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AUTUMN CARE OF BISCOE	401 LAMBERT ROAD P O BOX 708 BISCOE, NC 27209

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F 309 SS=G	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. 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, consistent with the resident's comprehensive assessment and plan of care. 483.25 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on medical record review, family and staff interviews, the facility failed to complete a head to toe assessment immediately following a fall for one of three residents reviewed for falls (Resident #2). Resident #2 fell on 12/31/16 and was not assessed at the time of the fall. On 1/1/17, it was determined that she had a fracture of her right femur. The findings included: Resident #2 was admitted to the facility on 6/7/11. Diagnoses included, in part, hemiplegia and	F 309	Past noncompliance: no plan of correction required.	2/13/17

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

Electronically Signed | 02/13/2017

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hemiparesis (partial paralysis) following unspecified cerebrovascular disease affecting left non-dominant side in 2012 and hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side 11/24/16, dementia and age related osteoporosis.

An Annual Minimum Data Set (MDS) dated 10/4/16 indicated Resident #2 was moderately impaired in cognition. She required extensive assistance of one person for transfers. Rising from a seated position, surface to surface transfers and toilet transfers did not occur during the assessment period. No falls occurred.

A nursing note dated 12/31/16 at 6:37PM stated Nurse #1 walked into the shower room to check on the nursing assistant. She found the nursing assistant #1 (NA#1) hanging onto Resident #2 who was sliding out of the wheelchair. The wheelchair had a fleece blanket and the total lift sling was under her. Resident #2 was sliding out of the chair. Nurse #1 and NA #1 sat Resident #2 on the floor, then assisted her to the chair the proper way. Resident #2 did not have any shoes or non-skid socks on her feet. The nursing note indicated Resident #2 did not fall. The nursing note did not indicate that a head to toe assessment was completed at the time of the fall.

An occurrence report dated 12/31/16 at 6:49PM stated Nurse #1 walked into the shower room to check on NA#1 and found her hanging onto Resident #2 who was sliding out of the wheelchair. The wheelchair had a fleece blanket and the total lift sling under Resident #2. Resident #2 was sliding out of the chair. Nurse #1 and NA#1 sat Resident #2 on the floor then assisted her to the chair. Immediate Intervention:

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Placed back in the shower chair. Resident #2 had right sided weakness. Neurological checks were within normal limits. Resident #2 had no complaints of pain. The form indicated it was an assisted fall. There was no documentation that a head to toe assessment was completed at the time of the fall and prior to moving Resident #2.

An incident report dated 12/31/16 at 6:49PM, completed by Nurse #1, stated Nurse #1 walked into the shower room to check on NA#1 and found NA#1 hanging onto Resident#2 who was sliding out of the wheelchair. The wheelchair had a fleece blanket and the total lift sling under her and she was sliding out of the chair. Nurse #1 and NA#1 assisted Resident #2 to the floor then assisted her to the chair. No injuries were observed. The incident report stated Resident #2 was alert. Predisposing environmental factors: wet floor; predisposing physiological factors: confused, incontinent. Predisposing situation factors: occurred during transfer. Witness: NA#1. There was no documentation that a head to toe assessment was completed at the time of the fall.

An emergency room report dated 1/1/17 stated Resident #2 fell on 12/31/16 and had continuous right leg pain with external rotation. A review of the x-ray revealed a displaced (not in alignment) distal femoral fracture of the right leg. Resident was transferred to (name) hospital and was hospitalized from 1/1/17-1/3/17.

Nurse #1's statement dated 1/4/17 stated she went into the shower room and observed Resident #2 was sliding out of the wheelchair. NA#1 was holding Resident #2 underneath her arms. There was a sling and cover in the

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wheelchair. They tried to pull Resident #2 back into the wheelchair but the sling and cover came out from under the resident so they eased her to the floor. Nurse #1's statement said Resident #2's left leg was out straight and her right leg was positioned outward and slightly to the side. They straightened Resident #2's legs while she was still in the floor. She showed no signs of pain at that time. At that time, they picked Resident#2 up and put her in the wheelchair, then attempted to use the sit to stand lift to transfer her to the shower chair. Resident #2 could not stand by herself so they stood her and pivoted her to the shower chair. Nurse #1 looked over her skin and rubbed her legs to see if there was any pain. The statement also indicated Nurse #1 was called by the Director of Nursing on 1/1/17 at 8:41AM and Nurse #1 said she did not notice any outward rotation at that time. She filled out an incident report but did not call the physician or notify the family of the fall.

