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	175466	A. BUILDING _____ B. WING _____	C 04/20/2022

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F 000	INITIAL COMMENTS A partial extended complaint investigation into complaints KS00170998, KS00170924, KS00170746, KS00170748, KS00170751, KS00170752, KS00170754, KS00170755, KS00170758, and KS00170618 was concluded by the Department of Aging and Disability Services on 04/20/22 on behalf of the Centers for Medicare and Medicaid Services. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. On 04/14/22 at 04:50 PM Administrative Staff A was provided a copy of the IJ template and notified that the facility failure to appropriately identify and confirm newly admitted R6 code during an emergency placed R6 in immediate jeopardy at F678. The immediate jeopardy at F678 also constituted Substandard Quality of Care at 42 CFR 483.25. The immediate jeopardy was determined to first exist on 04/12/22 at 11:30 PM, when facility staff did not convey the correct information to emergency responding staff. The facility provided an acceptable plan for removal of the immediate jeopardy n 04/14/22 at 07:29 PM. The survey team validated the immediate jeopardy was removed on 04/18/22 at 10:00 AM following the facility's implementation of the plan for removal of the immediate jeopardy. The deficient practice remained at a "G" scope and severity following the removal of the immediate jeopardy.	F 000		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary	F 677		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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services to maintain good nutrition, grooming, and personal and oral hygiene;
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 54 residents, with six residents included in the sample. Based on observation, interview, and record review the facility failed to ensure bathing and personal hygiene was provided for four residents who required assistance from staff to complete bathing care. This deficient practice placed resident (R)1, R2, R3, and R5 at risk for potential skin breakdown and/or complications from not maintaining good personal hygiene and bathing practices.

Findings included:

- R1's "Electronic Medical Record" (EMR) from the "Diagnoses" tab documented diagnoses of polyneuropathy (condition in which a person's peripheral nerves are damaged), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) and depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness).

The 07/28/21"Admission Minimum Data Set" (MDS) documented a Brief Interview of Mental Status (BIMS) score of 13, indicating intact cognition. R1 required extensive assistance of two staff members for all activities of daily living (ADL).

The 07/28/21 "ADL Functional/Rehabilitation Potential Care Area Assessment" (CAA) lacked information/work-up.

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The 01/05/22 "Quarterly MDS" documented a BIMS score of 13 which indicated intact cognition. R1 required extensive assistance of two staff members for all activities of daily living (ADL), and was totally dependent on staff for bathing.

The 07/30/21 "Care Plan" documented R1 preferred to bathe in the afternoon and required the assistance of one staff member for twice weekly bathing.

The "Bath Sheets" from 01/09/22 through 03/31/22 documented R1 received nine showers/baths, with one documented refusal, for a total of 10 documented bathing opportunities in 82 days.

On 04/07/22 at 04:04 PM R1 sat in a wheelchair next to the window. R1 did not appear to be in pain or in distress and R1's hair was braided and appeared clean.

Interview on 04/07/22 at 03:12 PM with Certified Nurse Aide (CNA) O revealed residents had two showers scheduled each week. The bath sheet would be documented for each resident's bath/shower with date and time of completion or the resident refusal. The bath sheet would then be turned into Administrative Nurse E. If a bath refusal was noted, the nurse on duty was to be notified.

An interview on 04/11/22 at 01:40 PM with Administrative Nurse E revealed she expected all residents to get a bath/shower when scheduled. Some of the residents frequently refused their bath/shower but stated the staff were not documented those. Administrative Nurse E stated without documentation, there was no proof that

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baths/showers were being completed.

An interview on 04/20/22 at 09:00AM with Administrative Nurse E revealed that resident's shower preferences were to be completed on admission to the facility. Administrative Nurse E said in January and February of 2022 the staff were not documenting resident refusals for bathing.

The 01/03/19 "Assisting with a Shower Policy" documented staff were to ensure the resident's preferences for showering was being honored, and to document the completion of the shower in the clinical record.

The facility failed to provide and document baths/showers at least twice weekly for R1.

