| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 105522 | A. Building<br>B. Wing | 06/21/2025 |

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| Lehigh Acres Healthcare & Rehab Center | 1550 Lee Boulevard<br>Lehigh Acres, FL 33936 |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>Based on observation, interview, and record review, the facility failed to ensure 2 (Residents #111 and #62) of 3 dependent residents reviewed for Activities of Daily Living received the necessary assistance for shaving per their preferences.<br><br>The findings included:<br><br>Review of the facility policy for Shaving the Resident revised February 2018, revealed the purpose of the procedure was to promote cleanliness and provide skin care. The following information should be recorded in the resident's medical record: 1. The date and time that the procedure was performed. 2. The name and title of the individual(s) who performed the procedure. 3. If and how the resident participated in the procedure or any changes in the resident's ability to participate in the procedure. 4. Any problems or complaints made by the resident related to the procedure. 5. If the resident refused the treatment, the reason(s) why and the intervention taken. 6. The signature and title of the person recording the data. Reporting: 1. Notify the supervisor if the resident refuses the procedure. 2. Report other information in accordance with facility policy and professional standards of practice.<br><br>Review of the clinical record for Resident #111 revealed an admission date of 5/30/25. Diagnoses included fracture of the right femur (thigh bone).<br><br>Review of the admission Minimum Data Set (MDS) with a target date of 6/3/25 revealed Resident #111 scored 6 on the Brief Interview for Mental Status (BIMS), indicative of severe cognitive impairment. The MDS noted Resident #111 required substantial/maximal assistance with oral hygiene, and upper body dressing and was dependent on staff for toileting hygiene and showering. The resident had no behavior and did not reject care.<br><br>Review of the care plan initiated on 6/6/25 revealed Resident #111 had self-care deficit for dressing, grooming and bathing. The goals included for the resident to have a clean, neat, appearance daily. The interventions included providing hands on assistance with dressing, grooming, and bathing.<br><br>On 6/15/25 at 11:53 a.m., Resident #111 was observed with facial hair. In an interview Resident #111 said he has been at the facility for over 2 weeks and no one has offered to shave his facial hair. He said normally he usually shaves every other day.<br><br>On 6/16/25 and 6/17/25, Resident #111 was observed in the hall and the facial hair was not shaved.<br><br>(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 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 6/17/25 at 3:15 p.m., in an interview the Occupational Therapist, (OT) said they have not worked on shaving yet.<br><br>On 6/17/25 at 3:27 p.m., in an interview Certified Nursing Assistant (CNA) Staff A said she takes care of Resident #111 and did not remember shaving him. CNA Staff A said she did not document shaving in the medical record.<br><br>On 6/17/25 at 3:37 p.m., in an interview Licensed Practical Nurse (LPN) Staff B said the facility protocol was to shave residents when showered. LPN Staff B said they shave residents when they need it and when they want it.<br><br>On 6/17/25 at 4:00 p.m., in an interview CNA Staff C said she tried to shave the resident on 6/16/25, but his facial hair was too long and the razor would not work.<br><br>On 6/17/25 at 3:46 p.m., during an interview Registered Nurse (RN) Supervisor Staff D said she could see Resident #111 needed to be shaved. When she asked the resident if he wanted to be shaved, Resident #111 said he would love to be shaved.<br><br>Review of the progress notes failed to reveal documentation Resident #111 had been shaved or refused to be shaved.<br><br>2. Review of the clinical record for Resident #62 revealed an admission date of 3/5/25. Diagnoses included Parkinson's Disease, cognitive communication deficit, and dementia. Review of the Quarterly Minimum Data Set (MDS) with a target date of 6/8/25 revealed Resident #62 scored 9 on the BIMS, indicative of moderate cognitive impairment. Resident #62 required substantial/maximal assistance from staff for personal hygiene including shaving. The MDS noted Resident #62 did not reject care.<br><br>Review of the care plan initiated on 3/17/25 revealed Resident #62 had self-care deficit for dressing, grooming, and bathing. The goals included for the resident to have a clean, neat, appearance daily. The interventions included staff to anticipate the resident's needs with ADLs.<br><br>On 6/15/25 at 10:49 a.m., and 6/16/25 at 11:29 a.m. observed in his bed sleeping with long facial hair.<br><br>On 6/16/25 at 1:22 p.m., during an interview, Resident #62's spouse said her spouse never had a beard and his facial hair was too long. The spouse said he needed to be shaved but no one offered to shave him. She had to pay out of pocket for the hairdresser to shave him.<br><br>On 6/17/25 at 3:33 p.m., in an interview CNA Staff A said she was assigned to Resident #62 and had not shaved him. During the interview, Resident #62 was observed in bed, sleeping. He remained unshaven.<br><br>On 6/17/25 at 4:00 p.m., in an interview RN Staff D said the spouse did not have to pay for shaving, the CNAs should be shaving him. RN Staff D verified the resident was not shaved.<br><br>Review of the progress notes revealed no documentation Resident #62 had been shaved or refused to be shaved. |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>Based on observations, record review, resident and staff interviews, the facility failed to provide care and services to prevent the development and worsening of a pressure ulcer for 1 (Resident #60) of 2 residents reviewed who developed a pressure ulcer at the facility.<br><br>The findings included:<br><br>On 6/15/25 at 10:45 a.m., Resident #60 was observed in bed. Resident #60 was able to answer interview questions. Resident #60 said he uses a lift for transfers but they do not always have the staff to get him out of bed. He said he had a wound on his buttocks and the Certified Nursing Assistants (CNAs) did not apply the ordered Zinc Oxide to his buttocks.<br><br>Review of the clinical record for Resident #60 revealed an admission date of 3/8/24. Diagnoses included Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, moderate protein calorie malnutrition, muscle weakness and peripheral vascular disease.<br><br>Review of the Quarterly Minimum Data Set (MDS) assessment with a target date of 5/8/25 revealed Resident #60 scored 15 on the Brief Interview for Mental Status, indicating the resident's cognitive skills for daily decision making were intact. Resident #60 was always incontinent of urine and frequently incontinent of bowel. The resident was not on a toileting program. The MDS noted the resident did not have a pressure ulcer at the time of the assessment but was at risk for developing pressure ulcers. Resident #60 had a pressure reducing device for the bed and the chair.<br><br>Review of the care plan initiated on 4/10/24 and revised on 9/12/24 noted Resident #60 was at risk for skin impairment/pressure ulcers related to impaired mobility, incontinence, history of pressure ulcers, fragile skin, Diabetes, Deep Vein Thrombosis (DVT), obesity and nutritional status. The goal was for the resident to remain free from pressure ulcer development. The interventions included but were not limited to turn and reposition to promote offloading of pressure, use proper positioning, transferring and turning techniques to minimize friction, pressure reducing mattress to bed.<br><br>Review of the weekly skin checks revealed on 6/14/25 Resident #60's skin was intact.<br><br>On 6/15/25 at 4:53 p.m., a wound evaluation documented Resident #60 had a right buttock, a left buttock and a sacrum stage II pressure ulcer.<br><br>On 6/17/25 at 9:45 a.m., during a follow-up interview Resident #60 said the mattress has a hole and he sinks through it. The resident said his buttocks rest on the metal frame and it hurts. He said he's told the Maintenance Director last week and previously about the mattress but nothing has been done. A pillow was observed underneath the resident's buttocks. Resident #60 said the CNA placed the pillow under his buttocks last night.<br><br>On 6/17/25 at 9:52 a.m., in an interview CNA Staff G said she was assigned to Resident #60 and also worked with him on 6/16/25. She said she did not see any open areas on his buttocks when she provided incontinent care. She said she helps Resident #60 turn and reposition in bed when she provides incontinent care or when he calls for assistance. She's never put a pillow under his buttocks but elevates his legs on a pillow.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 6/17/25 at 10:00 a.m., in an interview the Maintenance Director said he has been employed at the facility for 3 months. He changes residents' mattresses all the time. He said he did not remember speaking specifically to Resident #60 about his mattress. The Maintenance Director said he did not have a formal log to document residents' concerns but makes notes when he speaks to residents. He does not keep the notes. If a resident voices a concern, he reports it to nursing.<br><br>On 6/17/25 at 10:15 a.m., observation of Wound Care for Resident #60 with the Wound Care Nurse revealed redness to the resident's buttocks, posterior aspect of thighs and peri area. A small open area was observed to the resident's left and right buttocks and sacral area.<br><br>The Wound Care Nurse donned gloves and filled a wash basin with tap water. He added soap to the water from the wall mounted soap dispenser in the resident's shower.<br><br>With the help of a CNA the Wound Care Nurse turned the resident to the left to expose the open areas. The Wound Care Nurse used a washcloth and the soapy water to clean the resident's buttocks and sacral area twice. The Wound Care Nurse then patted the area with a dry washcloth and applied Zinc Oxide cream to the resident's buttocks and sacrum. He removed his gloves, did not wash his hands or perform hand hygiene. He donned a new pair of gloves and applied barrier cream to the resident's posterior thighs. The Wound Care Nurse removed his gloves, donned a new pair of gloves and assisted the CNA to change the resident's incontinent brief. He took the wash basin to the shared bathroom, rinsed it in the sink and placed the wet, uncovered wash basin on the grab bar of the shared shower to dry.<br><br>On 6/17/25 at 10:30 a.m., in an interview the Wound Care Nurse verified he did not rinse the soap from the resident's buttocks and open areas. He said the soap was a no rinse soap.<br><br>On 6/17/25 at 10:40 a.m., the container of soap used to wash Resident #60's wounds was observed with the Director of Nursing and the Housekeeping Supervisor. The instructions on the container of the Skin and Hair Cleanser read, For skin. Apply to wash cloth or directly to skin. Massage into a lather and rinse. During the observation, the DON was asked about the storage of the uncovered washbasin used to clean the resident's buttocks and wounds on the grab bar of the shared shower and an uncovered, unlabeled urinal stored on the grab bar behind the shared toilet. The DON said the improper storage of the washbasin and urinal were an infection control concern.<br><br>On 6/17/25 at 10:50 a.m., Resident #60 was interviewed with the DON related to the mattress concern. Resident #60 said, I have told so many people about the mattress, I feel disgusted. He said when his buttocks hit the hole, he lays directly on the metal frame and it hurts a lot.<br><br>On 6/17/25 at 11:00 a.m., the Wound Care Nurse read the instructions on the container of the Skin and Hair Cleanser used to clean Resident #60's buttocks and open areas and verified the instructions specified to rinse the soap. He said, I didn't rinse, I am sorry. The Wound Care Nurse said he didn't know what product was in the dispenser in the residents' rooms.<br><br>On 6/17/25 at 3:40 p.m., observation of Resident #60's bed revealed the resident's mattress had been replaced with an air mattress.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 6/17/25 at 3:42 p.m., in an interview Licensed Practical Nurse (LPN) Staff Q said Resident #60's mattress, was bad. There's a hole in it. He had not gotten out of bed recently, the mattress took the brunt of it. |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>Based on observations, record review, residents and staff interviews, the facility failed to implement ongoing training, competencies and supervision of staff to ensure the safe use of manual and mechanical lifts to prevent avoidable accidents for 1 (Resident #48) of 29 residents care planned for manual or mechanical lift transfer.