STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	694020	A. BUILDING _____ B. WING _____	**3/17/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDILODGE OF GAYLORD	**508 RANDOM LANE GAYLORD, MI 49735**

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F0000 SS=	INITIAL COMMENTS Medilodge of Gaylord was surveyed for an Abbreviated survey on 03/16/23 through 03/21/23. Intakes: #MI00135076, #MI00133622, #MI00133430, #MI00132424, #MI00135075, #MI00135084. Census = 71.	F0000		
F0689 SS= D	Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: This citation relates to Intake #MI00133430. Based on observation, interview, and record review, the facility failed to ensure safe, operational mechanical lift equipment for one Resident (#5) of four residents reviewed for accidents. This deficient practice resulted in Resident #5 sustaining bruising to their chest and right axilla (armpit area), shoulder injury, a chest hematoma (abnormal pooling of blood from a broken blood vessel), increased pain, and potentially pectoralis tear. Findings include: Review of Resident #5's Minimum Data Set (MDS) assessment, dated 06/16/22, revealed Resident #5 was admitted to the facility on 04/09/21, with diagnoses including coronary	F0689	F689 Resident # 5 no longer resides at the facility. Facility did an immediate investigation at the time the bruise was identified root cause was unintentional incident with lift. Resident was able to explain what occoured. Resident was on Eliquis and Asprin at the time of incident. Resident was sent out for evaluation and returned but he went back out the following day to the hospital secondary to COPD. A updated plan of care was instituted upon his return. Facility residents that use a mechanical lift have the potential to be affected by the deficient practice. Current facility residents and newly admitted residents will have have their assessments and care plans reviewed and updated timely if needed to reflect their use of a mechanical lift. Mechanical lifts will be inspected for proper functionality and will receive routine inspections/ maintenance to ensure the environment remains as free of accident hazards as possible. The licensed staff will receive re- education	4/25/2023

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

Electronically Signed | 04/13/2023

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	artery disease, lung disease, diabetes, seizure disorder, and depression. Resident #5 required extensive, two-person assistance for bed mobility, dressing, toileting, and hygiene, and two-person total assistance for transfers. The assessment revealed Resident #5 was incontinent of bowel and bladder and had no range of motion impairment. The nutritional assessment showed Resident #5 was 71" tall and weighed 233 pounds. The pain assessment revealed Resident #5 experienced pain "occasionally" and the pain intensity was "moderate". Resident #5 had no falls during the look-back period. The Brief Interview for Mental Status (BIMS) assessment revealed a score of 14/15, which indicated Resident #5 was cognitively intact. Review of Resident #5's confidential complaint intake to the State Agency, received 12/20/22, revealed on 8/13/22 Resident #5 was allegedly stuck in a mechanical lift for an unknown amount of time, with his "right arm stuck up" as the lift was stuck in the up position. The report described there were two physical therapists present with him. The complaint further read Resident #5 subsequently developed a hematoma on the right side of his chest. Resident #5 was sent to the hospital, x-rays were taken, and he was sent back to the nursing facility. On 08/14/(22), Resident #5 was described as unresponsive and went back to the hospital where he was admitted and was sent back to the nursing facility. During a phone interview on 03/15/23 at 11:33 a.m., Family Member (FM) "D" was asked about Resident #5's stay and care at the facility. FM "D" stated on 08/13/22 a mechanical lift was stuck in the upright position when Resident #5 was in the lift, causing bruising to the right upper arm and right side of his chest, and Resident #5 subsequently developed a large hematoma. FM "D" reported Resident #5 required a unit of blood and declined further after the incident, becoming		regarding the use/functions of the lifts with emphasis on the validation that the battery is adequately charged by viewing the battery light indicator and what to do if there is a concern with a mechanical lift. The DON will audit current and newly admitted /re-admitted residents records to verify that mechanical lift information is documented in residents clinical record. The environmental services director will inspect and perfom all maintenance as required and any lifts not functionly properly will be removed from use immedielty. The DON/designee will audit 4 licensed staff members weekly for 12 weeks to verify competance with lift functionality and when to report concerns. Findings will be documented and reported 1X per week to the IDT team and monthy to QAPI for 3 months. The maintenance director will verify that all lifts are in proper working order. Ongoing inspections will be done following the designated maintenance schedule. Weekly audits will be completed for 12 weeks and findings will be documented. The maintenance director will report findings weekly in the IDT meeting 1X per week and monthly to QAPI for 3 months. The NHA is responsible for sustaining compliance.	

