STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045288	A. BUILDING _____ B. WING _____	08/28/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CHENAL REHABILITATION AND HEALTHCARE CENTER	3115 S BOWMAN ROAD LITTLE ROCK, AR 72211

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0323 **Level of harm -** Actual harm **Residents Affected -** Few	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # (AR 610) was substantiated (all or in part) with these findings. Based on observation, record review and interview, the facility failed to ensure a mechanical lift and 2 staff were utilized for transfers in accordance with the resident's assessed transfer needs to prevent accidents / injuries for 1 (Resident #1) of 4 (Residents #1, #3, #6 and #7) case mix residents who required mechanical lift transfers. This failed practice resulted in actual harm to Resident #1, who was transferred manually by 1 Certified Nursing Assistant (CNA), fell to the floor and sustained a complex comminuted distal femur fracture. The CNA failed to immediately report the incident to a licensed nurse, to allow an assessment to be conducted before moving the resident, and failed to obtain assistance from trained nursing personnel to assist the resident off of the floor, which could result in further injury. The facility also failed to ensure staff avoided the use of residents' clothing as a lifting device during transfers, to prevent potential accidents / injuries or 2 (Residents #2 and #5) and failed to ensure the wheelchair brakes were locked prior to conducting a manual transfer to prevent potential falls for 1 (Resident #5) of 3 (Residents #2, #4 and #5) case mix residents who required manual transfers with a gait belt. The facility also failed to ensure chair alarms were maintained in proper working order to alert staff of unassisted transfer attempts in accordance with the plan of care for 1 (Resident #2) of 1 case mix resident who was care planned for the use of a wheelchair alarm. These failed practices had the potential to cause more than minimal harm for 8 residents who required mechanical lift transfers, 30 residents who required manual transfers with a gait belt and 4 residents who were care planned for alarms, as documented on lists provided by the Administrator on 8/28/15. The findings are: 1. Resident #1 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/16/15 documented the resident was severely impaired cognitive skills for daily decision making per a staff assessment of mental status, weighed 161 pounds, was totally dependent on the assistance of 2 persons for bed mobility and transfers, had no functional limitation in range of motion, had no complaints of pain in the past 5 days and had no falls since admission, re-entry or prior assessment. a. The Transfer/Mobility Status Criteria dated 5/12/14 documented, .Transfer Status: 4 (total dependence) .Totally non-weight bearing. Total lift with full body sling. Lift required: Yes . b. The Comprehensive Care Plan dated 6/7/15 documented, Fall Prevention Care Plan Problem: At risk for falls r/t (related to) cognition status, dependent mobility . Transfer using total lift assist (assistance) of two. High back w/c (wheelchair) with pommel cushion for positioning. c. Nurses' Notes dated 8/23/15 at 1:30 p.m. documented, Resident was Hoyer lift to bed, pain noted during transfer. R (resident) holding L (left) leg administered 2 Tylenol arthritis at 12:55 p.m. Abrasions to L side of face noted, (no) bleeding noted, also redness to L upper clavicle, L leg above knee. Swelling noted (and) bent inwards. Awaiting (name) for x-rays. 1650 (4:50 p.m.) (name) x-ray technician arrives for x-rays, stated resident had a femur break from looking at screen. (Physician) notified awaiting call back. 1830 (6:30 p.m.) N.O. (New Order) to send out to (Hospital) ER (emergency room). Ambulance notified. d. The Accident/Incident Report Form dated 8/23/15 documented, .Date 8/23/15 at 12:10 p.m . Status: Resident (Resident #1) Witness (Certified Nursing Assistant (CNA) #1), Falls . Transfer from bed to w/c (wheelchair) . Factors related to fall: (Resident) Alert (at time of accident) - Injuries observed: (blank). Range of motion limited ROM (range of motion) . e. The Situation / Background Assessment / Request (SBAR) Communication form dated 8/23/15 1:15 p.m., documented, .Situation: Fall with signs of hip L (left) leg pain. This condition, symptom or sign has occurred before: No. 8. Skin evaluation: Describe symptoms or signs: Lt (left) leg appears swollen and lt knee appears swollen and slightly turned inward. 