STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675093	A. Building B. Wing	03/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeside Rehabilitation and Care Center	4306 24th St Lubbock, TX 79410

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43344 Based on observation, interview, and record review, the facility failed to ensure the residents received treatment and care in accordance with professional standards of practice for 1 of 6 residents (Resident #1) reviewed for Quality of Care. The facility failed to transfer Resident #1 to bed on 03/03/25 resulting in him staying up in his wheelchair until the following morning (03/04/25). These failures could place residents at risk of not receiving necessary care or appropriate transfer. Findings included: Record review of Resident #1's face sheet, dated 03/11/25, revealed an [AGE] year-old-male was admitted to the facility on [DATE] with diagnoses to include muscle weakness, sleep apnea (sleep disorder characterized by repeated pauses in breathing during sleep), hereditary and idiopathic neuropathy (underlying nerve damage), and major depressive disorder, Transient Ischemic Attack (temporary interruption of blood flow to the brain that causes stroke-like symptoms that resolve within 24 hours). Record review of Resident #1's Comprehensive Minimum Data Set, dated dated [DATE], revealed: Section C Brief Interview for Mental Status score revealed a score of 12, which indicated the resident's cognition was mildly impaired. Section GG0115. Functional Limitation in Range of Motion: Impairment on both sides in lower extremity (hip, knew, ankle foot) Section GG0120. Mobility Devices: Wheelchair (manual or electric) Section GG0170. Functional Abilities- Admission: Chair to bed transfers:01 Dependent-Helper does all of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity. Section M Skin Conditions M0150. Risk of pressure ulcers/injuries (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Is this resident at risk of developing pressure ulcers/injuries? Coded 1 = Yes Does this resident have one or more unhealed pressure ulcers/injuries? Coded 0 =No Section V Care Area Assessment (CAA) Summary: CAA Results: 05. ADL Function Record review of Resident #1's care plan, dated 12/02/24, revealed: Problem: Resident #1 had an ADL self-Care performance deficit r/t paraplegia initiated 12/02/24. Goal: Resident #1 would maintain current level of function through the review date. (date initiated. (review period 02/08/25-04/28/25) Interventions: Transfer. Resident #1 was totally dependent on 2 staff for transferring. Initiated 1/28/25. Transfer. Resident #1 required Mechanical lift with 2 staff assistance for transfers. Initiated 1/28/25. Record review of Resident #1's physician order, dated 2/19/25, did not reveal a physician order for the use of a mechanical lift or any other alternative transfer methods. Record review of Resident #1's EMR revealed on 01/13/25 he weighed 286.2 pounds Record review of Resident #1's progress note dated, 1/11/25-03/12/25, revealed: On 03/04/25 at 7:37 AM, the ADM documented he spoke with Resident #1 about his refusal to allow the staff on the morning of 03/04/25 to transfer him to bed, and Resident #1's response was, I don't want to get out of my chair. The ADM documented when he asked Resident #1 if he was comfortable, Resident #1 responded, This chair was custom-made for me where it can go flat and offload. The ADM documented after multiple attempts, Resident #1 agreed to be transferred to his bed. Once the transfer was completed, Resident #1 stated he was comfortable and resting. On 03/04/25 at 8:11 AM, the ADON documented she entered the facility and discovered Resident #1 had not been assisted to bed throughout the PM shift. The ADON asked Resident #1 to allow them to put him to bed, and Resident #1 did not want staff to hurt his back and refused assistance to bed. The ADON documented Resident #1 provided her a letter stating the reason for not being assisted to bed r/t mechanical lift, and the night staff resident signed it. The ADON documented EMS was contacted to assist in putting Resident #1 to bed, and he refused. EMS staff (x3) arrived, but Resident #1 refused. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/04/25, LVN B documented Resident #1 needed extra assistance to be transferred into bed. She documented Resident #1 refused help from the EMT and stated it was not the EMT's job to put him in bed; it was facility's responsibility. She documented she attempted to educate Resident #1 on the importance of having an EMT assist with his transfer. Resident #1 continued to refuse. On 03/04/25 at 1:40 PM, RN A documented Resident #1 chose to stay awake and refused to go to bed because he wanted to use the mechanical lift. She documented the mechanical lift only worked for a little while. Record review of a handwritten note, undated, signed by RN A, CNA C, CNA D, and Resident #1 revealed: On this day 03/03/25 to 03/04/25 I CNA C and the other CNA (CNA D) had attempted to use the mechanical lift multiple times to put Resident #1 to bed with multiple attempts. The mechanical lift would not work with multiple attempts. We (CNA C and CNA D) tried plugging it up and unplugging it. The other CNA (CNA D) was able to get it to work for 5 seconds until it no longer decided to work. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/11/25 at 8:21 AM, Resident #1 stated on 03/03/25 the mechanical lift was not working, so he had to sit up in his wheelchair all night until the morning of 03/04/25. He stated he did not remember the names of the staff members who were working. He stated one of the aides started with the letter M. He stated there was one nurse and two aides. He stated that when he requested to go to bed (unsure of the time), the aide (did not know her name) attempted to use the mechanical lift, which was not working. He stated that he was not in any pain, but sitting in his wheelchair was uncomfortable. He stated after he requested to go to bed and they realized that the mechanical lift was inoperable, no additional attempts to put him in bed were made because he told the staff from the beginning that he did not want the staff to get hurt or risk the chance of being dropped. Resident #1 stated that the aide did offer to have him sit at the nurse's station with her and keep her company until they could figure out what to do. He stated he did not know if the staff contacted anyone to tell them that the mechanical lift was not working. He stated he did not feel neglected. He stated he did not have a bowel movement, but if he had one, that would have been challenging. He stated he did not have a need to be changed because he has a suprapubic catheter (urinary catheter that is inserted directly into the bladder) and did not have a bowel movement. Resident #1 stated he had one of the aides write a letter for him because he could not write for himself. He stated he had them sign it. He stated the letter indicated that he could not go to bed because the mechanical lift was not working. He stated the following day when the nurse came in he was told that he could get in trouble for having the aides sign the paper. He stated he did not know the nurse's name, but he gave her the letter and told her that he did get put in bed because the mechanical lift was not working. Resident #1 stated he reported to the nurse did not want the night staff to put him in bed because there were not enough of them. He stated he did not want the staff to get hurt, nor did he want the staff to drop him. He stated he had been dropped at another facility and was afraid of falling. He stated on 03/04/25 the nurse, whom he did not know her name, called the EMS, but he refused their services. He stated he did not want EMS to assist him because in the past, when he was at home, if he called EMS, he was sent a bill. He stated he did not want to pay a bill and he felt like the facility staff were paid to take care of him and they should be the one to put him to bed. He stated after he refused, the ADM came to him and explained that he would not be billed. Resident #1 stated there was only one mechanical lift in the facility. He stated if the mechanical lift were not working, he would need more than three people to lift him. He stated that he was tall, and he was dead weight. He stated, in the past, he had at least three people on each side. He stated on 03/04/25 it took 8 people to transfer him. He stated he had three people on each side, one at his head and one at his foot. He stated he could not remember the names of the staff members who helped transfer him but was confident that the DOR assisted him. He said he felt safe and comfortable with the transfer on the morning of 03/04/25. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/11/25 at 10:39 AM, the DOR stated she believed 03/06/25 was when the mechanical lift stopped working, and they had to assist in transferring Resident #1 from his wheelchair to the bed. She said it took a total of 8 people for safety and because of the weight of Resident #1. She stated Resident #1 was 300 plus pounds. She stated it was around 9:45 AM. She said she could not remember who had assisted, but she remembered it was her, the OT, the ADON, the ADM, CNA E, and maybe some other therapist and aides. She stated she did not know the details of how long he had been in his wheelchair. She stated Resident #1 came from a different facility and had always used the mechanical lift because of his size. She stated the nursing staff was responsible for training the clinical staff on the alternative transfer method if the mechanical lift was inoperable. She stated if the resident was on therapy services, therapy would have input. She stated determining an appropriate transfer for residents was for safety, weight bearing, skin integrity and ensuring that doctor orders were followed. She said nursing determined the transfer unless the resident was under therapy services. She said the facility had one mechanical lift. She said that Resident #1 alternative transfer when the mechanical lift was not working was a minimum of 4 staff should be used. She stated that it was a guess that a minimum of 4 staff should be used. She stated she was unaware of residents being left in their wheelchair for long periods. During an interview on 03/11/25 at 11:05 AM, the ADON stated the purpose of determining an appropriate transfer was to maintain overall safety. She stated therapy was responsible for determining a resident transfer. She stated if the mechanical lift was not working, the alternative was to get staff to put them in bed. She stated there were more staff during the day, and they could use therapy staff to their advantage. The ADON stated recently, there was an incident where a resident gave her a note. She stated she had discovered that the resident had been in his chair all night. The ADON said once this was brought to her attention, she started working on getting him in bed. She