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F 000	INITIAL COMMENTS The following citations represent the findings of a partial extended survey for complaint investigations #KS00179404 and #KS00179440. On 04/18/23 at 11:05 AM, the administrator was provided with the immediate jeopardy template and notified that the failure to ensure staff reported allegations of verbal and mental abuse which included threat of bodily harm when Certified Nurse Aide (CNA) M threatened cognitively impaired Resident (R)1 after he became upset when staff transferred him in the bathroom. R1 stated to get a gun and "Shoot me" and in response CNA M threatened this upset resident that he would be a second Samurai, bring two swords and if the first on failed, he had the second sword. Licensed Nurse I witnessed the verbal threat and did not report this to administrative staff or to the law enforcement. This failure to report placed the resident in immediate jeopardy. This 2567 was electronically sent to the facility on 05/03/23. A revision included that this deficient practice at F609 was cited as past non-compliance after the facility completed acceptable corrections on 04/10/23 at 01:30 PM, prior to the surveyor entrance on 04/11/23. The corrections were reviewed by the surveyor on 04/11/23. The exit and review dates were also corrected for this investigation. A revision of this 2567 was electronically sent to the facility on 05/16/23.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 05/03/2023

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 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: The facility reported a census of 51 residents. The sample included eleven residents care planned for mechanical lift. The sample of three residents included three residents reviewed for neglect. Based on record review and interview, on 04/06/23, the facility failed to ensure dependent Resident (R)1 remained free from neglect, when Certified Nurse Aide (CNA) M attempted an unsafe transfer of R1 from the toilet to his wheelchair, without the use of the baseline care planned and nursing/therapy communication mechanical lift. R1's legs buckled during the transfer, R1 "slumped" into the wall next to the toilet, and the CNA M transferred R1 on to the toilet. As R1 slid down the wall next to the toilet, the resident's right thigh broke the toilet paper dispenser. Licensed Nurse (LN) I, Licensed Nurse J, and Certified Nurse Aide (CNA) P assisted CNA M to transfer R1 with the Sit to Stand, R1's legs were too weak. LN I, LN J, CNA	F 600		

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P and CNA M then transferred R1 with mechanical lift from the toilet to the resident's bed. LN I, LN J, CNA P and CNA M did not report the unsafe transfer and the Administrator began and investigation on 04/10/23 when unidentified family member expressed concerns to Social Worker X. The staff failure of an unsafe transfer of R1 without the care planned mechanical lift and failure to report placed the resident at harm.

Findings included:

- R1's 03/31/23, signed "Hospital Discharge Order", documented the facility admitted the resident on 03/31/23. The resident's diagnoses included atrial fibrillation (rapid, irregular heartbeat), ataxia (impaired ability to coordinate movement), muscle weakness, unsteadiness of feet (abnormality of walking), and morbid obesity (excess body fat).

The 04/03/23 "Admission Minimum Data Set" (MDS), documented the resident had a Brief Interview for Mental Status (BIMS) score of seven, which indicated severely impaired cognition. He required total dependence of staff for transfer and toileting. The resident was not steady and was only able to stabilize with staff assistance. The resident used a manual wheelchair and walker for mobility.

The 04/10/23 "Cognitive Loss/Dementia Care Area Assessment" (CAA), documented the resident had deficits with orientation, memory, and recall.

The 04/10/23 "Activities of Daily Functional Status Care Area Assessment" (CAA), documented the resident required assistance with ADL's. The

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resident had impaired balance and transition during transfer and functional impairment.

The 03/31/23 Baseline Care Plan," revealed R1 required total dependence with transfer and toileting. The resident used a manual wheelchair, walker and mechanical lift.

The 03/31/23 "Nursing/Therapy Communication," revealed the resident required maximum assistance of two staff members for transfers. Staff were to use a gait belt, and if the resident had difficulty standing, the staff members were to utilize the Hoyer (a full body mechanical lift).

The "Clinical Notes", dated 04/02/23 through 04/04/23, documented the resident required the mechanical lift for transfer, and on 04/06/23, the resident was unable to stand with two staff members assistance. The mechanical lift was used to transfer the resident from the toilet to the bed.

The "Clinical Progress Notes" dated 03/31/23 through 04/11/23, located in the electronic health records, lacked documentation related to the unsafe transfer and notification to Administration or designee.

