STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555668	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Norwalk Skilled Nursing & Wellness Centre, LLC	11510 Imperial Highway Norwalk, CA 90650

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** 49573 Based on observation, interview and record review, the facility failed to ensure the resident, who was transferred by a mechanical lift (a device used to transfer residents from a bed to a chair or between surfaces), did not fall from the lift during transfer and sustained injuries for one of three sampled residents (Resident 1). The facility failed to: 1. Ensure Certified Nursing Assistant (CNA 1) did not transfer Resident 1 by herself from a bed to a shower chair (a movable or permanently installed seat for the tub or shower) by using a mechanical lift (a device used to transfer residents from a bed to a chair or between surfaces). 2. Ensure CNA 1 did not use a mechanical lift sling (accessory attached to a mechanical lift [device used to transfer residents from one surface to another]) with worn out straps to transfer Resident 1 from bed to shower chair. 3. Ensure staff followed the mechanical lift Manufacturer ' s User Manual guide dated 2016 and 10/1/2018 which indicated after each laundering the sling must be inspected for wear, tears, and loose stitching. Slings that have been bleached, torn, cut, frayed, or broken are unsafe and could result in injury and should be discarded immediately. These failures resulted in Resident 1 falling from the mechanical lift to the floor and sustaining a bump (swelling) on the right parietal (located near the back and top of the head) area of the head, a right frontal (front) scalp hematoma (discoloration of skin, due to bleeding under the skin) and soft tissue swelling (inflammation and fluid buildup, that can potentially feel tender or painful) in her right elbow. Resident 1 was admitted to the General Acute Care Hospital (GACH) for three days for evaluation and treatment. Findings: During a review of Resident 1 ' s Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including morbid obesity (having too much body fat), dementia (a progressive state of decline in mental abilities) and chronic kidney disease (a long-term condition that occurs when the kidney are damaged and can ' t filter blood properly). (continued on next page)

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
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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 a review of Resident 1 ' s History and Physical (H&P) dated 5/10/2024, the H&P indicated Resident 1 had fluctuating capacity to understand and make decisions. During a review of Resident 1 ' s Minimum Data Sheet (MDS- a resident assessment tool), dated 8/30/2024, the MDS indicated Resident 1 had moderately impaired cognitive (thought process) skills for daily decision making and was dependent (helper does all of the effort to complete activities, the assistance of two or more helpers is required) on self-care abilities such as oral hygiene, toileting, shower/bathing, upper and lower body dressing and mobility such as rolling left and right, sitting to lying, lying to sitting and bed to chair transfers. During a review of Resident 1 ' s untitled Comprehensive Care Plan dated 10/5/2022, the Comprehensive Care plan indicated Resident 1 was able to transfer from bed to chair with extensive assistance, requiring two persons assistance. During a review of Resident 1 ' s untitled Comprehensive Care Plan dated 5/16/2023, the Comprehensive Care Plan Indicated Resident 1 was dependent on staff and needed physical assistance with mobility (ability to move freely) and with completion of physical activities such as eating, bathing, and transfers. The Care Plan indicated to use a mechanical lift as indicated for transfer. During a review of the Nurses Progress Notes, dated 10/15/2024, and timed at 10:55 a.m., the Nurses Progress Notes indicated Resident 1 had a fall in her room on 10/15/2024. The Nurses Progress notes indicated Resident 1 had a pain level of 6 on a pain scale (a tool for pain rating as follows: 1-4 mild pain, 5-7 moderate pain, 8-10 severe pain) to the occipital (back of the head) area. The Nurses Progress Notes indicated Resident 1 was being transferred from bed to shower chair, and as she was being lowered with the mechanical lift at about two feet from the ground, the resident moved, the sling hook broke, and Resident 1 fell to the floor. During a review of Resident 1 ' s Change of Condition (COC), dated 10/15/2024 and timed at 10:40 a.m., the COC indicated Resident 1 had a fall in the resident ' s room on 10/15/2024. The COC indicated Resident 1 was complaining of a pain level of 6 out of 10 (pain scale 0-no pain - 