STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455673	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/07/2024
NAME OF PROVIDER OR SUPPLIER: Parkwood IN the Pines		STREET ADDRESS, CITY, STATE, ZIP CODE: 902 Hill Street, Lufkin, TX 75904	

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 0689 Level of Harm - Actual harm 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** 36491 Based on observation, interview, and record review the facility failed to provide adequate supervision and assistance devices to prevent accidents for 1 of 8 residents reviewed for accidents/supervision. (Resident #1) The facility failed to ensure Resident #1 was transferred to her bed using a mechanical lift on 10/2/24, causing pain to her right leg. This failure could place residents at risk of severe injuries. Findings included: Record review of Resident #1's undated current admission record indicated that Resident #1 was a [AGE] year-old female admitted to the facility 12/16/21, with diagnoses including hemiplegia (describes severe or complete unilateral loss of strength or paralysis) and hemiparesis (refers to weakness in one leg, arm, or side of the face) following cerebral infarction (the most common form of stroke), dysphagia (difficulty swallowing), muscle wasting and atrophy (wasting or thinning of muscle mass), type 2 diabetes (condition that results from insufficient production of insulin causing high blood sugar), end stage renal disease (kidney failure), and hypertension (high blood pressure). Record review of Resident #1's most recent quarterly MDS assessment dated [DATE] indicated Resident had a BIMS score of 10 indicating moderately impaired cognition. Record review of an undated care plan indicated Resident #1 required staff assistance with mobility. Interventions included: the resident requires extensive assistance by 2 staff to move between surfaces and uses a mechanical lift for transfers. (continued on next page)

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

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident #1's nurses notes dated 10/2/24 at 6:05 p.m. and signed by LVN E indicated the following: CNA came to nurses' station at 5:20 p.m. and notified me that resident verbalized complaints of pain in right thigh and knee during transfer from wheelchair to bed. Upon arrival into residents' room, resident was in bed and stated her pain was a 9/10. Vital Signs were blood pressure 110/78, heart rate 77, Temp 97. 8, O2 96% on room air, Respirations 20. When asking resident if she wanted to go to the ER for evaluation she stated I don't know. My family member is on her way, let me ask her. Family member arrived at 5:25 p. m. and resident decided she wanted to go the ER for evaluation. I called EMS for transport they arrived at 5:38 p.m. Resident left facility at 5:45 p.m. and was transported to hospital ER. Called report to hospital ER at 5:47p.m. Notified MD of sending resident to ER. Record review of Resident #1's nurses notes dated 10/2/24 at 8:44 p.m. and signed by LVN E indicated the following: Received report from hospital ER that resident was ready to come back to facility at 8:35 p.m. Resident has a knee immobilizer in place on right leg. She will need a follow up appointment with an orthopedic in 1-2 days. Record review of Resident #1's nurses notes dated 10/3/24 at 5:50 a.m. and signed by LVN F indicated the following: Patient returned to facility from hospital at approximately 1:08 a.m. Patient returned with brace to right leg to immobilize leg. Results of x-ray taken at hospital were not available. Patient expressed pain and discomfort but was medicated before leaving the hospital. When she returned from hospital mobile x-ray was contacted to conduct another x-ray at the request of on call MD. Mobile X-ray arrived at facility at approximately 3:17 a.m. Record review of Resident #1's nurses notes dated 10/3/24 at 8:10 a.m. and signed by LVN G indicated the following: Xray results received and reviewed with family. The impression shows no definite radiographic evidence of acute fracture or dislocation noted. No joint effusion (swelling of the tissues in or around a joint due to extra fluid). Moderate degree of osteoarthritis (inflammation of one or more joints), osteopenia (loss of bone density), and osteoporosis (a condition when bone strength weakens and is susceptible to fracture). Results sent to PA. No new orders received. Resident to follow up with Orthopedics. Awaiting a call back from them with appointment date and time. Family aware. Record review of Resident #1's nurses notes dated 10/3/24 at 1:09 p.m. and signed by LVN E indicated the following: Received a call from Orthopedics with a follow up appointment for 10/8/24 at 9:45 a.m. Resident and family notified. Record review of Resident #1's nurses notes dated 10/3/24 at 2:15 p.m. and signed by LVN E indicated the following: Resident was sent to ER per family request for CT to right knee. Record review of Resident #1's nurses notes dated 10/3/24 at 3:21 p.m. and signed by DON Indicated the following: Spoke with Medical Director. Informed resident had been sent to ER per family request to have CT completed. ER MD did not order CT, stated it was not emergent. Discussed family desire for MRI of right knee. Dr. gave order for MRI right knee. Contacted MRI facility for appointment. Requested order be sent prior to scheduling. Order faxed. Will follow-up for appt time. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident #1's nurses notes dated 10/4/24 at 8:30 a.m. and signed by LVN H indicated the following: Follow up call placed to Orthopedics to schedule appointment for MRI. Was notified that unable to schedule appointment due to inability to accommodate resident because she could not ambulate or pivot. When asked if resident could be transported via Ambulance so that EMT'S could assist with transferring resident, staff member states, can't bring that equipment in my room. Call placed to hospital scheduling department, appt. scheduled for Tuesday, October 8th, at 4pm. Resident should arrive at 3:30. Medical Director,administrative staff, and family member notified of appointment. Record review of a mobile x-ray interpretation report dated 10/3/24 indicated exam was done at 5:21 a.m. and reported at 5:22 a.m. Report indicated Resident #1 had a 3-view film of her right knee. Findings showed: no radiographic evidence of acute fracture or dislocation. The patella (kneecap), distal femur (lower part of the thigh bone) , proximal (describes a location closer to the center of the body) tibia (the inner and typically larger of the two bones in the lower leg) and fibula (the smaller of the two bones in the lower leg) were intact. There was no sign to suggest anterior cruciate ligament tear (a partial or complete tear of a specific ligament in the knee). The bony mineralization is moderately decreased. There is no joint effusion. Moderate narrowing of the medial and patella-femoral spaces (where the back of the kneecap and thigh bone meet. Femoral artery stent noted. Impression: No definite evidence of acute fracture or dislocation. If there are persistent symptoms, follow up x-ray or CT may be obtained as clinically warranted. No joint effusion. Moderate degree of osteopenia/osteoporosis. Moderate degree of osteoarthritis. Report was signed by MD on 10/3/24 at 5:21 a.m. Record review of a hospital radiology report indicated that on 10/2/24 at 6:45 p.m. a 2-view film of Resident #1's right knee was done. Findings included: There is a slightly separated fracture through the patella. There is advanced degenerative joint disease of the right knee. The bones are severely osteoporotic. There is soft tissue swelling in the prepatellar regions. There is vascular calcifications (where mineral deposits form on the walls of the blood vessels in the knee area). Impression: Slightly separated patellar fracture. Osteoporosis. Advanced degenerative joint disease of the right knee, Report revealed the MD signed the report on 10/3/24 at 8:13 a.m. The report showed that it was faxed to the facility on [DATE] at 12:51 p.m. Record review of a written statement dated 10/3/24 from CNA D indicated the following: Yesterday 10/2/24 about 5:15 p.m., Resident #1 returned back to nursing home from dialysis. She hit the call light to go to bed. I answered it, I went to get the mechanical lift and asked for help. I asked CNA J for help. Resident #1 asked for a top sheet. I went to get one and CNA J had her in the bed. Resident #1's leg popped, and she started to cry. I went to get LVN E, and we checked her over. Family came. Resident #1 made the statement that CNA J has never transferred her like that. Record review of an undated written statement from CNA J indicated the following: I was putting Resident #1 to bed and as I pick her up she said she was ok until I put her in the bed she said her leg hurt then she said it was her hip. I put her on in the bed and put pillows under her feet. Record review of an Employee Separation Report dated 10/4/24 indicated CNA J was terminated for policy violation. Employee failed to follow care plan when transferring a resident. Resident was care planned for 2-person mechanical lift transfer and staff member transferred her without assistance. Last day worked was 10/2/24. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident #1's kardex (a documentation system used to reference key patient information for care planning) indicated Resident #1 required extensive assistance by 2 staff to move between surfaces and uses a mechanical lift for transfers. Record review of Resident #1's pain scale and Medication Administration Record dated October 2024 indicated Resident #1 received the following pain medications: -Acetaminophen with Codeine 10/3/24 pain level 4 10/4/24 pain level 7 10/5/24 pain level 3 -Tylenol 325 mg 10/3/24 pain level 5 -Tramadol 10/3/24 pain level 7 10/4/24 pain level 8 Pain levels are documented using a scale of 0-10, with 0 indicating no pain, 1-3 mild pain, 4-6 moderate pain, and 7-10 severe pain. During an interview on 10/3/24 at 10:19 a.m. Family member A said Resident #1 had lived in the facility for over 5 years and required a mechanical lift to be transferred. Family member A said her family member B had contacted her on 10/2/24 after she had been notified of the incident. Family member A said Resident #1 was at dialysis that day. Family member A said two aides came in her room and Resident #1 was still in her wheelchair. The lady aide left the room to go get a sheet, and the guy lifted Resident #1 out of the wheelchair and put her in the bed. Resident #1 said that her leg popped and they had cameras in the room and her family member saw it and went to the facility. Family member A said Resident #1 was crying, then EMS came. Family member A said Resident #1 told the guy you can't lift me like this, and he kept doing it. Family member A said no one had come in the room on this date , (10/3/24) to check on Resident #1. Family member A said the nurse from the prior evening stood in the doorway and just looked in the room and did not come in to check on Resident #1. Family member A said on this date , (10/3/24) her family member went up to the front and was told Resident #1's knee was not broken. Family member A said she was unsure where she actually went or who her family member had talked to and that the facility was always short staffed, and the Administrator had not even come to check on Resident #1. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 10/3/24 at 12:00 p.m. during entrance conference, the Administrator said they had a family that was not happy and an aide transferred Resident #1 without using the mechanical lift. The Administrator said the Resident went to the hospital yesterday (10/2/24), and the x-ray done at the hospital was not going to be read until 10/3/24, so they called mobile x-ray to come in so they could see what was going on. Administrator said the report indicated no fracture and said CNA J should have waited for another CNA. She said Resident #1 was transferred incorrectly, and CNA J had probably seen the therapist do it and thought it was ok. The Administrator said CNA J said he asked Resident #1 if it was okay to transfer her to the bed and she said yes. The ADON said CNA J picked Resident #1 up and transferred her to the bed, and after that Resident #1 complained of hip/leg pain. ADON said there was no bruising noted to her leg. The DON said the aide should have waited for physical therapy to give the go ahead to transfer the resident without the mechanical lift. DON said in-service training was initiated for all staff on use of the mechanical lift and using it until therapy okay's not using it. During an interview and observation on 10/3/24 at 1:00 p.m. Resident #1 was noted to be lying in bed with her eyes closed. An immobilizer was noted to Resident #1's right leg. Three family members were present. Family member A stated her phone broke, and she did not have video footage on her phone. Family member B said she worked nights, and that on 10/2/24 she woke up to look at the camera in Resident #1's room to see if she had returned from dialysis and was in her room. She said she went to the bathroom and when she came back there was a tall man and a lady in the room. The man reached for Resident #1's arm where her dialysis catheter was. Family member B said she hollered don't grab her stop. Family member B stated he picked Resident #1 up and she started hollering. At this time, Resident #1 opened her eyes and said, I begged him to stop. Family member B stated she had a video on her phone. The first clip showed Resident #1 in her room sitting in her wheelchair. Family member B stated this was after she returned from dialysis. The second video clip showed Resident #1 lying in the bed as the male aide appeared to be placing a pillow under Resident #1's legs. Resident #1 appeared to be making a noise, but audio was very low and unable to make out what was said. The third video clip showed a man and a woman in the room. Family member B said she did not have a video of the aide transferring Resident #1, and she stated no, it may have been my phone. Family member B stated Resident #1 told the aide he could not get her up without the lift. Family member B