STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **185142**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **10/22/2015**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HERITAGE MANOR HEALTH CARE CENTER	**401 INDIANA AVE MAYFIELD, KY 42066**

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 0282 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide care by qualified persons according to each resident's written plan of care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, it was determined the facility failed to follow the plan of care for one (1) of three (3) sampled residents (Resident #1). Resident #1 was assessed and care planned to need the assistance of two (2) staff and a mechanical lift for transfers. On 02/21/15, Certified Nurse Aide (CNA) #1 provided Resident #1 a shower without a shower bed, and had the resident stand without the assistance of another staff or lift. The resident's knee buckled with the resident falling to his/her knees. Resident #1 had subsequent pain and swelling to the right mid-leg and was sent to the emergency roiagnom on [DATE] and was diagnosed with [REDACTED]. Closed reduction of the right distal fracture and external fixation surgery was performed. The findings include: Review of the facility's policy titled, Care Plans, dated 01/07/12, revealed a Comprehensive Care Plan is developed consistent with the patient's specific conditions, risks, needs, behaviors, preferences and with standards of practice including measurable objectives, interventions/services and timetables to meet the resident's needs as identified in the resident's assessment, or as identified in relation to the resident's responses to the interventions or changes in the resident's condition. The care plan addresses the resident's needs, strengths, and preferences identified in the comprehensive assessment; and addresses risk factors that might lead to avoidable declines in functioning or functional levels. Review of the facility's policy titled Managing Fall Risk, dated 08/17/14, revealed in the facility, residents are considered at risk for falls. Care plan interventions can then be tailored to the resident's individual needs to be more successful in reducing the resident's risk for falls. Interventions are implemented and evaluated for effectiveness as evidenced by the resident meeting his/her individual goals. Components: resident information is gathered to assist in identification of contributors. Sources of information may include resident History and Physical, Nursing Evaluation, Fall Risk Evaluation, physician's orders [REDACTED]. Resident's goals and interventions are documented on the resident's care plans. Record review revealed the facility admitted Resident #1 on 12/20/14 with [DIAGNOSES REDACTED]. Review of the Admission Minimum Data Set (MDS) assessment, dated 01/06/15, revealed the facility assessed Resident #1 as cognitively intact with a Brief Interview of Mental Status (BIMS) score of fourteen (14). Review of the Comprehensive Care Plan for limited physical mobility, dated 01/13/15, revealed due to neurological deficits, history of stroke with [MEDICAL CONDITION] and physical weakness, the goal was to be free of falls with related injury. The intervention for transfer was to use a mechanical lift and two (2) person assist. Review of the POS [REDACTED]. Further review revealed Resident #1 appeared weak, lost strength, and CNA #1 intercepted the fall by holding and lowering the resident to the floor with no injury identified. Resident #1 did not verbally or non-verbally express pain. Further review of the investigation revealed Resident #1 stated, I got weak and was being transferred to the wheelchair before the fall. Review of a Nurse's Note, dated 02/23/15 at 9:44 AM, revealed Resident #1 complained of right knee pain and left hand pain; and, at 3:02 PM, a new order was received for an x-ray of the right knee. Review of a Nurse's Note, dated 02/24/15 at 1:18 AM, revealed an X-ray Report Note which stated Resident #1 had a complete subacute [MEDICAL CONDITION] knee just superior to a knee replacement. At 8:30 AM, the Physician was notified and the report was sent for review. The Physician ordered an Orthopedic consult. Review of a Nurse's Note, dated 02/24/15 at 5:17 PM, revealed Resident #1 was sent to the hospital for evaluation. Review of the Hospital emergency room Note and History and Physical, dated 02/24/15, revealed Resident #1 stated he/she fell Saturday (three (3) days