10 excruciating pain) at the back of her head. During a record review of Resident 1 ' s Order Summary Report (Physician ' s orders) dated 10/15/2024, the Order Summary Report indicated a physician ' s order dated 10/15/2024 to transfer Resident 1 to the GACH via 911 (by emergency transportation services) due to a fall. During a record review of Resident 1 ' s GACH H&P Note dated 10/15/2024 and timed at 3:54 p.m., the GACH H&P Notes indicated Resident 1 was admitted for further management due to a mechanical fall with imaging results indicating a mild subarachnoid (brain tissue) hemorrhage and a right frontal scalp hematoma. During a review of Resident 1 ' s Nurses Progress Notes dated 10/18/2024 and timed at 3:03 p.m., the Nurses Progress Notes indicated Resident 1 was admitted back to the facility. The Nurses Progress Notes indicated that Resident 1 stated her right arm and the right side of her face were tender. The Nurses Progress Notes indicated Resident 1 had discoloration on the right shoulder, right upper arm, right elbow, and a bump with discoloration on the right parietal area of the head. Resident 1 complained of a headache pain level rated 3 out of 10. (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 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1 ' s Investigation Conclusion Letter, dated 10/19/2024, the Facility Investigation Conclusion Letter indicated CNA 1 was backing up the mechanical lift, with Resident 1 on it, from the bed to place Resident 1 on the shower chair, the upper right side of the sling ripped, and the resident fell on the floor. During a telephone interview on 11/25/2024 at 4:06 p.m., CNA 1 stated on 10/5/2024 she was transferring Resident 1 from the bed to the shower chair by herself with the mechanical lift but halfway to the shower chair, the right upper side of the sling hook latch ripped, and Resident 1 fell to the floor. CNA 1 stated the sling had a blue with green rim and was the correct color sling for the resident ' s body size according to what she was told during in-service education she received. CNA 1 stated she did not check the sling for damage such as wear and tear, or threadbare areas of the sling, because the laundry staff checked the slings for damage before they made them available for use to transfer residents. During a concurrent observation and interview on 11/26/2024 at 9:58 a.m., with Resident 1, in her room, Resident 1 stated on the day of the fall, CNA 1 put her on the mechanical lift and did the transfer by herself. Resident 1 stated she fell from the mechanical lift during the transfer and hit her head and arm. Resident 1 pointed to the right side of her head near her forehead where there was a bump. Resident 1 stated her head still hurts sometimes and that her right arm has been hurting after the fall. Resident 1 stated she used to eat independently but now it is harder because of the pain in her right arm. Resident 1 stated she was unable to elevate her right arm up since the fall. During an interview on 11/26/2024 at 11:43 a.m., CNA 2 stated he was the CNA that was helping CNA 1 with transferring residents from bed to shower chair using the mechanical lift on that day. CNA 2 stated he was helping CNA 3 transfer Resident 2 from bed to shower chair with the mechanical lift while CNA 1 was getting ready with the supplies needed to transfer Resident 1 from bed to a shower chair. CNA 2 stated he went back to Resident 1 ' s room and saw Resident 1 lying on the floor next to the bed. CNA 2 stated Resident 1 verbalized that her head and right shoulder were hurting. CNA 2 stated when using the mechanical lift to transfer residents, there should be two persons assisting with the mechanical lift. CNA 2 stated the old slings were defective and the facility ordered new slings. The old slings were worn out and ripped. During an interview on 11/26/2024 at 1:00 p.m., with the House Keeping Supervisor (HKS) stated that he has worked in the facility for over [AGE] years, and this was the first time they have replaced the slings in the facility. During an interview on 11/26/2024 at 1:16 p.m., Licensed Vocational Nurse (LVN 1) stated Resident 1 required a total care (residents who need help with all their daily activities such as bathing, toileting, eating). LVN 1 stated there could be severe injury when Resident 1 fell from the sling and hit her head on 10/15/2024. LVN 1 stated the situation could have been prevented if the transfer with a mechanical lift was done with two persons assistance and the sling was inspected prior to using it to transfer Resident 1. (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 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 11/26/2024 at 1:40 p.m., Registered Nurse Supervisor (RNS 1) stated Resident 1 was