STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305096	A. Building B. Wing	10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Goffstown Nursing and Rehab Center	29 Center Street Goffstown, NH 03045

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 0582 Level of Harm - Potential for minimal harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 47129 Based on interview and record review, it was determined that the facility failed to ensure that the resident and/or resident representative was informed of the Skilled Nursing Facility (SNF) Advance Beneficiary Notice (ABN) for 2 out of 3 residents reviewed for beneficiary notices (Resident Identifiers are #135 and #136). Findings include: Resident #135 Review on 10/20/24 of the Beneficiary Notice - Residents discharged Within the Last Six Months form, completed by the facility, revealed that Resident #135 was discharged from Medicare Services on 6/28/24 and remained in the facility. Review on 10/20/24 of Resident #135's SNF Beneficiary Protection Notification Review form revealed that Resident #135 was not provided a SNF ABN Form CMS-10055 notice prior to discharge from Medicare Part A services. Resident #136 Review on 10/20/24 of the Beneficiary Notice - Residents discharged Within the Last Six Months form, completed by the facility, revealed that Resident #136 was discharged from Medicare Services on 5/3/24 and remained in the facility. Review on 10/20/24 of Resident #136's SNF Beneficiary Protection Notification Review form revealed that Resident #136 was not provided a SNF ABN Form CMS-10055 notice prior to discharge from Medicare Part A services. Interview on 10/20/24 at 2:15 p.m. with Staff D (Director of Social Services) confirmed the above findings. Staff D stated that they had not completed the SNF ABN Form CMS-10055 for Resident #135 and Resident #136.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305096	A. Building B. Wing	10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Goffstown Nursing and Rehab Center	29 Center Street Goffstown, NH 03045

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 51109 Based on interview and record review, it was determined that the facility failed to report alleged violations of neglect to the State Survey Agency (SSA) for 1 of 3 residents reviewed for falls in a final sample of 15 residents (Resident Identifier #26). Findings include: Interview on 10/20/24 at approximately 10:48 a.m. with Resident #26 revealed that Resident #26 had fell from the hoyer lift about six weeks ago. Review on 10/22/24 of Resident #26's medical record revealed an Incident Note, entered 8/21/24, dated 8/20/24, that stated: .resident was being transferred from [pronoun omitted] wheelchair to [pronoun omitted] bed using a hoyer lift .More staff were called in for assistance and resident was lowered to the floor after moving the bed away and releasing the hoyer lift pad . Review on 10/22/24 of Resident #26's medical record revealed a provider note, dated 8/23/24, that stated . nursing reported that 2 days ago, [pronoun omitted] had an accidental fall during a mechanical lift transfer and got between [pronoun omitted] bed and [pronoun omitted] window sill slightly bumping [pronoun omitted] head . Interview on 10/22/24 at approximately 11:00 a.m. with Staff A (Administrator) revealed that Staff A was not aware of the above incident until 10/22/24 and was unable to provide any documentation of an investigation to determine if it should have been reported to the SSA. Review on 10/22/24 of facility policy titled, Accidents/Incidents Policy, dated 8/24/2024, revealed: .3. Reporting: D. The Administrator and/or DON (Director of Nursing) will verify that state reporting occurs within required time frames and via appropriate method of reporting .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305096	A. Building B. Wing	10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Goffstown Nursing and Rehab Center	29 Center Street Goffstown, NH 03045