<br><br>Resident #48's diagnoses included obesity, history of multiple strokes and functional limitation in range of motion of upper and lower extremities on one side.<br><br>On 5/2/25 the nurse on duty documented the resident was crying and in a lot of pain. Her ankle was swollen with purple bruising. Resident #48 reported she sustained the injury to her foot the previous night when the lift was used wrong. Resident #48 was diagnosed with a fracture of the left heel bone.<br><br>The facility had no documentation staff using manual and mechanical lifts to transfer Residents were trained and competent to safely use the lifts.<br><br>This lack of knowledge and ability placed all 29 residents care planned for manual and mechanical lift transfers at a likelihood of serious harm, and serious injury from improper use of the lift and resulted in the determination of Immediate Jeopardy.<br><br>The findings included:<br><br>Cross reference to F726, F835.<br><br>Review of the clinical record revealed Resident #48 had a date of admission of 10/18/21.<br><br>Review of the Annual Minimum Data Set (MDS) assessment with a target date of 5/12/25 revealed Resident #48 scored 15 on the Brief Interview for Mental Status (BIMS), indicating the resident's cognitive skills for daily decision making were intact. The resident had functional limitation in range of motion of the upper and lower extremities on one side of the body.<br><br>Review of the care plan initiated on 11/10/21 and revised on 9/19/24 revealed Resident #48 was at risk for falls and/or fall related injury related to history of multiple strokes, generalized weakness, impaired balance, and unsteady gait. Resident #48 required staff assistance with transfers and ambulation. The interventions included to provide hands on assistance with transfers and utilize (brand name) manual standing aid as ordered.<br><br>Review of the nursing progress notes revealed on 5/2/25 at 10:27 p.m., Licensed Practical Nurse (LPN) Staff O documented in a change in condition progress note, Nursing observations, evaluations, and recommendations are: Resident is crying in a lot of pain. Her left ankle is swollen and has purple bruising. She stated, We were using the (brand name) lift last night and it was used wrong. LPN Staff O documented the Advanced Practice Registered Nurse (APRN) was notified on 5/2/25 at 10:42 p.m. and ordered a STAT (Immediate) X-ray of the resident's left ankle.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Review of the Radiology Results Report of the resident's left ankle X-ray revealed the STAT X-ray was not done until 5/3/25 at 10:24 a.m. The results reported on 5/3/25 at 2:20 p.m., read, Left calcaneal (heel bone) fracture. The age of the fracture is indeterminate.<br><br>On 6/15/25 at 9:35 a.m., in an interview Resident #48 said she sustained a fracture of the left foot when her foot got stuck between the lift and the wheelchair during transfer. She said the Certified Nursing Assistant (CNA) did not place her feet correctly on the lift. Her left foot slipped off the lift and caused the injury. Resident #48 said she could not walk or stand. She tried but was not able to lift her feet or move her legs. She said, My foot was not on right. I told them that but they didn't fix it. My foot went between the lift and the floor.<br><br>On 6/17/25 at 3:40 p.m., in an interview, the Director of Nursing (DON) said she was out of town on 5/2/25 and did not know about Resident #48's left calcaneal fracture from the manual lift. The DON looked in the facility's incident investigations and said there was no documentation the incident was investigated.<br><br>On 6/17/25 at 4:30 p.m., in an interview Resident #48 said staff were still using the manual lift to transfer her. She said when she injured her left foot, 2 staff were transferring her with the lift. They were not paying attention. Her foot was not placed properly in the machine and moved. Her foot got stuck and twisted and caused the left heel bone fracture.<br><br>On 6/17/25 at 4:45 p.m., in an interview the Administrator said no one called him on 5/2/25 to report the incident. When the nurse told him about it on 5/5/25, he started an investigation but could not locate it. He said they started re-educating staff on the lifts. When asked to see documentation of the training, he said, Like I said, I can't find anything.<br><br>On 6/17/25 at 4:50 p.m., in an interview the Social Service Director said when there is an incident involving a resident, she is the one who interviews the affected resident. She said on 5/5/25 she became aware of Resident #48's left heel fracture and interviewed her. She said Resident #48 told her the injury happened when CNA staff G and another CNA transferred her with the (brand name) manual lift. She wrote the resident's statement but could not find it.<br><br>On 6/17/25 at 5:40 p.m., the DON was interviewed about facility processes related to safe use of the manual and mechanical lifts to ensure residents' safety during transfer with manual and mechanical lifts and prevent avoidable accidents. The DON said as part of orientation all staff watch a video on the use of the different lifts used at the facility. The therapy department evaluates residents to determine the transfer status, including the type of lift appropriate for each resident as necessary.<br><br>Requested documentation of training for CNA Staff G who was assigned to Resident #48 on 5/1/25.<br><br>Review of the employee file for CNA Staff G revealed a date of hire of 8/29/2018. There was no documentation of manual or mechanical lift training on orientation. A Competency Assessment-Mechanical lift from a previous company dated 1/11/19 was in CNA Staff G employee file. The form was not signed by CNA Staff G or reviewer. The form contained several questions.<br><br>A question mark was entered for: Able to demonstrate appropriate set up of mechanical lift.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | A 2 (supervision required) was documented for: Demonstrates ability to transfer from bed to chair and chair to bed using mechanical lift.<br><br>Not done was entered for: Demonstrates ability to transfer from floor to bed or chair using mechanical lift and demonstrates ability to transfer from chair to toilet using mechanical lift.<br><br>On 6/17/25 at 5:50 p.m., in an interview CNA Staff G said it has been 7 years since she's had training for mechanical lifts.<br><br>On 6/17/25 at 6:00 p.m., in a telephone interview CNA Staff P said she took care of Resident #48 on 5/2/25 from 7:00 p.m. to 7:00 a.m. She said that day Resident #48 requested to put her to bed earlier than her usual time of 8:30 p.m. She said Resident #48 said her ankle got injured the previous night when they transferred her with the manual lift. Resident #48 told her the CNA who transferred her didn't know what she was doing.<br><br>CNA Staff P said she immediately notified Licensed Practical Nurse (LPN) Staff O. The DON was present during the telephone interview conducted on speaker phone.<br><br>On 6/18/25 at 8:19 a.m., CNA Staff E and CNA Staff F were observed using the (brand name) manual sit-to-stand lift to transfer Resident #48 from bed to chair. The CNAs brought the manual lift to the bed and helped the resident place her feet on the footrest of the lift. Resident #48 was not able to pull herself in a standing position without extensive assistance of both CNAs. The CNAs stood on opposite sides of the resident. Both CNAs pulled the resident to a standing position on the lift. Resident #48 was able to grab and hold onto the handlebar during the transfer with the lift.<br><br>On 6/18/25 at 9:20 a.m., a joint interview was held with the Administrator and the DON about facility processes to investigate residents' incidents and accidents, and the lack of investigation related to Resident #48's incident during transfer with the manual sit-to-stand lift. The Administrator said he found the staff statements related to Resident #48's accident. He said, Her foot slipped, it was an accident. He provided employee statements related to the Resident #48's incident and said the statements were the investigation. He said based on what Resident #48 said he did not need to interview anyone else.<br><br>Review of the statements revealed:<br><br>On 5/5/25 the Social Services Director wrote on a signed statement, Visited resident regarding her foot (ankle) and she stated that when (CNA Staff G) and another CNA changed her briefs, her left foot slid and hit her ankle on the bar (to open and close) of the (brand name lift). She stated that this happened on Thursday May 1, 2025 @ (at) around 5 or 6 pm.<br><br>On 5/5/25 LPN Staff Q wrote on a signed statement, I was the nurse assigned to the resident (Resident #48's name) on 5/5/25. She told me that when the CNA was transferring her to the bathroom using the (brand name manual lift) that she hit her left ankle on it. At the time she could not remember the name of the CNA.<br><br>There was no documentation LPN Staff Q documented the interview with the resident or completed an incident report.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | On 5/5/25 CNA Staff G wrote on a signed statement, I did not take the resident to the bathroom on Thursday 5/1/25 and she did not hit her left ankle with me or reported anything to me about her ankle. The first time I'm hearing about it is today.<br><br>On 5/5/25 LPN Staff R wrote on a signed statement, On 5-2-25, I was the nurse assigned to (Resident #48) 7A-7P (7:00 a.m. to 7:00 p.m.). During my shift resident did not complain of pain.<br><br>One other CNA (CNA Staff S) signed a statement dated 5/5/25 noting she had not heard anything about Resident #48 hurting her foot.<br><br>Review of the nursing staffing schedule for 5/1/25 revealed 4 CNAs worked on the unit where Resident #48 resides during the 7:00 a.m., to 7:00 p.m. shift. Only one of the 4 CNAs was interviewed.<br><br>There was no statement from LPN Staff O.<br><br>On 6/18/25 at 9:30 a.m., the Director of Rehab provided documentation of a discharge from therapy summary for Resident #48 dated 10/30/23, a Quarterly Physical/Occupational Therapy Screening form dated 9/17/24, a Quarterly Physical/Occupational Therapy Screening form dated 5/12/25, and Change of Status Physical/Occupational Therapy Screening form dated 6/18/25.<br><br>Review of the discharge from therapy summary dated 10/30/23 revealed one of the therapy goals was to increase bilateral lower extremities strength to 4 minus out of 5 to facilitate patient's ability to perform sit to stand transfers with moderate assistance and 25% verbal cues with use of grab bars/manual standing aid (brand name sit-to-stand lift) while maintaining functional posture in order to decrease level of assistance from caregivers. The therapy discharge noted Resident #48 achieved a 3 minus out of 5 for the bilateral lower extremities strength and was total dependence for sit to stand.<br><br>Review of the Quarterly Physical/Occupational Therapy screening form dated 9/17/24 noted Resident #48 was reviewed for changes in functional status. Resident #48 remained appropriate for the (brand name) sit-to-stand lift. The source for the screening information was staff interview.<br><br>Review of the Quarterly Physical/Occupational Therapy screening form dated 5/12/25 noted no change in condition and No functional decline indicated. The source of the information was staff interview.<br><br>Review of the Physical/Occupational Therapy screening form dated 6/18/25 noted the screen was done for a change in transfer status for Resident #48. The Physical Therapy Assistant documented, Observed nursing staff perform (brand name manual sit-to-stand lift) with patient for safety. For transfers and toileting. No information regarding Resident #48's ability to use the lift was documented.<br><br>On 6/18/25 at 9:35 a.m., in an interview the Director of Rehab said a therapy screen did not necessarily involve an observation of the resident. She said, In that case it was talking with the staff.<br><br>On 6/18/25 at 9:40 a.m., in an interview the Physical Therapy assistant who conducted the screening on 6/18/25 said he observed the Director of Nursing and a CNA transfer Resident #48 with the (brand name) sit-to-stand manual lift. He said they did a great job. He verified the screening did not reflect the resident's ability to use the lift but said Resident #48 was able to do it correctly.<br><br>(continued on next page) |