- R2's EMR from the "Diagnoses" tab documented diagnoses of cerebrovascular accident (CVA, stroke; the sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), muscle wasting and atrophy (wasting or decrease in size of a part of the body), fracture (brake) of the first lumbar vertebra (bone in one's back), and bilateral (both) below knee amputation.

The 12/22/21"Admission MDS" documented a BIMS score of eight, indicating moderately impaired cognition. R2 was totally dependent on staff for all ADLs, including showers.

The 12/22/21 "ADL Functional/Rehabilitation Potential Care Area Assessment" (CAA) lacked information/work-up.

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The 02/23/22 "Quarterly MDS" documented a BIMS score of 15, indicating intact cognition. R2 was totally dependent on staff for all ADLs, including showers.

The 02/11/20 "Care Plan" documented R2 preferred to be showered with hair washing once weekly, but would sometimes decline. On 01/04/22, R2's care plan was updated to indicate two staff members were to complete bathing tasks in bed.

The "Bath Sheets" from 01/19/22 through 04/15/22 documented R2 received eight showers/baths, with eight documented refusals, for a total of 16 documented bathing opportunities in 86 days.

On 04/07/22 at 04:15 PM R2 sat in a wheelchair in her bedroom watching television. R2 wore a cervical brace (neck brace that prevents head/neck movement). R2 did not appear to be in pain or in distress.

Interview on 04/07/22 at 03:12 PM with Certified Nurse Aide (CNA) O revealed residents had two showers scheduled each week. The bath sheet would be documented for each resident's bath/shower with date and time of completion or the resident refusal. The bath sheet would then be turned into Administrative Nurse E. If a bath refusal was noted, the nurse on duty was to be notified.

An interview on 04/11/22 at 01:40 PM with Administrative Nurse E revealed she expected all residents to get a bath/shower when scheduled. Some of the residents frequently refused their bath/shower but stated the staff were not

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documented those. Administrative Nurse E stated without documentation, there was no proof that baths/showers were being completed.

An interview on 04/20/22 at 09:00 AM with Administrative Nurse E revealed that resident's shower preferences were to be completed on admission to the facility. Administrative Nurse E said in January and February of 2022 the staff were not documenting resident refusals for bathing.

The 01/03/19 "Assisting with a Shower Policy" documented staff were to ensure the resident's preferences for showering was being honored, and to document the completion of the shower in the clinical record.

The facility failed to provide and document baths/showers at least twice weekly for R2.

- R3's EMR from the "Diagnoses" tab documented diagnoses of muscle weakness, major depressive disorder (major mood disorder) and cellulitis (skin infection caused by bacteria characterized by heat, redness and swelling) of the left lower leg.

The 06/20/21"Annual MDS" documented a BIMS score of 15, indicating intact cognition. R3 required total assistance from two staff members for transfers and physical support with showers.

The 06/20/21 "ADL Functional/Rehabilitation Potential Care Area Assessment" (CAA) lacked information/work-up.

The 01/08/22 "Quarterly MDS" documented no relevant changes from the annual MDS.

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The 04/06/20 "Care Plan" documented R3 preferred to be showered Mondays, Wednesdays, and Fridays, with the assistance of two staff members.

The "Bath Sheets" from 01/04/22 through 04/01/22 documented R3 received eight showers/baths, with one documented refusal, for a total of nine documented bathing opportunities in 87 days.

On 04/07/22 at 03:36 PM R3 sat in a wheelchair next to the bed, with shoes on her feet. R3 did not appear to be in pain or distress.

Interview on 04/07/22 at 03:36 PM with R3 revealed showers were not provided when R3 wanted them. R3 stated that the scheduled shower days were changed and R3 was unaware.

Interview on 04/07/22 at 03:12 PM with Certified Nurse Aide (CNA) O revealed residents had two showers scheduled each week. The bath sheet would be documented for each resident's bath/shower with date and time of completion or the resident refusal. The bath sheet would then be turned into Administrative Nurse E. If a bath refusal was noted, the nurse on duty was to be notified.