On 04/11/23 at 09:00 AM, Administrative Staff A reported on 04/06/23 at 12:00 PM, CNA P CNA M, LN I, and LN J provided toileting cares for R1. The CNA M, CNA P, LN I, and LN J attempted an unsafe transfer for the cognitive impaired and dependent resident. The staff members failed to notify her that there was an unsafe transfer on 04/06/23 at 12:00 PM. Administrative Staff A reported that she was notified on 04/10/23 at 11:30 AM by Social Worker X that CNA M placed

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a gait belt around the resident and assisted the resident to stand. The resident's legs became weak, the resident and staff member "slid down" the wall, next to the toilet, and CNA M lowered the resident to the toilet seat. The resident's right thigh broke the toilet paper dispenser. CNA P CNA M, LN I, and LN J attempted to transfer R1 with the Sit to Stand. The resident's legs were too weak for the Sit to Stand. The staff members utilized the mechanical lift to transfer the resident from the toilet to resident's bed. Administrative Staff reported the resident's baseline care plan, dated 03/31/23, revealed the resident required total dependence with toileting and transfers. The resident's mobility devices were walker, wheelchair, and mechanical lift. Administrative Staff A verified the baseline care plan was incorrectly coded, and the resident should be total dependence with the mechanical lift for transfers and toileting.

On 04/17/23 at 08:30 AM, Administrative Nurse D reported on 04/06/23, an unidentified staff member reported that the resident had a decline in his physical ability to stand and R1 now required a mechanical lift. Administrative Nurse D reported on 04/06/23, a staff member who assisted with toileting, witnessed an unsafe transfer by CNA M. She reported an unidentified family member reported their concerns on 04/10/23 at approximately 11:00 AM to Social Worker X. On 04/10/23 at 11:30 AM, the Social Worker X reported the concerns to the facility administration and an immediate investigation was started. CNA M was interviewed and filled out a witness statement. In his witness statement, he admitted that he used the word "Samurai." On 04/10/23 at 11:30 PM, CNA M was suspended and then terminated on 04/13/23

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On 04/17/23 at 02:13 PM Social Services X reported an unidentified family member of R1 expressed concerns regarding CNA M. The unidentified family member reported R1 was care planned to be transferred with the Hoyer (a full body mechanical lift). CNA M did place the gait belt around R1 and stood the resident up. R1 reported to CNA M that he was unable to stand, and his legs were too weak to stand. The family member reported CNA M threw R1 against the wall in the bathroom, R1 slid down the wall, his right thigh broke the toilet paper roll, caused a bruise on his right thigh. The CNA M stated to the resident, "if you will just try you would do it" The resident then told CNA M "why don't you just shoot me now?" The unidentified family member reported she overheard CNA M who told R1 "he would be his Samuari, he would bring two swords, and if he failed with the first one, he would have a second one." The unidentified family member reported that CAN P, LN I, and LN J assisted with the unsafe transfer.

On 04/18/23 at 12:54 PM, Licensed Nurse I reported she asked for additional staff members to assist R1 to transfer the resident from the toilet to his wheelchair. LN J and CNA P also provided assistance. CNA M placed a gait belt around the resident, his arms around the resident and stood the resident up. The resident expressed to the staff members that his legs were too weak to stand, and the resident voiced he needed to sit down. CNA M advised the resident to try to stand up so that the other staff members could provide pericare and place the clean brief on him. The resident legs buckled, the resident and CNA M leaned on the wall and the resident slid onto the toilet seat. The resident's legs were too weak for

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the sit to stand lift and the staff members obtained and used the full body mechanical lift. The resident was care planned for maximum two-person assist, total dependence. His mobility devices are walker, wheelchair, and mechanical lift. LN I did not feel that the transfer was reportable since the resident was not hurt or fall on the floor.

On 04/18/23 at 01:08 PM, Certified Nurse Aide (CNA) M reported he was asked by LN I to assist with a transfer for R1. CNA M had proved cares for the resident once. CNA M verified he did not know the resident was care planned for mechanical lift for transfers.

The facilities policy "Abuse Prevention Program", revised 08/2006, documented the residents have the right to be free from abuse and neglect. The policy and procedures direct staff to report allegations of abuse and or neglect in a timely manner to Administration.

The facilities policy for, "Safe Lifting and Movement of Residents", dated 12/2013, documented staff would promote the safety and well-being of staff and residents, promote quality of care, use appropriate techniques and devices to lift and move residents.

