STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105596	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regents Park at Aventura	18905 NE 25th Ave Aventura, FL 33180

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45019 Based on observation, interviews and record review the facility failed to protect Resident #1's right to be free from Neglect by the facility's staff. Certified Nursing Assistants (CNAs), (Staff A) and (Staff B) failed to safely transfer Resident #1 from her bed to the chair with a Mechanical Lift. The facility neglected to effectively inspect and operate the Mechanical Lift in a safe manner during the transfer of Resident #1. This failure to operate the mechanical lift in a safe manner on [DATE] at 9:57 AM Staff A and Staff B who reported that during the transfer the Mechanical lift kept rising and when Staff B grabbed the lift pad to stop it from going higher Resident #1 suddenly fell from the Mechanical lift and landed face down on the floor sustaining injuries to her head. Resident #1 expired at the hospital approximately four hours later. There were 60 residents residing in the facility that required use of a mechanical lift for transfer. Refer to F 689, F 867, and F 908. The findings included: Review of the facility policy and procedures titled Abuse, Neglect, Exploitation, Mistreatment and Injury of Unknown Injury revision date [DATE] states: It is the policy of the facility to provide protection for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. During a focused tour on [DATE] starting at 8:50 AM on the 2nd and 3rd floor units; there were 4 mechanical lifts on the 2nd floor unit and 4 mechanical lifts on the 3rd floor unit. The most recent inspection stickers were dated [DATE], [DATE], [DATE] (Photos available) Review of the Mechanical Lift Preventative Maintenance Log documented the lifts were inspected for safety and functioning by maintenance staff on [DATE] and [DATE]. The lifts were inspected after the incident on [DATE]. and on [DATE] the medical equipment company inspected the mechanical lifts. Review of the Mechanical Lift training/Competency revealed Certified Nursing Assistant (Staff A) completed training on [DATE], [DATE] and [DATE]. Staff B completed training on [DATE], [DATE] and [DATE]. All other nursing staff completed training on [DATE]-[DATE], [DATE]-[DATE] and [DATE]-[DATE]. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Abuse, Neglect and Exploitation In-serviced revealed the most recent training for all staff at the facility was completed [DATE]-[DATE]. Review of the medical records for Resident # 1 revealed the resident was admitted to the facility on [DATE], readmitted on [DATE]. Clinical diagnoses included but not limited to: Chronic Obstructive Pulmonary Disease (COPD), Chronic, and Unspecified Dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Resident #1 was discharged on [DATE]. Review of the Physician's Orders Sheet for [DATE] revealed Resident #1 had orders that included but not limited to: order dated [DATE]: Transfer to [local hospital], Diagnosis: Fall/head trauma, order dated [DATE]-Recommend use of mechanical lift with nursing as needed. Medications included: Singular Tablet 10 Milligram (MG) -Give 1 tablet enterally at bedtime for COPD. Prednisone tablet 10 mg-give 1 tablet enterally one time a day related to COPD. Xanax Oral Tablet 0.5 MG -Give 1 tablet enterally one time a day related to anxiety disorder. Record review of Resident #1's Quarterly Minimum Data Set (MDS) dated [DATE] revealed: Section C for Cognitive Patterns documented the Brief Interview for Mental Status Score was unable to determine. Section E for Behaviors documented no behaviors exhibited. Section GG for Functional Abilities documented resident had Impairment on both sides of upper and lower extremities, dependent for transfer from chair to bed. Section K for Nutritional Status documented the resident weighed 100 pounds and is 60 inches in length, no unknown weight loss/gain. Section J for Health Conditions documented no shortness of breath, no falls since admission or readmission. Section N for Medications documented the resident was taking antianxiety medications. Section O for Special Treatments documented the resident was on oxygen therapy. Section P for Restraints documented the resident did not used any physical restraints or alarms. Record review of Resident # 1's Care Plans Dated [DATE] revealed: Resident#1 has a self-care deficit and needs staff assistance to perform and complete Activities of Daily Living (ADL's) secondary to: impaired mobility and dementia. Resident requires total assistance with all ADL functions. Interventions Included: mattress with bilateral side rail as recommended by manufacture. Recommend use of mechanical lift with nursing, bed to chair transfer as needed. Splint/Brace Bilateral hand rolls on at all times, may be remove for skin check and range of motion. Adaptive devices - Hip abductor brace/wheel on after morning care, off at nighttime. Observe for decline from current function and report if identified. Praise all attempts to complete tasks no matter how small. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Director of Nursing (DON) incident note on [DATE] timestamped 09:57 documented: Called to resident's room by assigned CNA upon entering the room the resident was observed on the floor lying next to bed and mechanical lift machine behind her, on assessment resident observed with an open area to nose bridge and with a split to upper left area of lips and bleeding from her mouth profusely. Pressure and ice applied; no other physical injuries were noted at this time. The resident was transferred back to bed with assist of 3 staff members, Head of bed elevated, head turned to the side to allow blood to run out freely. Blood pressure ,d+[DATE], heart rate 72, respirations 20, temperature 98.1, oxygen saturation 97% on nasal cannula. Neurological checks initiated. When asked what happened the CNA's stated while transferring the resident from the bed to the Geri chair with the use of a mechanical lifter with the assistance of two staff members, the machine went up abruptly too quick, the resident shift causing the machine to tilt and the resident slide out, unable to catch the resident on time she fell and her head hit the floor, nursing staff were called to the room immediately Nurse Practitioner was made aware of the resident clinical condition, order received to send the resident to the Hospital via 911, Diagnosis: Fall. 9:59 AM, 911 was called report given, nursing staff and respiratory team remains at the resident's bedside for close monitoring; 10:26 AM 911 arrived with three (3) personnel and took over however was not able to take resident to the hospital because their transportation broke down and they had to call for backup transportation. 10:46 AM the resident transferred to the Hospital accompanied by six (6) 911 attendants. Call placed to the hospital report given to emergency room nurse. Review of the nursing progress notes for Resident #1 dated [DATE] timestamped 14:00 documented: Call placed to the Hospital to check on the resident. Spoke with the emergency room nurse who stated that the resident had expired. Review of the Agency for Healthcare Administration (AHCA) immediate and five-day report revealed the reports were submitted timely. Date/Time of Incident: [DATE] 11:00 AM; Type of Incident: Neglect; Description of Incident: On [DATE] at 11:00 AM [Investigator from local community-based agency] came to the facility and met with the Administrator and DON regarding an allegation of neglect from an unknown caller received stating Resident #1 was raised six (6) feet high in the lifter then fell and hit her head and was transferred to the hospital where she expired. A comprehensive investigation was conducted which included medical record review, safety inspection of the mechanical lift, and staff interviews. On [DATE] at approximately 8:30 AM, a Detective from the local Police Department Criminal Investigations Division met with the Administrator and stated the medical examiner determined the cause of [Resident #1's] death was blunt force trauma due to an accident. Upon conclusion of the investigations, it appeared that during the transfer with the mechanical lift CNA, [Staff A], while trying to move the foot of the machine may have inadvertently pushed the remote with her body causing the lift to extend resulting in CNA [Staff B], reaching out to hold the lifter pad in attempt to keep the resident safe which caused the pad to tilt resulting in the resident accidentally falling from the lift. Our investigation concluded the neglect was unsubstantiated. facility's protocol was followed for mechanical transfer. Review of the adverse incident report revealed the report was submitted timely on [DATE]. The adverse report concluded CNA [Staff A] may have inadvertently push the remote with her body as she was moving the lift, which cause the lift to continue to rise in the air prompting CNA [Staff B] to grab onto the resident's lift pad causing the resident to fall. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on [DATE] at 12:58 PM the Maintenance Director stated: Currently there are nine (9) Mechanical lifts in the facility, we had 3 lifts on each floor (2nd and 3rd floor) for a total of 6, 1 in the maintenance area (Lift #846) that was involved in the incident with the resident and 2 new mechanical lifts that are now on the floor, one additional mechanical lift on each floor, for a total of 9. The most recent inspection for all the mechanical lifts started on [DATE] to [DATE]. The inspection date posted on the lifts are [DATE]. Prior inspections of the lifts were completed on [DATE] and [DATE].(medical equipment representative completed inspections after incident on [DATE]) On [DATE] at 11: 00 AM the Maintenance Director stated he started at the facility in mid-[DATE], he received training on [DATE] on the mechanical lifts from the representative from the medical equipment company, the training was about how to inspect the parts on the mechanical lifts to make sure they are in working order, all parts are clean and well maintained, this is to be completed monthly. If a part is broken or not working correctly on the mechanical lifts, they are not repaired they are replaced. What we do is we take the mechanical lift that is not functioning correctly off of the floor, order the needed part or parts, replace the part when received, inspect the mechanical lift for proper functioning and then we put the lift back on the floor for use. [Company Names] are the manufacturers of the 9 lifts that we have at the facility, currently they are all working/functioning correctly. Lift #846 (the mechanical lift involved in the incident with the resident) is not on the floor at this time, we have the lift stored in the maintenance area as instructed by the management. This Surveyor verified lift #846 is in working order and stored in maintenance room though observation and staff demonstration of the lift operating correctly. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on [DATE] at 11:07 AM the Medical Equipment Company Representative stated: I have been selling medical supplies and equipment for thirty (30) years, the medical equipment company is my company, I am a licensed Durable Medical Equipment company (DME) licensed and regulated by AHCA. Any equipment we sell to the facilities, we make sure we familiarize ourselves with the manuals and operating instruction. For mechanical lifts, manufacturers usually suggest preventative maintenance which may include cleaning lifts, detecting wear and damage monthly, lubricating the lift, and performing regular maintenance. The facility is currently checking the lifts monthly and my company oversees the facility's maintenance program. Approximately every six (6) months, during the monthly maintenance, and at any time if there is an issue with the lifts. If there is an issue with a mechanical lift, the maintenance team calls my company and order the parts needed for the repair and use the company personnel if needed for additional instructions on replacing the mechanical lifts parts. The parts on the mechanical lifts are never repaired they are always replaced if they are not functioning correctly. When I came to the facility on [DATE] I completed a visual inspection of all the mechanical lifts at the facility, I ran the lifts through their paces (extended the arm to its maximum height and depth), the mechanical lifts at the facility are electrical, they either work or they do not work, there is no in-between. The only parts that can truly malfunction is the remote-control button not working, or the lever that moves the lift up and down (actuator) stops moving. The levers and the remote controls on the mechanical lifts are the additional areas I checked on [DATE]. The operating instructions are the same for all three of the manufacturers of the mechanical lifts the facility has in stock and are currently using. I am a provider for all types of medical equipment, mechanical lifts, electrical beds, etc. When I train the facility staff, I ask them to put the mechanical lifts through its paces-make sure that all functioning parameters are working correctly-lifts opens and closes, goes up and down, brakes on the wheels locks and unlocks correctly etc. The evaluation of the training is on a pass or fail scale. The training I provide to the maintenance staff is completed/conducted in a very relaxed atmosphere and is very hands on, with live inspections and questions and answers in real time that must be answered and understanding verbalized before we move on to another area of the training. For example, for the mechanical lifts- the wheels ([NAME] Base) the training would be to visually inspect there are no missing wheels, casters, no debris, casters are attached correctly smooth, swivel and roll. The boom (Overhead bar) and mast (main pole)-visual inspections-Check the hardware and hangings for wear, make sure the boom is centered. Hanger bar-check the hooks, check the connection to the boom. Actuator assembly (motor)-inspect the hardware connected to the other parts of the machine, check for wear and deterioration (any loose parts). Lastly put the mechanical through its paces (up and down to its maximum level using the remote control) to ensure the lift is fully functional. As a vendor for all the medical equipment it is my job to be familiar with all the manufacturer manuals and pass on the information about the equipment to the facilities I work with, obviously the facility develops their own standards and policies and procedures for their staff to follow. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on [DATE] at 1:28 PM CNA, Staff B, (7:00 AM to 3:00 PM shift), 3rd floor stated I was one of the CNAs involved in the incident with the resident. I have been working here for over [AGE] years, I do this work because I love this work. On that particular morning after the resident received morning care I called the other CNA, [Staff A] for assistance with the transfer of the resident using the mechanical lift, we did our color code for the hook up of the lift pad and used a medium lift pad, upon hooking the pad to the lift [Staff A] came to the side where I was after hooking up the pad to the lift, myself and Staff A elevate the mechanical lift over the bed a little bit, checked the lift pad to make sure it was secure by pulling on it, [Staff A] pulled the lift out from over the bed a little bit then opened the legs of the lift for balance, [Staff A] held on to the lift and I held on to the lift pad on the side while [Staff A] continued to pull the mechanical lift out from over the bed at a safe height, the lift started to go up in the air, I held unto the pad on the side tighter, the pad tilted away from me to the opposite side with the resident inside and the resident fell out of the lift pad onto the floor at the side of the bed. I ran to call the nurse while [Staff A] stayed with the resident. I saw blood on the floor, the resident was bleeding from somewhere on the head, I just saw blood. The Licensed Practical Nurse (LPN), [Staff C] came and started her assessment on the resident and stated she needed help to get the resident into the bed. Myself [Staff A] and LPN, [Staff C] picked the resident up together and placed the resident in bed. At that time several nurses came into the room to help with the resident, and I went out of the room. On [DATE] the same day I received an in-service and several times after, the most recent was this morning on the mechanical lifts-operation, safety, how to use-what size lift pad the resident requires, get the correct size pad, make sure the mechanical lift is functioning correctly-check to make sure the battery is charged, use the remote control to make sure the lift goes up and down, emergency button is working-turn the lever and the weight of the resident will lower the lift on one machine, on the other machine pull up the emergency button and the lift is lowered back down with the resident. Since the incidents I have had several random observations completed by nurses and the charge nurses to make sure I am doing my transfers correctly. The feedback I have received so far, is that I am doing my transfers correctly. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on [DATE] at 2:15 PM CNA, Staff A (7:00 AM to 3:00 PM shift), 3rd floor stated: I have been working at this facility for two years. I was one of the CNAs involved in the incident with the resident. On [DATE] in the morning I was called by CNA [Staff B] to assist her with a mechanical lift transfer for [Resident #1], I went to the room, she had already checked the lift pad and the lift, I was operating the lift, while CNA [Staff B] was tending to the resident, I press the remote to start lifting the resident up from the bed, I started to move the resident towards the Geri chair in the lift, I started to pull the machine towards me and I may have accidentally press on the remote control, I was moving the machine towards me to turn and I did not notice the lift was going up, CNA [Staff B] grabbed the resident and the lift pad, I never saw the resident falling out of the lift pad, I noticed the resident on the floor, there was blood on the floor and on the resident's head on the side and her nose was bleeding. CNA [Staff B] went out of the room to call the nurse for assistance, I stayed in the room. LPN [Staff C] came to the room and assessed the resident, all three of us work together to put the resident back in bed. At that time several staff came into the room to help, and I left the room. I have been observed completing transfers with other staff by the Director of Nursing (DON), Assistant Director of Nursing (ADON) and several other nurses. Also, I have been retrained several times since the incident about the mechanical lift. mechanical lifts-operation, safety, how to use-what size lift pad the resident requires, get the correct size pad, make sure the mechanical lift is functioning correctly-check to make sure the battery is charged, use the remote control to make sure the lift goes up and down, emergency button is working-turn the lever and the weight of the resident will lower the lift on one machine, on the other machine pull up the emergency button and the lift is lowered back down with the resident. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on [DATE] at 2:30 PM LPN Staff C, stated: I was the nurse that the CNAs [Staff B] came and got to check on the resident, I went into the room, the resident was lying on the floor, there was blood on her face and head, I turned the resident on the side on the floor, I grabbed a sheet and with the help of the other two CNAs [Staff A and Staff B] we placed the resident into the bed. I activated the rescue team-call for additional help, the assigned nurse for the resident came in the room, I called 911, other nurses were in the room helping with the assessment/care of the resident, another nurse called the physician, orders were received to transfer the resident to the hospital. I cleaned the resident's face, the blood was coming from a laceration on the nose and left upper lip, gauze was placed and pressure applied to help stop the bleeding, the resident's head was elevated in the bed, the respiratory therapist applied oxygen to the resident via non-rebreather bag, the resident had an order for continuous oxygen via nasal cannula and an enteral tube. I left the room when the rapid response team came in the room to get the paperwork ready for the resident's transfer. Rescue arrived, and started working on the resident, trying to put an IV (Intravenous line) on the resident, I'm not sure why, they stayed in the room for about 15 to 20 minutes with the resident before transporting the resident out of the facility. An additional rescue team showed up with the gurney for transport and took the resident out of the facility. At the time of the transport, the resident was alive and being taken care of by the rescue team. The same day [DATE] I received in-service on mechanical lift-safety, how to use, make sure battery is charge, we have electric and battery-operated mechanical lifts, make sure the base of legs are open for balance during transfer, lift pad is in good conditions, check the wheels that they can lock and unlock, how and when to use the emergency button to stabilize and lower the lift, do not grab onto the resident. The DON, and the lift technician provided the in-services, and I have received several in-services since the incident. After the incident I was observed by the ADON and nurse manager during a transfer of a resident with a CNA, it has to be two people for lift transfers at all times. The Kardex task list have the information on what size mechanical lift pad to use for transfer for the resident, the lift pads range from small to extra-large. The lift pads are in the laundry department in the morning, once the residents are in bed at night, the lift pads are taken to the laundry to be washed. In the back of the pad the size is written on it and there is a color code circle for each size. Interview on [DATE] at 7:22 AM the Administrator (NHA) stated: I have been working at this facility for 3 weeks, this incident occurred on my second day of work at the facility. The DON alerted me that an incident has taken place with the resident, I went to the room, the resident was on the bed, they were several nursing staff in the room providing care while waiting for 911 rescue to arrive, the rescue truck broke down in front of the facility, so they had to call for another rescue to arrive. It took approx. 20 minutes for the second rescue to arrive, the resident left the facility alive, she was bleeding from the laceration on her lip. I did a follow up call to the resident's daughter after learning about the resident's death at the hospital and I called the resident's daughter with the DON present after the resident left the facility. I called maintenance to inspect the lift involved, Interviewed the two CNAs involved, and started a root cause analysis report about the incident. The next day the medical equipment vendor came to the facility and conducted training and competencies with maintenance staff and some nurses and CNAs and inspected all the Mechanical lifts to make sure they were functioning correctly. We completed mechanical lift competencies with the two CNAs involved in the incident and then continued with the other nursing staff. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 7:41 PM, with the ADON, DON/QAPI/Risk Manager; the DON stated that on [DATE] in the morning at around 9:55 AM, we got a call from the nurse manger to come to the 3rd floor, I went to the resident's room, I saw the resident in the bed receiving care from staff, they were trying to stop the bleeding from the nose and the mouth, the Mechanical lift was in the room on the side of the bed, I asked the staff what happened, everyone was busy working on the resident. CNAs [Staff B] explained to me she and another CNA [Staff A] were transferring the resident from the bed to the Geri-chair, she was guiding the resident and CNA [Staff A] was operating the lift. She noticed the lift started moving upwards and she grabbed onto the lift pad, the resident flipped out of the lift pad and fell to the floor. The DON stated: The mechanical lift was extended to its highest when I went into the room and the bar that the sling hooks onto was above my head, I am 5 feet 9 inches tall. [Staff A] and [Staff B] were so devastated, and I really could not get any more information from them at that time. I made sure rescue was on the way, rescue arrived at the facility, they wanted to know what happened to the resident, we explained about the fall, they took over the care of the resident, they placed a Nonrebreather mask on the resident, they could not take the resident right away because the rescue truck broke down at the facility, about 20 minutes later another rescue team came and took the resident to the hospital, the resident's daughter was called, we informed her of what happened. At that point the resident's oxygen saturation was fluctuating and her vitals were not stable. We started to do in-services right away with the CNAs and nurses on the 3rd floor, checked the machine right away for functioning, the maintenance director did not find any issues with the machine, but we removed the lift from the floor, the same day we started training and completing competencies for nurses and CNAs on mechanical lift transfers and was able to complete all nursing staff by [DATE]. Currently we are conducting weekly random competencies on every shift for nurses and CNAs, this is being conducted by myself (DON), ADON, unit managers and supervisors. As the risk manager on [DATE] we started an investigation to see if any staff had issues with the mechanical lifts prior to that day. We interviewed the two CNAS involved, [Staff A] and [Staff B] again that day, we had them walk us through the steps of what happened to see if they were following the facility policies and protocols. We discovered the machine was not the issue and one of the CNAs [Staff B] was the one that cause the incident by the way she grabbed onto the lift pad. I filed a neglect report based on the report from [local community-based agency] on [DATE] and completed the five-day investigation and submitted the reports timely. The adverse report was submitted on [DATE] after we completed our investigation. Our investigation concluded the neglect was unsubstantiated. Facility protocol was followed for mechanical transfer. The adverse report concluded CNAs [Staff A] may have inadvertently push the remote with her body as she was moving the lift, which cause the lift to continue to rise in the air prompting CNA [Staff B] to grab onto the resident's lift pad causing the resident to fall to the floor. Our last Quality Assurance and performance Improvement (QAPI) meeting was on [DATE], usually our QAPI meeting is the last Thursday of the month, and the last meeting prior to the [DATE] meeting was on [DATE]. We discussed all of our deficiencies from the AHCA recertification survey exit date [DATE], interventions were put in place, education was provided to the resident about why sharp razors cannot be kept at the bedside, we educated and retrained nursing staff, housekeeping, rehabilitation staff and other staff that visit resident's room about when doing rounds to check for any safety issues and report it to the nurse or nurse managers if any issues are found. Education was provided to residents and their family verbally about safety issues with razors and other items brought in the facility from outside. The QAPI meeting on [DATE] we discussed noncompliance regarding repeated deficiencies. We discussed the incident that occurred with Resident#1, investigated the root cause analysis of the incident, set goals for Education and competency for the nursing staff about safely completed mechanical lift transfers without any incident, Implemented a Performance Improvement Plan (PIP)and put a system in place for reporting findings from the PIP. (continued on next page)