stated the resident did not want the staff to transfer him because he stated they (the staff) had families and did not need to hurt their backs. The ADON stated she called EMS. The ADON stated the resident said he was not going to bed and they, (the staff) could not make him. The ADON identified the resident as Resident #1. She stated she was not notified by either of the 3 staff (RN A, CNA C, and CNA D) that the mechanical lift was not working. The ADON stated that they only have 1 mechanical lift. The ADON stated that Resident #1 transfer alternative was two people when the mechanical lift was not working. She said she did not help transfer Resident #1 to bed the morning (03/04/25) after he stayed up all night. During an interview on 03/11/25 at 11:59 AM, RN A stated she worked the night shift that started on 03/03/25 and ended on 03/04/2025. She said on 03/03/25, she offered to put Resident #1 to bed, and Resident #1 refused. She stated the reasoning that Resident #1 gave was because he did not want anyone to get hurt. RN A stated that it was reported to her by the aides who worked on 03/03/25 that the mechanical lift was not working. RN A stated she did not attempt to operate the mechanical lift. She said she did not test the mechanical lift because she never had the opportunity to do so. RN A said she did not report the issue with the mechanical lift or that they could not place Resident #1 in bed the entire night because Resident #1 was not in any pain. She said Resident #1 seemed to want to be up all night. She said Resident #1 did not say specifically that he wanted to be up all night. She said she assumed he wanted to be up all night because he was up all night talking to staff. She stated she did attempt to put him in bed, but he refused because he did not want to hurt the staff. She said Resident #1 was up all night and did not sleep. She said it was customary that he stayed up late. She stated she had not received any training on the mechanical lift. She stated she had not been trained on what to do if the mechanical lift was not working. She stated that she believed they may have been able to place Resident #1 in the bed, or they could have called EMS. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/11/25 at 12:15 AM, the OT stated that 03/04/25 he assisted with transferring Resident #1 from his wheelchair to his bed. He stated there were 3-4 staff on the same side that he was on. He said there were 3 to 4 staff on the other side and at least one staff supervising. He stated Resident #1 was nervous but the more staff that showed up to help Resident #1 became more comfortable. The OT stated he did not check the mechanical lift because he does not normally deal with the mechanical lift. He stated he assumed the mechanical lift had already been checked, which was why they performed the transfer. He said he assumed Resident #1 had been up since breakfast but was unsure how long Resident #1 had been up in his wheelchair. He said he does not feel like 2 people could safely do Resident #1's transfer manually because it would be unsafe due to his size. During an interview on 03/11/25 at 12:24 PM, MA F stated she worked on 03/03/25 and 03/04/25. She said she left late on 03/03/25 at 9:00 PM. She said she observed Resident #1 up in his wheelchair. She said it was not unusual for Resident #1 to be up late at night in his wheelchair. She said she returned the next day, on 03/04/25, at 7:00 AM, and noticed Resident #1 was still in his wheelchair. She said Resident #1 told her that he stayed up all night and never went to bed. She said Resident #1 said the mechanical lift was broken. She said Resident #1 wanted to wait for the DON, ADON, and the ADM so that he could talk with them. MA F said the ADON called EMS to help, but Resident #1 refused the help. She said Resident #1 said it was the facility's job to put him in bed. She said Resident #1 did not mention anything about staff attempting to put him in bed on the overnight shift. She said the mechanical lift had not stopped working before. She said this was the first time she knew Resident #1 had stayed up for 24 hours. She said if the mechanical lift was not operational, she does not believe two staff could transfer him because he was on the heavier side. She said it was her understanding that it took at least 5 people to transfer him, but she did not assist because she was on the other side of the facility. She said she did not observe the transfer but knew he was scared to be transferred as he did not want to hurt the staff. She said for sure with Resident #1, it would take at least 4 staff to transfer Resident #1 manually. She said she had not received mechanical lift training at the facility. She said there was one mechanical lift at the facility and that she had never been trained on what to do if the mechanical lift was inoperable. During an interview on 03/11/25 at 12:33 PM, CNA E stated on 03/04/25, she did not assist with transferring Resident #1 to his bed. She stated she could not help because there were too many people. She stated it was about 8 people in the room. She said that EMS was called, but Resident #1 refused their help because Resident #1 said placing him in bed was the facility staff's job. She said the mechanical lift had been out on 03/03/25. She said they had done bed baths on 03/03/25 because the mechanical lift was not working. She reported the issue to the DON, and the ADON looked at the mechanical lift. She said the mechanical lift will