The facility failed to ensure dependent Resident (R) 1 remained free from neglect, when Certified Nurse Aide (CNA) M attempted an unsafe transfer of R1 from the bath chair to her wheelchair, without use of the care planned mechanical lift. R1's legs buckled during the transfer and CNA M called for assistance; however, when CNA N entered the room, the two staff continued to transfer R1 to his wheelchair,

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F 600	Continued From page 7 without use of the care planned mechanical lift. The staff failure of an unsafe transfer of R1 without the care planned mechanical lift and failure to report the fall, placed R1 at harm.	F 600		
F 609 SS=J	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: The facility reported a census of 51 residents.	F 609		

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The sample included three residents reviewed for neglect. Based on interview and record review, the facility failed to ensure staff reported allegations of verbal and mental abuse, which included threats of bodily harm when Certified Nurse Aide (CNA) M threatened cognitively impaired Resident (R)1 after he became upset when staff transferred him in the bathroom. R1 stated "to get a gun" and "Shoot me" and in response CNA M threatened this upset resident that he would be a second Samurai, bring two swords, and if the first one failed, he had the second sword. Licensed Nurse (LN) I, Licensed Nurse J, and Certified Nurse Aide (CNA) P witnessed the mental and verbal abuse, and did not contact Administrative Staff, Corporate Staff, or local law enforcement. This failure to report allowed CNA M to continue his presence in the facility around all of the residents and staff. R1's family members witnessed the unsafe transfer and inappropriate comments by CNA M, which made the resident and family members afraid for their safety and to remain in the facility. This placed the residents in immediate jeopardy for mental and verbal abuse from CNA M.

Findings included:

- R1's 03/31/23, signed "Hospital Discharge Order", documented the facility admitted the resident on 03/31/23. The resident's diagnoses included atrial fibrillation (rapid, irregular heartbeat), ataxia (impaired ability to coordinate movement), muscle weakness, unsteadiness of feet (abnormality of walking), and morbid obesity (excess body fat).

The 04/03/23 "Admission Minimum Data Set" (MDS), documented the resident had a Brief

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Interview for Mental Status (BIMS) score of seven, which indicated severely impaired cognition. He required total dependence of staff for transfer and toileting. The resident was not steady and was only able to stabilize with staff assistance. The resident used a manual wheelchair and walker for mobility.

The 04/10/23 "Cognitive Loss/Dementia Care Area Assessment" (CAA), documented the resident had deficits with orientation, memory, and recall.

The 04/10/23 "Activities of Daily Functional Status Care Area Assessment" (CAA), documented the resident required assistance with ADL's. The resident had impaired balance and transition during transfer and functional impairment.

The 03/31/23 Baseline Care Plan," revealed R1 required total dependence with transfer and toileting. The resident used a manual wheelchair, walker and mechanical lift.

The 03/31/23 "Nursing/Therapy Communication," revealed the resident required maximum assistance of two staff members for transfers. Staff were to use a gait belt, and if the resident had difficulty standing, the staff members were to utilize the Hoyer (a full body mechanical lift).

The "Clinical Notes", dated 04/02/23 through 04/04/23, documented the resident required the mechanical lift for transfer, and on 04/06/23, the resident was unable to stand with two staff members assistance. The mechanical lift was used to transfer the resident from the toilet to the bed.

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The "Clinical Progress Notes" dated 03/31/23 through 04/11/23, located in the electronic health records, lacked documentation related to the verbal threat made by CNA M.

On 04/11/23 at 09:00 AM, Administrative Staff A reported the staff members who provided assistance for the cognitive impaired resident and witnessed the verbal abuse, failed to notify her there was an incident on 04/06/23 between R1 and certified medication aide (CMA) M, until 04/10/23 at 11:30 AM. CNA M, LN I, LN J and CNA P were in the resident's room and provided assistance for the resident. CNA M placed a gait belt around the resident and assisted the resident to stand. The resident's legs became weak, the resident and staff member "slid down" the wall, next to the toilet, and CNA M lowered the resident to the toilet seat. The resident's right thigh broke the toilet paper dispenser. Administrative Staff A reported the resident's baseline care plan, dated 03/31/23, revealed the resident required total dependence with toileting and transfers. The resident's mobility devices were walker, wheelchair, and mechanical lift. Administrative Staff A verified the baseline care plan was incorrectly coded, and the resident should be total dependence with the mechanical lift for transfers and toileting.