A review of the 5 day investigation working report revealed an addendum dated 1/6/17 that stated during the course of the investigation, it was found that Nurse #1 also failed to complete a thorough head to toe assessment.

On 1/27/17 at 11:00AM, an interview was conducted with the Administrator and the Regional Clinical Director of Services. They stated they had in-serviced nursing staff and put a POC (plan of correction) in place. He stated the facility had put an audit system into place and some audits had been completed since the incident. The Administrator stated two of the staff members involved in the incident had been terminated--Nurse #1 and NA#2 on 1/6/17. A third staff member who had assisted Nurse #1

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and NA#1 at the time of the fall had received re-education and returned to work on 1/6/17.

On 1/27/17 at 3:20PM, an interview was conducted with Nurse #3 who stated she worked 7:00AM-7:00PM on 1/1/17 when Resident #2 went to the hospital. She stated she came to work around 6:30AM on 1/1/17 and Nurse #2 asked her at that time to come and assess Resident #2's leg. Nurse #2 told her that Resident #2 had sustained a fall the evening before. Nurse #2 told her she had called Resident #2's family member when she observed that the leg did not look right and had obtained an order for an x-ray. Nurse #3 said, when she looked at Resident #2's leg, she noticed the abnormalities and told Nurse #2 she thought the leg was broken. She said she did not attempt to turn the resident. The family was called and Resident #2 was taken to the hospital.

On 1/27/17 at 5:38PM, an interview was conducted with NA#3. She stated she routinely provided care for Resident #2 and provided care for her on 12/31/16-1/1/17 (11:00PM-7:00AM shift). She stated Resident #2 slept well all night. She checked her twice during the night and she had not been incontinent of bladder or bowel so she let her sleep. At 6:00AM, Resident #2 was wet (incontinent of urine) and she felt Resident #2's bones moved when she went to turn her. She stated she immediately went and got the nurse to come and check resident because she knew that was not normal. NA#3 stated Resident #2 usually helped her with turning but she was unable to help that morning. She said the nurse came immediately and saw that something was wrong.

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F 309	Continued From page 5 On 1/27/17 at 5:36PM, Nurse #1 was called with no answer and unable to leave a message. On 1/27/17 at 5:40PM, Nurse #2 was called with the phone ringing, then cut off. Unable to leave a message. The corrective action for past non-compliance dated 1/1/17 was as follows: 1. The licensed nurse and the nursing assistant were placed on suspension and then terminated on 1/6/17 after the investigation was completed. The third nursing assistant received re-education and allowed to return to work on 1/6/17. Time of completion 1/6/17. 2. Other residents who had a fall within the past month were reviewed by the Director of Nursing on 1/4/17 and no other deficient practice was identified. Residents who required the use of the mechanical lift had head to toe assessments completed by the licensed nurse. Date of completion: 1/4/17. Falls will be reviewed in the morning risk meeting by the QAPI (Quality Assurance Performance Improvement) team members to ensure falls were investigated and timely notification of physician and responsible party. 3. 100% of all nursing staff (licensed and nursing assitants) were in-serviced by the Staff Development Coordinator and Director of Nursing starting 1/4/17 and employees received all in-services prior to working their assignment. In-services included: What is a fall, procedure to follow when a fall occurs which included that a complete head to toe assessment would be completed by the nurse and to notify the nurse of a fall or any change in transfer ability of a	F 309		