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| | 105522 | A. Building<br>B. Wing | 06/21/2025 |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | On 6/18/25 at 9:55 a.m., the DON provided a yearly performance appraisal for CNA Staff G dated 9/9/24. The form noted CNA Staff G scored 3 (average) in Personal Nursing Care Functions which included, Assist with lifting, turning, moving , positioning, and transporting residents into and out of beds, chairs, bathtubs, wheelchairs, lifts, etc. The DON verified there was no competency evaluation for the use of the manual or mechanical lifts or how the rating of 3 listed on the form was determined. She said CNA Staff G trained new CNAs which includes showing them how to use the lifts. She said she considered this an evaluation of the CNA's ability to use the manual and mechanical lifts since CNA Staff G was evaluating new CNAs.<br><br>On 6/18/25 at 2:22 p.m., in an interview LPN Staff T said she received training on the manual sit-to-stand lift 3 years ago. LPN Staff T was not able to explain or demonstrate how to use the manual sit-to-stand lift. She said, I don't know how to use the lift, I have never used it.<br><br>On 6/19/25 at 11:21 a.m., CNA Staff E and CNA Staff V were observed using a (brand name manual sit-to-stand lift) to transfer Resident #32 from bed to the wheelchair. Resident #32 was wearing tennis shoes. He sat on the edge of the bed with his feet on the floor. CNA Staff E placed herself on the resident's right side and CNA Staff V placed herself on the resident's right side. The CNAs positioned the (brand name) manual sit-to-stand lift in front of the resident. The CNAs instructed the resident to place his feet on the footrest and his hands on the handlebar. The resident placed only the front part of his feet on the footrest of the lift with the heels hanging off the back of the footrest. The resident's feet were not completely supported by the footrest. Resident #32 stood up with his heels off hanging off the footrest. The CNAs rotated the half seats underneath the resident's buttocks and transported the resident in the manual sit-to-stand lift with his heels hanging off the footrest. The CNAs did not ensure the resident's feet were properly placed on the footrest before wheeling the resident to the wheelchair. CNA Staff E moved over to the wheelchair. CNA Staff V transferred Resident #32 with the heels hanging off the back of the footrest.<br><br>Photographic evidence obtained.<br><br>Review of the instructions for use for the manual sit-to-stand lift provided by the representative via email revealed, Patient/Resident Assessment . Before use, the caregiver should always consider the patient's/resident's medical condition as well as physical and mental capabilities. In addition, the patient/resident must: . Have the ability to stand unaided or stand with minimal assistance. Safety instructions . This mobile lift must be used by a caregiver trained with these instructions . Before transferring the Patient . Position the (brand name lift) so that the patient's feet are placed on the footrest with knees comfortably against kneepad.<br><br>Review of the manufacturer's skills checklist and performance observation revealed, The patient's/resident's feet should be on the footrest with knees comfortably against kneepad during transfer<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | On 6/19/25 at 12:19 p.m., in a telephone interview CNA Staff G said she was assigned to Resident #48 on 5/1/24 from 7:00 a.m. to 7:00 p.m. She said CNA Staff U assisted her to transfer Resident #48 with the manual sit-to-stand lift. She said Resident #48 was totally dependent on staff for everything. Staff G said, She cannot turn, reposition herself or assist with the transfer with the (brand name sit-to-stand lift). CNA Staff G said it takes 2 staff to hold the resident by her pants and lift her to place her in the lift. She said Resident #48 cannot assist with the transfer with the lift, she is not even able to place her hands on the handlebar and cannot sustain her weight. Staff has to make all the effort to get her in the lift. CNA Staff G said after the incident someone must have realized the resident was not appropriate to use the lift and they changed it to a full body mechanical lift. She said for some reason, they went back to the manual sit-to-stand lift. CNA Staff G said she did not remember Resident #48 complaining about her foot with the transfer. When asked if she notified her supervisor of the difficulty Resident #48 had with the use of the manual sit-to-stand lift, she said she did not.<br><br>On 6/19/25 attempted to contact CNA Staff U via telephone and got an error message.<br><br>On 6/19/25 at 1:40 p.m., in a telephone interview LPN Staff O said on 5/2/25 Resident #48 was crying and was in a lot of pain. Her left foot was swollen and bruised. The resident said the CNAs used the lift wrong the previous evening and hurt her foot. She said she immediately reported it to the evening supervisor, Registered Nurse (RN) Staff D who instructed her to call the physician. LPN Staff O said she did not think she had to write an incident report since the incident did not happen on her shift.<br><br>On 6/19/25 at 2:58 p.m., a joint interview was held with the DON and the evening supervisor, RN Staff D. RN Staff D verified on 5/2/25 LPN Staff O told her about Resident #48's bruised and swollen left foot but did not tell her how the resident sustained the injury. She instructed LPN Staff O to call the resident's attending physician. Evening supervisor RN Staff D said she knew she was supposed to assess the resident but she already had her bag on her shoulder and was leaving.<br><br>The DON said the expectation was for the evening supervisor, RN Staff D to go assess the resident and give directions to the LPN.<br><br>Review of the personnel files for CNAs Staff C (date of hire 1/30/2008), Staff W (date of hire 3/12/2001), Staff S (Date of hire 3/4/2025) and Staff Y (Date of hire 4/1/25) failed to reveal documentation of training, in-service or competency evaluations on use of manual and mechanical lifts.<br><br>On 6/21/25 at 1:40 p.m., CNA Staff W and CNA Staff X were observed transferring Resident #33 with a (brand name) full body mechanical lift. The Assistant Director of Nursing (ADON) was in the room observing the transfer. The sling was worn out and the label was missing. Two holes were observed in the sling's fabric. The sling straps showed signs of damage and were frayed.<br><br>Photographic evidence obtained.<br><br>On 6/21/25 at 1:50 p.m., the ADON observed the holes in the sling's fabric and verified the sling was worn out and the label was missing. She also verified the straps showed signs of damage and were frayed. The ADON offered no explanation for the continued use of the worn out sling.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Review of the manufacturer's manual for use of the slings provided by a representative of the sling's manufacturer revealed, Before every use. WARNING. To avoid injury, always make sure to inspect the equipment prior to use. Check all parts of the sling . If any part is missing or damaged- Do NOT use the sling. Check for: Fraying, loose stitching, tears, fabric holes, soiled fabric, damaged clips, unreadable or damaged label.<br><br>Review of the facility's policy and procedure titled Lifting Machine, Using a Mechanical with a revised date of July 2017 revealed, The purpose of this procedure is to establish the general principles of safe lifting using a mechanical lifting device. Sling care: discard any worn, frayed or ripped slings.<br><br>On 6/21/25 the immediate actions implemented by the facility and verified by the survey team included:<br><br>On 6/21/25 the survey team verified through record review and interview with the Director of Nursing that the two CNAs who assisted resident #48 with the use of the manual sit-to-stand lift were suspended.<br><br>On 6/21/25 the survey team verified through record review the facility investigated the incident involving Resident #48 which included additional staff interviews, simulation of the incident with the resident describing how the injury occurred, review of the resident's medical record to identify underlying contributing factors, and root cause analysis.<br><br>On 6/21/25 the survey team verified through record review and interview with the Administrator that on 6/18/25 the facility reported the incident to the required State and local authorities.<br><br>On 6/21/25 the survey team verified through record review and interview with the Director of Nursing that on 6/20/25 the current residents were assessed. No injuries were noted. 45 residents were identified requiring a manual or mechanical lift for transfers.<br><br>On 6/21/25 the survey team verified through review of education records that on 6/20/25 the DON and ADON educated 53 of 58 CNAs on proper use of all facility lifts. The remaining untrained staff will receive training prior to working their next shift. Any new hire will receive training during facility orientation.<br><br>On 6/21/25 the survey team verified through review of education records that on 6/20/25 the DON and ADON educated 27 of 47 licensed nursing staff and 53 of 58 Certified Nursing Assistants on proper use of all facility lifts and demonstrated the use of the manual and mechanical lifts. The DON verified that the remaining untrained staff will receive training prior to working their next shift and any new hires would receive this training during facility orientation.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | On 6/21/25 the survey team verified through record review and interview with the DON and Administrator that on 6/19/25 the facility held an Ad Hoc (unplanned) QAPI (Quality Assurance and Performance Improvement) meeting and discussed the system failures and processes that needed to be implemented to prevent these failures in the future. The plan was approved by all in attendance, the Administrator, DON, ADON, Medical Director, Activities Director, Social Services Director, Dietary Manager, admission Director, Housekeeping Supervisor, Minimum Data Set Coordinator, Infection Preventionist, Medical Records, Maintenance Director, Human Resources, Therapy, 2 Nursing Unit Managers, and the Nurse Consultant.<br><br>On 6/21/25 the survey team verified through record review and interview with the DON that on 6/19/25 the competency evaluation forms for all facility lifts were revised to provide more specific instructions.<br><br>On 6/21/25 the survey team verified through record review of 3 CNAs and staff interviews that the DON and ADON used the revised competency evaluation forms to verify the staff skills with the use of facility lifts. 3 CNAs, and 3 Licensed Nurses were interviewed. They all verified they have received the training and were required to demonstrate competency for all the lifts used at the facility.<br><br>On 6/21/25 at 11:00 a.m., the ADON said she started employment at the facility on 6/10/25. She said every facility uses different lifts. She watched a video on the use of the lifts. She observes the CNAs use the lifts and whatever they did wrong I corrected them.<br><br>On 6/21/25 the survey team verified through observation of staff on duty, review of the staffing schedule and interview with the DON that the facility does not use agency staff.<br><br>The Facility alleged compliance with the removal plan as of 6/20/2025.<br><br>On 6/21/25 the survey team determined the facility was in compliance with their removal plan as of 6/21/25 when the worn out sling with frayed straps and holes used to transfer Resident #33 was removed from use and no other damaged sling was observed in use with residents care planned for transfer with mechanical lifts. |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>Based on observation, record review and interview, the facility failed to ensure 1 (Resident #76) of 3 residents reviewed for nutrition and weight loss received the prescribed diet for 2 of 3 meals observed, failed to ensure accurate documentation of resident's risk factors and interventions to prevent weight loss, and failed to ensure timely coordination when the resident experienced difficulty with chewing and swallowing food.<br><br>The findings included:<br><br>Review of the clinical record for Resident #76 revealed an admission date of 2/26/25. Diagnoses included Parkinson's disease, anemia, unspecified protein calorie malnutrition, muscle weakness and need for assistance with personal care.<br><br>Review of the admission Minimum Data Set (MDS) assessment with a target date of 3/2/25 revealed Resident #76 required partial/moderate assistance for eating (Ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented).<br><br>Review of the care plan initiated on 3/10/25 revealed Resident #76 was at risk for malnutrition, alteration in nutrition and/or hydration related to advanced age, recent hospitalization, multiple diagnoses, therapeutic diet, underweight, variable meal intake and recent weight loss. The goal was for the resident to remain free of significant weight loss. The interventions included but were not limited to provide diet as ordered, encourage adequate intake at meals and adequate fluid intake.<br><br>The care plan also noted to observe for difficulty chewing and modify the diet consistency as needed.<br><br>Review of the resident's weight record revealed:<br><br>On 3/2/25 Resident #76's weight was 151.2 pounds (lbs.).<br><br>On 4/24/25 the residents weight was 147.0 lbs.<br><br>On 5/7/25 the care plan was updated to reflect a significant weight loss despite nutritional interventions.<br><br>On 5/29/25 the weight was 142.8 lbs.<br><br>On 6/17/25 the weight was 141.8 lbs.<br><br>Review of the Interdisciplinary Progress note dated 6/3/25 revealed Resident #76 received a regular texture no added salt diet, fortified foods and ice cream twice a day for lunch and dinner.<br><br>An Unavoidable Weight Loss/Gain form for Resident #76 dated and signed on 6/3/25 revealed the information and interventions for the unavoidable weight loss were related to the development of pressure ulcers.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The form noted: The following lab values place the resident at risk for developing pressure ulcers: Serum Albumin less than 3.4 and weight loss greater than 10% in 30 days. Preventative interventions that have been in place listed: Inspect skin daily during care, weekly skin check, cleanse skin at time of soiling, nutrition assessment/intervention, supplements, repositioning, moisture barrier, labs assessed.<br><br>The Physician Attestation of the unavoidable weight loss form noted, In reviewing this resident, I believe the pressure area(s) meet the criteria for UNAVOIDABLE. The facility has evaluated the resident's clinical condition and risk factors, implemented interventions consistent with the resident's needs, followed the recognized standards of practice and revised the plan of care as appropriate.<br><br>On 6/16/25 at 8:40 a.m., Resident #76 was observed eating breakfast. The meal ticket noted the resident was to receive fortified oatmeal. The fortified oatmeal was not on the breakfast tray. Resident #76 was having difficulty eating and no staff was observed assisting the resident.<br><br>On 6/17/25 at 1:30 p.m., in an interview the Registered Dietitian said Resident #76 had a significant weight loss when he went to the hospital in March 2025. He started with a downward trend. She said Resident #76 was receiving supplements, and fortified food. The Dietitian said Resident #76's weight loss was unavoidable and it was documented in the clinical record. Upon reviewing the Unavoidable Weight Loss form dated 6/3/25 for Resident #76, the Registered Dietitian verified the form did not contain information related to the resident's weight loss. The information and interventions documented on the form were related to pressure ulcers.<br><br>On 6/17/25 at 5:24 p.m., Certified Nursing Assistant (CNA) Staff H was observed assisting Resident #76 with his dinner meal. Resident #76 received a grilled cheese and tomato sandwich, green beans, a cup of diced pears, a cup of country vegetable soup and 4 ounces of nutritious juice. Resident #76 did not receive the ice cream as ordered and listed on the meal ticket. The resident was observed coughing with the soup. CNA Staff H was observed dipping the grilled cheese sandwich and feeding it to the resident.<br><br>On 6/17/25 at 5:54 p.m., in an interview CNA Staff H said Resident #76 was not able to chew his food, she had to dip the sandwich in the soup to moisten it.<br><br>On 6/18/25 at 12:30 p.m., the observation of the resident's difficulty eating and the fortified food items missing from the resident's breakfast meal of 6/16/25 and the dinner meal on 6/17/25 were shared with the Registered Dietitian. The Registered Dietitian said she was not aware of the resident's difficulty chewing and will request a Speech Therapy Screen.<br><br>On 6/18/25 at 4:05 p.m., in a follow up interview CNA Staff H said she did not report the Resident's difficulty chewing to anyone and she should have.<br><br>On 6/18/25 the Registered Dietitian provided an updated Plan of Treatment signed and dated by the Speech Therapist on 6/18/25 at 3:34 p.m.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the updated Speech Therapy Plan of treatment revealed a new diagnosis of Dysphagia, oropharyngeal phase (difficulty initiating a swallow or moving food from the mouth through the throat) with an onset date of 6/18/25. The Plan of Treatment noted skilled SLP (Speech Language Pathology) services for dysphagia were warranted to reduce signs and symptoms of aspiration, minimize risk of aspiration, assess/evaluate least restrictive oral intake in order to enhance the resident's quality of life by improving ability to safely consume least restrictive diet. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>Based on record review, resident and staff interview and observations the facility failed to deliver the prescribed oxygen amount for 1 (Resident #60) of 6 residents sampled.<br><br>The findings included:<br><br>Review of the clinical record for Resident #60 revealed a physician's order dated 1/23/25 for oxygen to be delivered at 3 liters per minute via nasal cannula with humidifier for a diagnosis of Chronic Obstructive Pulmonary Disease (COPD).<br><br>On 6/15/25 at 10:30 a.m., in an interview, Resident #60 stated that his oxygen was to be set at 3 liters per minute. He said he was unable to get up and check the oxygen himself so he counted on the staff to make sure the concentrator was set at 3 Liters. Observation of the oxygen concentrator during the interview revealed it was set at 4 Liters (L) and had no humidifier.<br><br>Photographic evidence obtained<br><br>On 6/16/25 at 10:15 a.m., and 6/17/25 at 12:15 p.m., Resident #60 was observed in bed in his room. Resident #60 was receiving oxygen via nasal cannula. Observation of the oxygen concentrator revealed the oxygen was set at 4 liters per minute. No humidification.<br><br>On 6/17/25 at 12:15 p.m., in an interview Licensed Practical Nurse (LPN) Staff Q said Resident #60's order for oxygen is 3 liters per minute with humidification.<br><br>LPN Staff O verified the oxygen concentrator was set at 4 liters and said it should be at 3 liters. She also verified the humidifier was not on. When asked if she looked at the oxygen when she came on duty she said, I am not going to lie. I didn't. |