On 04/17/23 at 08:30 AM, Administrative Nurse D reported on 04/06/23, an unidentified staff member told her the resident had a decline in his physical ability to stand and he now required a mechanical lift. Administrative Nurse D reported on 04/06/23, a staff member who provided assistance with toileting, witnessed an unsafe transfer and the verbal abuse from CNA M. She reported an unidentified family member reported

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their concerns on 04/10/23 at approximately 11:00 AM to Social Worker X. On 04/10/23 at 11:30 AM, the Social Worker X reported the concerns to the facility administration and an immediate investigation was started. CNA M was interviewed and filled out a witness statement. In his witness statement, he admitted that he used the word "Samurai." On 04/10/23 at 11:30 PM, CNA M was suspended and then terminated on 04/13/23

On 04/17/23 at 02:13 PM Social Services X reported an unidentified family member of R1 expressed concerns regarding CNA M. The unidentified family member reported R1 was care planned to be transferred with the Hoyer (a full body mechanical lift). CNA M did place the gait belt around R1 and stood the resident up. R1 reported to CNA M that he was unable to stand, and his legs were too weak to stand. The family member reported CNA M threw R1 against the wall in the bathroom, R1 slid down the wall, his right thigh broke the toilet paper roll, caused a bruise on his right thigh. The CNA M stated to the resident, "if you will just try you would do it" The resident then told CNA M "why don't you just shoot me now?" The unidentified family member reported she overheard CNA M who told R1 "he would be his Samuari, he would bring two swords, and if he failed with the first one, he would have a second one."

On 04/18/23 at 12:54 PM, Licensed Nurse I reported she asked for additional staff members to assist R1 to transfer the resident from the toilet to his wheelchair. LN J and CNA P also provided assistance. CNA M placed a gait belt around the resident, his arms around the resident and stood the resident up. The resident expressed to the

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staff members that his legs were too weak to stand, and the resident voiced he needed to sit down. CNA M advised the resident to try to stand up so that the other staff members could provide pericare and place the clean brief on him. The resident legs buckled, the resident and CNA M leaned on the wall and the resident slid onto the toilet seat. The resident's legs were too weak for the sit to stand lift and the staff members obtained and used the full body mechanical lift. LN I reported she did hear the resident state, "just get a gun and shoot me." CNA M stated "ok, I will just get the samurai sword." The resident was care planned for maximum two-person assist, total dependence. His mobility devices are walker, wheelchair, and mechanical lift.

On 04/18/23 at 01:08 PM, Certified Nurse Aide (CNA) M reported he was asked by LN I to assist with a transfer for R1. CNA M had proved cares for the resident once. CNA M reported that he and did not know the resident was care planned for toileting and transfer. CNA M reported the resident became very upset because the staff members attempted to assist him stand. The resident stated, "just get a gun and shoot me." CNA M stated, "I told him that was illegal, but I do understand that you do not want to suffer anymore but I would be your second Samurai (noble warrior)." Staff member stated, "I stupidly quoted a culture that no one believes in and I should not have said that to the resident."

The facilities policy "Preventing Resident Abuse", Revised 12/2013, documented the facility would not condone any form of resident abuse. The policy included training all staff how to resolve conflicts appropriately, helping staff to deal appropriately with stress and emotions, training

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staff to understand and manage a resident's verbal or physical aggression, monitor staff on all shifts to identify inappropriate behaviors towards residents.

The facilities policy "Abuse Prevention Program", revised 08/2006, documented the residents have the right to be free from abuse and neglect. The policy and procedures direct staff to report allegations of abuse and or neglect in a timely manner to Administration.

The facilities policy for, "Safe Lifting and Movement of Residents", dated 12/2013, documented staff would promote the safety and well-being of staff and residents, promote quality of care, use appropriate techniques and devices to lift and move residents.

The facility failed to ensure the residents remained free from verbal and mental abuse, which included threat of bodily harm, when staff failed to report to the administrative management ,CNA M threatened this confused resident with bodily harm.

This deficient practice was cited as past non-compliance after the facility completed acceptable corrections on 04/10/23 at 01:30 PM, prior to the surveyor entrance on 04/11/23. The corrections reviewed and completed onsite on 04/11/23 included the following:

1. On 04/10/23 at 11:30 AM, the Facility Administration, became aware of the incident and began the investigation of the allegations. This included interviewing and suspending the alleged perpetrator at 01:30 PM.

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2. On 04/10/23 at 11:30 AM, the facility-initiated "Abuse and Neglect" and "Reporting of Incidents" to the facility by the Administrator or Designee immediately.

3. On 04/10/23 at 01:00 PM, the facility administration met with the Medical Director.

4. On 04/10/23 at 5:07 PM, the investigation of allegation was reported the State Agency.

5. On 04/13/23 at 01:30 PM, The alleged perpetrator was terminated.

6. On 04/16/23 at 11:30 AM, "Abuse and Neglect Education" was provided for all staff members available. Staff members who have not had "Abuse and Neglect Education" will be educated prior to working their next shift.