ago) at the nursing home while trying to get in a chair and landed on both knees. Resident #1 stated he/she fell from an upright position while standing. Resident #1 subsequently had progressive swelling and pain in the right mid-leg and was sent to the emergency room . X-rays were obtained which showed a distal femur fracture above the prosthetic right knee. Review of an Operative Report, dated 02/26/15, revealed a closed reduction of the right distal fracture and external fixation was performed on Resident #1's right leg. Interview with Resident #1, on 10/19/15 at 10:12 AM, revealed he/she fell in the shower and broke his/her leg and there was just one (1) CNA present. Resident #1 stated usually two (2) staff would get him/her up with the lift. During further interview, Resident #1 stated the CNA asked him/her to grab the bar and stand up until she could get the wheelchair but his/her hands slipped. Resident #1 stated his/her legs were under him/her and the CNA laid him/her down to go get help. The resident stated staff did not use a lift in the shower. Interview with CNA #1, on 10/21/15 at 1:37 PM, and review of CNA #1's written statement, dated 02/25/15, revealed Resident #1 was asked if he/she was able to stand in the shower room after his/her shower and Resident #1 said yes. The CNA stated Resident #1 grabbed the bar and stood up with his/her good leg while CNA #1 was drying him/her. The resident's knee gave way and CNA #1 caught him/her and set him/her on the floor. CNA #1 stated she caught Resident #1 and sat him/her on the floor. Resident #1 stated he/she was not in pain when assisted into the wheelchair and taken back to his/her room. CNA #1 stated she thought the care plan said one (1) person assist and she always did shower Resident #1 with one (1) assist. Interviews on 10/21/15 with CNA #6 at 2:56 PM, CNA #3 at 3:11 PM, and CNA #4 at 3:22 PM, revealed Resident #1 was transferred with a lift with two (2) person assist. CNA #6 stated it was in the CNA's book to use the lift and two (2) person assist; and, if a resident used a lift for transfers then the resident would be a two (2) person assist in the shower and, would be taken to the shower room on a shower bed. Interview with Licensed Practical Nurse (LPN) #1, on 10/21/15 at 3:37 PM, revealed Resident #1 was there for rehabilitation following a stroke, and could not stand by himself/herself and would be a two (2) assist or a mechanical lift. Interview with the Director of Nursing (DON), on 10/21/15 at 4:54 PM; and, on 10/22/15 at 10:45 AM, revealed it was the facility's standard of practice if a resident was transferred with a lift, they were to taken to the shower on a shower bed and they were to be assisted by two (2) staff. The DON stated she expected the staff to follow the care plan. The facility implemented the following actions to correct the deficient practice: 1. On 02/21/15, a fall's investigation, pain assessment and Fall Risk Assessment were completed by LPN #5. 2. On 02/25/15, CNA #1 was interviewed by the DON and wrote a statement about the incident. 3. On 02/25/15, CNA #1 was disciplined and re-educated by the DON. 4. On 02/25/15, Resident #1 was evaluated for appropriateness of the use of a lift by Therapy and the resident's care plan was reviewed and updated by the DON and Case Manager. 5. On 02/25/15, all residents who used lifts were evaluated for appropriateness of the use of lifts by Therapy. 6. On 02/25/15, all care plans and resident care guides were reviewed and updated as needed by Medical Records and the DON. 7. On 02/24/15 through 03/31/15, Education/Inservice was provided by the DON to all nursing staff to ensure staff was aware

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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NAME OF PROVIDER OF SUPPLIER **HERITAGE MANOR HEALTH CARE CENTER**	STREET ADDRESS, CITY, STATE, ZIP **401 INDIANA AVE** **MAYFIELD, KY 42066**

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 0282

Level of harm - Actual harm

Residents Affected - Few

(continued... from page 1)
that residents who were care planned to use lifts were to be transferred with lifts at all times. If this was not followed, disciplinary action would occur up to and including termination.
8. Random residents who were care planned for lifts will be observed for proper transfer using lift three (3) times a week for one (1) month, then two (2) times a week for one (1) month, then weekly times one (1) month by Nursing Management.
