STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265476	A. Building B. Wing	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunrise Nursing & Memory Care	600 E Sunrise Drive Raymore, MO 64083

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21003 Based on observation, interview and record review, the facility failed to ensure the resident rights of one sampled resident (Resident #1) for self determination by inappropriately placing the resident on a locked unit without his/her consent and without evidence, rationale or documentation showing the resident was at risk for elopement, was exit seeking or had wandering behaviors or was a danger to self and needed a more secured placement out of 5 sampled residents. The facility census was 127 residents. Review of the facility's undated Transfer of Resident from Non-Secure Unit to Secure Unit showed this policy outlines the process for transferring a resident within our facility from a non-secured, non-locked unit to a secure, locked unit. The transfer criteria include specific assessments, documentation, and approval to ensure resident safety and well-being. The policy showed: -The resident must have a recent elopement assessment that indicates a triggering risk for elopement. -Documentation should clearly outline concerns related to elopement risk. -The facility must have documented evidence of Power of Attorney/Guardianship from the responsible party. -A confirmed dementia diagnosis must be documented in the resident's medical record. -The care plan should be revised to address possible ineffective coping related to relocation stress. -The transfer process showed the interdisciplinary team will review the resident's case. If the criteria are met, the resident will be relocated to the secure unit. The responsible party will be notified of the transfer and must provide written agreement. -After placement in the secured locked unit, the facility will closely monitor the resident for 72 hours. Signs and symptoms of ineffective coping will be documented and the interdisciplinary team will assess the resident's adjustment during this time. Review of the facility's Wandering and Elopement policy and procedure dated 8/2020, showed: (continued on next page)

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.

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The Licensed Nurse will assess residents upon admission, readmission, quarterly and upon identification of significant change in condition, to determine their risk of wandering/elopement. -The resident's risk for wandering/elopement and preventative interventions will be documented in the resident's medical record, and will be reviewed and re-evaluated by the interdisciplinary team upon admission, readmission, quarterly and upon change in condition. -The interdisciplinary team may consider interventions listed in the Elopement Risk Reduction Approaches for residents identified to be at risk for elopement. -Residents with a history of wandering or who have been assessed for being at risk for wandering or elopement will have a photograph maintained in their medical record. 1. Review of Resident #1's Face Sheet showed he/she was admitted to the facility on [DATE], with diagnoses including stroke with paralysis affecting the left side, muscle weakness, difficulty walking, lack of coordination, Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements), depression, and schizophrenia (a serious mental condition of a type involving a breakdown in the relation between thought, emotion, and behavior, leading to faulty perception, inappropriate actions and feelings, withdrawal from reality and personal relationships into fantasy and delusion, and a sense of mental fragmentation). The resident did not have a diagnosis of dementia or memory loss. Review of the resident's admission Minimum Data Set (MDS-a federally mandated assessment tool to be completed by facility staff for care planning) dated 3/31/24, showed the resident: -Was alert and oriented with significant confusion. -Showed little interest, feeling down/depressed, trouble falling asleep, tired with little energy, poor appetite, trouble concentrating and social isolation. -Had no hallucinations, delusions, physical/verbal behaviors towards others, no self destructive behaviors, and did not reject care. -Had no wandering. -Had range of motion impairment on one side of the upper and lower extremities. -Used a wheelchair for mobility. -Needed moderate assistance for toileting, bathing, dressing, personal hygiene, and transferring. -Needed set up assistance for eating and oral hygiene. Review of the resident's Medical Record showed documentation from the resident's transferring facility showed: -The resident transferred from another facility on 3/27/24. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The Resident's Level One Pre Admission Screening dated 9/18/16, showed the resident had a serious mental illness that did not require hospitalization or psychiatric treatment in the last two years. The resident had dementia, but did not trigger for a PASSAR Level II screening. -Nursing Notes from 2/20/24 to 3/20/24 showed there was no documentation of the resident wandering, attempted elopement or exit seeking. There was no documentation of the resident having behaviors of verbal or physical aggression or agitation. Review of the resident's Smoking assessment dated [DATE] showed: -The resident smoked, knew the location of the designated smoking area, was able to get to the area independently, was able to light smoking materials safely and extinguish smoking materials completely in the appropriate receptacle. -The resident did not have tremors while smoking, did not fall asleep, had no past accidents while smoking, had no visible burn marks and did not have finger dexterity problems. -The resident was able to smoke safely with minimal supervision and the evaluation had been explained to the resident and responsible party. Review of the resident's Physician's Order Sheet (POS) dated 4/2024 showed: -The resident did not show additional diagnoses to include memory loss or dementia. -Alprazolram 0.5 milligrams (mg) three times daily for anxiety (ordered 3/27/24). -Lorazepam 2 mg, give .25 mg under the tongue as needed for anxiety (ordered 3/27/24). -Zoloft 100 mg once daily for depression (ordered 3/27/24). -Depakote 125 mg give three tablets 3 times daily for schizophrenia (ordered 3/27/24). -Xanax 0.5 mg give every 6 hours as needed for anxiety for 14 days (ordered 3/29/24). Review of the resident's Elopement Risk assessment dated [DATE] showed: -The resident was not able to make decisions regarding tasks of daily living. -The resident was cognitively impaired and ambulated/propelled self. The resident may go outdoors on occasion but made no attempt to leave the grounds. -The resident ambulated, propelled self or wandered. The resident has intentionally or unintentionally attempted to leave the community. -The resident did not verbalize plans to leave the community. -The resident was at risk for elopement due to the results of the elopement evaluation. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's Nursing Notes showed: -On 3/27/24 the resident was admitted to the facility and moved into room [ROOM NUMBER] (not on the locked unit). Documentation showed the resident had some confusion, and denied pain. -From 3/27/24 to 4/4/24 showed there was no documentation showing the resident had any wandering, exit seeking or elopement behaviors. There was no documentation showing the resident had any verbal or physically aggressive behaviors or agitation. Review of the resident's Social Services Notes showed: -From 3/27/24 to 4/5/24, there was no documentation showing the resident had any wandering, exit seeking or elopement behaviors and did not show the resident was referred or seen by the Social Service Designee for any verbal or physically aggressive behaviors or agitation. -On 4/5/24 the Social Service Designee documented he/she left a voice mail for the resident's Power of Attorney regarding the resident moving to room [ROOM NUMBER] (on the locked dementia unit) due to increased wandering. Review of the resident's Medical Record showed there was no documentation showing the resident had a history of elopement, exit seeking, wandering behaviors, physical or verbal aggression, or agitation. Review of the resident's Incident Report dated 4/6/24, showed: -The resident's room smelled of smoke and the nurse went to investigate. Staff found half of a cigarette laying on the resident's bedside table and the resident was rummaging in his/her closet. The nurse informed the resident that he/she could not smoke in his/her room and the resident began to yell and come towards the nurse, pushing him/her to the floor. -The resident was oriented to person and place and said the nurse couldn't tell him/her what to do and he/she could smoke when he/she wanted to. -Staff removed the resident from the area and monitored him/her, called for the nurse and called emergency services. -The resident had no injuries at the time of the incident or after the incident. -The report did not show that there were any predisposing environmental factors, physiological factors that affected the incident occurrence. -The predisposing situational factors showed the resident was smoking in his/her room due to the smell of smoke. The resident became agitated when the nurse informed him/her that his/her cigarette would have to be taken because he/she could not smoke in his/her room. The resident told the nurse he/she was going to smoke whenever he/she wanted and pushed the nurse down. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Usually when resident's are placed on the locked memory unit, they have dementia but are also a high flight risk. -He/She did not know the resident very well, but the resident was initially on the main unit before being moved to the locked unit. -He/She was not aware of the resident having any wandering or exit seeking behaviors while he/she was on the main unit, but he/she was not familiar with the resident. -He/She was unaware of why the resident was moved to the locked unit, but after this incident the resident was moved back onto the main unit. -To his/her knowledge, the resident had not had any further incidents, aggression, wandering or exit seeking behaviors. During an interview on 4/11/24 at 12:48 P.M., CNA E said: -He/She came in to work on the locked unit as the ambulance staff was taking RN B out of the facility to the hospital. -Nursing staff informed him/her of what happened and the resident was still on the locked unit but he/she was in his/her room. -The resident was on 15 minute checks, but staff stayed with him/her throughout the day and the resident ate all of his/her meals in his/her room. -The resident did not have any additional behaviors while on the locked unit that he/she was aware of. -He/She had worked on the main unit when the resident was initially placed and he/she did not seem to be very confused, he/she did not wander and was not exit seeking. The resident was able to go to the designated smoking area and smoked safely and return to his/her room without staff assistance. -The resident did not seem to have any behavioral problems while he/she was on the main unit. -He/She did not understand why the resident was placed on the locked unit, the resident did not begin to act out until he/she was placed on the locked unit and was not able to go out to smoke when he/she wanted to. -Now that the resident is back on the main unit, he/she did not seem to have any behavior issues and was not wandering or exit seeking. Observation on 4/11/24 at 1:30 P.M. showed the resident was dressed for the weather, mobilizing in his/her wheelchair down the hallway toward the smoking patio. He/She was interacting with staff and interactions were pleasant. The resident went out onto the designated smoking patio to smoke. During an interview on 4/11/24 at 1:34 P.M. with the Administrator and DON, the DON said: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-A resident is placed on the locked unit when the resident has impaired memory to the point they are not safe around others, if the resident was over-stimulated and will do better on a quiet environment, or at the request of the resident or family (preference). -Nursing staff reported that the resident had wandered out by the facility entrance which was not a designated smoking area and the ADON stated the resident had wandering behaviors but there was no documentation to support this. -There was no documentation in the records received from his/her prior facility that showed the resident had exit seeking/wandering behaviors or aggressive/agitation and the facility did not have a locked unit. -If there had been documentation showing the resident was at risk for elopement or had behaviors showing exit seeking/wandering, upon admission they would have initially placed the resident on the locked unit. -They determined that the resident had wandering behavior on 4/5/24 and decided to relocate the resident to the locked unit on 4/5/24. -Both the resident and his/he responsible party and family were also notified of the resident's relocation on 4/5/24 and he/she met with the resident's responsible party and family when they came to the facility on [DATE] and he/she informed them this may not be a permanent move and they were in agreement with the relocation. -After the incident, the interdisciplinary team met and decided to move the resident back to the main unit due to his/her agitation while on the locked unit and due to the freedom with being able to smoke on the main unit. -They have been monitoring the resident for wandering and the resident has not been observed wandering or exit seeking nor have they observed the resident have any aggressive behaviors or agitation since he has been back on the main unit. During a telephone interview on 4/17/24 at 9:51 A.M., RN B said: -He/She was working on the locked memory unit during the 7:00 P.M. to 7:00 A.M. shift on 4/5/24. -On the morning of 4/6/24 around 6:40 A.M., nursing staff told him/her that the resident was smoking in his/her room, so he/she went to the resident's room to speak with him/her. -When she got to the doorway of the resident's room she smelled cigarette smoke and saw half of a cigarette butt sitting on the resident's tray table. The resident was standing by his/her closet door. -He/She said to the resident that he/she was not allowed to smoke in his/her room and the resident immediately began yelling at him/her to get out of his/her face and he/she began approaching him/her. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She never touched the resident but as he/she was yelling for him/her to get out of his/ her room, the resident pushed him/her down. -The nursing staff came over to assist her and move the resident away from him/her. -The nurse came and stayed with him/her and got him/her ice for his/her head because he/she had hit his/her head on the floor and he/she had pain in his/her head. -He/she said he/she lost consciousness for a minute and when he/she aroused, he/she told the nursing staff to call 911. -LPN A stayed with him/her until the emergency service personnel came and took him/her to the hospital. -This was the first time he/she had any direct interaction with the resident. -He/She did not understand why the resident was moved onto the unit when the resident was used to smoking at will when he/she was on the main unit. -He/She did not know if the resident wandered or was exit seeking because he/she had not had any interaction with the resident during his/her shift other than the morning of 4/6/24. MO00234391

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21003 Based on observation, interview and record review, the facility failed to transfer one sampled resident (Resident #2) safely by failing to use a full body mechanical lift or a gait belt to transfer the resident safely from the shower chair to his/her bed, resulting in a hospitalization , left knee swelling,use of a knee brace and increased pain with movement out of five sampled residents. The facility census was 127 residents. A policy was requested and no policy was received by the facility. 1. Review of Resident #2's Face Sheet showed he/she was admitted to the facility on [DATE], with diagnoses including multiple sclerosis (a progressive disease involving damage to the sheaths of nerve cells in the brain and spinal cord, whose symptoms may include numbness, impairment of speech and of muscular coordination, blurred vision, and severe fatigue), lupus (a disease that occurs when your body's immune system attacks your own tissues and organs and causes inflammation in the body), pain, glaucoma (increased pressure within the eyeball, causing gradual loss of sight), anxiety, high blood pressure, and depression. Review of the resident's quarterly Minimum Data Set (MDS-a federally mandated assessment tool to be completed by facility staff for care planning) dated 3/17/24, showed the resident: -Was alert and oriented with no confusion. -Had impairment on both sides upper and lower extremities. -Used a wheelchair for mobility and did not walk. -Was totally dependent for transfers, bathing, dressing and hygiene; and needed maximum assistance for toileting, eating and hygiene. Review of the resident's Comprehensive Care Plan dated 9/2/23, showed the resident had a deficit with performing self-care, was at risk for falls and had impaired visual function. Interventions showed: -The resident required the extensive assistance of two persons for bed mobility (turning and repositioning), toileting, dressing, bathing/showering as necessary, personal hygiene as necessary. -The resident required a mechanical lift with the assistance of two persons for transfers. Review of the resident's Cardex (resident care card indicates how nursing staff is to provide care to the resident) showed: -The resident required extensive assistance of two staff to turn and reposition in bed. -The resident required a mechanical lift with two staff assistance for transfers. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-The resident needed the extensive assistance of two persons to provide his/her bath/shower as necessary. -The resident required the assistance of two persons to get dressed. Review of the resident's Physical Therapy Evaluation dated 3/18/24 showed: -The resident lower extremity weight bearing status was weight bearing as tolerated. -The resident's precautions was fall risk, mechanical lift to get out of bed and the resident used a power chair. -Prior therapy showed the resident was dependent for transfers out of his/her bed and into his/her wheelchair and required maximum assistance for rolling (in his/her wheelchair). -The resident's functional mobility assessment showed the resident needed maximum assistance for rolling left to right in bed, sitting to lying in bed, from lying to sitting up on the side of his/her bed, and was dependent for transferring from sitting to standing, transferring from chair/bed to chair/bed and toileting. -The resident did not walk and used a power wheelchair for mobility. -The resident was referred for physical therapy due to a decline in out of bed mobility. Resident had generalized