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F 309	Continued From page 6 resident. Date of completion: 1/6/17. 4. The Director of Nursing, Staff Development Coordinator or Assistant Director of Nursing will audit 2 falls weekly, if applicable x 3 weeks, then monthly to ensure total mechanical lift is used to lift a resident from the floor after a fall, head to toe assessment completed and timely notification of family and physician. Any area of identified concern will be addressed at the time and continued area of concern will be addressed by QAPI committee for further action plan. As part of the validation process on 1/26/17 and 1/27/17, the plan of correction was reviewed including the re-education of staff. Interviews with nursing staff (licensed and nursing assistants) revealed they were retrained in the areas of falls and doing head to toe assessments on residents who sustained accidents/ falls at the time of the incident. A review of the monitoring tools revealed that the facility completed the audit of falls as noted in their POC. 100% of in-servicing of nursing staff was completed on 1/4/17 including NA#3 who had assisted moving Resident #2 on 12/31/16. A review of the audits revealed audits had been conducted 1/13/17, 1/18/17, 1/20/17, 1/23/17 and 1/24/17. The final correction date was 1/6/17.	F 309		
F 323 SS=G	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and	F 323		2/13/17

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F 323	Continued From page 7 (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, record review, family and staff interviews, the facility failed to transfer a resident from the wheelchair to a shower chair based on the resident's care plan requiring a mechanical lift using two people based on the resident's mobility assessment requiring a mechanical lift for one of one residents (Resident #2) resulting in the resident sustaining a fracture of her right femur. After the fall, the resident was manually transferred back into the wheelchair and then manually back into bed. Facility policy for Falls (undated) stated, in part, if the resident is not being sent to the ER (emergency room), the resident must be gotten off the floor utilizing a total lift (no exceptions). Resident #2 was admitted to the facility on 6/7/11.	F 323	Past noncompliance: no plan of correction required.	

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Diagnoses included, in part, hemiplegia and hemiparesis (partial paralysis) following unspecified cerebrovascular disease affecting left non-dominant side in 2012 and hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side 11/24/16, dementia and age related osteoporosis.

An Annual Minimum Data Set (MDS) dated 10/4/16 indicated Resident #2 was moderately impaired in cognition. She required extensive assistance of one person for transfers. Rising from a seated position, surface to surface transfers and toilet transfers did not occur during the assessment period. No falls occurred during the assessment period.

A care plan dated 12/8/16 indicated that Resident #2 was at risk for falls related to decreased mobility, weakness, dementia, hemiparesis from cerebrovascular accident (CVA), osteoporosis and right femur fracture. Interventions dated 12/8/16 included, in part, out of bed with mechanical lift x two people. Maintain bed rest for comfort. Vital signs as ordered and as needed. Contact physician with any abnormalities.

A review of the Resident Mobility/ transfer Profile dated 12/27/16 revealed Resident #2 needed a total lift for transfers.

A nursing note dated 12/31/16 at 6:37PM stated Nurse #1 walked into the shower room to check on the nursing assistant. She found the nursing assistant #1 (NA#1) hanging onto Resident #2 who was sliding out of the wheelchair. The wheelchair had a fleece blanket and the total lift sling was under her. Resident #2 was sliding out

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of the chair. Nurse #1 and NA #1 sat Resident #2 on the floor, then assisted her to the chair. Resident #2 did not have any shoes or non-skid socks on her feet

An occurrence report dated 12/31/16 at 6:49PM stated Nurse #1 walked into the shower room to check on NA#1 and found her hanging onto Resident #2 who was sliding out of the wheelchair. The wheelchair had a fleece blanket and the total lift sling under Resident #2. Resident #2 was sliding out of the chair. Nurse #1 and NA#1 sat Resident #2 on the floor then assisted her to the chair. Immediate Intervention: Placed back in the shower chair. Resident #2 had right sided weakness. Neurological checks were within normal limits. Resident #2 had no complaints of pain. The form indicated it was an assisted fall.

An incident report dated 12/31/16 at 6:49PM, completed by Nurse #1, stated Nurse #1 walked into the shower room to check on NA#1 and found NA#1 hanging onto Resident#2 who was sliding out of the wheelchair. The wheelchair had a fleece blanket and the total lift sling under her and she was sliding out of the chair. Nurse #1 and NA#1 assisted Resident #2 to the floor then assisted her to the chair. No injuries were observed. The incident report stated Resident #2 was alert. Predisposing environmental factors: wet floor; predisposing physiological factors: confused, incontinent. Predisposing situation factors: occurred during transfer. Witness: NA#1.