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	unresponsive the next day and needed to go back to the hospital. FM "D" confirmed Resident #5 required a Hoyer lift for transfers during his time at the facility and was able to sit up in a regular wheelchair prior to the incident. FM "D" clarified Resident #5 was able to report to them the incident in the lift occurred with two physical therapists. FM "D" clarified they expected the lift to function, the lift should not have malfunctioned, and they did not want this to happen to another resident. FM "D" added while they did not believe the incident was directly the cause of Resident #5 passing away at the facility in September (2022), they did believe the incident escalated his medical decline, as Resident #5 worsened medically after the incident. Review of Resident #5's Investigation report, dated 08/13/22, by the former Director of Nursing, (DON) "A", revealed, "Resident [#5] complained of pain; nurse assessed and a bruise was noted and reported to DON. DON went to resident's room and assessed the resident [#5]. Resident [#5] stated that "it must have happened when he was in the lift." Resident #5 denied falling, and reported the physical therapists stopped when he was in pain and put him back to bed, and there were no nursing care concerns noted. The report continued, "DON interviewed therapists [Physical Therapist Assistant -PTA "B"] and Occupational Therapist - OT "C"] who noted they had to raise the bed while attempting to use the release on the lift, as the lift seemed to be moving slow as the battery had died. Therapist [PTA "B"] checked the battery prior to session; it was fine; however, they had [made] a few attempts at transfers...Therapist [unnamed] stated resident was in the lift approximately [sic] [no time noted] and the bed [sic] brought up to support him. Root cause: Resident was in the lift with two therapists and during therapy resident [#5] had stated he was in pain; the therapists stopped and were returning the resident to bed.			

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	The resident [sic] observed [by therapists] to be leaning on the lift strap in the appropriate area, with his body weight pushed against the sling area. Resident [#5] has poor trunk control [the bruise is consistent with where the therapists and the resident stated the sling was and where the bruise is located.] Resident [#5] is on Eliquis and Aspirin [anticoagulant medications] and his body habitus [build] (225.5 lbs. -pounds) contributed to the bruise." Review of Resident #5's SBAR [Situation, Background, Assessment and Recommendation] Communication Form, by Registered Nurse (RN) "E", dated 08/13/22, revealed, " ...Shoulder pain after using the lift on 8/12 [2022]. The lift got stuck during a transfer and resident [#5] was positioned arms up for a short period of time ... [with] swelling, pain, and bruising. [Resident #5] did have rotator cuff surgery in the past. Primary diagnosis: Chronic respiratory failure ....Respiratory: Labored breathing ...Assessment: Shoulder injury, reoccurring shoulder injury due to past injury ...Resident [#5] was being transferred with a lift when the lift got stuck and he was stuck in a position with his arms up. Resident [#5] has complained of pain on and off since yesterday [08/12/22] after the incident..." An x-ray and transfer to the hospital was recommended. Review of Resident #5's progress note, dated 08/13/22, by RN "E", revealed, "Resident [#5] complained about pain in his shoulder and upon examination I found a bruise on his chest and armpit; his right side of his chest was swollen and hard. [Resident #5] said the pain was 10/10 [in severity, with 10 being the worst pain] and said he couldn't handle the pain. I was told by Dr [unnamed] on call to send [Resident #5] to hospital ..."			

