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VERO HEALTH & REHAB OF SYLVA	417 CLOVERDALE ROAD SYLVA, NC 28779

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{F 000}	INITIAL COMMENTS An onsite revisit was conducted on 7/07/24 through 07/30/24. Tags F563, F580, F600, F684, F755, F760, F841 and F867 were corrected as of 7/30/24. Repeat tags were cited. New tags were also cited as a result of the recertification survey and complaint investigation survey that was conducted at the same time as the revisit. The facility is still out of compliance.	{F 000}		
F 584 SS=F	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition;	F 584		

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

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§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:
Based on observations, record review, and interviews with resident and staff the facility failed to maintain the wall and ceiling in sanitary condition at 1 of 2 nursing stations (nursing station #1). The facility failed to manage outside water drainage to prevent outside storm water from flooding into 1 of 4 hallways (Hallway #2), 1 of 1 dining room, and 2 of 2 resident rooms (room 216 and room 217). Furthermore, the facility failed to clean ceiling air vents located over the food prep and food service area that had a large amount of dark black substance visible on the outside of 3 of 6 vents. The facility also failed to maintain a footboard in good repair for 1 of 1 bed (Resident #37's bed) and failed to maintain a wheelchair in good repair for 1 of 1 resident (Resident #6) reviewed for a safe, clean, comfortable and homelike environment. These deficient practices had the potential to affect all residents residing in the facility.

Findings included:

1. An observation on 7/7/24 at 2:40 PM of the

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common area at nursing station #1 revealed an area on the wall and an area on the ceiling that had a dark black substance visible. The wallpaper was off the wall. Each area was approximately one foot in diameter. The dark black substance had a circular and dotted growth pattern with scattered small areas of gray colored fuzz. There was a brown/orange colored drip line that was moist and extended from the black substance on the ceiling down the wall.

Subsequent observation on 7/8/24 at 3:30 PM revealed the conditions remained unchanged.

An interview was conducted on 7/8/24 at 4:16 PM with the Maintenance Director. He stated he had been at the facility in his current role for a little over three months. He stated that the black substance on the wall and ceiling had been there since he had started and had not changed. He said he had checked the area previously and thought the area was glue because it had been tacky feeling and that it did not scrape off the wall. He was unsure why the wallpaper had been removed from that area.

An interview and observation was completed on 7/8/24 at 4:34 PM of the black substance on the wall and ceiling with the Maintenance Director. He touched the black substance on the wall and ceiling with two of his fingers. When he brought his fingers away from the wall/ ceiling a black residue was visible on his fingers. He touched along the seam of the wall and ceiling and stated the area was moist/ wet. He acknowledged there was a visible drip line from the ceiling extending down the wall. He said he thought the black substance on the wall and ceiling was "mold". He stated he thought the area was "mold" because

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the area was moist and because of the way the black residue came off onto his fingers when he touched the area.

A follow up observation on 7/9/24 10:05 AM of the area revealed the black substance had been cleaned off the ceiling and wall.

A follow up interview was conducted with the Maintenance Director on 7/10/24 at 3:14 PM. He said he had cleaned the black substance off the wall and ceiling with a bleach wipe. He said he had looked in the ceiling above the area and that there were pipes that ran above the area but that he had not seen anything leaking. He said there had been condensation and moisture in that area and that he had called a plumbing company to come out and check the pipes in that area.

An interview was conducted with the Administrator on 7/10/24 at 4:55 PM. She said she was unsure how long the black substance had been on the ceiling and wall. She stated she had not noticed the black substance on the wall and ceiling. She said if she had noticed the black substance on the wall and ceiling, she would have asked maintenance to check the area and clean it.

2. a. An observation on 7/7/24 at 1:41 PM revealed water flooded and pooled across the bathroom and room floor in rooms 216 and 217. A moisture mark that extended out from the wall approximately 3 feet was observed on the carpet in hallway #2 along the wall outside of room 217. The moisture mark on the carpet extended the length of approximately 8 feet of hallway #2 along the wall. The carpet was wet to touch.

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Subsequent observation on 7/8/24 at 11:26 AM revealed the carpet in hallway #2 continued to have a moisture mark extending from the wall and was moist to touch. There was a damp/ wet smell present. There was no water observed on the floor in room 216 or 217.

2. b. An observation on 7/7/24 at 2:23 PM of the dining room revealed water on the floor in front of the entrance door. The carpet in front of the dining room entrance door had a water moisture mark extending approximately 6 feet out on the carpet. The carpet was wet to touch.

Subsequent observation on 7/8/24 at 12:08 PM revealed the carpet in front of the dining room remained wet to touch. A wet/ moist smell was noted.