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| F 0726<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.<br><br>Based on observations, record reviews, residents and staff interviews, the facility failed to ensure nursing staff had the appropriate training and competencies to prevent avoidable accidents during residents' transfer with manual and/or mechanical lifts for 1 (Resident #48) of 29 residents care planned for transfers with manual or mechanical lifts.<br><br>Resident #48 diagnoses included a history of multiple strokes, obesity and unilateral functional limitation in range of motion of upper and lower extremities. Resident #48 was care planned for the use of a (brand name) manual sit-to-stand lift for transfers.<br><br>On 5/2/25 the nurse on duty documented the resident was crying and in a lot of pain. Her ankle was swollen with purple bruising. Resident #48 reported she sustained the injury to her foot the previous night when the lift was used wrong. On 5/3/25, Resident #48 was diagnosed with a fracture of the left heel bone. Resident #48 suffered serious injury from the improper use of the manual sit-to-stand lift.<br><br>The facility had no documentation staff using manual and mechanical lifts to transfer Residents were trained and competent to safely use the lifts.<br><br>This lack of knowledge and ability placed all 29 residents care planned for manual and mechanical lift transfers at a likelihood of serious harm, and serious injury from improper use of the lift and resulted in the determination of Immediate Jeopardy.<br><br>The findings included:<br><br>Cross reference F689, F835.<br><br>Review of the Center Facility Assessment-Tool- FORM revised 6/12/25 revealed, Upon hire staff attend orientation classroom orientation and floor orientation to review specific facility features and basic competencies, along with required federal and state requirements. Facility provides ongoing educational opportunities for staff related to patient centered items and staff competencies throughout the year . Potential data sources include . education, training, competency instruction, and testing policies.<br><br>Review of the facility's policy and procedure titled, In-Service Training Program revised October 2017 revealed, All personnel are required to attend regularly scheduled in-service training classes. Annual in-services must: . Ensure the continuing competence of personnel . All training classes attended by the employee shall be entered on the respective employee's Record of In-Service by the department supervisor or other person(s) as designated by the supervisor. Records shall be filed in the employee's personnel file or shall be maintained by the department supervisor.<br><br>Review of the facility's policy and procedure titled, Lifting Machines, Using a Mechanical revised July 2017 revealed, The purpose of this procedure is to establish the general principles of safe lifting using a mechanical lifting device. It is not a substitute for manufacturer's training or instructions . Lift design and operation vary across manufacturers. Staff must be trained and demonstrate competency using the specific machines or devices utilized in the facility .<br><br>(continued on next page) |

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| | 105522 | A. Building<br>B. Wing | 06/21/2025 |

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| Lehigh Acres Healthcare & Rehab Center | 1550 Lee Boulevard<br>Lehigh Acres, FL 33936 |

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| F 0726<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | On 6/15/25 at 9:35 a.m., in an interview Resident #48 said she could not stand or walk and staff transfer her with a lift. Resident #48 tried to lift her feet and move her legs during the interview and said she was not able to. She said she sustained a fracture of the left foot when her foot got stuck during transfer between the lift and the wheelchair. She said the Certified Nursing Assistant (CNA) did not place her feet correctly on the lift. Her left foot slipped off the lift and caused the injury. She said, My foot was not on right. I told them that but they didn't fix it. My foot went between the lift and the floor.<br><br>Review of the clinical record revealed Resident #48 had a date of admission of 10/18/21.<br><br>Review of the Annual Minimum Data Set (MDS) assessment with a target date of 5/12/25 revealed Resident #48 scored 15 on the Brief Interview for Mental Status (BIMS), indicating the resident's cognitive skills for daily decision making were intact. The resident had functional limitation in range of motion of the upper and lower extremities on one side of the body.<br><br>Review of the care plan initiated on 11/10/21 and revised on 9/19/24 revealed Resident #48 was at risk for falls and/or fall related injury related to history of multiple strokes, generalized weakness, impaired balance, and unsteady gait. Resident #48 required staff assistance with transfers and ambulation. The interventions included to provide hands on assistance with transfers and utilize (brand name) manual standing aid as ordered.<br><br>Review of the nursing progress notes revealed on 5/2/25 at 10:27 p.m., Licensed Practical Nurse (LPN) Staff O documented in a change in condition progress note, Nursing observations, evaluations, and recommendations are: Resident is crying in a lot of pain. Her left ankle is swollen and has purple bruising. She stated, We were using the (brand name) lift last night and it was used wrong. LPN Staff O documented the Advanced Practice Registered Nurse (APRN) was notified on 5/2/25 at 10:42 p.m. and ordered a STAT (Immediate) X-ray of the resident's left ankle.<br><br>Review of the Radiology Results Report of the resident's left ankle X-ray revealed the STAT X-ray was not done until 5/3/25 at 10:24 a.m. The results reported on 5/3/25 at 2:20 p.m., read, Left calcaneal (heel bone) fracture. The age of the fracture is indeterminate.<br><br>On 6/17/25 at 4:30 p.m., during a follow up interview Resident #48 said staff were still transferring her with the (brand name) manual lift. She said when she injured her left foot, 2 staff were transferring her with the lift. She said they were not paying attention. Her foot was not placed properly in the machine and moved. Her foot got stuck and twisted and caused the left heel bone fracture.<br><br>On 6/17/25 at 4:45 p.m., in an interview the Administrator said no one called him on 5/2/25 to report the incident. On 5/5/25 he started an investigation when the nurse reported the incident but could not locate the investigation. He said they also started re-educating the staff on using the lifts. When asked to see documentation of the re-education, he said, Like I said, I can't find anything.<br><br>(continued on next page) |