stated that Resident #1 was paralyzed on the right side. Family member C stated there was a girl in the room that told her the man lifted Resident #1 up and her leg was bent. Family member B stated she did not know her name. Family member C stated she had the same videos on her phone as well, but none of the actual transfer. Observation of the video clips provided lasted about 3-5 seconds each. No videos were seen of Family member B telling the aide to stop, when he was reaching for the Resident's arm, the actual transfer of Resident #1, or Resident #1 asking the aide to stop. Resident #1 was dozing on and off and did not answer any further questions. During an interview on 10/3/24 at 2:00 p.m. The DOR said she had worked in the facility since 2018. DOR said the PTA had been working with Resident #1 on transfers from the wheelchair to the bed and had been for quite some time. The DOR said Resident #1 felt comfortable with him as her therapist. DOR said staff knew that Resident #1 used a mechanical lift. DOR stated Resident #1 could be agreeable at times to certain things, and later will say she is not okay. DOR said they always had two people work with her for that reason. DOR said Resident#1 may have felt ok with CNA J transferring her, with him being a man. DOR said, I can't see the aide doing the transfer without Resident #1 telling him it was okay. I believe she would have said yes when he asked if he could transfer her. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 10/3/24 at 2:36 p.m. the PTA said he had worked in the facility for 1 1/2 years. The PTA said Resident #1 had been on service for a couple of months. PTA said he had been working with her on bed mobility, sitting on the edge of the bed, and transfer to wheelchair management. PTA said Resident #1's progress on transferring from sitting to standing to wheelchair was very slow. Said Resident #1 had weight bearing issues and paralysis to the right arm and leg. Said Resident #1 was making some progress, but it was slow. PTA said CNA J should have transferred Resident #1 with the mechanical lift. During an interview on 10/3/24 at 2:40 p.m. CNA D said she had worked in the facility since July of this year. CNA D said on 10/2/24, Resident #1 came back from dialysis around 5:10 p.m. Said Resident #1 used her call light and wanted to go back to bed. Said she went and got the mechanical lift and asked CNA J for help. CNA D said she left the room to go get a sheet, and CNA J transferred Resident #1 while she was out of the room. CNA D said she came back in the room as he was in the middle of transferring Resident #1 to the bed. CNA D said CNA J stated he had put Resident #1 to bed like that before. CNA D said Resident #1 was crying so she went and got the LVN E. Resident #1 said she had pain in her right upper hip and knee area. CNA D said Resident #1 was sent to the hospital. CNA D said she had not taken care of Resident #1 before and was just answering her light. CNA D said Resident #1 asked her if she heard the pop in her leg and, she said yes but did not know where it came from. CNA D said Resident #1 stated CNA J had never transferred her like that before. CNA D said she received mechanical lift training on hire, and recently had training, and had to complete a check off list. During an interview on 10/3/24 at 3:09 p.m. LVN E said she had worked in the facility for 2 weeks. LVN E stated that on 10/2/24 she was at the nurses' station and CNA D came up to her around 5:15 p.m. and told her Resident #1 was in pain. LVN E went in the room and Resident #1 was in bed crying, saying she was hurting in her right leg/thigh area. Resident #1 said her pain was a 9 out of 10. LVN E said Resident #1 had Tylenol ordered. LVN E said she told Resident #1 she wanted to send her to the hospital. Resident #1 said she had already called her family member, who came up and wanted her sent out as well. LVN E said she notified the ADON and called EMS. EMS arrived and left around 5:45 p.m. LVN E said she got report from the hospital that Resident #1 had a knee mobilizer in place and that the x-ray would be read on Thursday, 10/3/24 . LVN E said she was told the ER doctor saw the x-ray but could not say anything until the Radiologist read it. LVN E said she notified the NP and asked for a mobile x-ray to be done. During an interview on 10/3/24 at 4:00 p.m. The DON stated Resident #1's family was adamant that Resident #1 be sent out on this date, 10/3/24 for a Cat Scan of her leg. The DON said the family took Resident #1 to the hospital and was told it was not urgent and that they had already done an x-ray. DON said she notified the Medical Director as the family asked for an MRI. The doctor ordered it and it had to be scheduled due to not being urgent. DON said it was scheduled for Tuesday 10/8/24. DON said the x-ray done in the facility was negative, and the one at the hospital showed a fracture. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 10/7/24 at 8:45 a.m. LVN G said she had worked in the facility for 1 year. LVN G said she was not working the day of the incident with Resident #1. LVN G said she had heard that CNA J had transferred Resident #1, picked her up and transferred her to the bed. LVN G said she was not sure if CNA J knew that Resident #1 used a mechanical lift, but if there was a mechanical lift pad in the wheelchair, you are a mechanical lift. LVN G stated Resident #1 told a nurse (unknown name) her knee popped and that she had told CNA J to stop. CNA J said he had transferred Resident #1 that way before. LVN G said CNA J had been working in the facility maybe 3 weeks and worked 2-3 days a week. LVN G said she would notify her aides how they were to be transferred, and if there were any questions about transferring, she would wait for therapy to evaluate them. LVN G said the aides also have a kardex to refer to. LVN G said she received training on the mechanical lift upon hire which included a hands-on checkoff. LVN G said they had also received recent training and checkoffs. During an interview on 10/7/24 at 9:05 a.m. LVN H said she had worked in the facility for 2 years. LVN H said the aides have access to a kardex that indicates how a resident is to be transferred. LVN H said she received training on the mechanical lift on hire and completed skills check offs throughout the year. LVN H said she had not taken care of Resident #1 but knew she had always used a mechanical lift. LVN H said CNA J had only worked in the facility about 4 weeks. LVN H said he was a decent aide, always willing to help out. During an interview on 10/7/24 at 9:30 a.m. Resident #2 said she had lived in the facility for 6 years. Resident #2 said staff used a mechanical lift to get her in and out of bed. Resident #2 said sometimes she was not comfortable with her transfers. Said it was nothing the staff did, it's just me, being lifted up and moved. Resident #2 said there had not been any incidents and the staff did a good job. Said there were always 2 staff present. Said no one had tried to transfer her without using the mechanical lift. During an interview on 10/7/24 at 10:10 a.m. Resident #3 said he had lived in the facility for 1 1/2 years. Resident #3 said staff got him up using the mechanical lift. Resident #3 said he did not like being suspended in the air, but he was unable to walk. Resident #3 said he had not had any falls or any incidents when transferring. Said he only got up 1-2 times a week by his choice. Resident #3 said there were always 2 staff present to do his transfers and had no concerns. Said no one had tried to transfer him without using the mechanical lift. During an interview on 10/7/24 at 10:15 a.m. Resident #4 said he was not sure how long he had lived in the facility, but thought it was around 2 months. Resident #4 said he was transferred with a mechanical lift. Resident #4 said there were always 2 staff present and that he had not had any issues. Resident said no one had tried to transfer him without using the mechanical lift. During an interview on 10/7/24 at 10:42 a.m. CNA K said she had worked in the facility since July of this year. CNA K said she would check the kardex to see how residents were to be transferred. CNA K said the PTA would get Resident #1 up most of the time. Said he would transfer her from the bed to the wheelchair. CNA K said staff would transfer her back to bed with the mechanical lift. CNA K said she had never heard Resident #1 complain when being transferred. Stated Resident #1 always told staff how to do it. CNA K said she had received training on the mechanical lift when hired, and had an in-service last week, and had to do hands on demonstration. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 10/7/24 at 10:47 a.m. CNA J said he was hired as prn and had worked in the facility for 3 weeks. CNA J said he had worked over 30 hours per week. CNA J said on 10/2/24 he was sitting in the lobby and CNA D asked him to help transfer Resident #1. CNA J said he went into Resident #1's room, and he had seen the therapist transfer Resident #1 without using the mechanical lift. CNA J said he had transferred Resident #1 at least 2 other times without the mechanical lift, stating that's why I did it I saw the therapist do it. CNA J said once I got Resident #1 in the bed she complained of pain in her hip area, then she said it was her leg in the area of her knee. CNA J said he picked her up out of the wheelchair and transferred her to the bed. CNA J said he was told by other staff (unknown names) that when Resident #1 came back