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	Review of Resident #5's pain assessment, dated 08/13/22, revealed Resident #5 had pain which they rated as "severe", and "9/10", in their right shoulder/arm and lower back and buttocks. Review of Resident #5's Accident and Incident report, dated 08/13/22 at 19:00 [7:00 p.m.], revealed, " ...Bruising observed to chest and R [right] axillary area ...[Resident #5]: 'My shoulder hurts.' ...Resident [#5] to [hospital] ER [emergency room] for evaluation. Injury type: Bruise: Injury location: Chest. Injury type: Bruise: Injury location: Right shoulder [front] ...Mental Status: Oriented to person ...Oriented to place ...Predisposing environmental factors: Equipment ...Predisposing physiological factors: Confused, incontinent, impaired memory ...Predisposing situational factors: Use of [Brand name sit to stand mechanical] lift with therapy the day prior, utilized blood thinners ..." During an interview on 03/16/23 at 11:57 a.m., OT "C" was asked about Resident #5's injury in the [Brand name] sit to stand lift on 08/12/22. OT "C" reported they recalled the incident and reported they provided standby assistance [no physical contact] for a bed to wheelchair transfer, with PTA "B" operating the controls of the [Brand name] mechanical sit to stand lift during PTA "B's therapy session. OT "C" stated they were on the other side of the bed, and did not recall an incident with the transfer, but recalled the battery or lift malfunctioned. OT "C" clarified PTA "B" was having difficulty moving the lift the rest of the way up so he could safely complete the transfer, with Resident #5 partly standing in the lift. Since PTA "B" was not able to get the lift all the way back up, they used the emergency sit down function to set Resident #5 back down on the bed. OT "C" reported Resident #5's arms never fell off or slipped from the lift [handlebars]. Once seated, Resident #5 said his right arm hurt, and had said during the transfer, 'Put me down.'			

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	When asked to recall how long Resident #5 was suspended up in the lift, OT "C" said he could not specifically recall a specific amount of time but stated it was not a "significant amount". OT "C" believed the lift malfunctioned likely as the battery ran out, as they did not recall the lift being taken off the floor or tagged for service. OT "C" reported there were no concerns with the sling. OT "C" explained they were not aware of a concern until the next day, when they learned Resident #5 went to the hospital, and reported they were injured from the lift. OT "C" confirmed Resident #5 was being trialed with the sit to stand mechanical lift to progress him from the use of the full body mechanical lift, per Resident #5's goal. OT "C" stated during the incident they were not in line of sight of the battery discharge indicator, and were not aware of a low battery, as PTA "B" was facing the battery discharge indicator and operating the lift and controls. OT "C" described how to visualize when the lift battery was running low by viewing the battery light indicator. OT "C" was asked if they had completed any written documentation about the incident, such as an incident report or witness statement, and confirmed they did not, as the DON had interviewed them. OT "C" did not recall which lift or sling was involved in the incident. During a phone interview on 03/16/23 at 12:54 p.m., PTA "B" was asked if they recalled the incident with Resident #5 being injured in the [Brand name] mechanical sit to stand lift on 08/12/22. PTA "B" reported they recalled the incident and described how they and OT "C" transferred Resident #5 upright in the mechanical sit to stand lift during their therapy session, and the lift was in the up position briefly when Resident #5 started to say it was painful. When they went to place Resident #5 on the bed, the battery died, or there was a problem with the lift that wasn't allowing them to lower Resident #5			

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	back down to the bed. PTA "B" reported the emergency stop button did not work when engaged, so they brought the bed up to Resident #5's height to place him on the bed. PTA "B" was asked how long Resident #5 was suspended upright in the lift with his arms on the lift, and reported they could not remember as it was months ago. PTA "B" reported they were working quickly as they were trying to keep Resident #5 comfortable because he was in pain. PTA "B" clarified when asked about pain, Resident #5 reported right shoulder pain, which was monitored, and the nurse was notified after the transfer. Resident #5 reportedly agreed to participate in therapy after, and went to the therapy gym, and conveyed nothing out of the ordinary. When asked how high Resident #5's arms (at the shoulder) were in the air during the time the lift stopped (while Resident #5 was holding the lift handle bars), PTA "B" reported they would have been above 90 degrees (shoulder height). When asked how they would know the battery was going to die, PTA "B" initially stated, " ...There is an indicator [visual battery light bar] to use. I don't think there was a way to know the battery was going to die. I wouldn't have looked [after the lift was in use], as the indicators [lights] are not accurate, and sometimes they did not work." PTA "B" clarified when the user turned the mechanical sit to stand lift on, the battery screen displayed five battery 'light' bars, and they would have looked at the machine initially and checked the battery light to see what it read. PTA "B" reported when the battery was dead, the lift would beep [an audible alert] but they were not aware of a warning for a low battery. PTA "B" reported the lift had enough battery initially but must have drained as they had done a couple transfers with Resident #5. PTA "B" reported they were competent using the mechanical sit to stand lift and full body lift as they had been using the facility lifts for six years with residents and had never had a concern with the lift prior.			