The State Survey Agency validated the corrective actions taken by the facility as follows:
1. Review of the POS [REDACTED]. Resident #1 appeared weak-lost strength, and CNA #1 intercepted the fall by holding and lowering the resident to the floor with no injury identified. Resident #1 did not verbally or non-verbally express pain. Further review of the investigation revealed Resident #1 stated, I got weak and was being transferred to the wheelchair before the fall.
Review of a Fall Risk assessment conducted by LPN #5, dated 02/21/15 at 4:33 PM, revealed the resident had a Morse Fall Risk score of 30 (medium risk). Review of a Nurse's Note, dated 02/21/15, revealed a pain assessment was completed by LPN #5.
2. Interview with the DON, on 10/22/15 at 12:45 PM, revealed she interviewed CNA #1 and CNA #1 wrote a statement about the incident on 02/25/15.
3. Interview with the DON, on 10/22/15 at 12:45 PM, revealed CNA #1 was disciplined and re-educated on 02/25/15. Review of CNA's Performance Improvement Form, dated 02/25/15, revealed re-education and discipline were provided.
4. Interview with the Therapy Director, on 10/22/15 at 1:46 PM, revealed she assessed Resident #1 for the use of the lift on 02/25/15. Interview with the DON, on 10/22/15 at 12:45 PM, revealed she reviewed and updated Resident #1's care plan on 02/25/15.
5. Interview with the Therapy Director, on 10/22/15 at 1:46 PM, revealed the therapy staff assessed all residents for the use of the lift on 02/25/15.
6. Interview with the DON, on 10/22/15 at 12:45 PM, revealed she and the Medical Record staff reviewed and updated all residents' care plans on 02/25/15.
7. Review of an Activity Sign-In Sheet, dated 02/24/15 through 03/31/15, revealed signatures of all nursing staff indicating they were educated related to all residents who were care planned as lifts were to use lifts at all times, and if this policy was not followed, disciplinary action would occur up to and including termination.
Interview with the Staff Development Director, on 10/22/15 at 1:55 PM, revealed she was on the Quality Assurance (QA) Team. She stated she did not remember specifics; however, she remembered educating staff related to lifts and following the residents' care plans.
Interviews on 10/22/15 with LPN #2 at 12:52 PM, LPN #1 at 12:53 PM, LPN #4 at 1:00 PM, LPN #3 at 1:34 PM, CNA #10 at 12:56 PM, CNA #9 at 12:58 PM, CNA #5 at 1:02 PM, CNA #7 at 1:07 PM, and CNA #8 at 2:45 PM, revealed they were inserviced on always following care plans and falls, if residents were to use a lift, they were to always use a lift with two (2) people and a shower bed for showers.
8. Interview with the Activities Director, on 10/22/15 at 1:41 PM, revealed she was part of the Quality Assurance Team (QA) and she was monitoring the use of lifts to ensure they were used appropriately and staff was following the residents' care plans.
Interview with the Therapy Director, on 10/22/15 at 1:46 PM, revealed she was on the QA team and was doing Performance Improvement related to Resident #1's fall; and, she was ensuring lifts were being used for residents correctly.
Attempts to interview the Medical Director were unsuccessful, as he was on vacation.

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
Based on interview, record review, facility policy review, review of the Hospital emergency room Note, History and Physical, and Operative Report, it was determined the facility failed to provide supervision for one (1) of three (3) sampled residents (Resident #1).
The facility assessed and care planned Resident #1 to need the assistance of two (2) staff and a mechanical lift for transfers. The facility's standard of practice was if a resident required a lift the resident was supposed to be transported to the shower room per a shower bed and two (2) staff was to provide care. On 02/21/15, Certified Nurse Aide (CNA) #1 provided Resident #1 a shower without a shower bed, and had the resident stand without the assistance of another staff, and did not use a lift. The resident's knee buckled with the resident falling to his/her knees. Resident #1 had subsequent pain and swelling and was sent to the emergency roiagnom on [DATE]. The resident was diagnosed with [REDACTED]. Closed reduction of the right distal fracture and external fixation surgery was performed.