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's immediate Jeopardy Removal Plan included: [DATE]-Competency/training Mechanical Lift operations completed for CNAs Staff A and Staff B [DATE]-Medical Equipment Company checked all mechanical lifts to make sure they were functioning properly; no areas of concern were reported. [DATE]-Safe Handling policy for Mechanical lifts were reviewed with DON, ADON, NHA, Unit Managers, attendees were documented on the [DATE] QAPI sign in sheet. [DATE]-Reviewed Federal reports reviewed AHCA Immediate, Five- day and Adverse Incident Report-the reports were submitted timely. [DATE]-[DATE]-Safe and Proper Handling of Mechanical lifts training/competencies-completed for all nurses and CNAs. [DATE]-Reviewed interviews for alert residents and family interviews for alert residents about safety and abuse/neglect. [DATE]-Abuse and Neglect policy reviewed and revised [DATE], revisions were implemented in the employee training section. [DATE] New Abuse Investigate Protocol checklist was implemented, DON. ADON, NHA, SSD were in-serviced on the new form. [DATE]-In service on Abuse, Neglect and Exploitation was completed for all staff at the facility. [DATE]-The sixty (60) residents requiring Mechanical lift for transfers, care plans were reviewed.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45019 Based on observations, interviews and record review the facility's Certified Nursing Assistants (CNAs), (Staff A) and (Staff B) failed to ensure Resident #1 was safely transferred from the bed to the chair with a mechanical lift. The facility failed to effectively inspect, complete accurate safety check and maintain the mechanical lift to ensure it is safely operating during the transfer of Resident #1. This failure to ensure the mechanical lift is operating in a safe manner resulted in Resident # 1 falling from the mechanical lift on [DATE] at 9:57 AM while Certified Nursing Assistants (CNAs) Staff A and Staff B were transferring Resident #1 from bed to chair, Staff A and Staff B reported that during the transfer the mechanical lift kept rising and when Staff B grabbed the lift pad to stop it from going higher, Resident #1 suddenly fell from the lift and landed face down on the floor sustaining injuries to the head. Resident # 1 expired at the hospital approximately four (4) hours after the fall. There were 60 residents residing in the facility that required use of a mechanical lift for transfer. Refer to F 600, F 867, and F 908. The findings included: Review of the facility policy and procedures titled Safe Resident Handling Transfers revision date ,d+[DATE] states: It is the policy of this facility to ensure that residents are handled and transferred safely to prevent or minimize risks for injury and provide and promote a safe, secure and comfortable experience for the resident while keeping the employees safe in accordance with current standards and policies. Compliance guidelines: 3. Mechanical lifting equipment or other approved transferring aids will be used based on the residents' needs to prevent manual lifting except in medical emergencies. 4. Mechanical lifts may include equipment such as full body lifts, sit to stand lifts, or ceiling track mounted lifts. 6. The staff will inspect the equipment prior to use to ensure functionality and will alert maintenance or other designee if the equipment is not functioning properly. 7. Damaged, broken, or improperly functioning lift equipment will not be used and tagged out according to facility policy. 8. The facility will ensure there are appropriately amounts of varying sizes of slings to accommodate residents and that residents will be measured correctly as per manufacturer's instructions on proper sling size. 9. Ensure that the sling designed for the lift is utilized with that specific lift. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	10. Two staff members must be utilized when transferring residents with a mechanical lift 11. Staff will be educated on the use of safe handling/ transfer practices to include use of mechanical lift devices upon hire, annually and as the need arises or changes in equipment occur. 12. The staff must demonstrate competency in the use of the mechanical lifts prior to use and annually with documentation of the competency placed in their education file. 14. Resident lifting and transferring will be performed according to the resident/s individual care plan. Review of the facility policy and procedures titled Accidents and Incidents dated [DATE] states: It is the policy of the facility to report accidents and incidents in accordance to state and federal regulations. Procedure: 1. The facility will ensure that: a. The resident environment remains as free from accident hazards as is possible; and b. Each resident receives adequate supervision and assistance devices to prevent accidents. 2. The facility will provide an environment that is free from accidents hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents. This includes: a. Identify hazard (s) and risk(s). b. Evaluating and analyzing hazard(s) and risk(s). c. Implementing interventions to reduce hazard(s) and risk(s); and d. Monitoring for the effectiveness and modifying interventions when necessary. On [DATE] during a focused tour starting at 8:50 AM on the 2nd and 3rd floor units, revealed four mechanical lifts on the 2nd floor unit and four mechanical lifts on the 3rd floor unit with inspection stickers dated [DATE], [DATE], [DATE] (Photos available) Review of the Mechanical Lift preventative maintenance log documented the lifts were inspected for safety and functioning by maintenance staff prior to [DATE] on [DATE]. The lifts were inspected after [DATE] on [DATE] and [DATE]. Review of the Mechanical Lift training/Competency revealed Certified Nursing Assistant (Staff A) completed training on [DATE], [DATE] and [DATE]. Staff B completed training on [DATE], [DATE] and [DATE]. All other nursing staff completed training on [DATE]-[DATE], [DATE]-[DATE] and [DATE]-[DATE]. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Agency for Healthcare Administration (AHCA) immediate and five-day report revealed the reports were submitted timely. Date/Time of Incident: [DATE] 11:00 AM; Type of Incident: Neglect; Description of Incident: On [DATE] at 11:00am, a [community-based agency investigator] came to the facility and met with the Administrator and DON regarding an allegation of neglect from an unknown caller received stating [Resident #1] was raised six (6) feet high in the lifter then fell and hit her head and was transferred to the hospital where she expired. A comprehensive investigation was conducted which included medical record review, safety inspection of the mechanical lift, and staff interviews. On [DATE] at approximately 8:30 AM a Detective from the local Police Department Criminal Investigations Division met with the Administrator and stated the medical examiner determined the cause of [Resident #1's] death was blunt force trauma due to an accident. Upon conclusion of the investigations, it appeared that during the transfer with the mechanical lift CNA, Staff A, while trying to move the foot of the machine may have inadvertently pushed the remote with her body causing the lift to extend resulting in CNA, [Staff B], reached out to hold the lifter pad in attempt to keep the resident safe which caused the pad to tilt resulting in the resident accidentally falling from the lift. Our investigation concluded the neglect was unsubstantiated; the facility's protocol was followed for mechanical transfer. Review of the adverse incident report revealed the report was submitted timely on [DATE]. The adverse report concluded CNAs [Staff A] may have inadvertently push the remote with her body as she was moving the lift, which cause the lift to continue to rise in the air prompting CNA [Staff B] to grab onto the resident's lift pad causing the resident to fall. Review of the medical records for Resident # 1 revealed the resident was admitted to the facility on [DATE], readmitted on [DATE]. Clinical diagnoses included but not limited to: Chronic Obstructive Pulmonary Disease (COPD), Unspecified Dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Resident #1 was discharged on [DATE]. Review of the Physician's Orders Sheet for [DATE] revealed Resident #1 had orders that included but not limited to: order dated [DATE]- Transfer to [local hospital], Diagnosis: Fall/head trauma, order dated [DATE]- Recommend use of mechanical lift with nursing as needed. Medications included: Singulair Tablet 10 Milligram (MG) -Give 1 tablet enterally at bedtime for COPD. Prednisone tablet 10 mg-give 1 tablet enterally one time a day related to COPD. Xanax Oral Tablet 0.5 MG -Give 1 tablet enterally one time a day related to anxiety disorder, Record review of Resident #1's Quarterly Minimum Data Set (MDS) dated [DATE] revealed: Section C for Cognitive Patterns documented the Brief Interview for Mental Status Score was unable to determine. Section E for Behaviors documented no behaviors exhibited. Section GG for Functional Abilities documented resident had Impairment on both sides of upper and lower extremities, dependent for transfer from chair to bed. Section K for Nutritional Status documented resident weighed 100 pounds and is 60 inches in length, no unknown weight loss/gain. Section J for Health Conditions documented no shortness of breath, no falls since admission or readmission. Section N for Medications documented the resident was taking antianxiety medications. Section O for Special Treatments documented the resident was on oxygen therapy. Section P for Restraints documented the resident did not used any physical restraints or alarms. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's Care Plans dated [DATE] revealed: Resident#1 has a self-care deficit and needs staff assistance to perform and complete Activities of Daily Living (ADL's) secondary to: impaired mobility and dementia. Resident requires total assistance with all ADL functions. Interventions Included: Mattress with bilateral side rail as recommended by manufacture. Recommend use of mechanical lift with nursing, bed to chair transfer as needed. Splint/Brace Bilateral hand rolls on at all times, may be remove for skin check and range of motion. Adaptive devices - Hip abductor brace/wheel on after morning care, off at nighttime. Observe for decline from current function and report if identified. Praise all attempts to complete tasks no matter how small. Review of the Director of Nursing (DON) incident note on [DATE] timestamped 09:57 documented: Called to resident's room by assigned CNA upon entering the room the resident was observed on the floor lying next to bed and mechanical lift machine behind her, on assessment resident observed with an open area to nose bridge and with a split to upper left area of lips and bleeding from her mouth profusely. Pressure and ice applied; no other physical injuries were noted at this time. The resident was transferred back to bed with assist of 3 staff members, Head of bed elevated, head turned to the side to allow blood to run out freely. Blood pressure ,d+[DATE], heart rate 72, respirations 20, temperature 98.1, oxygen saturation 97% on nasal cannula. neurological checks initiated. When asked what happened the CNA's stated while transferring the resident from the bed to the chair with the use of a mechanical lifter with the assistance of two staff members, the machine went up abruptly too quick, the resident shift causing the machine to tilt and the resident slide out, unable to catch the resident on time she fell and her head hit the floor, nursing staff were called to the room immediately. Nurse Practitioner was made aware of the resident clinical condition, order received to send the resident to the hospital via 911, Diagnosis: Fall. 9:59 AM, 911 was called report given, nursing staff and respiratory team remains at the resident's bedside for close monitoring, 10:26 AM 911 arrived with three (3) personal and took over however was not able to take resident to the hospital because their transportation broke down and they had to call for backup transportation. 10.46 AM the resident transferred to the hospital accompanied by six (local emergency rescue) attendants. Call placed to the hospital report given to emergency room nurse. Review of the nursing progress notes for Resident #1 dated [DATE] timestamped 14:00 documented: Call placed to the hospital to check on the resident. Spoke with the emergency room nurse who stated that the resident had expired. Interview on [DATE] at 12:58 PM the Maintenance Director stated: Currently there are nine Mechanical lifts in the facility, we had three lifts on each floor (2nd and 3rd floor) for a total of six; one in the maintenance area (Lift #846) that was involved in the incident with the resident and two new mechanical lifts that are now on the floor, one additional mechanical lift on each floor, for a total of nine The most recent inspection for all the mechanical lifts started [DATE] to [DATE]. The inspection date we posted on the lifts are [DATE]. Prior inspections of the lifts were completed on [DATE]. (the medical equipment company did a visual inspection) (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on [DATE] at 11:00; the AM the Maintenance Director stated he started at the facility in mid-[DATE], he received training on [DATE] on the mechanical lifts from the representative from medical equipment company, the training was about how to inspect the parts on the mechanical lifts to make sure they are in working order, all parts are clean and well maintained, this is to be completed monthly. If a part is broken or not working correctly on the mechanical lifts, they are not repaired they are replaced. We take the mechanical lift that is not functioning correctly off of the floor, order the needed part or parts, replace the part when received, inspect the mechanical lift for proper functioning and then we put the lift back on the floor for use. [Company name] are the manufacturers of the nine lifts that we have at the facility, currently they are all working/functioning correctly. Lift #846 (the mechanical lift involved in the incident with the resident) is not on the floor at this time, we have the lift stored in the maintenance area as instructed by management. This surveyor verified lift #846 is in working order and stored in maintenance room though observation and staff demonstration of the lift operating correctly. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on [DATE] at 11:07 AM the medical equipment company representative stated: I have been selling medical supplies and equipment for thirty (30) years, the medical equipment company is my company, I am a licensed Durable Medical Equipment company (DME) licensed and regulated by AHCA. Any equipment we sell to the facilities, we make sure we familiarize ourselves with the manuals and operating instruction. For mechanical lifts, manufacturers usually suggest preventative maintenance which may include cleaning lifts, detecting wear and damage monthly, lubricating the lift, and performing regular maintenance. The facility is currently checking the lifts monthly and my company oversees the facility's maintenance program. Approximately every six (6) months, during the monthly maintenance, and at any time if there is an issue with the lifts. If there is an issue with a mechanical lift, the maintenance team calls my company and order the parts needed for the repair and use the company personnel if needed for additional instructions on replacing the mechanical lifts parts. The parts on the mechanical lifts are never repaired they are always replaced if they are not functioning correctly. When I came to the facility on [DATE], I completed a visual inspection of all the mechanical lifts at the facility, I ran the lifts through their paces (extended the arm to its maximum height and depth), the mechanical lifts at the facility are electrical, they either work or they do not work, there is no in-between. The only parts that can truly malfunction is the remote-control button not working, or the lever that moves the lift up and down (actuator) stops moving. The levers and the remote controls on the mechanical lifts are the additional areas I checked on [DATE]. The operating instructions are the same for all three of the manufacturers of the mechanical lifts the facility has in stock and are currently using. I am a provider for all types of medical equipment, mechanical lifts, electrical beds, etc. When I train the facility staff, I ask them to put the mechanical lifts through its paces-make sure that all functioning parameters are working correctly-lifts opens and closes, goes up and down, brakes on the wheels locks and unlocks correctly etc. The evaluation of the training is on a pass or fail scale. The training I provide to the maintenance staff is completed/conducted in a very relaxed atmosphere and is very hands on, with live inspections and questions and answers in real time that must be answered and understanding verbalized before we move on to another area of the training. For example, for the mechanical lifts- the wheels ([NAME] Base) the training would be to visually inspect there are no missing wheels, casters, no debris, casters are attached correctly smooth, swivel and roll. The boom (Overhead bar) and mast (main pole)-visual inspections-check the hardware and hangings for wear, make sure the boom is centered. Hanger bar-check the hooks, check the connection to the boom. Actuator assembly (motor)-inspect the hardware connected to the other parts of the machine, check for wear and deterioration (any loose parts). Lastly put the mechanical through its paces (up and down to its maximum level using the remote control) to ensure the lift is fully functional. As a vendor for all the medical equipment it is my job to be familiar with all the manufacturer manuals and pass on the information about the equipment to the facilities I work with, obviously the facility develops their own standards and policies and procedures for their staff to follow. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on [DATE] at 1:28 PM CNA, Staff B, 7:00 AM to 3:00 PM shift, 3rd floor stated: I was one of the CNAs involved in the incident with the resident. I have been working here for over [AGE] years, I do this work because I love this work. On that particular morning after the resident received morning care I called the other CNA, [Staff A] for assistance with the transfer of the resident using the mechanical lift, we did our color code for the hook up of the lift pad and used a medium lift pad, upon hooking the pad to the lift [Staff A] came to the side where I was after hooking up the pad to the lift, myself and [Staff A] elevate the mechanical lift over the bed a little bit, checked the lift pad to make sure it was secure by pulling on it, [Staff A] pulled the lift out from over the bed a little bit then opened the legs of the lift for balance, [Staff A] held on to the lift and I held on to the lift pad on the side while [Staff A] continued to pull the mechanical lift out from over the bed at a safe height, the lift started to go up in the air, I held unto the pad on the side tighter, the pad tilted away from me to the opposite side with the resident inside and the resident fell out of the lift pad onto the floor at the side of the bed. I ran to call the nurse while [Staff A] stayed with the resident. I saw blood on the floor, the resident was bleeding from somewhere on the head, I just saw blood. The Licensed Practical Nurse (LPN), [Staff C] came and started her assessment on the resident and stated she needed help to get the resident into the bed. Myself, [Staff A] and LPN, [Staff C] picked the resident up together and placed the resident in bed. At that time several nurses came into the room to help with the resident, and I went out of the room. On [DATE] the same day I received an in-service and several times after, the most recent was this morning on the mechanical lifts-operation, safety, how to use-what size lift pad the resident requires, get the correct size pad, make sure the mechanical lift is functioning correctly-check to make sure the battery is charged, use the remote control to make sure the lift goes up and down, emergency button is working-turn the lever and the weight of the resident will lower the lift on one machine, on the other machine pull up the emergency button and the lift is lowered back down with the resident. Since the incidents I have had several random observations completed by nurses and the charge nurses to make sure I am doing my transfers correctly. The feedback I have received so far, is that I am doing my transfers correctly. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on [DATE] at 2:15PM CNA, [Staff A] 7:00 AM to 3:00 PM shift, 3rd floor stated: I have been working at this facility for two years. I was one of the CNAs involved in the incident with the resident. On [DATE] in the morning I was called by CNA [Staff B] to assist her with a mechanical lift transfer for [Resident #1], I went to the room, she had already checked the lift pad and the lift, I was operating the lift, while CNA [Staff B] was tending to the resident, I press the remote to start lifting the resident up from the bed, I started to move the resident towards the Geri chair in the lift, I started to pull the machine towards me and I may have accidentally press on the remote control, I was moving the machine towards me to turn and I did not notice the lift was going up, CNA [Staff B] grabbed the resident and the lift pad, I never saw the resident falling out of the lift pad, I noticed the resident on the floor, there was blood on the floor and on the resident's head on the side and her nose was bleeding. CNA [Staff B] went out of the room to call the nurse for assistance, I stayed in the room. LPN [Staff C] came to the room and assessed the resident, all three of us work together to put the resident back in bed. At that time several staff came into the room to help, and I left the room. I have been observed completing transfers with other staff by the Director of Nursing (DON), Assistant Director of Nursing (ADON) and several other nurses. Also, I have been retrained several times since the incident about the mechanical lift. mechanical lifts-operation, safety, how to use-what size lift pad the resident requires, get the correct size pad, make sure the mechanical lift is functioning correctly-check to make sure the battery is charged, use the remote control to make sure the lift goes up and down, emergency button is working-turn the lever and the weight of the resident will lower the lift on one machine, on the other machine pull up the emergency button and the lift is lowered back down with the resident. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on [DATE] at 2:30PM LPN Staff C, stated: I was the nurse that the CNAs [Staff B] came and got to check on the resident, I went into the room, the resident was lying on the floor, there was blood on her face and head, I turned the resident on the side on the floor, I grabbed a sheet and with the help of the other two CNAs Staff a and [Staff B] we placed the resident into the bed. I activated the rescue team-call for additional help, the assigned nurse for the resident came in the room, I called 911, other nurses were in the room helping with the assessment/care of the resident, another nurse called the physician, orders were received to transfer the resident to the hospital. I cleaned the resident's face, the blood was coming from a laceration on the nose and left upper lip, gauze was placed and pressure applied to help stop the bleeding, the resident's head was elevated in the bed, the respiratory therapist applied oxygen to the resident via non-rebreather bag, the resident had an order for continuous oxygen via nasal cannula and an enteral tube. I left the room when the rapid response team came in the room to get the paperwork ready for the resident's transfer. Rescue arrived, and started working on the resident, trying to put an IV (intravenous line) on the resident, I'm not sure why, they stayed in the room for about 15 to 20 minutes with the resident before transporting the resident out of the facility. An additional rescue team showed up with the gurney for transport and took the resident out of the facility. At the time of the transport, the resident was alive and being taken care of by the rescue team. The same day [DATE] I received in-service on mechanical lift-safety, how to use, make sure battery is charge, we have electric and battery-operated mechanical lifts, make sure the base of legs are open for balance during transfer, lift pad is in good conditions, check the wheels that they can lock and unlock, how and when to use the emergency button to stabilize and lower the lift, do not grab onto the resident. The DON, and the lift technician provided the in-services, and I have received several in-services since the incident. After the incident I was observed by the ADON and nurse manager during a transfer of a resident with a CNAs, it has to be two people for lift transfers at all times. The Kardex task list have the information on what size mechanical lift pad to use for transfer for the resident, the lift pads range from small to extra-large. The lift pads are in the laundry department in the morning, once the residents are in bed at night, the lift pads are taken to the laundry to be washed. In the back of the pad the size is written on it and there is a color code circle for each size. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on [DATE] at 7:22AM Administrator (NHA) stated: I have been working at this facility for 3 weeks, this incident occurred on my second day of work at the facility. The DON alerted me that an incident has taken place with the resident, I went to the room, the resident was on the bed, they were several nursing staff in the room providing care while waiting for 911 rescue to arrive, the rescue truck broke down in front of the facility, so they had to call for another rescue to arrive. It took approximately 20 minutes for the second rescue to arrive, the resident left the facility alive, she was bleeding from the laceration on her lip. I did a follow up call to the resident's daughter after learning about the resident's death at the hospital and I called the resident's daughter with the DON present after the resident left the facility. I called maintenance to inspect the lift involved, Interviewed the two CNAs involved, and started a root cause analysis report about the incident. The next day the medical equipment vendor came to the facility and conducted training and competencies with maintenance staff and some nurses and CNAs and inspected all the mechanical lifts to make sure they were functioning correctly. We completed mechanical lift competencies with the two CNAs involved in the incident and then continued with the other nursing staff. We had a Quality Assurance and performance Improvement (QAPI) meeting to review our findings and set goals for compliance. Currently trainings and competencies are ongoing, we are conducting random observations of staff performing mechanical lift transfers with residents and we are going to continue to monitor the progress through QAPI. The staff and team are very receptive to the trainings and competencies that we have put in place. The purpose of the QAPI is having a forum where the interdisciplinary (IDT) team have an opportunity to bring issues to the team so we can rectify and implement interventions, put a plan in place, measure interventions through audits for effectiveness and revise plans and interventions as needed. (continued on next page)