An interview was conducted on 7/8/24 at 4:16 PM with the Maintenance Director. He stated he had been at the facility in his current role for a little over three months. He stated that since he had been at the facility the dining room had flooded 3-4 times. He stated it had flooded into rooms 216 and 217 one other time that he was aware of. He stated the flooding was from an issue with the drain located outside of the dining room at the exterior wall of rooms 216 and 217. He said the fooding occurred when it rained. The Maintenance Director stated he had tried things to correct the issue the other times that water had flooded from outside into the building, but that what he had tried had not fixed the issue with the drain. He said he thought that the drainpipe needed to be brought down to ground level so it would drain. He said there was gravel along the exterior building wall at rooms 216 and 217. The Maintenance Director stated he thought the

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flooding into the resident rooms and hallway had occurred because there was plastic under the gravel and water was getting under the plastic and going into the foundation. He said the gravel and plastic would need to be removed and the ground graded to prevent the rooms from flooding again.

A follow up interview was conducted with the Maintenance Director on 7/10/24 at 3:14 PM. He stated that they had cleaned the carpet that had been flooded a few times with the carpet cleaning machine. He said he had placed fans to blow and help the carpet dry.

An interview was conducted with the Administrator on 7/10/24 at 4:55 PM. She said she was aware that the dining room had flooded on Sunday during a storm. She said since Sunday she had heard comments that the flooding happened frequently but that she had not been aware before then that the flooding had happened frequently. She said the water coming into the building and resident rooms from the outside was being addressed by Maintenance.

3. An observation of the kitchen on 7/9/24 at 12:35 PM was completed with the Dietary Manager (DM) and revealed 3 out of 6 air vents located over the food preparation and service area had a large amount of black substance with a circular and dotted growth pattern visible on the outside of the vents.

An interview with Dietary Manager (DM) was conducted on 7/9/24 at 12:40 PM. She said she was not sure what the black substance on the vents was. She stated that the vents needing to be cleaned had been identified by the health

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department during the kitchen inspection in October of 2023. She said the health department did not say what the black substance on the vents was but that the vents needed to be cleaned or replaced. The DM said she had told maintenance about the vents needing to be cleaned or replaced when it had come up on the kitchen inspection in October. The DM said she had also mentioned that the vents needed to be cleaned or replaced to the new Maintenance Director. She said each time she had been told by Maintenance they would take care of the vents but that nothing had been done.

An interview was conducted with the Health Department Inspector on 7/9/24 at 2:33 PM. She said that the facility kitchen inspection was completed in October 2023 and that the inspection said the outside of the vents in the kitchen needed to be cleaned. She said this was a repeated issue from the facility's previous kitchen inspection.

An interview was conducted with the Maintenance Director on 7/10/24 at 3:14 PM. He stated he had not been aware that the kitchen vents needed to be cleaned. He said that the vents needing to be cleaned had not been mentioned to him. The Maintenance Director said he had been under the assumption that the kitchen staff were supposed to clean the stuff in the kitchen. He said he was not aware that the vents needed to be cleaned and that it had been an issue during the last kitchen inspection and had not been addressed. The Maintenance Director said the health department had come to the building yesterday and had looked at the vents in the kitchen. He said the health department inspector said the black substance on the kitchen vents could be

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"mold" and had told him to clean them with bleach water. He said the health department had said some of the vents also had dust that needed to be cleaned off. He stated that the kitchen vents would have to be cleaned after hours and that he had set up for the vents to be cleaned on Friday 7/12/24. The Maintenance Director said there had been a couple of spots on the bottom of the walls in two resident rooms (room 303 and room 304) that recently had to be replaced because of "mold". He said he had taken the baseboard off in rooms 303 and 304 because it had been peeling away from the wall. The Maintenance Director said that when he had removed the baseboard, he could see the "mold" behind it. He said had cut out the area and replaced it.

An interview was conducted on 7/10/24 at 4:55 PM with the Administrator. She stated she did not remember if the kitchen vents needing to be cleaned had been an issue during the facility's last kitchen inspection in October 2023. She said she did not remember if the kitchen vents needing to be cleaned had been brought up by the DM previously. The Administrator stated she was not sure why the kitchen vents had not been cleaned. She did not mention if there had been other areas located in the building that had to be repaired due to the growth of black substance. The Administrator stated that the health department had come to the facility yesterday (7/9/24) and they had mentioned that the kitchen vents needed to be cleaned. She said that maintenance was going to clean them.