The findings include:
Review of the facility's policy titled, Accidents and Supervision to Prevent Accidents, dated 04/28/11, revealed the Center provides an environment that is free from accident hazards over which the Center has control and provides supervision and assistive devices to each resident to prevent avoidable accidents. This includes systems and processes designed to identify hazards and risks, evaluate and analyze hazards and risks, and implement interventions to reduce hazards and risks. Both the Center's focused and resident directed approaches include evaluating hazard and accident risk data, analyzing potential causes for each hazard and accident risk, and identifying and designing interventions, including care plan interventions based on the severity of the hazards and immediacy of risk. The Center communicates the interventions to relevant staff, assigning responsibility to appropriately trained individuals, implementing and documenting interventions. The Falls Center evaluates the casual factors leading to a resident's fall to help support relevant and consistent interventions to try and prevent future occurrences.
Review of the facility's policy titled Managing Fall Risk, dated 08/17/14, revealed, in the facility, residents were considered at risk for falls. Care plan interventions can then be tailored to the resident's individual needs to be more successful in reducing the resident's risk for falls. Interventions are implemented and evaluated for effectiveness as evidenced by the resident meeting his/her individual goals. Components: resident information is gathered to assist in identification of contributors. Sources of information may include resident History and Physical, Nursing Evaluation, Fall Risk Evaluation, physician's orders [REDACTED]. Resident's goals and interventions are documented on the resident's care plans.
Record review revealed the facility admitted Resident #1 on 12/20/14 with [DIAGNOSES REDACTED]. Review of the Admission Minimum Data Set (MDS) assessment, dated 01/06/15, revealed the facility assessed Resident #1 as cognitively intact with a Brief Interview of Mental Status (BIMS) score of fourteen (14) indicating the resident was interviewable.
Review of the Resident Nursing Evaluation, dated 12/30/14, revealed Resident #1 had a history of [REDACTED]. The resident's fall risk score was sixty (60), which indicated the resident was at high risk for falls (high risk forty-five (45) and higher).
Review of the Admission physician's orders [REDACTED].
Review of the Rehabilitation Communications to Nursing forms, dated 01/01/15 and 02/13/15, revealed Resident #1 was at risk for falls, and a mechanical lift and the assistance of two (2) staff was required for transfers.
Interview with the Physical Therapist (PT), on 10/21/15 at 2:17 PM, revealed Resident #1 required assistance to stabilize his/her right knee when standing to prevent buckling, and, the resident did not have enough knee control to stand without assistance and would not be able to stand alone. The PT stated Resident #1 could not stand by himself/herself and needed someone beside him/her to give maximum assistance. The resident needed a second (2nd)person for safety.
Review of the Comprehensive Care Plan for limited physical mobility, dated 01/13/15, revealed a plan related to neurological deficits, history of stroke with hemiparesis and physical weakness. Goals included to be free of falls, and related injury. Interventions included to use a mechanical lift and two (2) person assist.