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 51109 Based on interview and record review, it was determined that the facility failed to ensure that alleged violations of neglect were thoroughly investigated for 1 of 3 residents reviewed for falls in a final sample of 15 residents (Resident Identifier #26). Findings include: Interview on 10/20/24 at approximately 10:48 a.m. with Resident #26 revealed that Resident #26 had fell from the hoyer lift about six weeks ago. Review on 10/22/24 of Resident #26's medical record revealed a provider note, dated 8/23/24, that stated . nursing reported that 2 days ago, [pronoun omitted] had an accidental fall during a mechanical lift transfer and got between [pronoun omitted] bed and [pronoun omitted] window sill slightly bumping [pronoun omitted] head . Interview on 10/22/24 at approximately 11:00 a.m. with Staff A (Administrator) revealed Staff A was not aware of the incident and Staff A was unable to provide documentation of an investigation of the incident. Interview on 10/22/24 at approximately 12:12 p.m. with Staff I (Licensed Nursing Assistant) revealed that he/she and another staff member were using the hoyer lift to transfer Resident #26 from Resident #26's wheelchair to their bed. The resident was flailing their arms and legs causing the hoyer lift to tip, and staff lowered Resident #26 to the floor. Staff I stated that the incident was reported to the Director of Nursing (DON), who was in the facility working on the unit at that time, but was not asked to provide a written statement of the incident. Review on 10/22/24 of facility policy titled Accidents/Incidents Policy dated 8/24/2024, revealed .4. Follow-up/Investigation: B. The Administrator, DON, or designee will review all accident/incidents to determine if: i) Accidents/Incidents or allegations have been appropriately and timely reported; ii) Required documentation has been completed; iii) Accident/Incident has been investigated . D. When conducting an investigation, the Administrator, DON, or designee will: i) Make every effort to ascertain the cause of the accident/incident; ii) Initiate a timeline chronology . iv) Conduct witness interviews from all staff and visitors who may have knowledge of the accident/incident; v) Document the root cause and initiate actions to prevent or reduce recurrence of further accident/incident . vii) Complete the investigation within five working days.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305096	A. Building B. Wing	10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Goffstown Nursing and Rehab Center	29 Center Street Goffstown, NH 03045

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 51109 Based on interview and record review, it was determined that the facility failed to perform neurological assessments after a resident fell and hit their head for 1 out of 3 residents reviewed for falls in a final sample of 15 residents (Resident Identifier #26). Findings include: Journal of Nursing; AJN, November 2007 Vol. 107, No. 11. Retrieved from https://www.nursingcenter.com/pdfjournal?AID=751198&an=00000446-200711000-00030&Journal_ID=54030&Issue_ID=751137 on 10/30/20: When a Fall Occurs Step three: monitoring and reassessment. After the patient returns to bed, perform frequent neurologic and vital sign checks. Interview on 10/20/24 at approximately 10:50 a.m. with Resident #26 revealed that Resident #26 had a fall when being transferred with the hoyer lift, resulting in Resident #26 hitting their head. Review on 10/22/24 of Resident #26's medical record revealed an Incident note, dated 8/20/24, entered 8/21/24, that stated .Provider got notified and order was obtained to do neuro [neurological] checks for 72 hours . Further review revealed no electronic documentation indicating neurological assessments had been performed. Interview on 10/22/24 at approximately 11:00 a.m. with Staff A (Administrator) revealed Staff A was unable to provide any documentation indicating neurological assessments had been performed following the fall on 8/20/24. Review on 10/22/24 of the facility's policy, Accidents/Incidents Policy, dated 8/27/24, revealed: . Evaluation/Assessment, Medical Assistance, Documentation: .v) The physician/APP (Advanced Practice Provider) will be notified of any fall resulting in head injury, suspected head injury .These residents will be observed for neurological abnormalities by performing neuro checks according to the Neurological Evaluation policy and procedure after the accident/incident occurs .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305096	A. Building B. Wing	10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Goffstown Nursing and Rehab Center	29 Center Street Goffstown, NH 03045

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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49819 Based on record review and interview, it was determined that the facility failed to identify trauma triggers to eliminate or mitigate triggers that may cause re-traumatization of the resident in 1 of 1 residents reviewed for Post Traumatic Stress Disorder (PTSD) in a final sample of 15 residents (Resident Identifier #10). Findings include: Record review on 10/22/24 of Resident #10's diagnosis list revealed a diagnosis of PTSD. Record review on 10/22/24 of Resident #10's last Minimum Data Set Assessment (MDS) with an Assessment Reference Date (ARD) of 8/8/24 revealed PTSD was a current diagnosis. Record review on 10/22/24 of Resident #10's care plans revealed a care plan for behaviors of crying, withdrawal, and lack of appetite associated with PTSD without identified triggers listed. Record review on 10/22/24 of Resident #10's Generations Psychiatry Progress Note dated 10/9/24, revealed no identified triggers for PTSD. Record review on 10/22/24 of Resident #10's behavior monitoring for [DATE] revealed Resident #10 had behaviors of grouchy, swearing and shrieking when moved. Record review on 10/22/24 of Resident #10's Social Services assessment dated [DATE] revealed no identified triggers for Resident #10's PTSD. Interview on 10/22/24 at approximately 10:45 a.m. with Staff A (Administrator) confirmed the facility had not been identified PTSD triggers for Resident #10.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305096	A. Building B. Wing	10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Goffstown Nursing and Rehab Center	29 Center Street Goffstown, NH 03045