9. Pain Evaluation: Does the resident have pain: Yes . Is the pain new: Yes . Does the resident show non-verbal signs of pain (for residents with dementia describe restless, pacing, grimacing, new change in behavior): Resident grimacing with movement and holding Lt leg . Appearance: Lt leg edematous and knee is slightly turned inward . Recommendations: Stat X-ray of Lt hip, upper leg and knee . f. The Fall Root Cause Investigation Report dated 8/23/15 documented, .Resident description or statement regarding the cause: Improper transfer of resident from bed to wc (wheelchair) by CNA . External/Environmental Contributing Factors. Transfer Status: Assist x (times) 2 - Devices used for transfer: Lift. Other: Transfer from bed to wc . Summary: Improper transfer at resident from bed to wc by CNA. Employee received disciplinary actions. g. The Radiology Report dated 8/23/15 documented, .Conclusion: Complex comminuted acute distal femur fracture. h. A Physician order [REDACTED]. Bedrest . 5. Immobilizer on at all times . 6. Tylenol arthritis strength 650 mg po TID (three times daily). 9. Contact (orthopedic specialty clinic) R/T (related to) follow up. L femur fx (fracture). i. The Office of Long Term Care (OLTC) Witness Statement form dated 8/23/15 at 12:20 p.m. documented, Witness Full Name: (Housekeeper #1). State in your own words what you witnessed (be very descriptive) and sign below: 'I was doing my daily routine. I was asked by a CNA worker to help a patient off the floor. Personally, I wasn't aware of what was going on. I admitted ly help the CNA worker with the lady. (Housekeeper #1) . j. The OLTC Witness Statement form dated 8/23/15 at 12:57 p.m. documented, Witness Full Name: (CNA #1) . State in your own words what you witnessed (be very descriptive) and sign below: 'I pulled her legs (Resident #1) around to the edge of the bed so they would dangle. I lifted her and placed her on the seat. I got weak. Sat her on the chair and she slid out of the chair .(CNA #1) . k. Nurses Notes dated 8/24/15 at 1:10 a.m. documented, R (Resident) returned to facility via (ambulance service) on stretcher. S/S (signs and symptoms) of pain observed. Given Tylenol 650 mg (milligrams) po (by mouth) as ordered. Abrasion to L (left) cheek and neck observed as previously noted. Immobilizer brace in place to LLE (left lower extremity). Foley Cath (catheter) inserted using sterile technique size 16 fr.(French) 10 cc (cubic centimeters) bulb. R to remain on bedrest . L Distal Femur Fx (Fracture). l. The Physician order [REDACTED]. m. Nurses Notes dated 8/24/15 at 12:15 p.m. documented, Spoke with (Physician's Nurse). Res (Resident) needs surgery but family does not (sic) & (and) refused surgical repair. Daughter at facility & stated she does not want to do surgery & just keep her comfortable at facility & palliative care . n. On 8/27/15 at 5:29 p.m., CNA #1 was interviewed as follows: The CNA was asked how long she had been employed by the facility and stated, One month; I finished CNA classes one month

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

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 0323 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 1) ago. The CNA stated she was on her second round of orientation. The CNA was asked how Resident #1 was supposed to be transferred and stated, (Resident #1) was a total lift, 2-person transfer. The CNA was asked, Why did you (manually) transfer the resident, who was supposed to be a total lift? The CNA stated, I was late from lunch and I was in a hurry. I just wanted to get her in her chair, to go to the lunch room. They wanted all the CNAs in the dining room to pass lunch trays. I didn't want to get in trouble. The CNA was asked, So, you transferred the resident by yourself? The CNA stated, Yes, there was nobody to help me. I couldn't find the nurse. I was the only one assigned to that hall. I sat her (Resident #1) up on the side of the bed. I got weak and sat her down, and she slid out of the wheelchair. I went to the hall, and the Housekeeper was there and she helped me get her back in the wheelchair, and I took her to the dining room. The CNA was asked, You got the resident out of