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| F 0726<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | On 6/16/25 at 5:40 p.m., an interview was held with the Director of Nursing (DON) to discuss processes in place to ensure staff were educated, had the skills set and competencies on safe use of manual and mechanical lifts, in accordance with facility's policies and procedures and manufacturer's specifications. The DON said as part of orientation all staff are required to watch a video on the use of the 3 different kinds of lifts used at the facility (manual sit-to-stand lift, mechanical sit-to-stand lift and full body mechanical lift). The therapy department evaluates residents to determine their transfer status, including the type of lift appropriate for each resident as necessary.<br><br>When asked for documentation of staff training and competencies for the safe use of the lifts, the DON said she made sure all staff watch the videos but had no documentation verifying the training or competence of staff related to safe use of the manual or mechanical lifts.<br><br>On 6/17/25 at 5:50 p.m., in an interview CNA Staff G said it has been 7 years since she's had training for mechanical lifts.<br><br>On 6/17/25 at 6:00 p.m., in a telephone interview CNA Staff P said she took care of Resident #48 on 5/2/25 from 7:00 p.m. to 7:00 a.m. She said that day Resident #48 requested to be put to bed earlier than her usual time of 8:30 p.m. Resident #48 said her ankle got injured the previous night when they transferred her with the manual lift. Resident #48 told her the CNA who transferred her didn't know what she was doing.<br><br>CNA Staff P said she immediately notified the LPN Staff O. The DON was present during the interview conducted on speaker phone.<br><br>On 6/18/25 at 8:19 a.m., CNA Staff E and CNA Staff F were observed using the (brand name) manual sit-to-stand lift to transfer Resident #48 from bed to chair. The CNAs brought the manual lift to the bed and helped the resident place her feet on the footrest of the lift. Resident #48 was not able to pull herself in a standing position without extensive assistance of both CNAs. The CNAs stood on opposite sides of the resident. Both CNAs pulled the resident to a standing position on the lift.<br><br>On 6/18/25 at 9:20 a.m., the Administrator said he found the staff statements related to Resident #48's accident. He said, Her foot slipped, it was an accident. The Administrator did not provide staff education on safe use of the lifts. He said they did a reenactment yesterday on 6/17/25, did not document the re-enactment but would document if needed.<br><br>Review of the statements revealed:<br><br>On 5/5/25 the Social Services Director wrote on a signed statement, Visited resident regarding her foot (ankle) and she stated that when (CNA Staff G) and another CNA changed her briefs, her left foot slid and hit her ankle on the bar (to open and close) of the (brand name lift). She stated that this happened on Thursday May 1, 2025 @ (at) around 5 or 6 pm.<br><br>On 5/5/25 CNA Staff G wrote on a signed statement, I did not take the resident to the bathroom on Thursday 5/1/25 and she did not hit her left ankle with me or reported anything to me about her ankle. The first time I'm hearing about it is today.<br><br>(continued on next page) |

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| F 0726<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | On 5/5/25 LPN Staff Q wrote on a signed statement, I was the nurse assigned to the resident (Resident #48's name) on 5/5/25. She told me that when the CNA was transferring her to the bathroom using the (brand name manual lift) that she hit her left ankle on it. At the time she could not remember the name of the CNA.<br><br>On 5/5/25 LPN Staff R wrote on a signed statement, On 5-2-25, I was the nurse assigned to (Resident #48) 7A-7P (7:00 a.m. to 7:00 p.m.). During my shift resident did not complain of pain.<br><br>One other CNA (CNA Staff S) signed a statement dated 5/5/25 noting she had not heard anything about Resident #48 hurting her foot.<br><br>Review of the nursing staffing schedule for 5/1/25 revealed 4 CNAs worked on the unit where Resident #48 resides during the 7:00 a.m., to 7:00 p.m. shift. Only one of the 4 CNAs was interviewed.<br><br>On 6/18/25 at 9:55 a.m., the DON provided a yearly performance appraisal for CNA Staff G dated 9/9/24. The form noted CNA Staff G scored 3 (average) in Personal Nursing Care Functions which included, Assist with lifting, turning, moving , positioning, and transporting residents into and out of beds, chairs, bathtubs, wheelchairs, lifts, etc. The DON verified there was no competency evaluation for the use of the manual or mechanical lifts or how the score of 3 listed on the form was determined. She said CNA Staff G trained new CNAs which includes showing them how to use the lifts. She said she considered this an evaluation of the CNA's ability to use the manual and mechanical lifts since CNA Staff G was evaluating new CNAs.<br><br>Review of the personnel file for CNA Staff G revealed a date of hire of 8/29/2018. There was no documentation of manual or mechanical lift training on orientation. A Competency Assessment-Mechanical lift from a previous company dated 1/11/19 was in the CNA Staff G employee file. The form was not signed by the CNA Staff G or reviewer. The form contained several questions.<br><br>A question mark was entered for: Able to demonstrate appropriate set up of mechanical lift.<br><br>A 2 (supervision required) was documented for: Demonstrates ability to transfer from bed to chair and chair to bed using mechanical lift.<br><br>Not done was entered for: Demonstrates ability to transfer from floor to bed or chair using mechanical lift and demonstrates ability to transfer from chair to toilet using mechanical lift.<br><br>Review of the personnel files for CNAs Staff C, Staff W and Staff S revealed:<br><br>CNA Staff C had a date of hire 1/30/2008. A Competency Assessment-Mechanical lift from a previous healthcare management company dated 1/15/19 noted the CNA was proficient to use a mechanical lift. The method of evaluation was return demonstration. There was no documentation of training or competency evaluation for the use of the (brand name) manual sit-to-stand lift. The most recent Performance Appraisal dated 2/11/25 noted CNA staff C scored above average in Personal Nursing Care Functions which included, Assist with lifting, turning, moving , positioning, and transporting residents into and out of beds, chairs, bathtubs, wheelchairs, lifts, etc. The form did not include a competency evaluation for the use of the manual or mechanical lifts.<br><br>(continued on next page) |

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| F 0726<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | CNA Staff Y had a date of hire of 3/12/2001. The personnel file did not contain documentation of competency evaluation on the safe use of manual and mechanical lifts. The employee's education log documented 15 minutes of education on (brand name) full body mechanical lift on 1/10/2007.<br><br>CNA Staff S had a date of hire of 3/4/2025. The personnel file did not contain documentation of training or competency evaluation for the safe use of the manual or mechanical lifts used by the facility.<br><br>On 6/18/25 at 2:22 p.m., in an interview LPN Staff T said she received training on the manual sit-to-stand lift 3 years ago. LPN Staff T was not able to explain or demonstrate how to use the sit-to-stand lift. She said, I don't know how to use the lift, I have never used it. LPN Staff T called a CNA over and said the CNA would be able to demonstrate how to use the lift.<br><br>On 6/19/25 at 11:21 a.m., CNA Staff E and CNA Staff V were observed using a (brand name manual sit-to-stand lift) to transfer Resident #32 from bed to the wheelchair. Resident #32 was wearing tennis shoes. He sat on the edge of the bed with his feet down to the floor. CNA Staff E positioned herself to the resident's left side and CNA Staff V positioned herself to the resident's right side. The CNAs positioned the (brand name) manual sit-to-stand lift in front of the resident. The CNAs instructed the resident to place his feet on the footrest and place his hands on the handlebar. The resident placed only part of his feet on the footrest of the lift with the heels hanging off the back of the footrest. The resident's feet were not completely on the footrest. Resident #32 stood up with his heels off hanging off the footrest. The CNAs rotated the half seats underneath the resident's buttocks and transported the resident in the manual sit-to-stand lift with his heels hanging off the footrest. The CNAs did not ensure the resident's feet were properly placed on the footrest before wheeling the lift and transferring the resident to the wheelchair. CNA Staff E moved over to the wheelchair. CNA Staff V transferred Resident #32 with the heels hanging off the back of the footrest.<br><br>Photographic evidence obtained.<br><br>On 6/19/25 at approximately 12:00 p.m., in an interview the Director of Rehab reviewed the photographic evidence of the positioning of Resident #32's feet on the manual sit-to-stand lift and said the resident's feet were not positioned properly and it was not safe.<br><br>Review of the manufacturer's instructions for use for the manual sit-to-stand lift provided by a manufacturer's representative of lift revealed, Patient/Resident Assessment . Before use, the caregiver should always consider the patient's/resident's medical condition as well as physical and mental capabilities. In addition, the patient/resident must: . Have the ability to stand unaided or stand with minimal assistance. Safety instructions . This mobile lift must be used by a caregiver trained with these instructions . Before transferring the Patient . Position the (brand name lift) so that the patient's feet are placed on the footrest with knees comfortably against kneepad.<br><br>Review of the manufacturer's skills checklist and performance observation revealed, The patient's/resident's feet should be on the footrest with knees comfortably against kneepad during transfer<br><br>(continued on next page) |