totally dependent on staff for shower and bathing. RNS 1 stated on the day of the fall (10/15/2024), she found Resident 1 on the floor and Resident 1 told her the back of her head was hurting. RNS 1 stated Resident 1 complained that her pain level was a 7 or 8 out of 10 on the pain scale. RNS 1 stated the incident could have been prevented if staff had inspected the sling to make sure it was in good condition. RNS 1 stated before CNA 1 transferred Resident 1, CNA 1should have been made sure there was another staff member to assist her transfer Resident 1 with the mechanical lift. RNS 1 stated that if CNA 1 had called for some help, it might have helped to prevent the fall. During an interview on 11/26/2024 at 2:05 p.m., the Director of Staff Development (DSD) stated staff were in-serviced (trained) on the use of a mechanical lift to use two or three persons transfer assistance. The DSD stated the slings were based on height and weight of the residents and staff were to use the slings associated with the residents ' height and weight. The DSD stated the correct size sling for Resident 1 was a large, which was the sling with the green and blue rim. The DSD stated the slings should be checked prior to using it to transfer the resident to make sure it was in good working condition. The DSD stated new slings were ordered after the incident that happened with Resident 1. The sling used to transfer Resident 1 was worn out and ripped indicating it was old, and the color was faded from multiple washes. The DSD stated the Administrator (ADM) and Central Supply staff ordered new slings after this fall incident. During an interview on 11/26/2024 at 4:03 p.m., the Director of Nursing (DON) stated on 10/15/2024, Resident 1 fell on the floor from the mechanical lift during transfer. The DON stated Resident 1 was transferred to the GACH because the resident fell with a head injury and the resident complained of pain to the back of her head. The DON stated the incident could have been avoidable if CNA 1 waited for another CNA to help her with Resident 1 ' s transfer via mechanical lift. The DON stated any transfer with the mechanical lifts must be done by two to three persons assistance. The DON stated the sling ripped on the hook that was attached to the black strap that was attached to the sling. The DON stated CNA 1 should have checked the sling before using it to transfer Resident 1. The DON stated all slings used to transfer residents with the mechanical lift were replaced on 10/22/2024 after Resident 1 ' s fall. The DON stated that slings were replaced if there were noted wear and tear, and the nursing staff should have checked to make sure all slings were intact. During an observation and interview on 11/27/2024 at 9:15 a.m., with the Occupational Therapist (OT) in Resident 1 ' s room, Resident 1 ' s OT treatment session was observed. The OT stated Resident 1 was dependent on staff for activities of daily living but was able to eat on her own. The OT stated Resident 1 did have pain with movement in her right arm. Resident 1 stated she was in pain in her head and right arm , and the OT told Resident 1 it was expected for someone who fell . During a record review of the facility's policy and procedure (P/P), titled Total Mechanical Lift, revised 4/27/23, indicated mechanical lifts are devices used to assist with transfers and movement of individuals who require support for mobility beyond the manual support provided by nursing staff alone .nursing staff will receive training on how to use the mechanical lift .at least two people are present while resident is being transferred with the mechanical lift. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a record review of the mechanical lift Manufacturer ' s User Manual dated 10/1/2018, the Manufacturer User Manual guide indicated recommends included that two assistants be used for all lifting preparation, transferring from, and transferring to procedures. After each laundering (in accordance with instructions on the sling), inspect sling(s) for wear, tears, and loose stitching. Slings that have been bleached, torn, cut, frayed, or broken are unsafe and could result in injury and should be discard immediately. During a record review of the mechanical lift Manufacturer ' s User Manual dated 2016, the Manufacturer User Manual instructions indicated to not lift a resident unless you are trained and competent to do so, plan your lifting operations before commencing, familiarize yourself with the operating control and safety features of a lift before lifting a patient, do not use a sling unless it is recommended for use with the lift, check the sling is suitable for the particular patient and is of the correct size and capacity and, never use a sling, which is frayed or damaged.