the floor before you told the nurse? The CNA stated, Yes. The CNA was asked, If a resident has a fall, are you supposed to move the resident before the resident is assessed by a nurse? The CNA stated, No. The CNA was asked, Is a housekeeper supposed to be assisting you with patient care? The CNA stated, I was too weak to pick the resident up; I didn't know at that time that she (Housekeeper #1) wasn't supposed to help. I told the nurse when we got to the dining room. The CNA was asked if it was appropriate to transfer Resident #1 via manual transfer when the resident was assessed to require a mechanical lift. The CNA stated, No. o. On 8/28/15 at 2:20 p.m., Housekeeper (HK) #1 was interviewed as follows: The Housekeeper was asked how long she had been employed by the facility and stated, Three months. The housekeeper was asked about her training and stated that she had 1 day of training. The Housekeeper was asked if she had worked in a nursing home before and stated, No. The Housekeeper was asked if she had assisted with any resident care. The Housekeeper stated, When the situation happened last week, I helped a CNA get her (Resident #1) off the floor; she didn't appear hurt at that time. The Housekeeper was asked, What position were her (Resident #1) legs in (while on the floor). The Housekeeper stated, Her (Resident #1) legs were crossed, Indian-style. The Housekeeper was asked, How did you pick the resident up? The Housekeeper stated, We put one arm under her arms and one hand under her legs (pointing to the upper thigh area) and we lifted her and sat her in the wheelchair. The Housekeeper was asked if she was supposed to be assisting with resident care. The Housekeeper stated, I was informed after that situation that I was not. The Housekeeper was asked, Were you told during your orientation that you were not to assist with any resident care. The Housekeeper stated, No. p. On 8/28/15 at 12:45 p.m., CNA #2 was asked her job title. The CNA stated, Lead CNA, when I am able, but I have been working on the hall for the last week. I am Lead CNA every other week. I watch them do transfers, make sure they do peri-care, help them out on the halls, the 300 and 400 halls, because there's 1 person for that hall, and whatever needs to be done. There's no specific job description for Lead CNA. The CNA was asked specifically about CNA #1's training and stated she had worked with CNA #1 for 2 days while CNA #1 was a student, then after she started her employment with the facility, I worked with her 1 day, then she rotated one day on each hall. The CNA was asked who checked CNA #1 off on transfers. The CNA stated, I did not . I stress that lifts, you don't do by yourself, you get another person; everybody knows that. q. On 8/28/15 at 1:22 p.m., the Director of Nursing (DON) was asked, When the CNAs are in training, who checks the CNAs off to ensure they have the ability to perform their job duties? The DON stated, The Lead CNA orientates the new CNAs until they feel they are competent. The DON was asked, But who checks off the new CNAs to ensure that the CNA is competent in their tasks? The DON stated, The Lead CNA. The DON was asked about the incident involving Resident #1. The DON stated, About (Resident #1), the CNA did an improper transfer. It was reported to me that the CNA did a manual transfer and then picked the resident up off the floor. That resulted in a femur fracture. The DON was asked, What steps have you taken to ensure that this does not happen again? The DON stated, We did a 4 step plan . The resident was placed on bedrest, close monitoring, a leg brace and air mattress. The family has elected not to have surgery, secondary to her age. The facility's '4 Point Plan' developed 8/23/15 documented, .2.Curent residents will have updated transfer/ mobility assessments completed by 8/24/15 .3) current staff will be re-educated by 8/25/15 .a. immediate post fall interventions .c. re-education on lift procedures .d. identification of transfers .4) fall investigations will be reviewed during the morning meeting .weekly audit by mock survey x (times) 3months . The DON was asked if the housekeeper was trained as a CNA. The DON stated, No. The DON was asked if it was appropriate for the Housekeeper to assist with lifting a resident. The DON stated, No. 2. Resident #2 had [DIAGNOSES REDACTED]. The MDS with an ARD of 6/5/15 documented the