sometimes not work if you do not plug it up. CNA E said she had been trained in using the mechanical lift and that the facility only had one. She said if the mechanical lift does not work, they will let the residents stay in bed and check on them every two hours. She said regarding Resident #1, no one knew what to do. She said they called the EMS, and Resident #1 did not want to get in bed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/11/25 at 1:01 PM, CNA G stated 03/03/25 they got Resident #1 up that morning with the mechanical lift. She said the battery was not staying charged. She said they could get him in the chair with the mechanical lift. She said they asked him if he wanted to return to bed when they saw the mechanical lift not operating correctly. CNA G stated Resident #1 said he wanted to stay up in his wheelchair. She said she reported the incident to LVN I. She said she thought everyone knew about it because Resident #1 said he would also tell everyone about it. She said the next day, on 03/04/25, Resident #1 was still up in his wheelchair and was told that the mechanical lift battery would not say charged. She said she spoke with CNA C and was told that they attempted to lay him down multiple times during the night shift, and Resident #1 was reused. She said Resident #1 did not want them (the staff on the morning of 03/04/25) to lay him (Resident #1) down. CNA G said Resident #1 wanted to wait for the ADM to come in. She said she immediately called the DON and reported Resident #1 was still up, the mechanical lift was not working, and Resident #1 refused to allow them to lay him down in bed. CNA G said the DON was unaware that Resident #1 had been up all night. CNA G said they offered to lay Resident #1, and the EMS staff also tried, but Resident #1 refused. She said after the ADM came in; Resident #1 agreed to have staff lay him down. CNA G said it took 4-5 staff to transfer Resident #1 to bed. She said CNA C told her she did not report the incident because Resident #1 refused when they tried to lay him down. She said she had been trained in the use of the mechanical lift. She said the facility only had 1 mechanical lift. She said this was the first time the mechanical lift had stopped working, so they had not been trained to do anything, but it also depended on Resident #1 if he refused or not. During an interview on 03/11/25 at 12:46 PM, CNA J stated Resident #1 used the mechanical lift with two people. She said she had been trained to get as many people as possible if the mechanical lift was not working. She said she had not been trained at the current facility but had worked with Resident #1 at another facility. She said in the past, it took at least four staff members to transfer Resident #1. She said she had no additional information regarding Resident #1 staying up all night. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/11/25 at 2:09 PM CNA C stated she worked on 03/03/25 and ended her shift on 03/04/2025. She said on 03/03/25 at 11:00 PM Resident #1 requested to be put in bed. She said okay and went to retrieve the mechanical lift. She stated that she attempted to move the mechanical lift with the remote, but the machine was inoperable. She stated that she could not get the mechanical lift arm to move up and down. She stated she asked CNA D to come and look at the mechanical lift. She stated they both tried to get the mechanical lift to work. She stated they plugged it in and checked back with the machine within 30 minutes. CNA C stated the mechanical lift was still not operating correctly. She stated CNA D told her (CNA C) that she was able to get the mechanical lift to work. CNA C stated she tried the machine again and the mechanical lift still was inoperable. She said the mechanical lift did move for about 4 minutes, but they did not have Resident #1 in the machine. CNA C stated she reported to RN A that the mechanical lift was not working. She said RN A said she would contact the DON. CNA C said she asked Resident #1 what he wanted to do, and he told her that he did not want them to try to get him in bed because he was too heavy. CNA C said she offered to make Resident #1 coffee and he accepted. CNA C said they only had 1 mechanical lift. CNA C said the mechanical lift had never stopped working before. She stated she had not been trained on the mechanical lift since she had been employed at the facility. She said she had been employed at the facility since 01/13/25. She said Resident #1 used the mechanical lift because his left leg does not work and he was a big [NAME]. She stated that they had not been trained on what to do if the mechanical lift was inoperable, and she felt that with the three staff that worked the night of 03/03/25, they would not have been unable to transfer Resident #1 safely. She said she believed it would take 5-6 people. She stated she was on the only staff that checked on Resident #1 as she was assigned to his hall. She stated she never observed any other staff checking on Resident #1. She said Resident #1 asked her to write a letter for him. She stated she cannot remember what the letter said exactly but it stated, I CNA C have tried to put Resident #1 down multiple times with the mechanical lift and it did not work. CNA C stated she signed it and CNA D signed it. She stated that she had not use the mechanical lift prior to attempting to put Resident #1 to bed. She stated she believed that someone had told CNA D that the mechanical lift was causing staff issues