An interview on 04/11/22 at 01:40 PM with Administrative Nurse E revealed she expected all residents to get a bath/shower when scheduled. Some of the residents frequently refused their bath/shower but stated the staff were not documented those. Administrative Nurse E stated without documentation, there was no proof that baths/showers were being completed.

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An interview on 04/20/22 at 09:00 AM with Administrative Nurse E revealed that resident's shower preferences were to be completed on admission to the facility. Administrative Nurse E said in January and February of 2022 the staff were not documenting resident refusals for bathing.

The 01/03/19 "Assisting with a Shower Policy" documented staff were to ensure the resident's preferences for showering was being honored, and to document the completion of the shower in the clinical record.

The facility failed to provide and document baths/showers at least twice weekly for R3.

- R5's EMR from the "Diagnoses" tab documented diagnoses of metabolic encephalopathy (condition in which brain function is disturbed either temporarily or permanently due to different diseases or toxins in the body), apraxia (inability to perform particular purposive actions, as a result of brain damage) and anxiety.

The 01/25/22 "Admission MDS" documented a BIMS score of 13, indicating intact cognition. R5 was totally dependent on staff for all ADLs, including showers.

The 01/25/22 "ADL Functional/Rehabilitation Potential Care Area Assessment" (CAA) lacked information/work-up.

The 03/07/22 "Care Plan" documented R5 preferred to be showered on Tuesdays and Fridays during the day. R5 was totally dependent on staff for showering.

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The "Bath Sheets" from 03/01/22 through 04/15/22 documented R5 received six showers/baths in 45 days.

On 04/07/22 at 04:20 PM R5 sat in a wheelchair in her room. R5 did not appear to be in pain or distress.

Interview on 04/07/22 at 03:12 PM with Certified Nurse Aide (CNA) O revealed residents had two showers scheduled each week. The bath sheet would be documented for each resident's bath/shower with date and time of completion or the resident refusal. The bath sheet would then be turned into Administrative Nurse E. If a bath refusal was noted, the nurse on duty was to be notified.

An interview on 04/11/22 at 01:40 PM with Administrative Nurse E revealed she expected all residents to get a bath/shower when scheduled. Some of the residents frequently refused their bath/shower but stated the staff were not documented those. Administrative Nurse E stated without documentation, there was no proof that baths/showers were being completed.

An interview on 04/20/22 at 09:00 AM with Administrative Nurse E revealed that resident's shower preferences were to be completed on admission to the facility. Administrative Nurse E said in January and February of 2022 the staff were not documenting resident refusals for bathing.

The 01/03/19 "Assisting with a Shower Policy" documented staff were to ensure the resident's preferences for showering was being honored,

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F 677	Continued From page 9 and to document the completion of the shower in the clinical record. The facility failed to provide and document baths/showers at least twice weekly for R5.	F 677		
F 678 SS=J	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: The facility reported a census of 54 residents, with 20 identified as a full code (a technique of basic life support for the purpose of oxygenating the brain and heart until appropriate medical treatment can restore normal heart and ventilation action) advanced directive status. Based on interview and record review the facility failed to appropriately identify and confirm newly admitted Resident (R) 6's code status during an emergency. The staff found R6 on her bedroom floor, unresponsive and in cardiac arrest, which initiated the need for Emergency Medical Services (EMS) and the start of Cardio-pulmonary Resuscitation (CPR). Facility staff obtained a resident face sheet, indicating the resident had a "Do Not Resuscitate" (DNR) code status and provided it to EMS personnel, resulting in the cancellation of CPR by EMS. R6 was wrongly identified as a different resident, who had a DNR directive, when R6 did in fact require a full code, indicating the need for CPR. The inability of the facility staff to properly identify R6's code	F 678		

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status and name, caused R6 to go without CPR for over three minutes before EMS personnel correctly identified the resident and then they initiated CPR again, without success. The facility failure placed this resident in immediate jeopardy.

Findings included:

- The 04/12/22 signed "Physician's Interagency Transfer Record and Admission Orders" identified R6 with a "Full Code" status and the orders included congestive heart failure (a condition with low heart output and the body becomes congested with fluid) monitoring.