resident was severely impaired in cognitive skills for daily decision making per a Staff Assessment for Mental Status (SAMS), required extensive assistance of 1 person for transfers and personal hygiene and extensive assistance of 2 persons for bed mobility and utilized a wheelchair for mobility. a. The Resident Transfer/Mobility Status Criteria dated 6/11/14 documented, .Transfer Status: (2), Limited assistance: Resident highly involved in activity; receives physical help in guided maneuvering of limbs or other non-weight bearing assistance. Lifting Aide to be used. Gait belt with assist of one if support of individual is unreliable, then use two person support . gait belt assist of 1. b. The Screening of Resident Falls form dated 3/30/15 documented, .Nursing Intervention: Alarms checked (and) functioning properly. Safety mat properly placed. c. The August 2015 Alarm Monitoring Log documented, 8/1/15 - 8/27/15: .Physician order [REDACTED].? Y . Alarm positioned correctly? Y . Alarm batteries working? Y . Alarms needed repair? N (no) . The form was initialed by the Restorative CNA. d. On 8/27/15 at 1:50 p.m., the resident was sitting in a wheelchair with an alarm on the left side of the wheelchair. The light was not flashing to indicate the alarm was functioning. e. On 8/27/15 at 2:17 p.m., CNA #1 and #2 assisted the resident to her room via wheelchair. The wheelchair alarm was on the back left side of the resident's wheelchair and was not flashing to indicate the alarm was functioning. The CNAs combed the resident's hair as the resident was trying to leave the room. The CNAs took the resident back to the day room area and the resident propelled herself back to the table and laid her head on the table. The CNAs did not check to ensure that the wheelchair alarm was functioning. f. On 8/27/15 at 3:09 p.m., Registered Nurse (RN) #1 was asked to check the resident's alarm. The RN checked the alarm. She stated, There are no batteries in the alarm. The RN put new batteries in the alarm, and a constant beeping started to sound, although the resident was positioned properly in the chair. CNA #1 and #2 took the resident to her room. The CNAs assisted the resident to stand using a gait belt and changed out the seat alarm pad for one that functioned properly. During the process of standing the resident up, the CNAs placed the gait belt around the resident's waist and grasped the gait belt with one hand and the waistband of the resident's pants with their other hand. They used the gait belt and the resident's pants to pull the resident up out of the wheelchair and hold the resident in an upright position while the cushion and alarm pad were changed in the wheelchair. After the procedure was completed, CNA #2 was asked how often the batteries in the chair alarms were checked. The CNA stated, Weekly. CNA #1 was asked, How often are the placement and functioning of the alarms checked? The CNA stated, I don't know. g. On 8/28/15 at 11:03 a.m., Licensed Practical Nurse (LPN) #1 was asked who was responsible for checking the placement and functioning of the wheelchair alarms. The LPN stated, The Restorative CNA (CNA #3). h. On 8/28/15 at 11:30 a.m., CNA #3 was asked about her job duties. The CNA stated, I check all bed and wheelchair alarms, fix drinks in the dining room for breakfast and lunch, apply splints for residents after discharge from therapy, perform range of motion for resident on the Restorative Nursing Program, perform weights on all new residents, Monday weights for weekly weights and monthly weights. The CNA was asked if she had checked the alarms on the wheelchairs on Thursday 8/27/15. The CNA stated, Yes. The CNA was asked if there were any issues related to the alarms. The CNA stated, Yes, on occasion, they are unplugged. CNA #3 was asked, Did you check (Resident #2's) wheelchair alarm on 8/27/15. The CNA stated, Yes. When asked if the chair alarm was functioning properly, she stated, Yes. The CNA was asked when she checked the alarm and stated, When I first get to work and before I leave at 3 (3:00 p.m.). CNA #3 was asked, Did you check the alarm for