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49573 Based on interview and record review, the facility failed to ensure Certified Nursing Assistant (CNA) 1 was competent to use the mechanical lift (a device used to transfer a resident from one surface to another) to transfer a resident (Resident 1) from bed to shower chair in accordance with professional standards of practice. This failure resulted in Resident 1 falling from the sling and suffering a head injury when CNA 1 transferred Resident 1 from bed to shower chair without assistance from another staff member. Findings: During a review of Resident 1 ' s Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including morbid obesity (having too much body fat), dementia (a progressive state of decline in mental abilities) and chronic kidney disease (a long-term condition that occurs when the kidney are damaged and can ' t filter blood properly). During a review of Resident 1 ' s History and Physical (H&P) dated 5/10/2024, the H&P indicated Resident 1 had fluctuating capacity to understand and make decisions. During a review of Resident 1 ' s Minimum Data Sheet (MDS- a resident assessment tool), dated 8/30/2024, the MDS indicated Resident 1 had moderately impaired cognitive (thought process) skills for daily decision making and was dependent (helper does all of the effort to complete activities, the assistance of two or more helpers is required) on self-care abilities such as oral hygiene, toileting, shower/bathing, upper and lower body dressing and mobility such as rolling left and right, sitting to lying, lying to sitting and bed to chair transfers. During a review of Resident 1 ' s untitled Comprehensive Care Plan dated 5/16/2023, the Comprehensive Care Plan Indicated Resident 1 was dependent on staff and needed physical assistance with mobility (ability to move freely) and with completion of physical activities such as eating, bathing, and transfers. The Care Plan indicated to use a mechanical lift as indicated for transfer. During a review of Resident 1 ' s untitled Comprehensive Care Plan dated 10/5/2022, the Comprehensive Care plan indicated Resident 1 was able to transfer from bed to chair with extensive assistance, requiring two persons assistance. During a review of Resident 1 ' s untitled Comprehensive Care Plan dated 5/16/2023, the Comprehensive Care Plan Indicated Resident 1 was dependent on staff and needed physical assistance with mobility (ability to move freely) and with completion of physical activities such as eating, bathing, and transfers. The Care Plan indicated to use a mechanical lift as indicated for transfer. (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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the Nurses Progress Notes, dated 10/15/2024, and timed at 10:55 a.m., the Nurses Progress Notes indicated Resident 1 had a fall in her room on 10/15/2024. The Nurses Progress notes indicated Resident 1 had a pain level of 6 on a pan scale (a tool for pain rating as follows: 1-4 mild pain, 5-7 moderate pain, 8-10 severe pain) to the occipital (back of the head) area. The Nurses Progress Notes indicated Resident 1 was being transferred from bed to shower chair, and as she was being lowered with the mechanical lift at about two feet from the ground, the resident moved, the sling hook broke, and Resident 1 fell to the floor. During a review of Resident 1 ' s Change of Condition (COC), dated 10/15/2024 and timed at 10:40 a.m., the COC indicated Resident 1 had a fall in the resident ' s room on 10/15/2024. The COC indicated Resident 1 was complaining of a pain level of 6 out of 10 (pain scale 0-no pain - 10 excruciating pain) at the back of her head. During a record review of Resident 1 ' s Order Summary Report (Physician ' s orders) dated 10/15/2024, the Order Summary Report indicated a physician ' s order dated 10/15/2024 to transfer Resident 1 to the GACH via 911 (by emergency transportation services) due to a fall. During a review of Resident 1 ' s Nurses Progress Notes dated 10/18/2024 and timed at 3:03 p.m., the Nurses Progress Notes indicated Resident 1 was admitted back to the facility. The Nurses Progress Notes indicated that Resident 1 stated her right arm, and the right side of her face were tender. The Nurses Progress Notes indicated Resident 1 had discoloration on the right shoulder, right upper arm, right elbow, and a bump with discoloration on the right parietal area of the head. Resident 1 complained of a headache pain level rated 3 out of 10. During a concurrent observation and interview on 11/26/2024 at 9:58 a.m., with Resident 1, in her room, Resident 1 stated on the day of the fall, CNA 1 put her on the mechanical lift and did the transfer by herself. Resident 1 stated she fell from the mechanical lift during the transfer and hit her head and