weakness and an inability to perform any bed mobility or transfers without assistance. Resident required maximum assistance from laying to sitting, transferring and scooting up in bed. He/She reported only getting out of bed every few weeks. Resident would benefit from physical therapy intervention. Review of the resident's Physician's Order Sheet (POS) dated 4/2024 showed physician's orders for: -Baclofen 10 milligrams (mg) twice daily for muscle relaxant (ordered 9/2/23). -Tylenol 500 mg every 6 hours as needed for pain (ordered 9/2/23). -Hydrocodone 7.5-325 mg every 12 hours as needed for pain (ordered 9/2/23). -Lidocaine patch 4% apply one half patch to both knees topically one time daily for pain, remove at bedtime and per schedule (ordered 10/23/23). -Physical Therapy three times per week for 30 days to maximize the resident's functional mobility and out of bed mobility (ordered on 3/18/24). Review of the resident's Medication Administration Record (MAR) dated 3/2024 showed: -The resident was administered Baclofen and Lidocaine patches as ordered. -The resident did not request or receive any as needed pain medication. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's Nursing Notes showed on 3/28/24, the resident stated that during a transfer today, he/she heard his/her left knee pop. This knee is swollen and warm to the touch. The nurse notified the Nurse Practitioner and x-rays were ordered. Review of the resident's Narcotic Record showed on 3/28/24, the nurse administered Hydrocodone 7.5-325 mg to the resident at 12:30 P.M. Review of the resident's Radiology Report dated 3/29/24 showed the reason for the exam was for localized edema in the resident's left knee. Two views were taken. The x-ray results showed the resident's left knee joint was in alignment with narrowing of the joint space due to degeneration. There was also degeneration in the thigh and leg bones. Clinical or repeat examination follow up was advised. Review of the resident's Nursing Notes showed on 3/29/24, the resident was sent to the hospital for follow up evaluation due to the result of the x-ray showing osteonecrosis (develops when the blood supply to the femoral head is disrupted) of the thigh bone, leg and large joint effusion (build up of fluid around the joint). Review of the resident's Hospital Record dated 3/29/24 showed: -The resident was seen for a knee effusion. -The resident had fluid on the knee and was ordered Voltaren Gel 100 grams (gm) to be applied to the area four times daily. -There was no evidence of acute fracture, sprain, other issues or concerns. Review of the resident's POS dated 4/2024 showed a physician's order for Voltaren Arthritis Pain Gel 1% apply to bilateral knees topically every shift for joint pain not to exceed 16 grams daily (ordered on 4/4/24). Observation and interview on 4/10/24, showed the resident was laying in his/her bed awake and dressed in bed clothes. The resident's left knee was elevated on a pillow and the knee was swollen but without any redness or bruising. Across from the resident was a black knee brace that was on a dresser. The resident was alert and oriented and said: -On 3/28/24, around lunch time on, he/she had a shower and when the nursing staff brought him/her back to his/he room, they did not transfer him/her with the mechanical lift like they were supposed to. -During the transfer, he/she heard a pop and his/her leg began hurting. Certified Nursing Assistant (CNA) A and CNA B finished transferring him/her to bed. -CNA A said to CNA B that they should not have transferred him/her without using the lift. -He/She felt the CNA staff transferred him/her without a lift because they were in a hurry. -He/She was working with physical therapy staff and they put on/removed his/her brace. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-The facility nurse sent him/her to the hospital and the hospital staff told him/her that his/her knee was bone on bone and he/she thought he/she had a fracture, but the hospital sent him/her back to the facility with pain medication and a knee brace. -At 12:50 P.M., Physical Therapy Assistant A came in the resident's room to put his/her knee brace on and said the resident did not have a fracture, but his/her knee was swollen and he/she was trying to maintain range of motion in his/her lower extremities, but he/she was not flexing the resident's knee too much due to pain. During an interview on 4/10/24 at 1:00 P.M., CNA A said: -He/She was working on the date the incident with the resident occurred, but was not assigned to the resident. -CNA B had given the resident's shower and he/she went to assist CNA B to transfer the resident back to his/her bed. -The resident was sitting in a shower chair and there was no sling under him/her so they did not use a mechanical lift to transfer the resident into his/her