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F 0323 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) (Resident #2) before you left on 8/27/15? The CNA stated, No. i. On 8/28/15 at 1:22 p.m., the Director of Nursing (DON) confirmed that CNA #3 was supposed to check the alarms when she arrived at work and again before she left for the day. The DON stated the Restorative CNA (CNA #3) did not check the alarms before she left on 8/27/15. 3. Resident #5 had [DIAGNOSES REDACTED]. a. The Transfer /Mobility Status Criteria dated for 5/12/14 documented, .Transfer Status: 2 (limited assistance) . receives physical help in guided maneuvering of limbs or other non-weight bearing assistance. Lifting Aid to be used. Gait belt with assist of one; If support of individual in unreliable, then use two-person support. b. The Comprehensive Care Plan dated 2/5/15 documented, .Problem, Self-Care Deficit, ambulation related to impaired balance, generalized weakness. Hx (history) fear of falling . Lt (left) Hemiparesis, non-ambulatory . Goal: Resident will continue to transfer with assist of one. Interventions/Approaches: Provide assistance as needed with transfers. Transfer with assist of one for toileting. c. On 8/27/15 at 1:37 p.m., the resident stated she was wet. CNA #2 assisted her to the bathroom. The CNA placed a gait belt around the resident's waist, then assisted the resident to stand by grasping the gait belt and the waistband of the resident's pants and pulling in an upward motion. The CNA did not lock the wheelchair brakes during the transfer. After the resident finished toileting, she asked to go to bed. The CNA took the resident to the bed in the wheelchair and positioned the wheelchair at the foot of the bed. The CNA again grasped the gait belt and the resident's pants and pivoted the resident to the bed. The CNA did not lock the wheelchair brakes during the transfer.
F 0498 **Level of harm -** Actual harm **Residents Affected -** Few	**Make sure that nurse aides show they have the skills and techniques to be able to care for residents' needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # (AR 610) was substantiated (all or in part) with these findings. Based on observation, record review and interview, the facility failed to ensure Certified Nursing Assistants (CNAs) were able to demonstrate competency in properly transferring residents in accordance with their assessed and care planned needs, as evidenced by: Failure to ensure a mechanical lift and 2 staff were utilized for transfers in accordance with the resident's assessed transfer needs to prevent accidents / injuries for 1 (Resident #1) of 4 (Residents #1, #3, #6 and #7) case mix residents who required mechanical lift transfers. This failed practice resulted in actual harm to Resident #1, who was transferred manually by 1 Certified Nursing Assistant (CNA), fell to the floor and sustained a complex comminuted distal femur fracture. The CNA then failed to immediately report the incident to a licensed nurse, to allow an assessment to be conducted before moving the resident, and failed to obtain assistance from trained nursing personnel to assist the resident off of the floor, which could result in additional injury; Failure to ensure CNAs avoided the use of residents' clothing as a lifting device during transfers, to prevent potential accidents / injuries for 2 (Residents #2 and #5) and failed to ensure the wheelchair brakes were locked prior to conducting a manual transfer to prevent potential falls for 1 (Resident #5) of 3 (Residents #2, #4 and #5) case mix residents who required manual transfers with a gait belt. These failed practices had the potential to cause more than minimal harm for 8 residents who required mechanical lift transfers and 30 residents who required manual transfers with a gait belt, as documented on lists provided by the Administrator on 8/28/15. The findings are: 1. Resident #1 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/16/15 documented the resident was severely impaired cognitive skills for daily decision making per a staff assessment of mental status, weighed 161 pounds, was totally dependent on the assistance of 2 persons for bed mobility and transfers, had no functional limitation in range of motion, had no complaints of pain in the past 5 days and had no falls since admission, re-entry or prior assessment. a. The Transfer/Mobility Status Criteria dated 5/12/14 documented, .Transfer Status: 4 (total dependence) . Totally non-weight bearing. Total lift with full body sling. Lift required: Yes . b. The Comprehensive Care Plan dated 6/7/15 documented, Fall Prevention Care Plan Problem: At risk for falls