Review of the Post Fall Investigation, dated 02/21/15 at 12:30 PM, revealed Resident #1 had a fall in the shower room next to the wheelchair during an assisted transfer. Resident #1 appeared weak, lost strength, and CNA #1 intercepted the fall by holding and lowering the resident to the floor with no injury identified. Resident #1 did not verbally or non-verbally express pain. Further review of the investigation revealed Resident #1 stated, I got weak and was being transferred to the

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F 0323 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) wheelchair before the fall. Review of an Interdisciplinary Team Note, dated 02/23/15 at 9:35 AM, related to a fall on 02/21/15, revealed the resident was being transferred with the assistance of two (2) staff and became weak and was lowered to the floor. However, review of CNA #1's written statement and interview with CNA #1 and Resident #1 revealed the CNA was alone when providing care. Further review revealed the immediate intervention was to educate staff on correct transfer techniques. Review of a Nurse's Note, dated 02/23/15 at 9:44 AM, revealed Resident #1 complained of right knee pain and left hand pain. Further review of the Nurse's Notes revealed, at 3:02 PM, a new order was received for an x-ray to the resident's right knee related to right knee pain with a recent witnessed fall. Review of a Nurse's Note, dated 02/24/15 at 1:18 AM, revealed an X-Ray Report Note, which stated Resident #1 had a complete subacute fracture of the right knee just superior to a knee replacement. At 8:30 AM, the Physician was notified and the Report was sent for review. The Physician called the facility stating the area of concern appeared to be an old injury, possibly an old fracture. However, given the resident's complaints of discomfort with the use of his/her right lower extremity, an Orthopedic Consult was ordered. Review of a Nurse's Note, dated 02/24/15 at 5:17 PM, revealed Resident #1 was sent to the hospital for evaluation. Review of the Hospital emergency room Note, and History and Physical, dated 02/24/15, revealed Resident #1 stated he/she fell Saturday (three (3) days ago) at the nursing home while trying to get in a chair and landed on both knees. Further review revealed Resident #1 stated he/she fell from an upright position while standing and subsequently had progressive swelling and pain in the right mid-leg and was sent to the emergency room . X-rays were done, which showed a distal femur fracture above a prosthetic right knee. Review of the Operative Report, dated 02/26/15, revealed a closed reduction of the right distal fracture and external fixation was performed on Resident #1's right leg. Interview with Resident #1, on 10/19/15 at 10:12 AM, revealed he/she fell in the shower and broke his/her leg with one (1) CNA present. Resident #1 stated usually two (2) staff would get him/her up with the lift. Resident #1 stated the CNA asked him/her to grab the bar and stand up until she could get the wheelchair, but his/her hands slipped. Resident #1 stated his/her legs were under him/her and the CNA laid him/her down to go get help. The resident revealed staff did not use a lift in the shower. Interview with CNA #1, on 10/21/15 at 1:37 PM, and review of CNA #1's written statement, dated 02/25/15, revealed Resident #1 was asked if he/she was able to stand in the shower room after his/her shower and Resident #1 stated Yes. CNA #1 stated Resident #1 grabbed the bar and stood up with his/her good leg while CNA #1 was drying him/her and then the resident's knee gave way. CNA #1 caught him/her and set him/her on the floor. She stated Resident #1 stated he/she was not in pain when she was assisted into the wheelchair and taken back to his/her room. The CNA stated she thought the care plan said one (1) assist and she always showered Resident #1 with one (1) assist. Interview with CNA #6, on 10/21/15 at 2:56 PM, revealed Resident #1 was a lift all the time and it was in the CNA's book to use the lift and two (2) person assist. CNA #6 stated if a resident was a lift, then staff should use two (2) person assist in the shower, as per facility policy. Interview with CNA #3, on 10/21/15 at 3:11 PM, revealed Resident #1 was a two (2) person assist with care and a mechanical lift. She stated if a resident was a mechanical lift and two (2) person assist, they were taken to the shower room on the shower bed. Interview with Licensed Practical Nurse (LPN) #1, on 10/21/15 at 3:37 PM, revealed Resident #1 was there for rehabilitation following a stroke, and could not stand by himself/herself and would be a two (2) assist or a mechanical lift. Interview with the Director of Nursing (DON), on 10/21/15 at 4:54 PM and on 10/22/15 at 10:45 AM, revealed she was notified of the fall on 02/21/15 and they reviewed the fall the next work day in the Interdisciplinary Team (IDT) meeting. The DON stated they determined the root cause of the fall was the CNA did not provide the appropriate amount of assistance per the care plan. The DON said it was the facility's standard of practice that all residents who required a lift for transfers were taken to the shower on a shower bed and were an assist of two (2) for showers. The facility implemented the following actions to correct the deficient practice: 1. On 02/21/15, a fall's investigation, pain assessment and Fall Risk Assessment were completed by LPN #5. 