earlier in the day. An observation was made on 03/11/25 at 3:15 PM of the facility's only mechanical lift. It was not plugged in. CNA K used the remote and observed that the mechanical lift arm went all the way up and the mechanical lift arm went all the way down. The locks worked properly. The mechanical lift legs opened and closed. No observations were made of any glitches or malfunctions in the operation of the machine. During an interview on 03/11/25 at 3:28 PM, the Maintenance Supervisor said he was unaware of any issues with the mechanical lift. He stated he did not know much about the incident where the mechanical lift was not working, and Resident #1 stayed up all night. He stated he heard about it and was asked by the ADM to go and look to see if it was charged. He stated he was unaware of the exact date, but when he looked at the mechanical lift, it was operational and did not malfunction. He stated he had no documentation to reflect when he had conducted the check. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/11/25 at 3:59 PM, the DON stated the purpose of an appropriate transfer for residents was to prevent injury to the staff and residents. The DON said that they have two mechanical lifts at the facility. She said there was one on each side of the hall and that they had two batteries as backup. She said regarding Resident #1, if the mechanical lift was not operating, it would take 3-4 staff members, depending on their body type. She stated that on 03/04/25, she received a call from CNA G. She reported Resident #1 stayed up all night in his chair. The DON said she attempted to contact RN A, but she (RNA) did not answer. The DON stated she told CNA G to ensure Resident #1 was placed in bed. She stated she told CNA G to get staff together to assist. The DON stated the ADON and CNA G had told her that the mechanical lift was not working. The DON stated the ADON told her that Resident #1 reported that he did not allow the staff overnight to transfer him because he did not want to hurt the staff. She reported that Resident #1 refused EMS services because putting him in bed was not their (EMS) job. The DON said she knew that something was going on with the mechanical lift around 3:00 PM on 03/03/25, but it was her understanding that the ADM and the maintenance supervisor had checked it. The DON said she did not look at the mechanical lift because she trusted that the ADM said he was taking care of it. The DON stated Resident #1 had a history of refusing treatment. She said she expected to be called if the mechanical lift was not working and Resident #1 refused to go to bed. During an interview on 03/11/25 at 4:23 PM, the ADM stated the purpose of having appropriate transfers was to transfer residents safely. He said the facility only had one mechanical lift. He said it was purchased 3-4 months ago, and the Maintenance Supervisor put it together. He said when he came in on 03/04/25, it was around 7:40 AM. He said the ADON explained to him that Resident #1 was still in his chair from the previous night and that they had contacted EMS. The ADM stated that the ADON told him Resident #1 refused EMS services. The ADM stated he explained to Resident #1 that he (Resident #1) would not be billed and was not taking emergency services away from anyone as Resident #1 had told the ADM those were his concerns. The ADM stated he convinced Resident #1 to allow staff to transfer him. The ADM stated he was focused on ensuring Resident #1 was placed in his bed because he (Resident #1) had an appointment on 03/04/25 at 2:00 PM. The ADM stated that he was unsure but believed it took 3-4 staff to transfer him. The ADM asked Resident #1 about the previous night, and he was told that the mechanical lift was not working and he (Resident #1) did not want the staff to get hurt by transferring him manually. The ADM stated he explained to Resident #1 that the staff were trained to transfer him. He stated after he and his staff transferred Resident #1 on 03/04/25, he checked the mechanical lift, and it worked. The ADM stated no one reported to him on 03/03/25 that the mechanical lift was malfunctioning. He said he was unaware if the Maintenance Supervisor looked at the mechanical lift. The ADM stated they had another battery that was on order. The ADM stated Resident #1 was in a 0-gravity chair which helped relieved pressure. The ADM stated Resident #1 had the right to refuse to be transferred. The ADM stated he was unaware if Resident #1 had a history of refusing ADL care. During an interview on 03/11/25 at 5:32 PM, CNA D stated the mechanical lift was inoperable on 03/03/25. She stated she believed it was the battery. She stated they offered to lift Resident #1 out of his wheelchair manually to the bed but Resident #1 refused stating that he wanted the ADM to see him. CNA D stated Resident #1 said it was the ADM responsibility to make sure the mechanical lift was working. CNA D stated she had been trained by the ADON that three people could transfer Resident #1 if the mechanical lift was not working. CNA D stated that she had been trained on the use of the mechanical lift. CNA D stated that Resident #1 did not allow them to try and transfer him because he was scared and did not believe the staff could do it. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675093	A. Building B. Wing	03/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeside Rehabilitation and Care Center	4306 24th St Lubbock, TX 79410