The "Face Sheet" with a "Run Date/Time" of 04/13/22 at 02:19 AM revealed Resident (R)6 admitted to the facility on 04/12/22 at 12:52 PM with a "Full Code" advanced directive status. R6's admitting diagnoses included: metabolic encephalopathy (alteration of brain function or consciousness due to failure of other internal organs), epileptic seizures (brain disorder characterized by repeated seizures), congestive heart failure (CHF), respiratory failure with hypercapnia (excessive amounts of carbon dioxide in the blood), acute kidney failure (AKF, abrupt decrease in kidney function), and paroxysmal atrial fibrillation (a sudden recurrence or attack of rapid, irregular heart beat).

The "Clinical Notes Report" revealed an assessment by Licensed Nurses (LN) G dated 04/13/22 at 05:18 AM documented the direct care staff found the resident unresponsive on the floor of her room at 11:10 PM (on 04/12/22). The staff last saw the resident at 10:20 PM on the bench of her walker at the side of her bed, facing her bed, with no distress observed. LN G noted the

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resident was unresponsive and pulseless at 11:15 PM and noted the resident was a "FULL code" with chest compressions initiated at 11:15 PM. According to the assessment, the resident was absent of radial pulse, morbidly obese, difficult to locate carotid pulse, with no chest rise, skin cold and clammy, with bluish discoloration to the hands, and her pupils were equal and nonreactive to light. The note revealed staff notified emergency medical services and LN G reported the resident had a "Full code" directive to the dispatcher. Staff completed five cycles of CPR when EMS arrived on the scene at 11:23 PM. EMS pronounced the time of death at 12:03 AM on 04/13/22.

Review of the "Fire Department Report" revealed on 04/12/22 the fire department dispatched to the facility for a not breathing call with CPR in progress. On arrival EMS was on scene and had taken over patient care and code blue (cardiac or respiratory arrest with ongoing resuscitation efforts) at 11:30 PM. The facility staff handed the emergency response officer patient paperwork, which noted the resident was a DNR. The emergency response officer looked at the paperwork and said they needed the DNR, not just the face sheet that said Advanced Directive was DNR. Emergency responders continued with CPR for several cycles until the nurse got back with the printed off paper that confirmed the DNR status, and code black (cardiac or respiratory arrest after discontinued resuscitation efforts or no resuscitation efforts due to specific criteria outlined in treatment protocols, such as a DNR) was given at 11:27 PM. As the emergency response fire squad were leaving the parking lot, they were called back to the scene by the emergency response officer and they were in

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code blue, and again doing CPR. The facility LN H identified the patient as R7, when in fact the resident they were working on was R6, a full code patient, not a DNR. Full resuscitative efforts were given, but R6 was triaged Code Black 12 cycles later at 12:03 AM.

The "Witness Statement" by Certified Nurse Aide (CNA) M, signed and dated 04/18/22, revealed on the night of the incident (04/12/22) she and CNA N saw the resident on the floor of her room, unconscious, and they both left R6 to get the LN. CNA M said the LN asked for the vital machine and went to R6's room, but then came running down the hall asking for the crash cart. The LN asked CNA M and CNA N to start CPR.

The "Witness Statement" by LN H, signed and dated 04/18/22, revealed on 04/12/22 at 10:22 PM LN (LN G) told her she had someone coding. LN H asked the aide who came out of the room "who the resident was" to which the aide identified the resident as R7. LN H then returned to the nurse's station and immediately called the DON and pulled up the documentation for R7 and noticed R7 was a DNR. LN H then gathered all documentation for R7 and went to the room where the LN (LN G), EMTs, and CNA were and realized the resident was not R7. LN H immediately went to the 300/400 hallway nurse's station to find out who the resident was and called the DON back. The DON informed LN H the resident was a new admission who arrived that afternoon. LN H gave the phone to the nurse on that assignment and proceeded to take the correct documentation to the EMTs for R6.