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Regents Park at Aventura	18905 NE 25th Ave Aventura, FL 33180

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on [DATE] at 7:41 PM with the ADON, DON/QAPI/Risk Manager; the ADON stated I started working at the facility in [DATE]. The DON stated she has been working at the facility since 2013. On [DATE] in the morning at around 9:55AM, we got a call from the nurse manger to come to the 3rd floor, I went to the resident's room, I saw the resident in the bed receiving care from staff, they were trying to stop the bleeding from the nose and the mouth, the mechanical lift was in the room on the side of the bed, I asked the staff what happened, everyone was busy working on the resident. CNA [Staff B] explained to me she and another CNA [Staff A] were transferring the resident from the bed to the Geri-chair, she was guiding the resident and CNA [Staff A] was operating the lift. She noticed the lift started moving upwards and she grabbed onto the lift pad, the resident flipped out of the lift pad and fell to the floor. The DON stated: The mechanical lift was extended to its highest when I went into the room and the bar that the sling hooks onto was above my head, I am 5 feet 9 inches tall. Staff A and Staff B were so devastated, and I really could not get any more information from them at that time. I made sure rescue was on the way, rescue arrived at the facility, they wanted to know what happened to the resident, we explained about the fall, they took over the care of the resident, they placed a Nonrebreather mask on the resident, they could not take the resident right away because the rescue truck broke down at the facility, about 20 minutes later another rescue team came and took the resident to the hospital, the Resident's daughter was called, we informed her of what happened. At that point the resident's oxygen saturation was fluctuating and her vitals were not stable. We started to do in-services right away with the CNAs and nurses on the 3rd floor, checked the machine right away for functioning, the maintenance director did not find any issues with the machine, but we removed the lift from the floor, the same day we started training and completing competencies for nurses and CNAs on mechanical lift transfers and was able to complete all nursing staff by [DATE]. Currently we are conducting weekly random competencies on every shift for nurses and CNAs, this is being conducted by myself (DON), ADON, unit managers and supervisors. As the risk manager, on [DATE] we started an investigation to see if any staff had issues with the mechanical lifts prior to that day. We interviewed the two CNAS involved, [Staff A] and [Staff B] again that day, we had them walk us through the steps of what happened to see if they were following the facility policies and protocols. We discovered the machine was not the issue and one of the [Staff B] was the one that cause the incident by the way she grabbed onto the lift pad. I filed a neglect report based on the report from [community-based agency] on [DATE] and completed the five-day investigation and submitted the reports timely. The adverse report was submitted on [DATE] after we completed our investigation. Our investigation concluded the neglect was unsubstantiated. Facility protocol was followed for mechanical transfer. The adverse report concluded CNA [Staff A] may have inadvertently push the remote with her body as she was moving the lift, which cause the lift to continue to rise in the air prompting CNA [Staff B] to grab onto the resident's lift pad causing the resident to fall to the floor. The QAPI meeting on [DATE] we discussed noncompliance regarding repeated deficiencies. We discuss the incident that occurred with [Resident#1], investigated the root cause analysis of the incident, set goals for education and competency for the nursing staff about safely completed mechanical lift transfers without any incident, implemented a Performance Improvement Plan (PIP)and put a system in place for reporting findings from the PIP. The QAPI committee members are Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Infection Prevention, Maintenance Director, Registered Dietitian, Activities Director, Social Services Director, Admission Director, Maintenance Director, Housekeeping Director and Department Heads/Representatives. The purpose of QAPI is to identify any potential risk, trends, risk factors to patients and try to prevent it from happening by coming up with interventions and a plan to prevent and minimize any safety concerns. Interventions and plans are monitored for effectiveness though audits, in-services, and feedback from staff. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility's immediate jeopardy removal plan included: [DATE]-Lift #846 was inspected and found to be functioning correctly, currently not being used on the floor, stored in the maintenance room (photo available with inspection dates). [DATE]-Competency/training Mechanical Lift operations completed for CNAs Staff A and Staff B. [DATE]-[DATE]-Safe and Proper Handling of mechanical lifts training/competencies-completed for all nurses and CNAs. [DATE]-ADHOC Quality Assurance and Performance Improvement (QAPI) meeting on Mechanical lift transfers completed with the QAPI team. [DATE]-Safe Handling policy for mechanical lifts were reviewed with DON, ADON, NHA, Unit Managers, attendees were documented on the [DATE] QAPI sign in sheet. [DATE]-Medical Equipment Company checked all mechanical lifts to make sure they were functioning properly; no areas of concern were reported. [DATE]-Monthly Maintenance Mechanical lift logs completed on [DATE], and [DATE] by Maintenance Director. [DATE]-Residents' Kardex audited/updated for mechanical lift pad sizes [DATE]-Mechanical sling size assessment for the 60 residents using mechanical lifts were completed by Unit Managers. [DATE]-[DATE]-Safe and Proper Handling of Mechanical lifts training/competencies-completed for all nurses and CNAs. [DATE], [DATE], [DATE]-Weekly Maintenance Mec [TRUNCATED]