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	During an interview on 03/16/23 at approximately 3:40 p.m., the NHA reported they interviewed the therapists involved with the lift incident on 08/12/22 with Resident #5, after the incident was discovered, and both therapists told them they used the lift appropriately. The NHA stated Resident #5 reported his shoulder hurt briefly after the transfer, and the next day the nursing staff reviewed the incident and determined Resident #5's injuries (bruising and shoulder pain) led back to the incident with the lift on 08/12/22. The NHA believed the anticoagulant medication Resident #5 was taking caused the bruise on Resident #5's right side and chest and stated Resident #5 was hospitalized with pneumonia. Surveyor asked about the battery/lift reportedly malfunctioning as earlier described, and the concern with the emergency stop button not engaging, per a staff interview regarding the incident. The NHA requested Surveyor follow up with the (former) DON "A" regarding these concerns, as they were not aware of this. Surveyor requested a staff member walk Surveyor through the mechanical sit to stand lift maintenance and operational processes, including inspections, battery charging and use, training/education, etc... The NHA shared their educator had recently left their position, and they had overseen this, and there was no contact person available for Surveyor to speak with respective to these processes at that time. During an observation on 03/17/23 at 11:57 a.m., OT "C" demonstrated proficient use of the [Brand name] mechanical sit to stand lift. OT "C" confirmed PTA "B" used a green sling with Resident #5 on 08/12/22, which was accurate for his weight on the [Brand name] sling sizing chart. OT "C" was asked to describe how high Resident #5's arms would have been positioned in the lift. OT "C" demonstrated when the lift was at the maximal height, for a person of Resident #5's			

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	height (which was similar to their height), the shoulder range of motion would be a maximum of 60 degrees (below shoulder height) while Resident #5 was holding onto the lift handles. When asked if the emergency release engaged during Resident #5's transfers, OT "C" recalled PTA "B" using the emergency release button and did not recall a concern. OT "C" clarified they then recalled the lift battery running out, and an aide obtained a new battery. OT "C" was not consistent with their recall of the events. Review of Resident #5's [Company Name] EMS [Emergency Medical Services] transportation report [to hospital ER], dated 08/13/22 at 14:42 [2:42 p.m.], revealed, " ...Dispatch Complaint: Traumatic Injury, Emergent ...Complaint location: Chest, possible injury: Yes ...Symptoms: Pain: shoulder, arm, hand. Other symptoms: Pain - chest wall [non-cardiac]... Provider impressions: Primary impression: Trauma/Injury: Shoulder or Upper arm. Other impressions: Trauma/Injury: Thorax/Chest. [EMS] dispatched via 911 [emergency phone number] for emergent [urgent] response to the above location for a male pt [patient - Resident #5] with a shoulder injury ...male pt in room D4. Staff on scene stated that the pt [patient - Resident #5] was in a Hoyer lift yesterday when it malfunctioned. Pt [Patient] 'was stuck with his arms above his head for a long time'. Staff is unable to tell how long the pt was stuck in that position. Today the pt is having increased pain. Pt is lying supine in bed. Pt is on 8LPM [liters per minute] of O2 [oxygen] for respiratory failure ...assessment ...[assessment] finds pt to be alert and oriented to person, place, time, and events ...pt has significant swelling and bruising to right shoulder and chest ...There is no deformity or crepitus noted. Pt's right arm is secured with triangle bandage ...Pt has some bruising just below sternum ...pt has limited range of motion in all extremities ..."			