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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 47129 Based on interview and record review, it was determined that the facility failed to ensure that a Registered Nurse (RN) was on duty for 8 consecutive hours a day, 7 days a week, for 3 of 30 days reviewed between September 15, 2024 - October 20, 2024. Findings include: Review on 10/21/24 of the facility's daily nursing time sheets for September 15, 2024 - October 19, 2024, revealed the following: On 9/15/24 there were no RN hours documented as worked; On 9/28/24 there were no RN hours documented as worked; On 10/13/24 there were no RN hours documented as worked. Interview on 10/21/24 at 9:00 a.m. with Staff E (Scheduler) confirmed that there was no RN on duty on 9/15/24, 9/28/24, and 10/13/24. Interview on 10/21/24 at 10:00 a.m. with Staff B (Director of Nursing) revealed that he/she was on call every other weekend when there was not an RN working but was not physically in the building for 8 consecutive hours.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305096	A. Building B. Wing	10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Goffstown Nursing and Rehab Center	29 Center Street Goffstown, NH 03045

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 49819 Based on record review and interview, it was determined that the facility failed to ensure that resident's who take psychotropic medications received a Gradual Dose Reduction (GDR) or document if GDR was clinically contraindicated for 1 of 5 resident's reviewed for unnecessary medications in a final sample of 15 residents (Resident Identifier #13). Findings include: Review on 10/21/24 of Resident #13's physician orders revealed an order for Seroquel 50 milligrams (mg), 1 tablet by mouth 3 times a day. Review on 10/21/24 of Resident #13's Pharmacy Consultant Report, dated 8/8/2024, revealed a recommendation to attempt a gradual dose reduction for Resident #13's Seroquel medication. The report further revealed the provider checked decline and wrote please see visit note from 9/5/24. The report was signed 9/24/24. There was no documentation of continued clinical appropriateness for the Seroquel. Review on 10/22/24 of Resident #13's Generations Geriatric Psychiatry Progress Note in Facility, dated 9/5/24, revealed the last GDR attempt was May 2021, and further revealed .Goals for Next Visit: consider med decrease . Follow up interval: 2-3 months . There was no documentation of continued clinical appropriateness for the Seroquel. Interview on 10/22/24 at approximately 11:30 a.m. with Staff B (Director of Nursing) confirmed there was no documentation for an attempt or documentation of GDR being clinically contraindicated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305096	A. Building B. Wing	10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Goffstown Nursing and Rehab Center	29 Center Street Goffstown, NH 03045

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 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 47129 Based on interview and record review, it was determined that the facility failed to submit to the Centers for Medicare & Medicaid Services (CMS) complete and accurate direct care staffing information based on payroll data for Fiscal Quarter 3 (April 1, 2024 - June 30, 2024). Review on 10/20/24 of the facility's Payroll Based Journal Staffing Data Report for Quarter 3 2024 (April 1, 2024 - June 30, 2024) revealed that the facility failed to submit data for the quarter. Interview on 10/22/24 at 1:00 p.m. with Staff F (Business Office Manager) confirmed the above findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305096	A. Building B. Wing	10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Goffstown Nursing and Rehab Center	29 Center Street Goffstown, NH 03045