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| F 0726<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | On 6/19/25 at 12:19 p.m., in a telephone interview CNA Staff G said she was assigned to Resident #48 on 5/1/24 from 7:00 a.m. to 7:00 p.m. She said CNA Staff U assisted her to transfer Resident #48 with the manual sit-to-stand lift. She said Resident #48 was totally dependent on staff for everything. Staff G said, She cannot turn, reposition herself or assist with the transfer with the (brand name sit-to-stand lift). CNA Staff G said it takes 2 staff to hold the resident by her pants and lift her to place her in the lift. She said Resident #48 cannot assist with the transfer with the lift, she is not even able to place her hands on the handlebar and cannot sustain her weight. Staff has to make all the effort to get her in the lift. CNA Staff G said after the incident someone must have realized the resident was not appropriate to use the lift and they changed it to a full body mechanical lift. She said for some reason, they went back to the manual sit-to-stand lift. CNA Staff G said she did not remember Resident #48 complaining about her foot with the transfer.<br><br>On 6/21/25 at 1:40 p.m., CNA Staff W and CNA Staff X were observed transferring Resident #33 with a (brand name) full body mechanical lift. The Assistant Director of Nursing (ADON) was in the room observing the transfer. The sling was worn out and the label was missing. Two holes were observed in the sling's fabric. The sling's straps showed signs of damage and were frayed.<br><br>Photographic evidence obtained.<br><br>On 6/21/25 at 1:50 p.m., the ADON observed the holes in the sling and verified the sling was worn out and the label was missing. She also verified the straps showed signs of damage and were frayed. The ADON offered no explanation for the continued use of the damaged sling.<br><br>Review of the manufacturer's manual for use of the slings revealed, Before every use. WARNING. To avoid injury, always make sure to inspect the equipment prior to use. Check all parts of the sling . If any part is missing or damaged- Do NOT use the sling. Check for: Fraying, loose stitching, tears, fabric holes, soiled fabric, damaged clips, unreadable or damaged label.<br><br>Review of the facility's policy and procedure titled Lifting Machine, Using a Mechanical with a revised date of July 2017 revealed, The purpose of this procedure is to establish the general principles of safe lifting using a mechanical lifting device. Sling care: discard any worn, frayed or ripped slings.<br><br>On 6/21/25 the immediate actions implemented by the facility and verified by the survey team included:<br><br>On 6/21/25 the survey team verified through record review and interview with the Director of Nursing that the two CNAs who assisted resident #48 with the use of the manual sit-to-stand lift were suspended.<br><br>On 6/21/25 the survey team verified through review of residents' assessments and interview with the Director of Nursing that on 6/20/25 the current residents were assessed. No injuries were noted. 45 residents were identified requiring a manual or mechanical lift for transfers.<br><br>(continued on next page) |

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| F 0726<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | On 6/21/25 the survey team verified through review of education records that on 6/20/25 the DON and ADON educated 53 of 58 CNAs on proper use of all facility lifts. The remaining untrained staff will receive training prior to working their next shift. Any new hire will receive training during facility orientation. 3 CNAs interviewed verified receipt of the training and were able to verbalize the content of the training.<br><br>On 6/21/25 the survey team verified through review of education records that on 6/20/25 the DON and ADON educated 27 of 47 licensed nursing staff on proper use of all facility lifts and demonstrated the use of the manual and mechanical lifts. 3 Licensed nurses were interviewed and verified receipt of the training and were able to describe the content of the training.<br><br>5 different CNAs were observed transferring 3 residents using the manual sit-to-stand lift and full body mechanical lift.<br><br>On 6/21/25 the survey team verified through review of the education, sign-in sheets and interview with 3 CNAs and 3 Licensed Nurses that on 6/20/25 the DON and ADON educated 79 of 145 facility staff regarding the proper reporting of all incidents and/or changes in condition. The training included what to report, who to report incidents to, when and how to report.<br><br>On 6/21/25 the survey team verified through record review and interview with the DON and Administrator that on 6/19/25 the facility held an Ad Hoc (unplanned) QAPI (Quality Assurance and Performance Improvement) meeting and discussed the system failures and processes that needed to be implemented to prevent these failures in the future. The plan was approved by all in attendance, the Administrator, DON, ADON, Medical Director, Activities Director, Social Services Director, Dietary Manager, admission Director, Housekeeping Supervisor, Minimum Data Set Coordinator, Infection Preventionist, Medical Records, Maintenance Director, Human Resources, Therapy, 2 Nursing Unit Managers, and the Nurse Consultant.<br><br>On 6/21/25 the survey team verified through record review and interview with the DON that on 6/19/25 the competency evaluation forms for all facility lifts were revised to provide more specific instructions.<br><br>The facility has a separate competency evaluation form for each type of lift used by the facility. The survey team verified through review of 5 random competency evaluations that the new forms were used to verify staff competency on safe use of the lifts.<br><br>On 6/21/25 the survey team verified through review of licensed nurses education and interview with the DON that as of 6/20/25 26 of 47 licensed nurses were educated on the new electronic incident reporting system. The incidents are also monitored and reviewed by an outside contracted consulting service. On 6/21/25 at 3:20 p.m., The DON demonstrated the use of the new electronic incident reporting system. The DON verified that all remaining untrained staff will not be permitted to work until the training has been completed.<br><br>(continued on next page) |

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| F 0726<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | On 6/21/25 the survey team verified through review of education content and sign-in sheets, interview with 3 licensed nurses, the DON and the evening supervisor that on 6/20/25 14 of 47 licensed nurses were educated on proper supervision of the Certified Nursing Assistants. The DON verified that all untrained nurses would receive the education prior to their next scheduled shift. Each nurse interviewed said they are now required to supervise all transfers with lifts to ensure the safety of residents. They are the CNAs direct supervisors. Training included ADL (activities of daily living), transfers, meals delivery and feeding . Provide redirection, instructions, guidance as needed according to the resident's plan of care. Report any need for education or concerns to the management team.<br><br>The Facility alleged compliance with the removal plan as of 6/20/2025.<br><br>On 6/21/25 the survey team determined the facility was in compliance with their removal plan as of 6/21/25 when the worn out sling with frayed straps and holes used to transfer Resident #33 was removed from use and no other damaged sling was observed in use with residents care planned for transfer with mechanical lifts. |

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| F 0835<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Administer the facility in a manner that enables it to use its resources effectively and efficiently.<br><br>Based on observations, record review, residents and staff interviews, the facility's Administration failed to utilize its resources effectively to maintain oversight and ensure staff were trained and competent in the safe use of manual and mechanical lifts to transfer residents and appropriately respond to residents' incidents for 1 (Resident #48) of 29 residents care planned for manual or mechanical lifts for transfers.<br><br>Resident #48 diagnoses included a history of multiple strokes, obesity and unilateral functional limitation in range of motion of upper and lower extremities. Resident #48 was care planned for the use of a manual sit-to-stand lift for transfers.<br><br>On 5/2/25 the nurse on duty documented the resident was crying and in a lot of pain. Her ankle was swollen with purple bruising. Resident #48 reported she sustained the injury to her foot the previous night when the lift was used wrong. On 5/3/25, Resident #48 was diagnosed with a fracture of the left heel bone. Resident #48 suffered serious injury from the improper use of the manual sit-to-stand lift.<br><br>The facility administration failed to investigate the incident, failed to have documentation staff using manual and mechanical lifts to transfer residents were trained and competent to safely use the lifts, and failed to ensure nursing staff implemented the facility's policies and procedures and immediately reported the allegation of improper use of the lift resulting in serious injury to Resident #48.<br><br>The facility administration failure to provide oversight, monitoring, and staff training to ensure the safe delivery of nursing care and related services placed all 29 residents care planned for manual and mechanical lift transfers at a likelihood of serious harm, and serious injury, or death from improper use of the lift and resulted in the determination of Immediate Jeopardy.<br><br>The findings included:<br><br>Cross reference F689 and F726<br><br>Review of the signed Administrator's job description dated 9/19/2024 revealed, The primary purpose of your position is to direct the day-to-day functions of the Facility in accordance with current federal, state and local standards guidelines, and regulations that govern nursing facilities to assure that the highest degree of quality care can be provided to our residents at all times . Duties and responsibilities . Review accident and incident reports . Monitor to determine the effectiveness of the Facility's risk management program .<br><br>(continued on next page) |

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| F 0835<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Review of the signed Director of Nursing's job description dated 4/16/2020 revealed, General description. Responsible for planning, coordination, implementation, evaluation and supervision of the nursing services. The Director of Nursing is responsible for maintaining consistent, safe and effective nursing practices and the management of the overall operation of the Nursing Department in accordance with policies, standards of nursing practices and regulatory requirements. Establish processes that are outcome focused as to maintain the highest possible level of care and services for each resident . Essential job functions: . Responsible for . orientation, training, evaluation . of nursing personnel. Provides leadership to the nursing department in accordance with guidelines and regulations concerning the delivery of care to assure appropriate nursing services are delivered . Nursing care and documentation function. Establish and maintain systems including chart audits for . incident reports, etc., regarding patient services. Instruct nursing staff on appropriate required action. Resident comfort and safety . Ensure equipment . are safe . and any hazardous conditions are addressed.<br><br>Review of the clinical record for Resident #48 revealed an admission date of 10/18/21.<br><br>The care plan initiated on 11/102021 and revised on 9/19/24 noted Resident #48 was at risk for falls and/or fall related injury due to generalized weakness, impaired balance, unsteady gait and required staff assistance with transfers and ambulation. The care plan noted the resident had a history of multiple strokes. The interventions included to provide hands on assistance with transfers and utilize (brand name) manual standing aid (manual sit-to-stand lift) as ordered.<br><br>Review of the nursing progress notes revealed on 5/2/25 at 10:27 p.m., Licensed Practical Nurse (LPN) Staff O documented in a change in condition progress note, Nursing observations, evaluations, and recommendations are: Resident is crying in a lot of pain. Her left ankle is swollen and has purple bruising. She stated, We were using the (brand name) lift last night and it was used wrong. LPN Staff O documented the Advanced Practice Registered Nurse (APRN) was notified on 5/2/25 at 10:42 p.m. and ordered a STAT (Immediate) X-ray of the resident's left ankle.<br><br>Review of the Radiology Results Report of the resident's left ankle X-ray revealed the STAT X-ray was not done until 5/3/25 at 10:24 a.m. The results reported on 5/3/25 at 2:20 p.m., read, Left calcaneal (heel bone) fracture. The age of the fracture is indeterminate.<br><br>On 6/15/25 at 9:35 a.m., in an interview Resident #48 said she sustained a fracture of the left foot when her foot got stuck between the lift and the wheelchair during transfer. She said the Certified Nursing Assistant (CNA) did not place her feet correctly on the lift. Her left foot slipped off the lift and caused the injury. Resident #48 said she could not walk or stand. She tried but was not able to lift her feet or move her legs. She said, My foot was not on right. I told them that but they didn't fix it. My foot went between the lift and the floor.<br><br>The facility's Incident by incident type list from 1/1/25 through 6/14/25 was reviewed and did not include the improper transfer of Resident #48 on 5/1/25 with the manual sit-to-stand lift that resulted in Resident #48's serious injury to the left foot.<br><br>On 6/17/25 at 3:40 p.m., an interview was held with the Director of Nursing (DON) to review the incident, including immediate reporting, investigation, root cause and measures implemented to prevent further avoidable incidents when using manual or mechanical lifts to transfer residents.<br><br>(continued on next page) |