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	Review of Resident #5's [Hospital Name] ED [Emergency Department] report, dated 08/13/22, revealed, "Time seen by provider: 16:45 [4:45 p.m.] ...Stated complaint: Shoulder injury. PT [patient - Resident #5] was stuck in Hoyer Lift for unknown amount of time. [Resident #5] was in the lift and it got stuck in the up position with his right arm lifted up. Bruising to right upper arm and right side of chest ... At facility for respiratory failure, on 8L [oxygen] with SPO2 [oxygen blood saturation] at 92%...Lots of swelling to the right side of chest wall and right arm. [Resident #5] is on Eliquis [a blood thinner]. [Resident #5] is in a homemade sling and is a DNR [Do Not Resuscitate]. [Resident #5] has no other injuries noted ...Current severity: moderate ...Quality: Aching. Location of pain: Right chest. Radiation: Right arm ...Progress: [Resident #5] was given Morphine [strong opioid medication) for pain ...[DIAGNOSIS]: Large chest wall hematoma that is not actively bleeding. [Facility] told to apply ice and give [an over the counter pain medication]. Review of Resident #5's CT chest report, dated 08/13/22, at 5:24 p.m., revealed, " ...Comparison: CT chest dated July 12, 2022, ...Impression: Large hematoma within right chest wall without evidence of acute fracture. Suspected recent trauma or pectoralis musculature [large muscle in the upper chest located from the chest to the shoulder] tearing ...[earlier noted] Additional Comments: Hematoma is noted within the right chest wall involving the pectoralis region measuring up to 13.4 x 7 cm axial [horizontal anatomical plane location] and 14 cm craniocaudal [reference size from anatomical plane location head to foot] ..." Review of Resident #5's [Hospital] History and Physical, dated 08/14/22, revealed, "Admission diagnoses: 1. Hospital-acquired pneumonia. 2. Chest trauma with large right-side hematoma. The			

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	patient [Resident #5] is 79-year-old gentlemen, who resides at the [nursing facility], presented to the emergency room the day before [08/13/23] when he was caught in the Hoyer lift. The patient had a right arm and right chest-wall hematoma. [Resident #5] was seen in the emergency room and discharged back to the [facility]. At that time, the patient had some difficulty breathing ...Today it seems that the patient got worse. [Resident #5's] oxygen requirement is increasing, and he appears to be in more pain ...There was also some decrease in his hemoglobin concerning for enlarging hematoma on his chest wall ...Imaging: CT scan showed possible left lower lobe [of lung] bilateral atelectasis [partial or complete collapse of lung] verses infiltrate [abnormal test showing a substance denser than air in the lung]. There is also a large hematoma on his right lateral chest wall. Assessment and Plan: 1. Bilateral pneumonia [lung infection] consistent with the finding on the CT scan, leukocytosis [elevated white blood cell count often indicative of infection], and increased lactate [a possible indicator of systemic infection] ...2. Large chest hematoma with possible pulmonary contusion [bruised lung]. The patient is a DO NOT RESUSCITATE and for now he will be admitted to a monitored bed in the ICU [Intensive Care Unit]. Use BiPAP [a breathing machine which uses pressurized air to open the airway] if needed. Treatment will be supportive at this point ...5. Anemia [low oxygenated red blood cells]. His hemoglobin [amount of protein in red blood cells to carry oxygen] dropped one point since yesterday, possibly bleeding into the hematoma. We will continue to monitor ...Encounters: Admitted Inpatient ...Encounter diagnosis: Chest wall hematoma ...HCAP [health care acquired pneumonia] ...Leukocytosis ...Sepsis [systemic infection of the bloodstream]". Review of Resident #5's [Hospital] Discharge Summary, signed 08/30/22 (for the admission on			

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	08/14/22), revealed: "Final diagnoses: 1. Right chest wall hematoma. 2. Hospital acquired pneumonia with elevated lactic acidosis. 3. Acute renal [kidney] failure. 4. Sepsis with lactic acidosis. 5. Altered mental status, unspecified. 6. Acute blood loss anemia. 7. Chronic respiratory failure. 8. Pulmonary hypertension. 9. Seizure disorder. 10. Acute-on-chronic diastolic heart failure ....At the time of discharge, the patient is fairly comfortable. [Resident #5] looks as good as expected since I know this patient really well. [Resident #5] does have some pain in moving the right arm and chest wall still shows the hematoma, even though improving. These injuries are going to show symptoms for some time ..." During a phone interview on 03/17/23 at 2:37 p.m., the (former) DON "A" was asked about Resident #5's injury, discovered on 08/13/22 by nursing staff. DON "A" reported Resident #5 typically used a full body lift, and the therapists had been trialing a [Brand name] sit to stand lift, when Resident #5 said 'ow' to them when [he was] in the lift, and they [therapists] lowered him back down. DON "A" reported they observed bruising and confirmed it happened from the sit to stand lift sling, due to the placement of the sling on Resident #5's side in the location where the bruise was located. DON "A" indicated anticoagulant medication contributed to the bruising. DON "A" could not recall how long Resident #5 was suspended in the lift, as this was not in their investigation report. DON "A" reported the bruising was in the chest area and could not give an estimated size. DON "A" clarified the bruise was not discolored, swollen, and did not appear to be a hematoma. DON "A" confirmed Resident #5 complained of shoulder pain after the incident. When asked about Resident #5's arms being up in the air per nursing and hospital documentation, DON "A" reported they did not believe the lift could elevate the			