2. On 02/25/15, CNA #1 was interviewed by the DON and wrote a statement about the incident. 3. On 02/25/15, CNA #1 was disciplined and re-educated by the DON. 4. On 02/25/15, Resident #1 was evaluated for appropriateness of the use of a lift by Therapy and the resident's care plan was reviewed and updated by the DON and Case Manager. 5. On 02/25/15, all residents who used lifts were evaluated for appropriateness of the use of lifts by Therapy. 6. On 02/25/15, all care plans and resident care guides were reviewed and updated as needed by Medical Records and the DON. 7. On 02/24/15 through 03/31/15, Education/Inservice was provided by the DON to all nursing staff to ensure staff was aware that residents who were care planned to use lifts were to be transferred with lifts at all times. If this was not followed, disciplinary action would occur up to and including termination. 8. Random residents who were care planned for lifts will be observed for proper transfer using lift three (3) times a week for one (1) month, then two (2) times a week for one (1) month, then weekly times one (1) month by Nursing Management. The State Survey Agency validated the corrective actions taken by the facility as follows: 1. Review of the Post Fall Investigation, dated 02/21/15 at 12:30 PM, revealed Resident #1 had a fall in the shower room next to the wheelchair during an assisted transfer. Resident #1 appeared weak-lost strength, and CNA #1 intercepted the fall by holding and lowering the resident to the floor with no injury identified. Resident #1 did not verbally or non-verbally express pain. Further review of the investigation revealed Resident #1 stated, I got weak and was being transferred to the wheelchair before the fall. Review of a Fall Risk assessment conducted by LPN #5, dated 02/21/15 at 4:33 PM, revealed the resident had a Morse Fall Risk score of 30 (medium risk). Review of a Nurse's Note, dated 02/21/15, revealed a pain assessment was completed by LPN #5. 2. Interview with the DON, on 10/22/15 at 12:45 PM, revealed she interviewed CNA #1 and CNA #1 wrote a statement about the incident on 02/25/15. 3. Interview with the DON, on 10/22/15 at 12:45 PM, revealed CNA #1 was disciplined and re-educated on 02/25/15. Review of CNA's Performance Improvement Form, dated 02/25/15, revealed re-education and discipline were provided. 4. Interview with the Therapy Director, on 10/22/15 at 1:46 PM, revealed she assessed Resident #1 for the use of the lift on 02/25/15. Interview with the DON, on 10/22/15 at 12:45 PM, revealed she reviewed and updated Resident #1's care plan on 02/25/15. 5. Interview with the Therapy Director, on 10/22/15 at 1:46 PM, revealed the therapy staff assessed all residents for the use of the lift on 02/25/15. 6. Interview with the DON, on 10/22/15 at 12:45 PM, revealed she and the Medical Record staff reviewed and updated all residents' care plans on 02/25/15. 7. Review of an Activity Sign-In Sheet, dated 02/24/15 through 03/31/15, revealed signatures of all nursing staff indicating they were educated related to all residents who were care planned as lifts were to use lifts at all times, and if this policy was not followed, disciplinary action would occur up to and including termination. Interview with the Staff Development Director, on 10/22/15 at 1:55 PM, revealed she was on the Quality Assurance (QA) Team. She stated she did not remember specifics; however, she remembered educating staff related to lifts and following the residents' care plans. Interviews on 10/22/15 with LPN #2 at 12:52 PM, LPN #1 at 12:53 PM, LPN #4 at 1:00 PM, LPN #3 at 1:34 PM, CNA #10 at 12:56 PM, CNA #9 at 12:58 PM, CNA #5 at 1:02 PM, CNA #7 at 1:07 PM, and CNA #8 at 2:45 PM, revealed they were inserviced on always following care plans and falls, if residents were to use a lift, they were to always use a lift with two (2) people and a shower bed for showers. 8. Interview with the Activities Director, on 10/22/15 at 1:41 PM, revealed she was part of the Quality Assurance Team (QA) and she was monitoring the use of lifts to ensure they were used appropriately and staff was following the residents' care plans. Interview with the Therapy Director, on 10/22/15 at 1:46 PM, revealed she was on the QA team and was doing Performance Improvement related to Resident #1's fall; and, she was ensuring lifts were being used for residents correctly. Attempts to interview the Medical Director were unsuccessful, as he was on vacation.