4. During an interview with Resident #37 on 7/7/24 at 10:28 AM, his footboard was observed coming off his bed on one side when he backed into it with his wheelchair. Resident #37 stated

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that his footboard needed to be fixed because the screw had come loose. He stated that the footboard had been broken like this for two months, but he was not sure if the Maintenance Director knew about it.

A follow-up observation on 7/8/24 at 8:24 AM revealed Resident #37's footboard was missing a screw and was not attached tightly to the bed frame.

An interview with Nurse Aide (NA) #2 on 7/10/24 at 8:43 AM revealed she had known about Resident #37's broken footboard a couple of weeks ago, and had told Unit Manager #2 about it because she did not know where the work orders were located.

An interview with Unit Manager (UM) #2 on 7/10/24 at 10:16 AM revealed she did not know about Resident #37's footboard needing repair, and that she did not remember NA #2 telling her about the broken footboard. UM #2 stated that if she had known about it, she would have texted the Maintenance Director right away to get it taken care of. She also stated that she did not know that NA #2 did not know where the work orders were located.

An observation and interview with the Maintenance Director on 7/9/24 at 2:50 PM revealed staff should fill out a work order or tell him verbally if something needed to be repaired inside a resident's room. The Maintenance Director stated that he did a walk through once a month, but he did not know about Resident #37's broken footboard. He looked at Resident #37's footboard and when he moved it, the footboard came off the bed frame. He stated that he

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needed to replace the screw, but that he was not aware that it had been broken.

An interview with the Administrator on 7/10/24 at 5:07 PM revealed that all department managers did daily rounds, and each had room assignments where they should be looking for equipment that needed repair. The Administrator stated that they had to change Resident #37's foot board a number of times, and the common way to notify the Maintenance Director of needed repairs was verbally.

5. Resident #6 was admitted to the facility on 09/08/16.

The quarterly Minimum Data Set (MDS) assessment dated 04/27/24 coded Resident #6 with severe impairment in cognition. The MDS indicated she had impairment for one side of her upper and lower extremities and utilized a wheelchair as the main mobility device for locomotion.

Review of the weekly skin assessment from 05/01/24 through 07/08/24 revealed Resident #6's skin was intact without any issues.

During an observation conducted on 07/07/24 at 11:21 AM, Resident #6 was seen sitting in her wheelchair outside of her room in the hallway. The armrest for both sides of the wheelchair were observed with multiple spots that were torn, cracked, and ripped with sharp edges approximately 2.5 inches in diameter. Resident #6 was wearing a short sleeves shirt while sitting in the wheelchair with both arms contacting the broken armrests during the observation.

An interview was conducted with Resident #6 on

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07/07/24 at 11:24 AM. She could not recall how long the armrests for her wheelchair had been in disrepair. She stated she wore a short sleeve shirt most of the time, and the broken armrests had caused skin irritation at times.

During a subsequent observation conducted on 07/08/24 at 11:41 AM, Resident #6 was seen sitting in her wheelchair wearing a short sleeve shirt pedaling in the hallway. The armrests remained in disrepair.

A joint observation was conducted on 07/09/24 at 12:24 PM with Nurse Aide (NA) #5 and Nurse #5. Resident #6 was seen sitting in her wheelchair wearing a short sleeve shirt in the activity room in 400 halls. The armrests remained in disrepair.

An interview was conducted with Nurse Aide (NA) #5 on 07/09/24 at 12:26 PM. She stated she had provided care for Resident #6 in the past few months, but she did not notice the armrests were in disrepair. She added Resident #6 wore a short sleeve shirt frequently and explained the broken portion of the armrests were covered by Resident #6's arms most of the time to make it harder to identify repair needs.

During an interview conducted with Nurse #5 on 07/09/24 at 12:28 PM. She stated she had provided care for Resident #6 in the past few months, but she did not notice the armrests for the wheelchair were broken. She acknowledged that it needed to be fixed immediately as it could cause skin irritation. She added the rehab department was responsible for checking the wheelchair routinely and fixing it as needed.

An interview was conducted with the Rehab

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Director on 07/09/24 at 12:34 PM. She stated Resident #6 was under rehab department's caseload, she was responsible to check her wheelchair at least once per month. She could not explain why she missed Resident #6's wheelchair during the monthly audit. For residents who were not under rehab department's caseload, the maintenance department was responsible to check the wheelchair to ensure they were in good repair. She added the rehab department also depended on nursing staff to report repair needs. She acknowledged that the armrests for Resident #6's wheelchair were in disrepair, and it needed to be fixed immediately.

During an interview conducted on 07/09/24 at 2:51 PM, the Maintenance Director stated the maintenance department did not check repair needs for wheelchairs on a regular basis. Nursing staff or rehab staff would notify him whenever they identified repair needs for wheelchairs. He did not know Resident #6's wheelchair armrests were broken and acknowledged that they should be fixed immediately.