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 45019 Based on observations, interview and record review, the facility failed to demonstrate effective plan of actions were implemented to correct identified quality deficiencies in the problem area related to repeated deficient practices for F689-Free of Accident Hazards/Supervision/Devices. As evidenced by: F689 was cited during a complaint survey ending 12/14/23 when the facility failed to provide adequate supervision and additional interventions to ensure the safety of vulnerable residents and to prevent repeated falls that resulted in injuries and during the recertification survey with exit dated 08/21/24 razors were observed on Resident #382 's nightstand The findings included: Record review of the facility's survey history revealed, during a recertification conducted on July 29, 2024, through August 1, 2024, at the facility, F689-Free of Accident Hazards/Supervision/Devices was cited as the facility failed to ensure resident's room was free of accident hazards (razors at bedside) for 1 of 40 sampled residents (Resident #382). Review of the facility policy and procedures titled Quality Assurance and Performance Improvement (QAPI) dated 09/10/2021 states: It is the policy of this facility to develop, implement, and maintain an effective, comprehensive data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. Interview on 9/19/24 at 7:22 AM the Administrator (NHA) stated: I have been working at this facility for 3 weeks, this incident occurred on my second day of work at the facility. On 8/30/24 we had a Quality Assurance and performance Improvement (QAPI) meeting to review our findings and set goals for compliance. Currently trainings and competencies are ongoing, we are conducting random observations of staff performing mechanical lift transfers with residents and we are going to continue to monitor the progress through QAPI. The staff and team are very receptive to the trainings and competencies that we have put in place. The purpose of the QAPI is having a forum where the interdisciplinary (IDT) team have an opportunity to bring issues to the team so we can rectify and implement interventions, put a plan in place, measure interventions through audits for effectiveness and revise plans and interventions as needed. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 9/19/24 at 7:41 PM the Director of Nursing (DON)/QAPI revealed the last Quality Assurance and performance Improvement (QAPI) meeting was on 8/30/24, usually our QAPI meeting is the last Thursday of the month, the last meeting prior to the 8/30/24 meeting was on 8/26/24. On 08/26/24 we discussed all of our deficiencies from the AHCA recertification survey exit date 8/1/24, interventions were put in place, education was provided to the resident about why sharp razors cannot be kept at the bedside, we educated and retrained nursing staff, housekeeping, rehabilitation staff and other staff that visit resident's room about when doing rounds to check for any safety issues and report it to the nurse or nurse managers if any issues are found. Education was provided to residents and their family verbally about safety issues with razors and other items brought in the facility from outside. The QAPI meeting on 08/30/24 we discussed noncompliance regarding repeated deficiencies. We discuss the incident that occurred with Resident#1, investigated the root cause analysis of the incident, set goals for Education and competency for the nursing staff about safely completed Mechanical lift transfers without any incident, implement a Performance Improvement Plan (PIP)and put a system in place for reporting findings from the PIP. The QAPI committee members includes the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Infection Prevention, Maintenance Director, Registered Dietitian, Activities Director, Social Services Director, Admission Director, Maintenance Director, Housekeeping Director and Departments Heads/Representatives. The purpose of QAPI is to identify any potential risk, trends, risk factors to patients and try to prevent it from happening by coming up with interventions and a plan to prevent and minimize any safety concerns. Interventions and plans are monitored for effectiveness though audits, in-services, and feedback from staff.

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F 0908 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45019 Based on observations, interviews and record review the facility failed to effectively inspect and operate the Mechanical Lift in a safe manner during the transfer of Resident #1. This failure to operate the mechanical lift in a safe manner led to Resident # 1 falling out of the mechanical lift on [DATE] at 9:57 AM from the bed to the chair by two Certified Nursing Assistants (CNAs), Staff A and Staff B who reported that during the transfer the Mechanical lift kept rising and when Staff B grabbed the lift pad to stop the lift from going higher, Resident #1 suddenly fell from the lift and landed face down on the floor sustaining injuries to the head and expired at the hospital approximately four (4) hours after the fall. There were 60 resident that required transfer with the mechanical lift. Refer to F 600, F 689, and F 867. The findings included: Review of the facility policy and procedures titled Medical Equipment revision date ,d+[DATE] states: The facility is committed to ensure that medical equipment used by our center is safe. We commit to assuring this by organizing our preventative maintenance schedule of all equipment in our center according to the manufacturer's guidelines. If guidelines are not available or vague, we develop a best practice method and track maintenance accordingly. Our system is set up to document our safety checks according to these guidelines, department responsible for checking, and schedule. Procedure: We identify, in writing, frequency for inspecting, testing, and maintaining medical equipment in the inventory based on criteria such as manufacturers' recommendations, risk levels, or current organization experience. Review of the facility policy and procedures titled Safe Resident Handling Transfers revision date ,d+[DATE] states: It is the policy of this facility to ensure that residents are handled and transferred safely to prevent or minimize risks for injury and provide and promote a safe, secure and comfortable experience for the resident while keeping the employees safe in accordance with current standards and policies. Compliance guidelines: 3. Mechanical lifting equipment or other approved transferring aids will be used based on the residents' needs to prevent manual lifting except in medical emergencies. 4. Mechanical lifts may include equipment such as full body lifts, sit to stand lifts, or ceiling track mounted lifts. 6. The staff will inspect the equipment prior to use to ensure functionality and will alert maintenance or other designee if the equipment is not functioning properly. (continued on next page)