7. On 04/18/23 at 04:40 PM, State Surveyor verified a sign was posted at the facility time clock, that staff members are not allowed to work until education for "Abuse and Neglect Police and Procedure" had been completed.

8. New hires will be educated upon hire for "Abuse and Neglect Police and Procedure", "Safe Transfers/Body Mechanics/Lift Use/Communication," "Reporting of Incidents," "Following Care Plan," and "Communication with Dementia Behavior."

9. All incidents of "Abuse and Neglect" & "Failure to Report" will be monitored through QAPI.

10. Furthermore, on 04/19/23 through 04/21/23, the facility continued further advanced training and provided a Skills Fair 2023 for Skills

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F 609	Continued From page 15 Checklist from 02:00 PM through 04:30 PM for all staff members. The facility provided education on "Safe Transfers/Body Mechanics/Lift Use/Communication," "Resident Rights/Care plan meetings/Communication with Dementia/Non-Pharmalogical Interventions," and "Abuse, Neglect & Exploitation Review/Customer Services/QAPI." This deficient practice was cited as past non-compliance after the facility completed approved corrections on 04/10/23 at 01:30 PM, prior to the surveyor entrance to the facility on 04/11/23.	F 609		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable.	F 655		

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§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-
(i) Is developed within 48 hours of the resident's admission.
(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.
(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
(iv) Any updated information based on the details of the comprehensive care plan, as necessary.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 51 residents. The sample included eleven residents care planned for mechanical lift. The sample of three residents included three residents reviewed for transfer. Based on record review and interview, on 04/06/23, the facility failed to provide an effective baseline care plan to reflect Resident (R)1, appropriate transfer intervention.

Findings included:

- R1's 03/31/23, signed "Hospital Discharge Order", documented the facility admitted the resident on 03/31/23. The resident's diagnoses included atrial fibrillation (rapid, irregular heartbeat), ataxia (impaired ability to coordinate

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movement), muscle weakness, unsteadiness of feet (abnormality of walking), and morbid obesity (excess body fat).

The 04/03/23 "Admission Minimum Data Set" (MDS), documented the resident had a Brief Interview for Mental Status (BIMS) score of seven, which indicated severely impaired cognition. He required total dependence of staff for transfer and toileting. The resident was not steady and was only able to stabilize with staff assistance. The resident used a manual wheelchair and walker for mobility.

The 04/10/23 "Cognitive Loss/Dementia Care Area Assessment" (CAA), documented the resident had deficits with orientation, memory, and recall.

The 04/10/23 "Activities of Daily Functional Status Care Area Assessment" (CAA), documented the resident required assistance with ADL's. The resident had impaired balance and transition during transfer and functional impairment.

The 03/31/23 Baseline Care Plan," revealed R1 required total dependence with transfer and toileting. The resident used a manual wheelchair, walker and mechanical lift.

The 03/31/23 "Nursing/Therapy Communication," revealed the resident required maximum assistance of two staff members for transfers. Staff were to use a gait belt, and if the resident had difficulty standing, the staff members were to utilize the Hoyer (a full body mechanical lift).

The "Clinical Notes", dated 04/02/23 through 04/04/23, documented the resident required the

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mechanical lift for transfer, and on 04/06/23, the resident was unable to stand with two staff members assistance. The mechanical lift was used to transfer the resident from the toilet to the bed.

On 04/11/23 at 09:00 AM, Administrative Staff A reported R1's baseline care plan was coded incorrectly. Administrative Staff A clarified the resident should be total dependence with the mechanical lift for all transfers.

On 04/17/23 at 08:30 AM, Administrative Nurse D reported on 04/06/23, an unidentified staff member told her the resident had a decline in his physical ability to stand and R1 now required a mechanical lift. Verified that the baseline care plan revealed total dependence, however does not provide that the resident should be transferred with mechanical lift at all times.

On 04/18/23 at 12:54 PM, Licensed Nurse I reported that the resident was care planned for maximum two-person assist, total dependence. His mobility devices are walker, wheelchair, and mechanical lift.

On 04/18/23 at 01:08 PM, Certified Nurse Aide (CNA) M reported he was asked by LN I to assist with a transfer for R1. CNA M had proved cares for the resident once. CNA M reported that he and did not know the resident was care planned for toileting and transfer.

The facilities policy for, "Baseline Care Plan", undated, documented this facility will develop an initial person-centered care plan within the first forty-eight (48) hours of admission to promote continuity of care and communication among all

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F 655	Continued From page 19 facility staff members, increase resident safety and safeguard against adverse events. The facility failed to provide an effective baseline care plan to reflect Resident (R)1, appropriate transfer intervention.	F 655		