An emergency room report dated 1/1/17 stated Resident #2 fell on 12/31/16 and had continuous right leg pain with external rotation. A review of

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the x-ray revealed a displaced (not in alignment) distal femoral fracture of the right leg.
An x-ray report dated 1/1/17 was reviewed and indicated there was an obliquely (slanted) oriented fracture of the distal third of the femur (end down by the knee) just below the long stem intramedullary rod. Right knee arthroplasty (knee replacement). Mildly foreshortened as well. Diffuse osteopenia (bone loss). Degenerative changes in the hip and knee. Impression: Fracture of the distal third of the femur which is a spiral fracture and occurred just below the intramedullary rod.

A diagram dated 1/1/17 completed by Nurse #1 showed Resident #2 was lying with right leg bent back at the knee. She was lying on her back. The diagram indicated that Resident #2 fell from her wheelchair in the bathing room.

A review of the fall investigation report completed on 1/3/17 at 1:13PM stated, in part, that there was a fleece type blanket plus lift sling was in the chair which contributed to Resident #2 sliding down in the wheelchair in the shower room. She had no shoes or non-skid socks on at the time of the fall and staff assisted resident to the floor.

Interviews conducted by the facility at the time of the investigation were reviewed and revealed the following:
On 1/4/17, NA #1's statement stated she worked on 12/31/16 until 7:00PM. She got Resident #2 out of bed using the total lift and put her in the wheelchair. She wheeled Resident #2 to the shower room in the wheelchair without leg rests. Resident #2 started to slide out of the wheelchair (she had a fleece blanket and lift sling under her and did not have any leg rests for foot

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placement). Nurse #1 came into the shower room. NA#1 had her arms under Resident #2's arms. Nurse #1 said to sit Resident #2 on the floor. Nurse #1 went and got NA#2 and the three of them lifted Resident #2 off the floor and back into her wheelchair. NA#1 stated they tried to stand Resident #2 to transfer her from the wheelchair to the shower chair but that did not work. NA#1 gave Resident #2 her shower and after the shower, Resident #2 was taken back to her room with one staff member holding her legs and transferred back to bed.

On 1/4/17, NA#2's statement stated she was asked by Nurse #1 to go to the shower room. When she arrived, Resident #2 was on the floor in front of her wheelchair. She stated she picked up Resident #2's legs and the other staff (Nurse #1 and NA#1) were on each side of the resident and they placed her back in the wheelchair. They attempted to use the sit to stand lift but Resident #2 began to slip so they picked her up and placed her in the shower chair. NA#2 stated, after the shower, they took Resident #2 back to her room with staff holding her feet up and transferred her back to bed. There was no documentation if the total lift was used at that time.

On 1/4/17, NA#3's statement stated she worked the night shift (11:00PM-7:00AM) on 12/31/16. She stated she checked Resident #2 during the night and did not have to roll or change Resident #2 until her last rounds at 6:00AM. She said Resident #2 could not help her roll on her side like she normally did and NA#3 noticed Resident #2's leg did not look normal so she informed the charge nurse to come and check Resident #2's leg.

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Nurse #1's statement dated 1/4/17 stated she went into the shower room and observed Resident #2 was sliding out of the wheelchair. NA#1 was holding Resident #2 underneath her arms. There was a sling and cover in the wheelchair. They tried to pull Resident #2 back into the wheelchair but the sling and cover came out from under the resident so they eased her to the floor. Nurse #1's statement said Resident #2's left leg was out straight and her right leg was positioned outward and slightly to the side. They straightened Resident #2's legs while she was still in the floor. She showed no signs of pain at that time. At that time, they picked Resident#2 up and put her in the wheelchair, then attempted to use the sit to stand lift to transfer her to the shower chair. Resident #2 could not stand by herself so they stood her and pivoted her to the shower chair. Nurse #1 looked over her skin and rubbed her legs to see if there was any pain. The statement also indicated Nurse #1 was called by the Director of Nursing on 1/1/17 at 8:41AM and Nurse #1 said she did not notice any outward rotation at that time.