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F 0908 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	7. Damaged, broken, or improperly functioning lift equipment will not be used and tagged out according to facility policy. 8. The facility will ensure there are appropriately amounts of varying sizes of slings to accommodate residents and that residents will be measured correctly as per manufacturer's instructions on proper sling size. 9. Ensure that the sling designed for the lift is utilized with that specific lift. 10. Two staff members must be utilized when transferring residents with a mechanical lift 11. Staff will be educated on the use of safe handling/ transfer practices to include use of mechanical lift devices upon hire, annually and as the need arises or changes in equipment occur. 12. The staff must demonstrate competency in the use of the mechanical lifts prior to use and annually with documentation of the competency placed in their education file. 14. Resident lifting and transferring will be performed according to the resident/s individual care plan. On [DATE] starting at 8:50 AM observations on the 2nd and 3rd floor units, revealed 4 mechanical lifts on the 2nd floor unit and 4 mechanical lifts on the 3rd floor unit with inspection stickers, dated [DATE], [DATE], [DATE] (Photos available) Review of the Mechanical Lift preventative maintenance log documented the lifts were inspected for safety and functioning by maintenance staff on [DATE]. The lifts were inspected [DATE] on [DATE] and [DATE]. Review of the Mechanical Lift training/competency revealed Certified Nursing Assistant (Staff A) completed training on [DATE], [DATE] and [DATE]. Staff B completed training on [DATE], [DATE] and [DATE]. All other nursing staff completed training on [DATE]-[DATE], [DATE]-[DATE] and [DATE]-[DATE]. Review of the adverse incident report concluded CNA Staff A may have inadvertently pushed the remote with her body as she was moving the lift, which cause the lift to continue to rise in the air prompting CNA Staff B to grab onto the resident's lift pad causing the resident to fall. Review of the medical records for Resident # 1 revealed the resident was admitted to the facility on [DATE], readmitted on [DATE]. Clinical diagnoses included but not limited to: Chronic Obstructive Pulmonary Disease (COPD), Chronic Respiratory Failure with Hypoxia and Unspecified Dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Resident #1 was discharged on [DATE]. Review of the Physician's Orders Sheet for [DATE] revealed Resident #1 had orders that included but not limited to: [DATE]- Transfer to [local hospital], Diagnosis: Fall/head trauma, order dated [DATE]- Recommend use of mechanical lift with nursing as needed. (continued on next page)

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F 0908 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's Quarterly Minimum Data Set (MDS) dated [DATE] revealed: Section C for Cognitive Patterns documented the Brief Interview for Mental Status Score was unable to determine. Section GG for Functional Abilities documented resident had Impairment on both sides of upper and lower extremities, dependent for transfer from chair to bed. Section K for Nutritional Status documented resident weighed 100 pounds and is 60 inches in length, no unknown weight loss/gain. Record review of Resident # 1's Care Plans Dated [DATE] revealed: Resident#1 has a self-care deficit and needs staff assistance to perform and complete Activities of Daily Living (ADL's) secondary to: impaired mobility and dementia. Resident requires total assistance with all ADL functions. Interventions included: mattress with bilateral side rail as recommended by manufacturer. Recommend use of mechanical lift with nursing, bed to chair transfer as needed. Review of the Director of Nursing (DON) incident note on [DATE] timestamped 09:57 documented: Called to resident's room by assigned CNA upon entering the room the resident was observed on the floor lying next to bed and mechanical lift machine behind her, on assessment resident observed with an open area to nose bridge and with a split to upper left area of lips and bleeding from her mouth profusely. Pressure and ice applied; no other physical injuries were noted at this time. The resident was transferred back to bed with assist of 3 staff members, head of bed elevated, head turned to the side to allow blood to run out freely. Blood pressure ,d+[DATE], heart rate 72, respirations 20, temperature 98.1, oxygen saturation 97% on nasal cannula. neurological checks initiated. When asked what happened the CNAs stated: While transferring the resident from the bed to the Geri chair with the use of a mechanical lifter with the assistance of two staff members, the machine went up abruptly too quick, the resident shift causing the machine to tilt and the resident slide out, unable to catch the resident on time she fell and her head hit the floor, nursing staff were called to the room immediately Review of the nursing progress notes for Resident #1 dated [DATE] timestamped 14:00 documented: Call placed to the hospital to check on the resident. Spoke with the emergency room nurse who stated that the resident had expired. Interview on [DATE] at 12:58 PM the Maintenance Director revealed: currently there are nine (9) mechanical lifts in the facility, 3 lifts on each floor (2nd and 3rd floor) for a total of 6, one in the maintenance area (Lift #846) that was involved in the incident with the resident and two new mechanical lifts that are now on the floor, one additional mechanical lift on each floor, for a total of nine. The most recent inspection for all the mechanical lifts started on [DATE] to [DATE]. The inspection date posted on the lifts are [DATE]. Prior inspections of the lifts were completed on [DATE] and [DATE]. (with the medical equipment representative) (continued on next page)

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F 0908 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 11:00 AM the Maintenance Director stated he started at the facility in mid-[DATE], he received training on [DATE] on the mechanical lifts from the medical equipment company representative, the training was about how to inspect the parts on the mechanical lifts to make sure they are in working order, all parts are clean and well maintained, this is to be completed monthly. If a part is broken or not working correctly on the mechanical lifts, they are not repaired they are replaced. What we do is we take the mechanical lift that is not functioning correctly off of the floor, order the needed part or parts, replace the part when received, inspect the mechanical lift for proper functioning and then we put the lift back on the floor for use. [Company names] are the manufacturers of the 9 lifts that we have at the facility, currently they are all working/functioning correctly. Lift #846 (the mechanical lift involved in the incident with the resident) is not on the floor at this time, we have the lift stored in the maintenance area as instructed by management. This surveyor verified lift #846 is in working order and stored in maintenance room though observation and staff demonstration of the lift operating correctly. (continued on next page)

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F 0908 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on [DATE] at 11:07 AM the medical equipment company representative stated: I have been selling medical supplies and equipment for thirty (30) years, the medical equipment company is my company, I am a licensed Durable Medical equipment company (DME) licensed and regulated by AHCA. Any equipment we sell to the facilities, we make sure we familiarize ourselves with the manuals and operating instruction. For mechanical lifts, manufacturers usually suggest preventative maintenance which may include cleaning lifts, detecting wear and damage monthly, lubricating the lift, and performing regular maintenance. The facility is currently checking the lifts monthly and my company oversees the facility's maintenance program. Approximately every six (6) months, during the monthly maintenance, and at any time if there is an issue with the lifts. If there is an issue with a mechanical lift, the maintenance team calls my company and order the parts needed for the repair and use the company personnel if needed for additional instructions on replacing the mechanical lifts parts. The parts on the mechanical lifts are never repaired they are always replaced if they are not functioning correctly. When I came to the facility on [DATE] I completed a visual inspection of all the mechanical lifts at the facility, I ran the lifts through their paces (extended the arm to its maximum height and depth), the mechanical lifts at the facility are electrical, they either work or they do not work, there is no in-between. The only parts that can truly malfunction is the remote-control button not working, or the lever that moves the lift up and down (actuator) stops moving. The levers and the remote controls on the mechanical lifts are the additional areas I checked on [DATE]. The operating instructions are the same for all three of the manufacturers of the mechanical lifts the facility has in stock and are currently using. I am a provider for all types of medical equipment, mechanical lifts, electrical beds, etc. When I train the facility staff, I ask them to put the mechanical lifts through its paces-make sure that all functioning parameters are working correctly-lifts opens and closes, goes up and down, brakes on the wheels locks and unlocks correctly etc. The evaluation of the training is on a pass or fail scale. The training I provide to the maintenance staff is completed/conducted in a very relaxed atmosphere and is very hands on, with live inspections and questions and answers in real time that must be answered and understanding verbalized before we move on to another area of the training. For example, for the mechanical lifts- the wheels ([NAME] Base) the training would be to visually inspect there are no missing wheels, casters, no debris, casters are attached correctly smooth, swivel and roll. The boom (overhead bar) and mast (main pole)-visual inspections-check the hardware and hangings for wear, make sure the boom is centered. Hanger bar-check the hooks, check the connection to the boom. Actuator assembly (motor)-inspect the hardware connected to the other parts of the machine, check for wear and deterioration (any loose parts). Lastly put the mechanical through its paces (up and down to its maximum level using the remote control) to ensure the lift is fully functional. As a vendor for all the medical equipment it is my job to be familiar with all the manufacturer manuals and pass on the information about the equipment to the facilities I work with, obviously the facility develops their own standards and policies and procedures for their staff to follow. (continued on next page)

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F 0908 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on [DATE] at 1:28 PM CNA, Staff B, 7:00 AM to 3:00 PM shift, 3rd floor stated: I was one of the CNAs involved in the incident with the resident. I have been working here for over [AGE] years, I do this work because I love this work. On that particular morning after the resident received morning care I called the other CNA, [Staff A] for assistance with the transfer of the resident using the mechanical lift, we did our color code for the hook up of the lift pad and used a medium lift pad, upon hooking the pad to the lift [Staff A] came to the side where I was after hooking up the pad to the lift, myself and [Staff A] elevate the mechanical lift over the bed a little bit, checked the lift pad to make sure it was secure by pulling on it, [Staff A] pulled the lift out from over the bed a little bit then opened the legs of the lift for balance, [Staff A] held on to the lift and I held on to the lift pad on the side while [Staff A] continued to pull the mechanical lift out from over the bed at a safe height, the lift started to go up in the air, I held unto the pad on the side tighter, the pad tilted away from me to the opposite side with the resident inside and the resident fell out of the lift pad onto the floor at the side of the bed. I ran to call the nurse while [Staff A] stayed with the resident. I saw blood on the floor, the resident was bleeding from somewhere on the head, I just saw blood. The Licensed Practical Nurse (LPN), [Staff C] came and started her assessment on the resident and stated she needed help to get the resident into the bed. we, [Staff A] and LPN, [Staff C] picked the resident up together and placed the resident in bed. At that time several nurses came into the room to help with the resident, and I went out of the room. On [DATE] the same day I received an in-service and several times after, the most recent was this morning on the mechanical lifts-operation, safety, how to use-what size lift pad the resident requires, get the correct size pad, make sure the mechanical lift is functioning correctly-check to make sure the battery is charged, use the remote control to make sure the lift goes up and down, emergency button is working-turn the lever and the weight of the resident will lower the lift on one machine, on the other machine pull up the emergency button and the lift is lowered back down with the resident. Since the incidents I have had several random observations completed by nurses and the charge nurses to make sure I am doing my transfers correctly. The feedback I have received so far, is that I am doing my transfers correctly. (continued on next page)