An interview was conducted with the Director of Nursing (DON) on 07/09/24 at 4:31 PM. She expected the staff to be more attentive to resident's mobility devices, and to report all the repair needs to the maintenance department or rehab department in a timely manner. It was her expectation for all the mobility devices to be in good repair at all the times.

During an interview conducted on 07/10/24 at 5:06 PM, the Administrator expected the staff to pay attention to the condition of residents' mobility devices and report repair needs in a timely manner. It was her expectation for residents'

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F 584	Continued From page 12 mobility devices to be in good repair while in the facility.	F 584		
{F 609} SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to submit an Initial Allegation Report to the State Agency for 1 of 1 resident reviewed	{F 609}		

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{F 609}	Continued From page 13	{F 609}		

for neglect (Resident #238).

The findings included:

The facility's policy "Abuse Investigations," dated 2017 indicated all reports of resident abuse, neglect and injuries of unknown source shall be promptly and thoroughly investigated by facility management.

The facility's policy "Reporting Abuse to State Agencies and Other Entities/Individuals," dated 2017 indicated: Should a suspected violation or substantiated incident of mistreatment, neglect, injuries of an unknown source, or abuse be reported, the facility Administrator or his/her designee, will promptly notify the following persons or agencies (verbally and written) of such incident, including law enforcement officials.

During a complaint investigation survey on 4/22/24 through 5/22/24, the facility was cited for neglect for Resident #238 when Nurse Aide (NA) #18 neglected to provide incontinence care to Resident #238.

Review of the state agency records revealed the facility did not submit an initial report to the State Agency following the notification of neglect through the CMS-2567.

An interview with the Administrator on 7/10/24 at 5:07 PM revealed that she was not made aware of neglect while the surveyors were onsite during the complaint investigation survey which ended on 5/22/24. The Administrator stated she found out about neglect on Resident #238 which involved NA #18 when she received the CMS-2567. The Administrator explained that NA

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{F 609}	Continued From page 14 #18 was uncomfortable with taking care of Resident #238 and requested to be re-assigned and spoke with the nurse. The nurse was aware that NA #18 was uncomfortable and had agreed to provide personal care for Resident #238. The Administrator stated that she did not file an initial report on NA #18 for neglect to the State Agency because she felt like she thoroughly investigated the issue, and she did not know that NA #18 was neglectful of Resident #238. According to the CMS-2567 from 5/22/24, the Administrator was notified of neglect when she was notified of immediate jeopardy on 5/11/24 at 10:37 AM.	{F 609}		
{F 689} SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interviews, the facility failed to safely transfer a resident from bed to wheelchair using a total mechanical lift when staff did not lock the wheels of the lift prior to lifting Resident #69 from bed and lowering to his wheelchair. This deficient practice had the potential to cause an injury during transfers using a total mechanical lift for 1 of 6 residents reviewed for accidents (Resident #69).	{F 689}		

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The findings included:

Resident #69 was admitted to the facility on 10/1/23 with diagnoses that included hemiplegia (paralysis that affects one side of the body) and hemiparesis (muscle weakness) following cerebral infarction (stroke) affecting left non-dominant side.

Resident #69's care plan dated 11/13/23 indicated he needed extensive/dependent assistance with activities of daily living due to left hemiparesis, and poor posture/positioning. Interventions included Resident #69 needed a total mechanical lift for transfers.

The quarterly Minimum Data Set assessment dated 4/8/24 indicated Resident #69 was cognitively intact, had range of motion impairment on one side of both upper and lower extremities, and was dependent for chair/bed-to-chair transfer.

An observation was made on 7/7/24 at 1:50 PM of Resident #69 being transferred from bed to wheelchair using a total mechanical lift by Nurse #1 and Nurse Aide (NA) #1. Nurse #1 brought a green sling into the room, and it was placed underneath Resident #69 while in bed. NA #1 suggested that they crisscross the sling under Resident #69's thighs before securing it to the lift. Nurse #1 positioned the total mechanical lift so that the base was underneath Resident #69's bed frame. Nurse #1 asked NA #1 how to spread the lift's legs and NA #1 instructed Nurse #1 to move the lever from left to right. Nurse #1 moved the lever from left to right and this caused the lift's legs to spread wide. Both staff members secured

