14 at 4:25 p.m. showed two CNAs (#12 and #13) transferred the resident from a recliner to her wheelchair, to the toilet, and back to her wheelchair with no gait belt or right knee brace. Observation showed Resident #11 leaning forward at the waist and unsteady.

During an interview on 07/16/14 at 9:30 a.m., an administrative nursing staff member (#3) confirmed Resident #11 has involuntary movements from Parkinson's and staff should apply a gait belt and offer/place her right knee brace prior to transfers.

- A random observation on 07/15/14 at 9:15 p.m. showed an unidentified CNA transported Resident #21 from the dining room to her room with one of the resident's legs dangling off the foot rests on her wheelchair. At one point, Resident #21's feet touched the floor.

- A random observation on 07/15/14 at 12:35 p.m. showed a transport aide (#15) transported Resident #22 from the dining room to his room. Observation showed Resident #22's feet brushing the floor. After wheeling the resident into his room, the aide stated, "I forgot your foot rests," then asked the resident "Do you have foot rests?"

- Review of Resident #4's medical record occurred on July 14-15, 2014 and diagnoses included osteoarthritis, dementia, muscle weakness, and paralysis agitans-parkinsons. The annual MDS, dated 04/23/14, identified extensive assistance of two or more staff members for transfers. The current care plan stated, ". . . Problem: Impaired Mobility/Ambulation R/T Parkinson's . . . Approach: Transfers 04/22/14 Extensive assist of 1-2 04/16/14 May use EZ lift

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as needed. . . ." The CNA resident care guide care guide stated, ". . . Transfers: transfer 1-2 assist with walker. . . ."

Observation on 07/15/14 at 9:45 a.m. showed a CNA (#17) transferred Resident #4 from the wheelchair to the recliner using a gait belt.

Observation on 07/15/14 at 12:01 p.m. showed a CNA (#17) obtained the sit to stand lift and stated she is utilizing the sit-to-stand lift because Resident #4 is not transferring well today. The CNA used the lift and transferred Resident #4 onto the toilet and then to the recliner.

Observation on 07/15/14 at 4:15 p.m. showed two CNAs (#9 and #18) assisted Resident #4 to the bathroom. The CNA (#18) attempted to stand the resident by pulling on the back of the resident's pants. Resident #4 was unable to stand. Both CNAs (#9 and #18) assisted the resident to stand by pulling on the back of the resident's pants. Once standing, the CNA (#18) unzipped Resident #4's pants, but the resident became unsteady and the CNAs sat the resident into the wheelchair.

During an interview on 07/16/14 at 9:45 a.m., an administrative nurse (#2) stated she expected the CNAs to check with the nurse before using the sit-to-stand lift to transfer Resident #4 and staff are expected to use a gait belt and not pull on the resident's pants.

- Review of Resident #7's medical record occurred on July 14-15, 2014 and medical diagnoses included Alzheimer's disease and generalized pain. The quarterly MDS, dated, 06/03/14 identified extensive assistance of one staff for transfers.

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Observation on 07/15/14 at 10:00 a.m. showed a CNA (#19) used a gait belt and assisted Resident #7 onto the toilet. The CNA assisted Resident #7 off the toilet by lifting under the resident's arm.

During an interview on 07/16/14 at 10:40 a.m., an administrative nurse (#20) stated she expected staff to use a gait belt and avoid lifting under residents' arm.

- Review of Resident #12's medical record occurred on all days of survey. Diagnoses included fractures to the right second and third metatarsals and phalanges (foot and toes) related to a fall from self transferring (07/10/14). Resident #12's care plan related to the fractured foot and toes stated, ". . . S/L [stand lift] PRN [as needed] for transfers . . ." The care plan failed to clearly identify how staff members are expected to transfer Resident #12.

Observation on 07/15/14 at 9:00 a.m. showed Resident #12 seated on the toilet in her room. The CNA (#24) placed a harness/sling around the resident's waist and lifted her to an upright position with the stand lift. As the resident stood, the harness loosened and slid upwards and and her shoulders shrugged up towards her ears. Observation showed Resident #12's perineal area soiled with stool, requiring the CNA (#24) several minutes to provide cares. During cares, the resident let go of the left hand grip. The CNA failed to encourage Resident #12 to hold onto the lift and failed to tighten the harness.

During an interview on 07/16/14 at 10:50 a.m., the nurse manager (#2) stated the direct care staff were instructed to utilize the stand lift after

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F 323	Continued From page 15 Resident #12 fractured her foot and she would expect the staff to tighten the harness.	F 323		