bed. -They should have transferred the resident with the mechanical lift because the resident is non-weight bearing and they had to manually lift the resident to his/her bed. -He/She asked CNA B how the resident was transferred into the shower chair and he/she told CNA B that he/she should have not transferred the resident into the shower chair without a sling and mechanical lift. -As he/she and CNA B transferred the resident to his/her bed, the resident winced and said he/she was hurting. -They put the resident into his/her bed and then he/she and CNA B went to tell the nurse that the resident was in pain. -He/She then went back to his/her hall. During an interview on 4/10/24 at 2:45 P.M., the Director of Nursing (DON) said: -The nursing staff know how to transfer the resident by looking at the resident's Cardex. -The resident should have been transferred using a mechanical lift. -If the staff did not use a mechanical lift, they should have used a gait belt when transferring him/her. -He/She did not know how the resident was transferred when he/she was taken to the shower, but staff typically used a shower bed, not a shower chair, so a lift would not need to have been used to transfer him/her. In this case the nursing staff would use a slide board. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-The resident did not fall, but he/she was aware the resident complained of knee pain once he/she was transferred back into his/her bed, so they received physician's orders for an x-ray to be completed as a standard protocol to rule out injury. -The resident did not have any acute injuries to his her knee and was sent back to the facility. During an interview on 4/10/24 at 4:08 P.M., CNA A clarified his/her prior statement and said: -When he/she and CNA B transferred the resident, they did not use a gait belt because the resident was not wearing clothes and was wet. -The resident was in a shower chair, not a shower bed when they transferred the resident. -When they transferred the resident, they were on each side of the resident and he/she placed one arm under the resident's arm and the other arm around his/her waist to pivot transfer the resident to his/her bed. -They should have gotten a sling and transferred the resident with the mechanical lift. During an interview on 4/10/24 at 4:12 P.M., the resident said: -When he/she was taken to the shower room that morning around lunch time, CNA B did not use a gait belt or a mechanical lift. Nursing staff told him/her to hug him/her around his/her neck and then he/she picked the resident up and put him/her on the shower chair. -When he/she came back to his/her room is when CNA A and CNA B transferred him/her into bed and he/she felt pain in his/her leg. -He/She received Tylenol for pain but he/she had chronic pain and received scheduled pain medication for it, so he/she was not in more pain than usual. -Once he/she was in bed, he/she only had additional pain when they came in to move him/her to take the x-ray and when they moved him/her to go to the hospital. During an interview on 4/11/24 at 8:26 A.M., CNA B said: -On the day of the occurrence, he/she went to get the resident to take him/her to give the resident a shower. -He/She did not transfer the resident into the shower chair, the resident was already in the shower chair when he/she went to get the resident. -The resident did not have a sling in the shower chair. -He/She gave the resident a shower and CNA A assisted him/her to transfer the resident back into his/her bed. -They did not use a gait belt or a mechanical lift to transfer the resident. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-He/She put one arm under the resident's arm and the other arm under the resident's leg (he/she did not remember if he/she was on the left or right) and lifted the resident into his/her bed. -He/She never heard a 'pop' sound from the resident, but CNA A said his/her knee popped as they were transferring the resident. -The resident said that his/her leg hurt once he/she was in bed so he/she and CNA A went to tell the charge nurse. -This was the first time he/she had ever transferred the resident and was unaware of how the resident was supposed to be transferred. During an interview on 4/11/24 at 12:35 P.M., Physical Therapy Assistant A said: -They were working with the resident for range of motion, bed mobility, activity tolerance, and strengthening. -The resident was supposed to be transferred using a full body mechanical lift because he/she was non weight bearing. -If the nursing staff used a stand and pivot transfer with the resident, they should always use a gait belt to assist with transferring him/her. -He/She had never seen the resident transferred with a stand and pivot transfer and had only known the resident to transfer using a full body mechanical lift. MO00324304