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	105596	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regents Park at Aventura	18905 NE 25th Ave Aventura, FL 33180

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

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F 0908 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on [DATE] at 2:15 PM CNA, [Staff A] 7:00 AM to 3:00 PM shift, 3rd floor stated: I have been working at this facility for two years. I was one of the CNAs involved in the incident with the resident. On [DATE] in the morning I was called by CNA [Staff B] to assist her with a mechanical lift transfer for [Resident #1], I went to the room, she had already checked the lift pad and the lift, I was operating the lift, while CNA [Staff B] was tending to the resident, I press the remote to start lifting the resident up from the bed, I started to move the resident towards the Geri chair in the lift, I started to pull the machine towards me and I may have accidentally press on the remote control, I was moving the machine towards me to turn and I did not notice the lift was going up, CNA [Staff B] grabbed the resident and the lift pad, I never saw the resident falling out of the lift pad, I noticed the resident on the floor, there was blood on the floor and on the resident's head on the side and her nose was bleeding. CNA [Staff B] went out of the room to call the nurse for assistance, I stayed in the room. LPN [Staff C] came to the room and assessed the resident, all three of us work together to put the resident back in bed. At that time several staff came into the room to help, and I left the room. I have been observed completing transfers with other staff by the Director of Nursing (DON), Assistant Director of Nursing (ADON) and several other nurses. Also, I have been retrained several times since the incident about the mechanical lift. mechanical lifts-operation, safety, how to use-what size lift pad the resident requires, get the correct size pad, make sure the mechanical lift is functioning correctly-check to make sure the battery is charged, use the remote control to make sure the lift goes up and down, emergency button is working-turn the lever and the weight of the resident will lower the lift on one machine, on the other machine pull up the emergency button and the lift is lowered back down with the resident. (continued on next page)

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F 0908 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on [DATE] at 2:30 PM LPN Staff C, stated: I was the nurse that the [Staff B] came and got to check on the resident, I went into the room, the resident was lying on the floor, there was blood on her face and head, I turned the resident on the side on the floor, I grabbed a sheet and with the help of the other two CNAs [Staff A] and [Staff B] we placed the resident onto the bed. I activated the rescue team-call for additional help, the assigned nurse for the resident came in the room, I called 911, other nurses were in the room helping with the assessment/care of the resident, another nurse called the physician, orders were received to transfer the resident to the hospital. I cleaned the resident's face, the blood was coming from a laceration on the nose and left upper lip, gauze was placed and pressure applied to help stop the bleeding, the resident's head was elevated in the bed, the respiratory therapist applied oxygen to the resident via non-rebreather bag, the resident had an order for continuous oxygen via nasal cannula and an enteral tube. I left the room when the rapid response team came in the room to get the paperwork ready for the resident's transfer. Rescue arrived, and started working on the resident, trying to put an IV (intravenous line) on the resident, I'm not sure why, they stayed in the room for about 15 to 20 minutes with the resident before transporting the resident out of the facility. An additional rescue team showed up with the gurney for transport and took the resident out of the facility. At the time of the transport, the resident was alive and being taken care of by the rescue team. The same day [DATE] I received in-service on mechanical lift-safety, how to use, make sure battery is charge, we have electric and battery-operated mechanical lifts, make sure the base of legs are open for balance during transfer, lift pad is in good conditions, check the wheels that they can lock and unlock, how and when to use the emergency button to stabilize and lower the lift, do not grab onto the resident. The DON, and the lift technician provided the in-services, and I have received several in-services since the incident. After the incident I was observed by the ADON and nurse manager during a transfer of a resident with a CNA, it has to be two people for lift transfers at all times. The Kardex task list have the information on what size mechanical lift pad to use for transfer for the resident, the lift pads range from small to extra-large. The lift pads are in the laundry department in the morning, once the residents are in bed at night, the lift pads are taken to the laundry to be washed. In the back of the pad the size is written on it and there is a color code circle for each size. Interview on [DATE] at 7:22 AM Administrator (NHA) stated: I called maintenance to inspect the lift involved, Interviewed the two CNAs involved, and started a root cause analysis report about the incident. The next day the medical equipment vendor came to the facility and conducted training and competencies with maintenance staff and some nurses and CNAs and inspected all the mechanical lifts to make sure they were functioning correctly. We completed mechanical lift competencies with the two CNAs involved in the incident and then continued with the other nursing staff. We had a Quality Assurance and performance Improvement (QAPI) meeting to review our findings and set goals for compliance. Currently trainings and competencies are ongoing, we are conducting random observations of staff performing mechanical lift transfers with residents and we are going to continue to monitor the progress through QAPI. The staff and team are very receptive to the trainings and competencies that we have put in place. The purpose of the QAPI is having a forum where the interdisciplinary (IDT) team have an opportunity to bring issues to the team so we can rectify and implement interventions, put a plan in place, measure interventions through audits for effectiveness and revise plans and interventions as needed. (continued on next page)

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F 0908 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on [DATE] at 7:41 PM the ADON, DON/QAPI/Risk Manager-ADON stated: I started working at the facility in [DATE]. The DON stated she has been working at the facility since 2013 and; on [DATE] in the morning at around 9:55AM, We got a call from the nurse manger to come to the 3rd floor, I went to the resident's room, I saw the resident in the bed receiving care from staff, they were trying to stop the bleeding from the nose and the mouth, the Mechanical lift was in the room on the side of the bed, I asked the staff what happened, everyone was busy working on the resident. CNA [Staff B] explained to me she and another CNA [Staff A] were transferring the resident from the bed to the chair, she was guiding the resident and CNA [Staff A] was operating the lift; she noticed the lift started moving upwards and she grabbed onto the lift pad, the resident flipped out of the lift pad and fell to the floor. The DON further stated: The mechanical lift was extended to its highest when I went into the room and the bar that the sling hooks onto was above my head, I am 5 feet 9 inches tall. [Staff A and Staff B] were so devastated, and I really could not get any more information from them at that time. I made sure rescue was on the way, rescue arrived at the facility, they wanted to know what happened to the resident, we explained about the fall, they took over the care of the resident, they placed a Nonrebreather mask on the resident, they could not take the resident right away because the rescue truck broke down at the facility, about 20 minutes later another rescue team came and took the resident to the hospital, the Resident's daughter was called, we informed her of what happened. At that point the resident's oxygen saturation was fluctuating and her vitals were not stable. We started to do in-services right away with the CNAs and nurses on the 3rd floor, checked the machine right away for functioning, the maintenance director did not find any issues with the machine, but we removed the lift from the floor, the same day we started training and completing competencies for nurses and CNAs on mechanical lift transfers and was able to complete all nursing staff by [DATE]. Currently we are conducting weekly random competencies on every shift for nurses and CNAs, this is being conducted by myself (DON), ADON, unit managers and supervisors. As the risk manager, on [DATE] we started an investigation to see if any Staff had issues with the mechanical lifts prior to that day. We interviewed the two CNAs involved, [Staff A and Staff B] again that day, we had them walk us through the steps of what happened to see if they were following the facility policies and protocols. We discovered the machine was not the issue and one of the CNAs [Staff B] was the one that cause the incident by the way she grabbed onto the lift pad. I filed a neglect report based on the report from [community-based agency] on [DATE] and completed the five-day investigation and submitted the reports timely. The adverse report was submitted on [DATE] after we completed our investigation. Our investigation concluded the neglect was unsubstantiated. The facility's protocol was followed for mechanical transfer. The adverse report concluded CNA [Staff A] may have inadvertently push the remote with her body as she was moving the lift, which cause the lift to continue to rise in the air prompting CNA [Staff B] to grab onto the resident's lift pad causing the resident to fall to the floor. Our last Quality Assurance and performance Improvement (QAPI) meeting was on [DATE], usually our QAPI meeting is the last Thursday of the month, and the last meeting prior to the [DATE] meeting was on [DATE]. We discussed all of our deficiencies from the AHCA recertification survey exit date [DATE], interventions were put in place, education was provided to the resident about why sharp razors cannot be kept at the bedside, we educated and retrained nursing staff, housekeeping, rehabilitation staff and other staff that visit resident's room about when doing rounds to check for any safety issues and report it to the nurse or nurse managers if any issues are found. Education was provided to residents and their family verbally about safety issues with razors and other items brought in the facility from outside. The QAPI meeting on [DATE] we discussed noncompliance regarding repeated deficiencies. We discuss the incident that occurred with [Resident#1], investigated the root cause analysis of the incident, set goals for education and competency for the nursing staff about safely completed mechanical lift transfers without any incident, implemented a Performance Improvement Plan (PIP)and put a system in place for reporting findings from the PIP. (continued on next page)

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