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 47129 Based on observation, record review, and interview, it was determined that the facility failed to follow Center For Disease Control (CDC) guidance for wearing Personal Protective Equipment (PPE) for Enhanced Barrier Precautions (EBP) for 1 of 1 residents reviewed for an indwelling catheter in a sample of 15 residents (Resident Identifier #32). Findings include: Observation on 10/20/24 of Resident #32's room revealed an indwelling catheter bag hanging from the bed. There was no sign posted indicating Resident #32 was on EBP, and there was no PPE provided for care. Further observation revealed an Licensed Nursing Assistant (LNA) performing care without PPE. Interview on 10/22/24 at 8:34 a.m. with Staff M (LNA) confirmed he/she provided care to Resident #32 on 10/20/24 without using PPE. Staff M stated they were not aware Resident #32 was on EBP. Review on 10/22/24 of Resident #32's active orders revealed an order for a urinary catheter, entered on 10/15/24 and an order for EBP, entered on 10/20/24. Further review revealed an order for Ciprofloxacin (Cipro) Oral Table 250 milligrams (mg) by mouth every 12 hours for Urinary Tract Infection (UTI), dated 10/22/24. Interview on 10/22/24 at 8:30 a.m. with Staff B (Director of Nursing) and Staff C (Infection Prevention) confirmed that Resident #32 was not on EBP. 51109

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305096	A. Building B. Wing	10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Goffstown Nursing and Rehab Center	29 Center Street Goffstown, NH 03045

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. 47129 Based on interview and record review, it was determined that the facility failed to follow antibiotic use protocols related to the appropriate use of antibiotic monitoring, tracking, and reviewing antibiotic use for 9 of 12 months reviewed for antibiotic use. Findings include: Review on 10/21/24 of the facility's line listing for antibiotic use from November 2023 through October 2024 revealed that the facility did not have documentation of a system to track antibiotic use within the facility from November 2023 through May 2024 and September 2024 to present. Interview on 10/21/24 at 12:00 p.m. with Staff C (Infection Prevention) confirmed the above findings. Interview further revealed that the facility did not have antibiotic monitoring and tracking from September 13, 2024, to present, including documentation that antibiotics met criteria for use. Staff A (Administrator) confirmed that the facility had residents with infections and who were on antibiotics from September 2024 to date. Review on 10/21/24 of the facility's policy titled, Infection Control - Antibiotic Stewardship, revised 2/11/22, revealed: .2. Accountability: a. An ASP Team will establish to be accountable for stewardship activities . i. Review infections and monitor antibiotic usage patterns on a regular basis. ii. Obtain and review antibiograms for institutional trends of resistance. iii. Monitor Antibiotics resistance patterns . iv. Report on number of antibiotics prescribed (e.g., days of therapy) and the number of residents treat each month. iv. Include a separate report for the number of residents on antibiotics that did not meet criteria for active infections .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305096	A. Building B. Wing	10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Goffstown Nursing and Rehab Center	29 Center Street Goffstown, NH 03045

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. 51109 Based on interview and record review, it was determined that the facility failed to maintain resident care equipment according to manufacturer's instructions for the hoyer lift. Findings include: Interview on 10/22/24 at approximately 9:57 a.m. with Staff J (Maintenance Director) revealed that the legs on the hoyer lift were difficult to open. Staff J stated that they had not performed routine inspections on the hoyer lift to determine any wear since he/she became employed at the facility approximately four months ago. Staff J revealed they had never performed routine maintenance on the hoyer lift, and did not have any documentation that the hoyer lift had been maintained, inspected or repaired at any time. Staff J confirmed that the hoyer lift was more than a year old and routine inspection and maintenance was required. Interview on 10/22/24 at approximately 10:29 a.m. with Staff K (Licensed Nursing Assistant(LNA)) revealed the hoyer lift is difficult to maneuver when a resident is in the lift. Interview on 10/22/24 at approximately 10:37 a.m. with Staff L (LNA) revealed the hoyer lift was hard to move and wobbly at times. Review on 10/22/24 of the hoyer lift manual, page 12 revealed: .Performing Maintenance, After the first year of use, the hooks of swivel bar and the mounting brackets of the boom should be inspected every three months to determine the extent of wear. If these parts become worn, replacements must be made .Casters and axle bolts require inspections every six months to check tightness and wear. After the first twelve months of operation, inspect the swivel bar and the eye of the boom (to which it attaches) for wear. If the metal is worn, the parts MUST be replaced. Make this inspection every six months thereafter. Regular maintenance of patient lifts and accessories is necessary to assure proper operation . Review on 10/22/24 of the Maintenance Safety Inspection Checklist in the hoyer lift manual, page 32, revealed: .for institution use of the hoyer lift, the lift and all components should be inspected or adjusted monthly .