r/t (related to) cognition status, dependent mobility . Transfer using total lift assist (assistance) of two. High back w/c (wheelchair) with pommel cushion for positioning. c. Nurses' Notes dated 8/23/15 at 1:30 p.m. documented, Resident was Hoyer lift to bed, pain noted during transfer. R (resident) holding L (left) leg administered 2 Tylenol arthritis at 12:55 p.m. Abrasions to L side of face noted, (no) bleeding noted, also redness to L upper clavicle, L leg above knee. Swelling noted (and) bent inwards. Awaiting (name) for x-rays. 1650 (4:50 p.m.) (name) x-ray technician arrives for x-rays, stated resident had a femur break from looking at screen. (Physician) notified awaiting call back. 1830 (6:30 p.m.) N.O. (New Order) to send out to (Hospital) ER (emergency room). Ambulance notified. d. The Accident/Incident Report Form dated 8/23/15 documented, .Date 8/23/15 at 12:10 p.m . Status: Resident (Resident #1) Witness (Certified Nursing Assistant (CNA) #1), Falls . Transfer from bed to w/c (wheelchair) . Factors related to fall: (Resident) Alert (at time of accident) - Injuries observed: (blank). Range of motion limited ROM (range of motion) . e. The Situation / Background Assessment / Request (SBAR) Communication form dated 8/23/15 at 1:15 p.m. documented, .Situation: Fall with signs of hip L (left) leg pain. This condition, symptom or sign has occurred before: No. 8. Skin evaluation: Describe symptoms or signs: Lt (left) leg appears swollen and lt knee appears swollen and slightly turned inward. 9. Pain Evaluation: Does the resident have pain: Yes . Is the pain new: Yes . Does the resident show non-verbal signs of pain (for residents with dementia describe restless, pacing, grimacing, new change in behavior): Resident grimacing with movement and holding Lt leg . Appearance: Lt leg [MEDICAL CONDITION] and knee is slightly turned inward . Recommendations: Stat X-ray of Lt hip, upper leg and knee . f. The Fall Root Cause Investigation Report dated 8/23/15 documented, .Resident description or statement regarding the cause: Improper transfer of resident from bed to wc (wheelchair) by CNA . External/Environmental Contributing Factors. Transfer Status: Assist x (times) 2 - Devices used for transfer: Lift. Other: Transfer from bed to wc . Summary: Improper transfer at resident from bed to wc by CNA. Employee received disciplinary actions. g. The Radiology Report dated 8/23/15 documented, .Conclusion: Complex comminuted acute distal femur fracture. h. A Physician order [REDACTED]. Bedrest . 5. Immobilizer on at all times . 6. Tylenol arthritis strength 650 mg po TID (three times daily). 9. Contact (orthopedic specialty clinic) R/T (related to) follow up. L femur fx (fracture). i. The Office of Long Term Care (OLTC) Witness Statement form dated 8/23/15 at 12:20 p.m. documented, Witness Full Name: (Housekeeper #1). State in your own words what you witnessed (be very descriptive) and sign below: 'I was doing my daily routine. I was asked by a CNA worker to help a patient off the floor. Personally, I wasn't aware of what was going on. I admitted ly help the CNA worker with the lady. (Housekeeper #1) . j. The OLTC Witness Statement form dated 8/23/15 at 12:57 p.m. documented, Witness Full Name: (CNA #1) . State in your own words what you witnessed (be very descriptive) and sign below: 'I pulled her legs (Resident #1) around to the edge of the bed so they would dangle. I lifted her and placed her on the seat. I got weak. Sat her on the chair and she slid out of the chair .(CNA #1) . k. Nurses Notes dated 8/24/15 at 1:10 a.m. documented, R (Resident) returned to facility via (ambulance service) on stretcher. S/S (signs and symptoms) of pain observed. 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F 0498 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 3) The CNA was asked how long she had been employed by the facility and stated, One month; I finished CNA classes one month ago. The CNA stated she was on her second round of orientation. The CNA was asked how Resident #1 was supposed to be transferred and stated, (Resident #1) was a total lift, 2-person transfer. The CNA was asked, Why did you (manually) transfer the resident, who was supposed to be a total lift? The CNA stated, I was late from lunch and I was in a hurry. I just wanted to get her in her chair, to go to the lunch room. They wanted all the CNAs in the dining room to