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| F 0835<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | The DON reviewed the facility's incidents and verified Resident #48's injury sustained on 5/1/25 during transfer with the manual sit-to-stand lift was not listed on the incidents log. She said there was no documentation the incident was investigated. The DON said she was out of town and the facility Administrator would have been responsible for the investigation.<br><br>On 6/17/25 at 4:30 p.m., in an interview Resident #48 said staff were still using the manual lift for all transfers. She said when she injured her left foot, 2 staff were transferring her with the lift. Resident #48 said they were not paying attention. Her foot was not placed properly in the machine and moved. Her foot got stuck and twisted and caused the left heel bone fracture.<br><br>On 6/17/25 at 4:45 p.m., in an interview the Administrator said on 5/2/25, when Resident #48 reported she was injured during transfer with a lift, no one notified him. The nurse on duty reported the incident to him on 5/5/25. The Administrator said he started an investigation on 5/5/25 but could not locate it. He said they also started re-educating staff on the lifts. When asked to see documentation of the training, he said, Like I said, I can't find anything.<br><br>On 6/17/25 at 4:50 p.m., in an interview the Social Service Director said when there is an incident involving a resident, she is the one who interviews the affected resident. She said on 5/5/25 she became aware of Resident #48's left heel fracture and interviewed her. She said Resident #48 told her the injury happened when Certified Nursing Assistant (CNA) staff G and another CNA transferred her with the (brand name) manual lift. She wrote the resident's statement but could not find it.<br><br>On 6/17/25 at 5:40 p.m., an interview was held with the DON to review facility's processes to ensure staff were trained and competent to safely transfer residents with manual and mechanical lifts.<br><br>The DON said as part of orientation, all staff watch a video on the use of the different lifts used at the facility (manual sit-to-stand lift, mechanical sit-to-stand lift and full body mechanical lift). She said the therapy department evaluates residents to determine their transfer status, including the type of lift appropriate for each resident as necessary.<br><br>Review of the facility's policy titled, Resident Safe Handling Policy revised 8/3/2015 revealed, In order to provide a safe environment for our residents and Clinical team, this facility has adopted a Safe Resident Handling philosophy. Clinical team(s) responsible for the transferring or repositioning of residents will receive instruction on the safe operation of mechanical lifts, the non-mechanical standing aid, and assistive transfer/repositioning devices . The Clinical Educators will be responsible for the training of current Lateral slide/repositioning devices, and the policy of Safe Resident handling. Clinical Educators will also coordinate with Physical Therapy for training employees on the use of all Safe Resident Handling devices. Training will be conducted upon hire with re-instruction as needed. Nursing Leadership will monitor the appropriate use of all Safe Resident Handling devices by the Clinical team and provide instructions as deemed necessary and appropriate .The Administrative team and Nursing leadership will support and enforce this retraining for the safety of the Clinical team and Residents.<br><br>The policy noted the (brand name) sit-to-stand manual lift was an example of a non-mechanical standing aid device.<br><br>(continued on next page) |

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| F 0835<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | When asked for documentation of staff training and competencies for the safe use of the lifts for Certified Nursing Assistant (CNA) Staff G and other CNAs, the DON said she made sure all staff watch the videos but had no documentation verifying the training or competency of staff related to safe use of the manual or mechanical lifts.<br><br>Review of the personnel file for CNA Staff G revealed a date of hire of 8/29/2018. There was no documentation of manual or mechanical lift training on orientation. A Competency Assessment-Mechanical lift from a previous company dated 1/11/19 was in CNA Staff G employee file. The form was not signed by CNA Staff G or the reviewer. The form contained several questions.<br><br>A question mark was entered for: Able to demonstrate appropriate set up of mechanical lift.<br><br>A 2 (supervision required) was documented for: Demonstrates ability to transfer from bed to chair and chair to bed using mechanical lift.<br><br>Not done was entered for: Demonstrates ability to transfer from floor to bed or chair using mechanical lift and for, demonstrates ability to transfer from chair to toilet using mechanical lift.<br><br>The personnel file did not contain training or competency evaluation for the use of the (brand name) sit-to-stand lift used on 5/1/25 to transfer Resident #48.<br><br>CNA Staff G's personnel file contained a Safe Resident Handling Policy Acknowledgement form dated 1/1/19. The form noted, I acknowledge that I have received the information concerning this policy and agree to work within the guidelines set forth. The date of employee training was 1/11/19. The form was not signed by CNA Staff G and did not contain the Clinical Educator Signature.<br><br>Review of the personnel files for CNAs Staff C (date of hire 1/30/2008), Staff W (date of hire 3/12/2001), Staff S (Date of hire 3/4/2025) and Staff Y (Date of hire 4/1/25) failed to reveal documentation of training, in-service or competency evaluations on use of manual sit-to-stand lifts.<br><br>On 6/17/25 at 5:50 p.m., in an interview CNA Staff G said it has been 7 years since she's had training for mechanical lifts.<br><br>On 6/17/25 at 6:00 p.m., in a telephone interview CNA Staff P said she took care of Resident #48 on 5/2/25 from 7:00 p.m. to 7:00 a.m. She said that day Resident #48 requested to be put to bed earlier than her usual time of 8:30 p.m. Resident #48 said her ankle got injured the previous night when they transferred her with the manual lift. Resident #48 told her the CNA who transferred her didn't know what she was doing.<br><br>The DON was present during the interview done on speaker phone.<br><br>On 6/18/25 at 8:19 a.m., CNA Staff E and CNA Staff F were observed using the (brand name) manual sit-to-stand lift to transfer Resident #48 from bed to chair. The CNAs brought the manual lift to the bed and helped the resident place her feet on the footrest of the lift. Resident #48 was not able to pull herself in a standing position without extensive assistance of both CNAs. The CNAs stood on opposite sides of the resident. Both CNAs pulled the resident to a standing position on the lift.<br><br>(continued on next page) |

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| F 0835<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Review of the documentation for 6/18/25 for the task: Transfer: Self Performance (How resident moves between surfaces including to or from bed, chair, wheelchair, standing position) revealed the CNA placed a check mark on Limited assistance. Resident highly involved in activity, staff provides guided maneuvering of limbs or other non-weight-bearing assistance.<br><br>Review of the manufacturer's instructions for use for the manual sit-to-stand lift provided by a manufacturer's representative of the lift revealed, Patient/Resident Assessment . Before use, the caregiver should always consider the patient's/resident's medical condition as well as physical and mental capabilities. In addition, the patient/resident must: . Have the ability to stand unaided or stand with minimal assistance. Safety instructions . This mobile lift must be used by a caregiver trained with these instructions . Before transferring the Patient . Position the (brand name lift) so that the patient's feet are placed on the footrest with knees comfortably against kneepad.<br><br>Review of the manufacturer's skills checklist and performance observation revealed, The patient's/resident's feet should be on the footrest with knees comfortably against kneepad during transfer.<br><br>On 6/18/25 at 9:20 a.m., the Administrator said he found the staff statements related to Resident #48's accident. He said, Her foot slipped, it was an accident. The Administrator did not provide staff education on safe use of the lifts. He said they did a reenactment yesterday on 6/17/25 but did not document the reenactment. He said if needed he would document. When asked about the incident investigation, the Administrator said the staff statements were the investigation.<br><br>The staff statements did not include a statement from LPN Staff O. The Administrator said he did not interview anyone else after reading the resident's interview.<br><br>The DON who was present during the interview said she had a call out to LPN Staff O who documented Resident #48's change in condition but did not report it to anyone. She said, Staff know they are supposed to fill out an incident report and nothing was done.<br><br>Review of the staff statements revealed:<br><br>On 5/5/25 the Social Services Director wrote on a signed statement, Visited resident regarding her foot (ankle) and she stated that when (CNA Staff G) and another CNA changed her briefs, her left foot slid and hit her ankle on the bar (to open and close) of the (brand name lift). She stated that this happened on Thursday May 1, 2025 @ (at) around 5 or 6 pm.<br><br>On 5/5/25 CNA Staff G wrote on a signed statement, I did not take the resident to the bathroom on Thursday 5/1/25 and she did not hit her left ankle with me or reported anything to me about her ankle. The first time I'm hearing about it is today.<br><br>On 5/5/25 LPN Staff Q wrote on a signed statement, I was the nurse assigned to the resident (Resident #48's name) on 5/5/25. She told me that when the CNA was transferring her to the bathroom using the (brand name manual lift) that she hit her left ankle on it. At the time she could not remember the name of the CNA.<br><br>On 5/5/25 LPN Staff R wrote on a signed statement, On 5-2-25, I was the nurse assigned to (Resident #48) 7A-7P (7:00 a.m. to 7:00 p.m.). During my shift resident did not complain of pain.<br><br>(continued on next page) |

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| F 0835<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | One other CNA (CNA Staff S) signed a statement dated 5/5/25 noting she had not heard anything about Resident #48 hurting her foot.<br><br>Review of the nursing staffing schedule for 5/1/25 revealed 4 CNAs worked on the unit where Resident #48 resides during the 7:00 a.m., to 7:00 p.m. shift. Only one of the 4 CNAs was interviewed.<br><br>On 6/18/25 at 9:55 a.m., the DON provided a yearly performance appraisal for CNA Staff G dated 9/9/24. The form noted CNA Staff G scored 3 (average) in Personal Nursing Care Functions which included, Assist with lifting, turning, moving , positioning, and transporting residents into and out of beds, chairs, bathtubs, wheelchairs, lifts, etc. The DON verified there was no competency evaluation for the use of the manual or mechanical lifts or how the rating of 3 listed on the form was determined. She said CNA Staff G trained new CNAs which includes showing them how to use the lifts. She said she considered this an evaluation of the CNA's ability to use the manual and mechanical lifts since CNA Staff G was evaluating new CNAs.<br><br>On 6/18/25 at 2:22 p.m., in an interview LPN Staff T said she received training on the manual sit-to-stand lift 3 years ago. LPN Staff T was not able to explain or demonstrate how to use the manual sit-to-stand lift. She said, I don't know how to use the lift, I have never used it. LPN Staff T called a CNA over and said she would be able to demonstrate how to use the lift.<br><br>On 6/19/25 at 11:21 a.m., CNA Staff E and CNA Staff V were observed using a (brand name manual sit-to-stand lift) to transfer Resident #32 from bed to the wheelchair. Resident #32 was wearing tennis shoes. He sat on the edge of the bed with both feet on the floor. CNA Staff E positioned herself to the resident's left side and CNA Staff V positioned herself to the resident's right side. The CNAs positioned the (brand name) manual sit-to-stand lift in front of the resident. The CNAs instructed the resident to place his feet on the footrest and his hands on the handlebar. The resident placed only part of his feet on the footrest of the lift with the heels hanging off the back of the footrest. The resident's feet were not completely on the footrest. Resident #32 stood up with his heels hanging off the footrest. The CNAs rotated the half seats underneath the resident's buttocks and transported the resident in the manual sit-to-stand lift with his heels hanging off the footrest. The CNAs did not ensure the resident's feet were properly placed on the footrest before wheeling the lift and transferring the resident to the wheelchair. CNA Staff E moved over to the wheelchair. CNA Staff V transferred Resident #32 with the heels hanging off the back of the footrest.<br><br>Photographic evidence obtained.<br><br>On 6/19/25 at approximately 12:00 p.m., during an interview the Director of Rehab reviewed the photographic evidence of the positioning of Resident #32's feet on the manual sit-to-stand lift. She said the resident's feet were not positioned properly and it was not safe. The Director of Rehab said the therapy department did not conduct staff training on the use of the manual or mechanical lifts.<br><br>(continued on next page) |