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{F 689}	Continued From page 16 the sling on the bottom loop onto the total mechanical lift. Without locking the wheels on the total mechanical lift, Nurse #1 proceeded to lift Resident #69 off the bed, moved the lift to where Resident #69 was positioned over his wheelchair and started lowering Resident #69 to his wheelchair without locking the wheels on the lift. While Nurse #1 lowered Resident #69 onto his wheelchair, the lift was observed to be unstable as it kept on moving while Resident #69 was being moved. An interview with Nurse #1 on 7/7/24 at 2:02 PM revealed he had never assisted before in lifting a resident with a total mechanical lift. He stated that he thought he had locked the wheels on the lift prior to moving Resident #69. He stated that he realized that he should have locked the wheels on the lift. An interview with the Rehabilitation Manager (RM) on 7/10/24 at 8:26 AM revealed that while using a total mechanical lift, staff should make sure the lift's legs were spread out so that there was a wide base, and this would cause the lift to less likely tip over during the transfer. The RM stated that staff should make sure that the wheels on the lift were locked as locking the wheels would make it more stable, and prevent the lift from rolling out while the resident was being lifted or lowered with the lift. An interview with the Director of Nursing (DON) on 7/10/24 at 1:56 PM revealed staff should make sure that they were locking the wheels on the lift while using them on a resident.	{F 689}		
{F 726} SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c)	{F 726}		

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{F 726}	Continued From page 17	{F 726}		

§483.35 Nursing Services
The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).

§483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

§483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.

§483.35(c) Proficiency of nurse aides.
The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.
This REQUIREMENT is not met as evidenced by:
Based on record review, observation and staff interviews, the facility failed to ensure staff was trained on how to use a total mechanical lift for 1 of 1 resident observed for transfers (Resident #69). This was for 1 of 5 staff members (Nurse #1) reviewed for competency.

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{F 726}	Continued From page 18	{F 726}		

The findings included:

A review of the employee file for Nurse #1 indicated verification of an active license to practice in the state, and a new hire packet dated 6/7/24. The new hire staff orientation checklist did not include training on how to use a lift. Nurse #1 signed the "Nurse Supervisor" job description on 6/7/24.

An observation was made on 7/7/24 at 1:50 PM of Resident #69 being transferred from bed to wheelchair using a total mechanical lift by Nurse #1 and Nurse Aide (NA) #1. Nurse #1 brought a green sling into the room, and it was placed underneath Resident #69 while in bed. NA #1 suggested that they crisscross the sling under Resident #69's thighs before securing it to the lift. Nurse #1 positioned the total mechanical lift so that the base was underneath Resident #69's bed frame. Nurse #1 asked NA #1 how to spread the lift's legs and NA #1 instructed Nurse #1 to move the lever from left to right. Nurse #1 moved the lever from left to right and this caused the lift's legs to spread wide. Both staff members secured the sling on the bottom loop onto the total mechanical lift. Without locking the wheels on the total mechanical lift, Nurse #1 proceeded to lift Resident #69 off the bed, moved the lift to where Resident #69 was positioned over his wheelchair and started lowering Resident #69 to his wheelchair without locking the wheels on the lift. While Nurse #1 lowered Resident #69 onto his wheelchair, the lift was observed to be unstable as it kept on moving while Resident #69 was being moved.

An interview with Nurse #1 on 7/7/24 at 2:02 PM

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revealed he was a travel nurse, and that he worked as the weekend supervisor on Fridays, Saturdays, and Sundays. Nurse #1 stated that he had never assisted before in lifting a resident with a total mechanical lift. He stated that he thought he had locked the wheels on the lift prior to moving Resident #69, but that he realized that he should have locked the wheels on the lift. Nurse #1 further stated that he did not receive training at the facility on how to use their mechanical lifts, and that he did not think that he should because he had experience at other facilities using different kinds of mechanical lifts.

An interview with the Certified Occupational Therapist Assistant (COTA) on 7/10/24 at 8:49 AM revealed she was responsible for providing lift training to the nursing staff. The COTA stated that she had a running list of all new hires, but she did not keep up with agency staff and only provided lift training to agency staff as needed. The COTA stated she did not train Nurse #1 on how to use the mechanical lifts because she did not usually come in on the weekends, and there had been only two to three Fridays that she had worked at the facility. The COTA further stated that she used a check off list when providing training to staff, and included in the training was instruction that they had to lock the wheels on the lift prior to moving the resident.

An interview with the Director of Nursing (DON) on 7/10/24 at 1:56 PM revealed staff should make sure that they were locking the wheels on the lift while using them on a resident. The DON stated that Nurse #1 told her about not locking the wheels on the total mechanical lift when he transferred Resident #69 from his bed to his wheelchair. She further stated that they needed to

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{F 726}	Continued From page 20 have a more extensive orientation list to include the use of lifts and to cover all agency staff.	{F 726}		