pass lunch trays. I didn't want to get in trouble. The CNA was asked, So, you transferred the resident by yourself? The CNA stated, Yes, there was nobody to help me. I couldn't find the nurse. I was the only one assigned to that hall. I sat her (Resident #1) up on the side of the bed. I got weak and sat her down, and she slid out of the wheelchair. I went to the hall, and the Housekeeper was there and she helped me get her back in the wheelchair, and I took her to the dining room. The CNA was asked, You got the resident out of the floor before you told the nurse? The CNA stated, Yes. The CNA was asked, If a resident has a fall, are you supposed to move the resident before the resident is assessed by a nurse? The CNA stated, No. The CNA was asked, Is a housekeeper supposed to be assisting you with patient care? The CNA stated, I was too weak to pick the resident up; I didn't know at that time that she (Housekeeper #1) wasn't supposed to help. I told the nurse when we got to the dining room. The CNA was asked if she was off of orientation at the time of the incident and stated, Yes, I was the only CNA that was assigned to that hall. The CNA was asked, How do you determine how a resident is to be transferred? The CNA stated, It's documented on the sheet on the resident's closet door, the sticker outside the resident's room and the ADL book that we document in at the nurses station. The CNA was asked what the sticker outside Resident #1's door indicated. The CNA stated, TL - that is a total lift. The CNA was asked, If a resident is a total lift / mechanical lift, should the resident be transferred without the lift? The CNA stated she had worked with some staff who did transfer the resident without the lift, but with 2-person assistance, during her orientation, but did not provide the names or dates/times that occurred. The CNA was asked if it was appropriate to transfer Resident #1 via manual transfer when the resident was assessed to require a mechanical lift. The CNA stated, No. o. On 8/28/15 at 2:20 p.m., Housekeeper (HK) #1 was interviewed as follows: The Housekeeper was asked if she had assisted with any resident care. The Housekeeper stated, When the situation happened last week, I helped a CNA get her (Resident #1) off the floor; she didn't appear hurt at that time. The Housekeeper was asked, What position were her (Resident #1) legs in (while on the floor). The Housekeeper stated, Her (Resident #1) legs were crossed, Indian-style. The Housekeeper was asked, How did you pick the resident up? The Housekeeper stated, We put one arm under her arms and one hand under her legs (pointing to the upper thigh area) and we lifted her and sat her in the wheelchair. p. On 8/28/15 at 12:45 p.m., CNA #2 was asked her job title. The CNA stated, Lead CNA, when I am able, but I have been working on the hall for the last week. I am Lead CNA every other week. I watch them do transfers, make sure they do peri-care, help them out on the halls, the 300 and 400 halls, because there's 1 person for that hall, and whatever needs to be done. There's no specific job description for Lead CNA. The CNA was asked what she did with new CNAs. The CNA stated, For new CNAs, I'm on the hall; they orientate with me for 1 day before they move to another hall. The CNA was asked, They (new hires) only work with you for 1 day? The CNA stated, Yes, then they work on another hall with another CNA and they rotate through the halls and job duties. The CNA was asked specifically about CNA #1's training and stated she had worked with CNA #1 for 2 days while CNA #1 was a student, then after she started her employment with the facility, I worked with her 1 day, then she rotated one day on each hall. The CNA was asked who checked CNA #1 off on transfers. The CNA stated, I did not . I stress that lifts, you don't do by yourself, you get another person; everybody knows that. The CNA was asked how the staff knew how a resident was to be transferred. The CNA stated, There is a sticker on the door, a care plan on the closet door and the ADL book. If that is not available, you can check with the nurse. q. On 8/28/15 at 1:22 p.m., the Director of Nursing (DON) was asked about the facility's orientation for CNAs. The DON stated, The Lead CNA does the training. The DON was asked who completed the assessments to determine how the residents should be transferred. The DON stated, The ADON (Assistant Director of Nursing). The DON was asked, When the CNAs are in training, who checks the CNAs off to ensure they have the ability to perform their job duties? The DON stated the, Lead CNA orientates the new CNAs until they feel they are competent. The DON was asked, But who checks off the new CNAs to ensure that the CNA is competent in their tasks? The DON stated, The Lead CNA. The DON was asked about the incident involving Resident #1. The DON stated, About (Resident #1), the CNA did an improper transfer. It was reported to me that the CNA did a manual transfer and then picked the resident up off the floor. That resulted in a femur fracture. The DON was asked, What steps have you taken to ensure that this does not happen again? The DON stated, We did a 4 step plan . The resident was placed on bedrest, close monitoring, a leg brace and air mattress. The family has elected not to have surgery, secondary to her age. The facility's '4 Point Plan' developed 8/23/15 documented, .2.Curent residents will have updated transfer/ mobility assessments completed by 8/24/15 .3) current staff will be re-educated by 8/25/15 .a. immediate post fall interventions .c. re-education on lift procedures .d. identification of transfers .4) fall investigations will be reviewed during the morning meeting .weekly audit by mock survey x (times) 3months . The DON was asked if there had been other residents who had been injured related to improper transfers. The DON stated, No. The DON was asked if the housekeeper was trained as a CNA. The DON stated, No. 2. Resident #2 had [DIAGNOSES REDACTED]. The MDS with an ARD of 6/5/15 documented the resident was severely impaired in cognitive skills for daily decision making per a Staff Assessment for Mental Status (SAMS), required extensive assistance of 1 person for transfers and personal hygiene and extensive assistance of 2 persons for bed mobility and utilized a wheelchair for mobility. a. The Resident Transfer/Mobility Status Criteria dated 6/11/14 documented, .Transfer Status: (2), Limited assistance: Resident highly involved in activity; receives physical help in guided maneuvering of limbs or other non-weight bearing assistance. Lifting Aide to be used. Gait belt with assist of one if support of individual is unreliable, then use two person support . gait belt assist of 1. b. On 8/27/15 at 3:09 p.m., CNA #1 and #2 took the resident to her room in a wheelchair to change out the wheelchair alarm pad, which was not functioning. During the process of standing the resident up for the alarm pad change-out, the CNAs placed the gait belt around the resident's waist and grasped the gait belt with one hand and the waistband of the resident's pants with their other hand. They used the gait belt and the resident's pants to pull the resident up out of the wheelchair and to hold the resident in an upright position while the cushion and alarm pad were changed in the wheelchair. 3. Resident #5 had [DIAGNOSES REDACTED]. a. The Transfer /Mobility Status Criteria dated for 5/12/14 documented, .Transfer Status: 2 (limited assistance) . receives physical help in guided maneuvering of limbs or other non-weight bearing assistance. Lifting Aid to be used. Gait belt with assist of one; If support of individual in unreliable, then use two-person support. b. The Comprehensive Care Plan dated 2/5/15 documented, .Problem, Self-Care Deficit, ambulation related to impaired balance, generalized weakness. Hx (history) fear of falling . Lt (left) [MEDICAL CONDITION], non-ambulatory . Goal: Resident will continue to transfer with assist of one. Interventions/Approaches: Provide assistance as needed with transfers. Transfer with assist of one for toileting. c. On 8/27/15 at 1:37 p.m., the resident stated she was wet. CNA #2 assisted her to the bathroom. The CNA placed a gait belt around the resident's waist, then assisted the resident to stand by grasping the gait belt and the waistband of the resident's pants and pulling in an upward motion. The CNA did not lock the wheelchair brakes during the transfer. After the resident finished toileting, she asked to go to bed. The CNA took the resident to the bed in the wheelchair and positioned the wheelchair at the foot of the bed. The CNA again grasped the gait belt and the resident's pants and pivoted the resident to the bed. The CNA did not lock the wheelchair brakes during the transfer.