On 1/4/17, Nurse #2's statement stated she worked from 7:00PM-7:00AM on 12/31/16. During shift change report, Nurse #1 stated that Resident #2 had been lowered to the floor in the shower room. Nurse #1 reported no injuries were found at that time. Nurse #2 stated she checked on Resident #2 to make sure her feet were not hanging over the bed and to make sure her mat was between her bed and wall. Nurse #2 did not look under Resident #2's covers. Resident did not show any signs of pain. Resident #2 remained in bed all night. Sometime around 6:00AM, NA#3 informed her that "something was not right" with Resident #2's leg. Nurse #2 went immediately

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down to check on Resident #2. Her right foot and leg was rotated outward. Resident #2 grimaced and moaned when Nurse #2 attempted to move her leg.

On 1/4/17, NA#3's statement stated she worked the evening shift on 12/31/16. She stated she asked NA#1 if she needed help getting Resident #2 strapped into the total lift. NA#3 said Resident #2 was not in her wheelchair correctly because her right leg was dragging. Her left leg was in a straight position. She said NA#1 asked her for the sit to stand lift because someone told her to use that lift for Resident #2 and NA#3 got the sit to stand lift for her. NA#3 said she told Nurse #1 later in the shift about Resident #2's feet dragging on the floor when NA#1 took Resident #2 to the shower room. NA#3 said she repositioned Resident #2 later in the shift with no complaints by the resident.

A review of the 5 day investigation working report revealed an addendum dated 1/6/17 that stated during the course of the investigation, it was found that three employees did not follow facility protocol regarding safe patient transfer. In addition to this the nurse also failed to complete a thorough head to toe assessment.

On 1/27/17 at 11:00AM, an interview was conducted with the Administrator and the Regional Clinical Director of Services. They stated they had in-serviced nursing staff and put a POC (plan of correction) in place. The Administrator stated they had also identified some other issues during the investigation and had in-serviced staff on those also. He stated the facility had put an audit system into place and some audits had been completed since the

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incident. The Administrator stated two of the staff members involved in the incident had been terminated--Nurse #1 and NA#1 on 1/6/17. A third staff member (NA#2) who had assisted Nurse #1 and NA#1 at the time of the fall had received re-education and returned to work on 1/6/17.

On 1/27/17 at 2:00PM, an observation of Resident #2 was conducted. She was lying in bed on her back with her eyes closed. Resident #2 was moving her left arm and hand with no other response noted. A family member was in the room with Resident #2 and stated she had not eaten since sometime last week and no longer responded verbally. She stated she was at the facility the night the resident fell and was there until around 6:00PM. She stated the resident was talking at that time but was not able to get out of bed independently---that she had had strokes and it had affected her right side and she could not move her right side.

On 1/27/17 at 3:20PM, an interview was conducted with Nurse #3 who stated she worked 7:00AM-7:00PM on 1/1/17 when Resident #2 went to the hospital. She stated she came to work around 6:30AM on 1/1/17 and Nurse #2 asked her at that time to come and assess Resident #2's leg. Nurse #2 told her that Resident #2 had sustained a fall the evening before. Nurse #2 told her she had called Resident #2's family member when she observed that the leg did not look right and had obtained an order for an x-ray. Nurse #3 said, when she looked at Resident #2's leg, she noticed the abnormalities and told Nurse #2 she thought the leg was broken. She said she did not attempt to turn the resident. The family was called and

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Resident #2 was taken to the hospital.

On 1/27/17 at 5:38PM, an interview was conducted with NA#3. She stated she routinely provided care for Resident #2 and provided care for her on 12/31/16-1/1/17 (11:00PM-7:00AM shift). She stated Resident #2 slept well all night. She checked her twice during the night and she had not been incontinent of bladder or bowel so she let her sleep. At 6:00AM, Resident #2 was wet (incontinent of urine) and she felt Resident #2's bones moved when she went to turn her. She stated she immediately went and got the nurse to come and check resident because she knew that was not normal. NA#3 stated Resident #2 usually helped her with turning but she was unable to help that morning. She said the nurse came immediately and saw that something was wrong.