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| F 0835<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | On 6/19/25 at 12:19 p.m., in a telephone interview CNA Staff G said she was assigned to Resident #48 on 5/1/24 from 7:00 a.m. to 7:00 p.m. She said CNA Staff U assisted her to transfer Resident #48 with the manual sit-to-stand lift. She said Resident #48 was totally dependent on staff for everything. Staff G said, She cannot turn, reposition herself or assist with the transfer with the (brand name sit-to-stand lift). CNA Staff G said it takes 2 staff to hold the resident by her pants and lift her to place her in the lift. She said Resident #48 cannot assist with the transfer with the lift, she is not even able to place her hands on the handlebar and cannot sustain her weight. Staff has to make all the effort to get her in the lift. CNA Staff G said after the incident someone must have realized the resident was not appropriate to use the lift and they changed it to a full body mechanical lift. She said for some reason, they went back to the manual sit-to-stand lift. CNA Staff G said she did not remember Resident #48 complaining about her foot with the transfer.<br><br>On 6/19/25 at 1:40 p.m., in a telephone interview LPN Staff O said on 5/2/25 Resident #48 was crying and was in a lot of pain. Her left foot was swollen and bruised. The resident said the CNAs used the lift wrong the previous evening and hurt her foot. She said she immediately reported the incident to the evening supervisor, Registered Nurse (RN) Staff D who instructed her to call the physician. LPN Staff O said she did not think she had to write an incident report since the incident did not happen on her shift.<br><br>On 6/19/25 at 2:58 p.m., a joint interview was held with the DON and the evening supervisor, RN Staff D to discuss processes in place to address residents' incidents, including post-incident assessment, DON and Administrator immediate notification.<br><br>RN Staff D verified that on 5/2/25 LPN Staff O told her about Resident #48's bruised and swollen left foot but did not tell her how the resident sustained the injury. She instructed LPN Staff O to call the attending physician. Evening Supervisor RN Staff D said she knew she was supposed to assess the resident but she already had her bag on her shoulder and was leaving. She verified she did not follow up to ensure an incident report was completed and the incident was reported to the DON or Administrator.<br><br>The DON said the expectation was for the Evening Supervisor, RN Staff D to go assess the resident and give directions to the LPN. She said LPN Staff O should have notified her or the Administrator. The expectation was for LPN Staff O to complete an incident report and she did not. The DON said she started educating the licensed nurses and CNAs on incident reporting and investigation. She said the facility began training the licensed nurses on a new electronic incident reporting system.<br><br>The DON provided a sign-in sheet dated 5/21/25 for an in-service on Incident Reporting/Grievance new portal. The content was, All incidents/Grievances must be completed in the (electronic incident reporting system) portal timely. The instructions included to contact their supervisors with any questions and noted, Not completing an incident during your shift is not an option.<br><br>22 of 37 Licensed Nurses hired prior to 5/21/25, including LPN Staff O and Evening Supervisor RN Staff D attended the in-service.<br><br>On 6/21/25 the DON provided documentation that on 6/20/25, 53 of 58 Certified Nursing Assistants were educated regarding the proper use of all facility lifts.<br><br>(continued on next page) |

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| F 0835<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | On 6/21/25 at 1:40 p.m., CNA Staff W and CNA Staff X were observed transferring Resident #33 with a (brand name) full body mechanical lift. The Assistant Director of Nursing (ADON) was in the room observing the transfer. The sling's label was missing. Two holes were observed in the fabric of the sling. The sling's straps showed signs of damage and were frayed.<br><br>Photographic evidence obtained.<br><br>On 6/21/25 at 1:50 p.m., the Assistant Director of Nursing (ADON) observed the holes in the sling and verified the sling's label was missing. She also verified the straps showed signs of damage and were frayed. The ADON offered no explanation for the continued use of the damaged sling.<br><br>Review of the manufacturer's manual for use of the slings provided by a representant of the slings manufacturer revealed, Before every use. WARNING. To avoid injury, always make sure to inspect the equipment prior to use. Check all parts of the sling . If any part is missing or damaged- Do NOT use the sling. Check for: Fraying, loose stitching, tears, fabric holes, soiled fabric, damaged clips, unreadable or damaged label.<br><br>Review of the facility's policy and procedure titled Lifting Machine, Using a Mechanical with a revised date of July 2017 revealed, The purpose of this procedure is to establish the general principles of safe lifting using a mechanical lifting device. Sling care: discard any worn, frayed or ripped slings.<br><br>On 6/21/25 the immediate actions implemented by the facility and verified by the survey team included:<br><br>On 6/21/25 the survey team verified through review of the education and interview with the DON and Administrator that on 6/20/25, the Regional Nurse reviewed the reporting process and job descriptions with the Administrator and Director of Nursing to ensure oversight and effective monitoring are maintained on facility processes to include reporting requirements, conducting investigations and completing root cause analysis.<br><br>On 6/21/25 the survey team verified through review of education and interview with the DON and ADON that on 6/19/25 the Regional Nurse educated the Administrator and department heads regarding reporting and incident investigations.<br><br>On 6/21/25 at 11:25 a.m., in an interview evening supervisor RN Staff D said the situation with Resident #48 opened my eyes to me thorough with her assessments and stopping to see what staff is doing. She said she was educated and knows that if someone comes to her with a problem, she must go and assess the resident. She must call the DON and if not able to reach the DON she must call the Administrator. If staff call her, she has to go immediately. As a supervisor, she makes rounds and ask staff what they need help with. She also said she was trained on the use of the lifts this week.<br><br>On 6/21/25 at 11:45 a.m., in an interview RN Staff AA said she started employment at the facility approximately 3 months ago. She said the training of the usage of the lifts was a good idea. After she was trained, she helped trained the CNAs. She had to tell them that the residents' feet have to be completely inside the footboard platform of the lift. She said the training started on 6/19/25 and she's had to correct at least 2 CNAs who were not using the lift correctly. She said for now they are observing every single transfer with a lift and they keep training and educating.<br><br>(continued on next page) |

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0835<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | On 6/21/25 the survey team verified through review of residents' assessment that on 6/20/25 all residents requiring use of facility lifts were identified and assessed with no injuries noted.<br><br>On 6/21/25 the survey team verified through review of the education and interview with 3 licensed nurses, 3 CNAs and the ADON that on 6/20/25 the DON and ADON educated 79 of 145 facility staff regarding the proper reporting of all incidents. All remaining staff will be required to complete this education prior to working in the facility.<br><br>On 6/21/25 the survey team verified through record review and interview with the Administrator and DON that on 6/19/25 the facility conducted an Ad Hoc (unplanned) QAPI (Quality Assurance and Performance Improvement) meeting to review the system failures and processes that need to be implemented to prevent these failures in the future. This Plan was approved by all in attendance including the Medical Director.<br><br>On 6/21/25 the survey team verified through review of the education and interview with the Administrator and DON that a new electronic incident reporting system was implemented. On 6/21/25 the DON demonstrated the use of the new system. She verified that all incidents are reviewed internally by the DON, ADON, Nurse Consultant, and Administrator. These same incident reports are also monitored and reviewed by their contracted outside consulting service. She verified that as of 6/20/25, 26 of 47 full time licensed nurses have completed the training. The remaining untrained nurses will not be permitted to work until training has been completed.<br><br>On 6/21/25 the survey team verified through review of the schedule and interview with the DON that the facility does not use agency staff.<br><br>On 6/21/25 the survey team verified through review of additional staff statements and facility investigation the Administrator conducted a more thorough investigation to include additional staff interviews, simulation of incident with resident describing how the injury occurred with the manual sit-to-stand lift, review of medical record to identify any underlying contributing factors, and root cause analysis.<br><br>The Administrator provided documentation that on 6/19/25 a Federal reporting was initiated and submitted.<br><br>The Facility alleged compliance with the removal plan as of 6/20/2025.<br><br>On 6/21/25 the survey team determined the facility was in compliance with their removal plan as of 6/21/25 when the sling with frayed straps and holes used to transfer Resident #33 was removed from use and no other damaged sling was observed in use with residents care planned for transfer with mechanical lifts. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 105522 | A. Building<br>B. Wing | 06/21/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Lehigh Acres Healthcare & Rehab Center | 1550 Lee Boulevard<br>Lehigh Acres, FL 33936 |

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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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>On 6/17/25 at 10:15 a.m., the Wound Care Nurse was observed cleaning Resident #60's open areas to the buttocks and sacrum.<br><br>The Wound Care Nurse donned gloves and filled a wash basin with tap water. He added soap to the water from the wall mounted soap dispenser in the resident's shower. The Wound Care Nurse used a washcloth and the soapy water in the wash basin to clean the resident's open areas to the buttocks and sacrum. The Wound Care Nurse took the wash basin to the shared bathroom and rinsed it in the sink. He placed the wet, uncovered wash basin on the grab bar of the shared shower to dry. An uncovered, unlabeled urinal was observed hanging from the grab bar behind the toilet.<br><br>On 6/17/25 at 10:40 a.m., the DON verified the observation of the unlabeled and uncovered wash basin stored on the grab bar of the shared shower and the uncovered, unlabeled urinal stored on the grab bar behind the shared toilet. The DON said the improper storage of the washbasin and urinal were an infection control concern.<br><br>Based on observation and resident and staff interviews, the facility failed to maintain infection prevention practices by failing to store residents' care items such as wash basins, bedpans and urinals in a sanitary manner for 5 (Residents #62, #106, #56, #111, and #60) of 5 sampled residents.<br><br>The findings included:<br><br>On 6/15/25 at 10:48 a.m., observation of the shared bathroom of Residents #62 and #106 revealed an uncovered, unlabeled bedpan was observed tucked between the grab bar and the wall and an unlabeled, uncovered urinal was hanging from the grab bar next to the toilet.<br><br>On 6/15/25 at 12:05 p.m., observation of Residents #56 and #111's shared bathroom revealed an unlabeled, uncovered urinal laying on the floor next to the toilet. An uncovered, unlabeled bedpan was stored tucked between the grab bar and the wall. In an interview during the observation Resident #111 said staff assist him with the bedpan and he uses the bathroom to wash up. Resident #111 said he did not place the bedpan on the grab bar.<br><br>On 6/16/25 at 11:24 a.m., observation of Residents #56 and #111's shared bathroom revealed the unlabeled, uncovered urinal hanging from the grab bar in the residents shared bathroom. In an interview during the observation, Resident #56 said staff use the urinal to empty his urinary catheter drainage bag. Resident #56 said he uses the bathroom to wash up. He said he did not like having the urinal hanging from the grab bar as it contained urine. He said, It's disgusting. Resident #56 said he did not place the urinal on the grab bar, it was not clean or sanitary.<br><br>On 6/18/25 at 9:00 a.m., during an interview with the Infection Preventionist, she said staff were trained to label bedpans and urinals with the name of the residents they are used for. These items are then to be stored in plastic and placed in the nightstand to reduce the chance of resident infection and contamination. |