arm. Resident 1 pointed to the right side of her head near her forehead where there was a bump. During a telephone interview on 11/25/2024 at 4:08 p.m., CNA 1 stated she received in-service education for the mechanical lift, but it was general verbal education and sometimes return demonstration with the mechanical lift, but it was not done often. CNA 1 stated it would have been nice to have more in-services with return demonstration, so the staff can get immediate feedback on what they did well or what they need to improve. During an interview on 11/26/2024 at 1:20 p.m., Licensed Vocational Nurse (LVN) 1 stated Resident 1 needed help with all transfers. LVN 1 stated two persons need to assist for transfers with the mechanical lift. During an interview on 11/26/2024 at 1:43 p.m., RNS 1 stated CNA 1 did not ask for help to transfer Resident 1 with the mechanical lift. RNS 1 stated staff were in-serviced on how to use the mechanical lift for transfers, but a return demonstration was not done for all the staff that participated in the in-service. (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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 11/26/2024 at 2:15 p.m., the Director of Staff Development (DSD), the DSD stated the last mechanical lift in-service done for the staff was lecture based meaning it was verbal education, and no return demonstration. The DSD stated when CNA 1 used a mechanical lift, CNA 1 did not follow the policy and procedure and call for help. The DSD stated the CNA 1 did not wait for another CNA to come help with the mechanical lift transfer. During an interview on 11/26/2024 at 4:05 p.m. the Director of Nursing (DON), stated with a mechanical lift transfer, two staff members need to assist with the transfer. The DON stated during a mechanical lift transfer one person guides the resident when they are being lowered while the other person controls the mechanical remote. The DON stated CNA 1 should not have transferred Resident 1 with a mechanical lift by herself. During a concurrent observation and interview on 11/27/2024 at 10:37 a.m., with Restorative Nursing Assistant (RNA) 1 and RNA 2 a demonstration on how to use the mechanical lift with the Maintenance Supervisor (MS) as the willing participant and the DON was observed. The RNAs stated they do not remember the last in-service on the mechanical lift. The MS sat on the mechanical lift sling that had been placed in the wheelchair. RNA 1 put the hook in the yellow and green hook latches on the mechanical lift arms incorrectly. RNA 2 put the hook in the red and green hook latch on the Hoyer lift arms correctly. RNA 1 used the mechanical remote to lift the MS up with the mechanical lift while RNA 2 guided the MS who was sitting in the sling, up and off the wheelchair. RNA 1 and RNA 2 did not engage the brakes after the MS was suspended off the wheelchair and moved away from the wheelchair. The RNAs then repositioned the MS above the wheelchair to lower the MS back down into the wheelchair. The RNAs stated they have never had to do a return demonstration on the mechanical lift during in-services they have received. RNA 1 and RNA 2 stated it would have been better to do the return demonstration to know if they performed the task correctly and if they need to make any changes. During an interview on 11/27/2024 at 10:50 a.m., with the DON, who observed the two RNAs demonstrate how to use the mechanical lift, the DON stated to operate the Hoyer lift, there needs to have 2 persons to check the other ' s work. The DON stated the hook latches need to be placed on the on the correct hook latches. The DON stated the brakes needed to be engaged after lifting the MS up and moving the MS off the wheelchair. During a record review of the facility ' s policy and procedure (P/P) titled Transfer of Residents, dated 5/4/23, the P/P indicated residents will be lifted or transferred according to the assessment and needs of residents . residents who require assistance in transferring may be transferred using a gait/transfer belt or with a mechanical lift .nursing staff receive education on good body mechanics, proper procedures for transfers, and use of assistive devices. During a record review of the facility ' s job description, titled Director of Staff Development, no date, indicated coordinates and conducts an effective on going in service plan to all employees .provides and coordinates mandatory annual in-services to all facility employees in accordance with state and federal regulations and company policy .monitor, support, teach and supervise the nursing staff on established procedures, both clinical and theory, on an on-going basis including follow through with one on one teaching techniques as needed .provide annual proficiency evaluations on nurse assistants while supervising nursing skills and procedures as they relate to the nurse assistant ' s duties. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of the facility ' s job description, titled Certified Nursing Assistant, no date, indicated perform all duties as assigned and in accordance with facility ' s established policies and procedures, nursing care procedures and safety rules and regulations .attends in services educational programs, on the job training programs and meeting as directed.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49573 Based on observation, interview and record review, the facility failed to maintain and calibrate (the process than ensures the reading and functionality of a device is accurate and in full working order) on 2 of 5 mechanical lifts (a device used to transfer residents from a bed to a chair or other similar places) mechanical lift 1 and mechanical lift 2 for use to transfer residents of the facility from one surface to another in the facility. This deficient practice had the potential to cause injury to any resident if the mechanical lift that was used to determine the weight of the resident was inaccurate. The inaccurate weight of the resident could lead to the wrong sling being used to transfer residents based on the height and weight of the resident. Findings: During a concurrent observation and interview on 11/27/2024 at 10:30 a.m. with the Maintenance Supervisor (MS), Restorative Nursing Assistant (RNA) 1 and RNA 2 and the Director of Nursing (DON), the RNAs are demonstrating the use of the mechanical lift 1 to weigh the MS and show the lifting procedure. Based off what the MS stated his weight was, the sling with the green trim was chosen. The sling was placed on the wheelchair and the MS sat in the seat. The RNAs calibrated mechanical lift 1 by using a 25 pounds (lbs., unit of measurement) weight to zero the mechanical lift scale. The RNAs lifted the MS off the wheelchair and weighed the MS with mechanical lift 1. The MS weighed 164.4 lbs. on mechanical lift 1. Next the RNAs calibrated the standing scale (weight reading obtained by standing on the base) doing the same method of calibration with mechanical lift 1. The MS stepped onto the standing scale; the weight showed the MS weighed 167.9 lbs. During a concurrent observation and interview on 11/27/2024 at 11:11 a.m., with the MS, RNA 1, RNA 2 and the DON, the RNAs demonstrated the use of mechanical lift 2 to weigh the MS. The RNAs calibrated mechanical lift 2 doing the same method of calibration with mechanical lift 1. The RNAs lifted the MS off the wheelchair with mechanical lift 2 and sling and weigh the MS. The MS weighed 169.4 lbs. The MS stated the Mechanical lifts were calibrated annually with the last calibration date being January 2024, so the next calibration date was January 2025. The MS stated if there were discrepancies, he would call the manufacturer to troubleshoot and calibrate the mechanical lifts but does not know if there were any discrepancies unless the facility weighs each resident multiple times on multiple mechanical lifts that they have in the facility which was not feasible. The MS stated with the three different numbers for weights, the machines were not accurate in determining weight. During an interview on 11/27/2024 at 12:31 p.m., the Administrator (ADM) stated we need to have the correct weight of the resident to use the correct sling. The ADM stated if the weight of the resident was incorrect, the wrong sling would be used to transfer the resident. The ADM stated if the wrong sling was used, the sling could break and there could be injury to the resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555668	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Norwalk Skilled Nursing & Wellness Centre, LLC	11510 Imperial Highway Norwalk, CA 90650

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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of the Admission Record for Resident 1, the Admission Record indicated Resident 1 was admitted to facility on 9/23/22 and readmitted on [DATE] with diagnoses of morbid obesity (having too much body fat), dementia (a progressive state of decline in mental abilities) and chronic kidney disease (a long-term condition that occurs when the kidney are damaged and can ' t filter blood properly). During a record review of the manufacturer's user manual titled mechanical lift User Manual dated 2022, the manual indicated the mechanical lift will be calibrated at the factory with the load cell. Should it be necessary to recalibrate the scale, complete the following instructions. To calibrate the Mechanical lift, when CAL1 was selected, you would need 50 pounds of weight to calibrate the Mechanical lift and when CAL2 was selected, you would need 200 pounds of weight to calibrate the Mechanical lift.