On 1/28/17 at 11:05AM, an interview was conducted with NA#4. She stated staff know what type of lift to use and how many people are needed to use the lift by checking in the kiosk. She stated if there were any changes, nursing assistants verbally told each other during shift change report.

Observations conducted throughout 1/27/17-1/28/17 revealed total lifts were available and were available for use in the shower rooms.

On 1/27/17 at 4:29PM, NA#1 was called. The phone had been disconnected.

On 1/27/17 at 5:36PM, Nurse #1 was called with no answer and unable to leave a message.

On 1/27/17 at 5:34PM, NA#2 was called and a

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message was left with no return call on 1/27/17 or 1/28/17.

On 1/27/17 at 5:40PM, Nurse #2 was called with the phone ringing, then cut off. Unable to leave a message.

On 1/27/17 at 5:45PM, an attempt was made to call the nursing assistant (NA#3) who had also worked on the evening shift on 12/31/16. The telephone was disconnected.

The corrective action for past non-compliance dated 1/1/17 was as follows:
1. The licensed nurse and the nursing assistant were placed on suspension and then terminated on 1/6/17 after the investigation was completed. The third nursing assistant received re-education and allowed to return to work on 1.6.17. Time of completion 1/6/17.

2. Other residents who had a fall within the past month were reviewed by the Director of Nursing on 1/4/17 and no other deficient practice was identified. Date of completion: 1/4/17. Falls will be reviewed in the morning risk meeting by the QAPI (Quality Assurance Performance Improvement) team members to ensure falls were investigated and timely notification of physician and responsible party. Also residents who require the use of the mechanical lift had head to toe assessments completed by the licensed nurses on 1/6/17.

3. 100% of nursing staff (licensed and nursing assistants) were in-serviced by the Staff Development Coordinator and Director of Nursing starting 1/4/17 and employees received all in-services prior to working their assignment.

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In-services included: timely notification of family and physician. What is a fall, procedure to follow when a fall occurs which included use of the total lift regardless of lift status to lift a resident from the floor, how direct care staff are to locate the lift status information, procedure to follow when a change is noted with a resident. , fall scene investigation, use of wheelchair pedals and proper seating surface to prevent sliding when seated in a wheelchair. Date of completion: 1/6/17.

4. The Director of Nursing, Staff Development Coordinator or Assistant Director of Nursing will audit 2 falls weekly, if applicable x 3 weeks, then monthly to ensure total mechanical lift is used to lift a resident from the floor after a fall, head to toe assessment completed and timely notification of family and physician. The Director of Nursing, Staff Development Coordinator will audit 2 residents randomly weekly x 3 weeks, then monthly x 3 months to ensure residents have appropriate seating surface to prevent sliding and proper wheelchair legs. Pedals as indicated. Also, the Director of Nursing or the Assistant Director of Nursing will randomly observe 3 residents weekly x 3 weeks, then monthly x 3 to ensure residents are being transferred as assessed. Any area of identified concern will be addressed at the time and continued area of concern will be addressed by QAPI committee for further action plan.

As part of the validation process on 1/26/17 and 1/27/17, the plan of correction was reviewed including the re-education of staff and observations of transfers from wheelchairs to shower chairs. Resident #2 could not be observed for a lift transfer/ transfer to wheelchair

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or shower chair due to her physical condition and unresponsiveness. Observations of other residents being transferred were conducted on 1/26/17 and 1/27/17 and all were completed correctly. Interviews with licensed staff and nursing assistants revealed they were retrained in the areas of transfers, falls, where to obtain the information of what type of transfer should be used for a resident, notification of physician and family if an incident occurred, to use the proper lift for a resident when transferring them and to use leg rests when transporting a resident in the wheelchair. A review of the monitoring tools revealed that the facility completed the audit of falls as noted in their POC. 100% of in-servicing of nursing staff was completed on 1/4/17 including NA#3 who had assisted moving Resident #2 on 12/31/16. A review of the audits revealed audits had been conducted 1/13/17, 1/18/17, 1/20/17, 1/23/17 and 1/24/17.

The final correction date was 1/6/17.