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation was made on 03/12/25 at 11:12 AM of two staff (CNA G and CNA L) operating the mechanical lift to transfer the ADM from the bed to a chair. The mechanical lift did not malfunction throughout the duration of the transfer. Staff demonstrated their ability to operate the mechanical lift safely. During an interview on 03/12/25 at 11:39 AM the ADON stated regarding quality of care the facility did not have a policy. She said the purpose of quality of care was to maintain continuity. She said the facility could not run properly without a standard of quality of care. The ADON stated that quality of care was a must for taking care of their residents. The ADON stated that the PNO of subpar quality of care could become unsafe for the residents. She said there could be a break in continuity of care. She said good quality of care included the proper transfer and functioning of equipment. The ADON said she was unaware of the mechanical lift was as not working on the night of 03/03/25, She said she was unaware Resident #1 was up the entire night. She said the facility's system to monitor quality of care was they (management) review things such as progress notes daily. She said they also speak with residents and also speak with staff. The ADON stated she had been at the facility since 01/31/25 and she had not had any specific training on quality of care nor had her staff. The ADON stated she expected that quality of care be at 100 percent. She said that since she had been at the facility, she had observed broken systems, but none were related to the mechanical lift and patient transfers. The ADON stated everyone was responsible for the quality of care. She said she was unaware of why Resident #1 did not receive the quality of care he needed or was able to be placed in bed on the night of 03/03/25. During an interview on 03/12/25 at 12:00 PM the DON stated regarding quality of care they did not have a facility policy. She said the purpose of quality of care was to ensure each resident was receiving the best care that they can receive according to what their wants and desires were. She said quality of care was how the resident wants to be treated. She said the resident had the right to refuse to go to bed. She said the PNO if quality of care was subpar was it could lead to neglect or abuse. She said she was unaware of the incident and at the time it happened. She said when she was made aware on 03/04/25 she started telling staff what they needed to do. She said her system to ensure quality of care was acceptable was to check with the staff, residents and utilization of the SW and safe surveys when there was any concerns with ANE. The DON stated as a nurse she had been trained on the importance of quality of care. She stated she expected the quality of care to be superb at the facility. She said everyone was responsible. She said the clinical nursing staff were especially responsible because they have the most interaction and they were at the forefront of quality of care. She said she does not know the exact reason why Resident #1 did not receive the quality of care he wanted but she believed it had a lot to do with him refusing care. She said it was her understanding that Resident #1 said there were not enough staff members to transfer him on 03/03/25. She said she felt like Resident #1 did not allow the staff to transfer him. She said she felt that Resident #1 had not been educated on what the circumstances may have been. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675093	A. Building B. Wing	03/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/12/25 at 12:37 PM the ADM stated in regard to quality of care there was no specific policy but that he was familiar with the concept of quality care. He said it was self-explanatory. The ADM said quality of care was providing good competent care. He said the PNO of subpar quality of care was anything can have a negative outcome. He said he felt as a non-clinician he did not know if he could state what the negative outcome was accurately. The ADM stated he was unaware Resident #1 was not placed in bed on 03/03/25. He stated his system for monitoring quality of care was ensuring staff was had their competencies. He stated he makes rounds throughout the day and he also spoke with staff and residents about quality of care. He stated he had not had any specific training on quality of care but understands what quality of care was. The ADM said he was ultimately responsible for anything that happened in the facility. Attempted to contact LVN B on 03/14/25 and 03/18/25 and the attempts were unsuccessful. Attempted obtain the EMS records electronically on 03/12/25, 03/13/25 and 03/14/25 and all attempts were unsuccessful. Record review of facility sign, undated, revealed the following: For all clinical Calls (change of condition, accident/incident, falls etc.) Contact the DON [phone number listed] Record review of the facility policy, Pressure Injury Risk Assessment, date revised March 2020, revealed: Purpose The purpose of this procedure is to provide guidelines for the structured assessment and identification of residents at risk of developing new pressure injuries or worsening of existing pressure injuries (PIs). Risk factors that increase a resident's susceptibility to develop or to not heal PIs include, but are not limited to: Impaired/decreased mobility and decreased functional ability. Resident refusal of some aspects of care and treatment. Reporting [TRUNCATED]