The "Witness Statement" by Administrative Nurse D, signed and dated 04/18/22, revealed LN H

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called her at 11:23 PM on 04/12/22 and Administrative Nurse D attempted to walk LN H through accessing paperwork on the computer. LN H informed Administrative Nurse D, LN G was in the room and EMS was already in the facility. Administrative Nurse D informed LN H she would call her back once she could gain remote access. LN H called her back at 11:23 PM and stated it was not R7 who coded, but it was R6. Administrative Nurse D arrived to the facilty at approximately 11:59 PM and EMS continued compressions on the resident. EMS pronounced the resident deceased at 12:03 AM. Administrative Nurse D notified Administrative Staff A of the situation at 01:04 AM on 04/13/22.

Interview with CNA N on 04/14/22 at 01:33 PM revealed she saw the resident on the floor in her room face up, her face was blue and her arms were above her head. CNA N checked the resident's wrist and felt a pulse. She told the LN (LN G) the resident was on the floor, but the room number had no name. When the LN, CNA N, and CMA M went to the room, the LN said the resident was a full code and said to start CPR. We started CPR and the LN called EMS. She got a copy of the face sheet. CNA N said she talked to the 911 dispatcher and because the resident was a new resident, they did not know her that well. CNA N said another LN (LN G) told her the resident was R7 and said R7 was a DNR. CNA N then ran down to the room to tell them the resident was a DNR, but the first nurse said no it was not R7, and this resident was a full code.

Interview with Administrative Staff A and Administrative Nurse D on 04/14/22 at 11:50 AM attest when in-house staff found the resident, they initiated CPR, called EMS, and obtained the

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	175466	A. BUILDING _____ B. WING _____	C 04/20/2022

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crash cart. They stated staff continued CPR until EMS arrived. Staff obtained the face sheet for the resident and the CNA told the team the resident was a DNR. It was noted by the nurse the paperwork was for the wrong resident, and the CNA went to get the correct face sheet. Administrative Staff A and Administrative Nurse D stated EMS/Fire stopped CPR and remained hands-off for four minutes, calling a CODE BLACK. The CNA came back with the correct face sheet and noted the resident was in fact a full code, so EMS/Fire restarted CPR, but stopped once Administrative Staff D arrived on-site.

The facility "CPR Policy," updated 03/29/22, revealed the facility staff were responsible for determining the Advance Directive information on admission and it would be documented in the resident's clinical record. The facility staff would be in-serviced at the time of hire, prior to providing direct care, and at least annually, and contracted staff would be trained prior to providing any direct care to any resident. The facility developed a system of identification of "CPR status" for immediate identification of the resident's code status (located under advanced directives order in the electronic charting system). In the event a resident was found without vital signs or unresponsive by any staff member, that staff member will immediately notify an LN and will stay in the presence of the resident and begin CPR if appropriate per resident advanced directives. The LN was responsible for verifying the resident's wishes for CPR, based on the wishes of the resident and/or DPOA.

The facility failed to appropriately identify and confirm newly admitted R6's code status during

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F 678	Continued From page 15 an emergency, misidentified the resident as R7 (a DNR resident) which caused EMS to stop CPR measures on R6 for over three minutes before R6's was correctly identified and her full code status acknowledged and acted upon. This failure placed R6 in immediate jeopardy. On 04/14/22 at 04:50 PM Administrative Staff A was provided a copy of the IJ template and notified that the facility failure to appropriately identify and confirm newly admitted R6 code during an emergency placed R6 in immediate jeopardy. On 04/14/22 at 07:29 PM Administrative Staff A provided a plan for removal of the IJ which included the following actions taken: 1. Before the DON left around 04:00 AM on 04/13/22, the DON provided on site education to the staff present at the facility regarding the CPR/Code Status policies and procedures, immediately post code. The DON rounded on entire facility and ensured all residents had appropriate name tags on their doors. 2. On 4/13/22 the facility implemented hospital transfer packets to be kept at nurses' stations for their respective residents: including but not limited to their code status, signed DNR if applicable, their face sheet, and their DPOAH. 3. Education would be provided at an all staff, mandatory in service, on 4/15/22 covering the facility CPR/Code Status Procedure. The surveyor verified the implementation of the removal plan onsite on 04/18/22. The deficient practice remained at a "G" (isolated, with actual harm) scope and severity following removal of the immediate jeopardy.	F 678		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		

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§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:
The facility identified a census of 54 residents, with six residents sampled, and four reviewed for transfers. Based on observation, interview, and record review the facility failed to ensure staff safely positioned Resident R (2) in the sling during a mechanical lift transfer from the wheelchair to the bed.