from dialysis that evening, she was complaining of hip pain. CNA J said he asked Resident#1 if she wanted him to transfer her like he did before, and she agreed. CNA J said she had not had any complaints any other time he had transferred her to bed. If she had complained at any point, I would never have done it again, if she had any pain. CNA J said he did not hear anyone talking on the camera in her room while he was in there. CNA J said he did not know Resident #1 used a mechanical lift, he had just seen how therapy transferred her. CNA J said Resident #1 did not complain of any pain until she was in the bed. CNA J said when he asked Resident #1 if she wanted him to transfer her, he told her remember how I transferred you the last time?, and the Resident said, okay baby. CNA J said Resident #1 never asked him to stop while he was transferring her. CNA J said he had transferred Resident #1 2-3 times before by himself, without the mechanical lift. CNA J said this was a big accident, and it has been heavy on my heart. I am very regretful, and now going forward I'll always use the [mechanical lift] and will always check the kardex. I had no intentions whatsoever to do any harm to the Resident. CNA J said he had been an aide for 9 months. During an interview on 10/7/24 at 11:08 a.m. CNA L said she had worked in the facility since the end of May this year. CNA L Said she had received training on the mechanical lift on hire and had just recently had another training with check off skills. CNA L said she always checked the kardex if she did not know how a resident transferred. CNA L said there always had to be 2 people doing a mechanical lift, and you need to make sure they are in it right, or you can jack them up. CNA L said she had never transferred a resident on the mechanical lift by herself. CNA L said Resident #1 never complained of not wanting to get in the mechanical lift. CNA L said she was not working the day of the incident, but the next day Resident #1 told her she was transferred without the mechanical lift the night before, and her leg got twisted but she never hit the floor. CNA L said Resident #1 was alert and oriented and said she had pain in her right leg. CNA L said Resident #1 had never asked her to be transferred the way therapy did (not using the mechanical lift). CNA L said she always waited for a 2nd person to assist with any mechanical lifts. During an observation on 10/7/24 at 11:49 a.m. CNA M, CNA N, and CNA O were observed doing a wheelchair to bed mechanical lift transfer on Resident #5. Resident was non interviewable. During an observation on 10/7/24 at 12:10 p.m. CNA M, CNA O, and CNA P were observed doing a bed to wheelchair mechanical transfer on Resident #6. Resident was non interviewable. During an observation on 10/7/24 at 12:25 p.m. CNA K, and CNA Q were observed doing a wheelchair to bed transfer on Resident #7. Resident #7 was non interviewable. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455673	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/07/2024
NAME OF PROVIDER OR SUPPLIER Parkwood IN the Pines		STREET ADDRESS, CITY, STATE, ZIP CODE 902 Hill Street Lufkin, TX 75904	

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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 0689 Level of Harm - Actual harm Residents Affected - Few	During an observation and interview on 10/7/24 at 12:45 p.m. CNA R, and CNA L were observed doing a wheelchair to bed transfer with the mechanical lift on Resident #8. Resident #8 said he felt comfortable during transfers, had never had any problems and had no issues with the staff transferring him. No issues were found with observations. During an interview on 10/7/24 at 1:05 p.m. the DON said that all staff were being inserviced on the mechanical lift, and competency check offs were being done. Record review of a facility policy titled Lifting Machine, Using a Mechanical with a revision date of 1/125/24 indicated At least two nursing assistants are needed to safely move a resident with a mechanical lift Record review of in-service training records provided by the facility indicated the following: On 10/2/24 CNA J was inserviced on[mechanical] lift transfers/2 person assist. All residents listed as 2 person assist/mechanical lift transfers must be transferred per kardex/care plan for safety of staff and resident. Training record was signed by CNA J. On 10/2/24 clinical staff were inserviced on mechanical lift transfers/2 person assist. On 10/4/24 clinical staff were inserviced on how to access care information on the kardex. Record review of a Competency Assessment form for lifting machine, mechanical lift indicated that from 10/4/24-10/6/24, 43 staff members had completed competency check offs on using the mechanical lift.