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occupant's arms above shoulder height. DON "A" reported the lift batteries were changed on an as needed basis. DON "A" clarified when the battery discharge indicator light showed the battery was in the low range on the battery light bar, staff obtained a new battery. DON "A" reported they did annual lift training with nursing staff, reported slings were inspected daily by floor staff, and the lifts were inspected regularly by maintenance.

During an interview on 03/17/23 at 3:24 p.m., the Maintenance Director, Staff "F", was asked about the lift inspection process. Staff "F" reported there were five sit to stand mechanical lifts, and four full body mechanical lifts in the facility they inspected regularly. When asked about the battery charging process, Staff "F" reported when the battery was low, the green bars (on the battery discharge indicator initially viewed when the battery was full) started turning yellow, the user had to change the batteries. Staff "F" indicated the user should not wait until the battery indicator was in the red range, as this meant the battery was not safe for use as it was nearly or fully drained. Staff "F" clarified they had not heard about an incident with Resident #5 on 08/12/22, or any subsequent concerns. Staff "F" reported they were working at the facility when Resident #5 was a resident and had not inspected the lift or sling after the incident.

Review of the manufacture's guidelines for the [Brand name] sit to stand lift, revealed on Page 7, "Emergency Stop Button (red) ...: If you have to immediately stop any powered movement [other than by releasing pressure on the bottom on the hand control], press the red emergency stop button located on the side panel above the battery ..." Page 17 revealed, "Care and Preventative Maintenance", and a chart showed the slings should have daily, weekly, and annual checks, and the lift was designated to have weekly and

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annual checks, with inspection areas specified for both on this chart.

Further review revealed on Page 13: "The [brand name] incorporates a battery discharge indicator, situated on the rear of the battery/electronics compartment ...It is recommended the battery is removed from the equipment and charged when the battery discharge indicator displays three filled segments [lights] and buzzer beeps once every 10 seconds, but lifting is possible until the display shows one filled segment and buzzer beeps continuously, at this point the battery must be charged as soon as possible ...To ensure the [Brand name sit to stand lift] is always ready for use, it is recommended that a freshly charged battery pack is always available. This is achieved by having additional battery packs available and keeping one on charge while the other is in use ..."

Review of the document, Work History Report, dated 03/16/23, provided on 03/17/23 by Maintenance Director, Staff "F", (and reviewed with Staff "F"), revealed monthly lift inspections had been completed for all facility lifts by Staff "F". Staff "F" described completing lift inspections monthly for all facility lifts, for the areas designated specifically in the [Brand name] mechanical sit to stand lift manufacturer's guidelines and was knowledgeable of the lift operation and battery usage.

During an interview on 03/21/23 at approximately 9:30 a.m., the (former) DON "A" was asked for additional clarification regarding Resident #5's incident in the mechanical lift on 08/12/23. When asked to confirm the Root cause of the bruising, DON "A" stated the bruising was in the exact presentation of the sling for the sit to stand lift. DON "A" clarified the full body mechanical lift sling would not have caused

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	bruising, as it fully covered the body in this area, and their investigation yielded no other cause than the mechanical sit to stand lift and sling. DON "A" confirmed there was no additional investigation, other than their two-page investigation report, including no witness statements or other relevant documentation. The DON added the therapists had told her the lift had a charged battery when they started, and they had done multiple transfers with Resident #5. When asked how long the batteries should last on the mechanical sit to stand lift, the DON reported the batteries should last more than one shift however could not give a specific time range, as this depended on how often they were used. The DON confirmed the investigation report included all their investigation documentation, the root cause analysis, and their witness interviews (no witness statements), and there was no additional investigation documentation to provide Surveyor related to Resident #5's lift incident and injury investigation. A copy of an email dated 08/19/22 was provided to surveyor on 03/21/23 at 5:35 p.m., just prior to survey exit, by RN "G". The email from PTA "B" to the (former) DON "A" was not found in record review or disclosed during the four days of the survey. The email was not mentioned by DON "A" during both interviews, PTA "B", or any administrative, clinical, nursing, or management staff during multiple interviews and multiple facility-initiated communications with Surveyor to provide input and seek feedback related to the potential for deficient practice related to this investigation. The email showed a description of the incident on 08/12/23 per PTA "B". The email revealed Resident #5 was participating in a therapy session with them, and they used the [Brand name] mechanical lift to stand with Resident #5 twice, using the green sling, when Resident #5 began to feel discomfort [unspecified] when he was seated on the edge of			