Findings included:

- Review of R2's pertinent diagnoses from the 10/07/20 "Physician's Order" in the "Electronic Medical Records" (EMR) documented cerebrovascular accident (CVA, stroke; the sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), muscle wasting and atrophy (wasting or decrease in size of a part of the body), fracture (broken bone) of the first lumbar vertebra (bones in the lower back), and bilateral (both) below knee amputation.

The 12/22/21"Admission Minimum Data Set (MDS)" documented a Brief Interview for Mental Status (BIMS) score of eight, indicating moderately impaired cognition. R2 was totally dependent on staff for transfers with the use of a

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mechanical lift.

The 12/22/21 "ADL Functional/Rehabilitation Potential" CAA and "Falls" CAA lacked information/work-up.

The 02/23/22 "Quarterly MDS" documented a BIMS score of 15, indicating intact cognition. R2 was totally dependent on staff for transfers with the use of a mechanical lift.

The 02/11/20 "Care Plan" documented R2 required the assistance of two staff members for all transfers with a mechanical lift. R2 fell from the mechanical lift on 03/29/22 and therapy services were to follow-up for evaluation of appropriate sling size for R2.

On 04/07/22 at 04:15 PM R2 sat in a wheelchair in her bedroom watching television. R2 wore a cervical brace (neck brace that prevents head/neck movement). R2 did not appear to be in pain or in distress.

On 04/20/22 at 12:45 PM Certified Nurse Aide (CNA) P and CNA Q assisted R2 from her wheelchair to her bed with the use of a sling and mechanical lift. Observation revealed the sling was in place underneath R2 prior to the transfer. The red loops of the sling were secured on the mechanical lift's hooks near R2's head, and the green loops of the sling were secured on the mechanical lift's hooks by R2's thighs. CNA P and CNA Q began lifting R2 into the air with the mechanical lift, revealing R2 positioned in a manner that leaned her toward the right side once she was fully lifted in the air and noted the sling was not correctly placed underneath R2's left thigh. The sling was just past R2's buttock toward

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the left thigh, but did not cover the left thigh. Further observation revealed the top edge of the sling was noted to be approximately one-foot above R2's head. The surveyor asked CNA P and CNA Q if the sling was in an appropriate position for transfer. CNA Q responded that R2 was at dialysis and was left in the sling in that position, and CNA Q and CNA P continued to transfer R2 and placed her in bed without attempts at sling readjustment for safety. Once in bed, the two staff removed the sling from behind R2.

During an interview on 04/20/22 at 12:47 PM, CNA Q confirmed the sling was too high behind R2's head and was not appropriately placed underneath R2's legs.

An interview on 04/20/22 at 11:00AM with Administrative Nurse D revealed she expected the staff to check and readjust the sling, as needed, prior to every transfer. Administrative Nurse D said the sling was to cover the residents' back and cover the back of the resident's thighs. If the staff raised the resident into the air with the mechanical lift and noted the sling was incorrectly placed, Administrative Nurse D expected the staff to bring the resident back down, readjust the sling to the correct position, and then continue with the transfer.

The 04/20/22 "Skills Fair sign-in sheet" did not include CNA P or CNA Q signatures, indicating both staff did not complete the education for the proper use of a mechanical lift.

The 01/03/19 "Mechanical Lift Transfer Policy" documented staff members were not to use the mechanical lift until they demonstrated competency of the task. The sling was to be

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F 689	Continued From page 19 placed behind the resident's backbone but high enough to support the resident's head and neck. The sling was also to be placed under the resident's thighs with the sling tightened. Staff was to ensure the leg straps were properly crisscrossed. The facility failed to ensure the staff safely positioned R2 in the sling during a mechanical lift transfer from the wheelchair to the bed.	F 689		