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the bed. A third transfer was described, as follows: " ...On the third attempt the machines battery died, and the patient was left hanging in the [Brand name mechanical sit to stand] Lift a little longer, probably close to a minute before we were able to raise the bed to match the patient's bottom height and give him some relief from the sling ..." The email further described Resident #5 continued to participate in therapy with no complaints of chest pain, and some complaints of shoulder discomfort. It was unclear why the third transfer was initiated when Resident #5 felt "discomfort" after the second transfer, as Resident #5 was reportedly seated on the bed.

During an interview on 03/21/23 at approximately 5:45 p.m., the NHA and RN "G", were asked if they would like to provide any additional input upon further review of Resident #5's incident and injury from the mechanical sit to stand lift on 08/12/22. The NHA confirmed there were no witness statements, only the DON's investigation report, and the accident and incident report, and there was no other documentation to provide related to the incident that had not been provided. The concerns related to the potential deficient practice were reviewed, including the battery running out of charge during Resident #5's transfer, increased pain, and shoulder injury from the mechanical lift, the development of a chest hematoma per the ER report (dated 08/13/22), and lack of a thorough investigation related to Resident #5's injury. Surveyor reiterated earlier conveyed concern to the NHA regarding PTA "B"'s description of the battery indicators reportedly not consistently working (or being read accurately) on the [Brand name] mechanical sit to stand lifts. There was also no evidence of reeducation or monitoring found or provided after the incident, and no lift inspection was completed.

Review of the policy, "Safe Lifting and

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	Movement of Residents", dated 10/30/20, revised 01/01/2022, revealed, "Each resident is assessed through the Resident Assessment Instrument (RAI) and interdisciplinary team to determine lifting and movement assistance needs. At times, it is necessary to include the use of mechanical lifts to protect the safety and well-being of staff and residents, and to promote quality care. ... The manufacturer of purchased equipment shall provide initial staff training on the use of mechanical lifts, as well as on the routine checks and long-term maintenance of equipment. Subsequent training and retraining of staff on the use of mechanical lifting devices shall be conducted by designated team leaders. ...Mechanical lifts shall be made readily available and accessible to staff 24 hours a day. Back-up battery packs on remote chargers shall be provided so that lifts can be used 24 hours a day while batteries are being recharged ...Mechanical lift equipment shall undergo routine checks and maintenance by the nursing and maintenance staff, respectively, to ensure that equipment remains in good working order". Review of the policy, "Accidents and Supervision", revised 08/11/2022, revealed, " ...Each resident will receive adequate supervision and assistive devices to prevent accidents. This includes: 1. Identifying hazard(s) and risk(s). 2. Evaluating and analyzing hazard(s) and risk(s). 3. Implementing interventions to reduce hazard(s) and risk(s). 4. Monitoring for effectiveness and modifying interventions when necessary. Definitions: "Accident" refers to any unexpected or unintentional incident, which results in injury or illness to a resident ..."Hazards" refers to elements of the resident environment that have the potential to cause injury or illness. "Risk" refers to any external factor, facility, characteristic (e.g., staffing or physical environment) or characteristic of an individual resident that influences the likelihood of an			

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	accident ...Identification of Hazards and Risks: The process through which the facility becomes aware of potential hazards in the resident environment and the risk of a resident having an avoidable accident. a. All staff (i.e., professional, administrative, maintenance, etc.) are to be involved in observing and identifying potential hazards in the environment, while taking into consideration the unique characteristics and abilities of each resident. b. The facility should make a reasonable effort to identify the hazards and risks for each resident ..."			