STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435109	A. BUILDING _____ B. WING _____	C 01/22/2025

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FIRESTEEL HEALTHCARE CENTER	1120 EAST 7TH AVENUE MITCHELL, SD 57301

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F 000	INITIAL COMMENTS A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 1/21/25 through 1/22/25. Area surveyed included quality of care and resident safety related to a resident who had eloped from the facility and a resident who fell while being transferred with a mechanical lift. Firesteel Healthcare Center was found not in compliance with the following requirement: F689 and was found to have past noncompliance at F684.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based South Dakota Department of Health (SD DOH) facility reported incident (FRI), record review, interview and policy review the provider failed to ensure one of one sampled resident (1) who was identified as an elopement risk on admission had been accounted for when a door alarm activated. This citation is considered past non-compliance based on review of the corrective actions the provider implemented immediately following the incident. Findings include:	F 684	Past noncompliance: no plan of correction required.	

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

Petar Mirkovic | *Executive Director* | *2/14/2025*

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

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F 684	Continued From page 1 1. Review of the provider's SD DOH FRI regarding resident 1 revealed: *The report had been submitted on 1/16/25 at 7:00 a.m. and indicated resident 1 had eloped (left the facility without staff knowledge) at 6:53 a.m. on 1/16/25. *The resident was found by a city policeman and maintenance supervisor (MS) E and was brought back to the facility. *Her vitals were Blood pressure 135/89, temp 98.2, pulse rate 97 beats per minute, respiratory rate 18 breaths per minute, and oxygen saturation (oxygen level in the blood stream) of 94%. *Resident 1's physician was notified of the elopement and orders were received. 2. Review of resident 1's electronic medical record (EMR) revealed she had: *Admitted on 1/15/25. *Diagnoses of disorientation, dementia without behavioral, psychotic, mood, and anxiety disturbance. -A Brief interview mental assessment (BIMS) assessment completed on 1/15/25 with a score of 7 which indicated severe cognitive impairment. *Been assessed and was determined to have a risk for elopement on 1/15/25. *A 1/15/25 order for the placement of a Wander Guard (door alarm activating bracelet) and to ensure the wander guard was in place twice daily. 3. Observation and interview on 1/22/25 at 3:50 p.m. with resident 1 and her husband revealed: *Her husband had been notified of resident 1's elopement. *She did not have a history of wandering, exit-seeking, and/or elopement. *Resident 1 stated "It was cold out that day and	F 684		

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rainy, but I had a coat on. I spoke with the policeman too."
* Resident 1's husband denied any further concerns with the care she was receiving and stated, "She is safe back here now."

4. Interview on 1/22/25 at 10:12 a.m. with registered nurse (RN) F regarding resident 1's Wander Guard placement and function revealed:
*Resident 1 had a Wander Guard on since she was admitted on 1/15/25.
*The Wander Guard book was up to date with resident 1's name and identification.
*Her Wander Guard had been checked for placement by nursing staff on the evening of 1/15/25 and the morning of 1/16/25.
*Resident 1 was moved to the memory care hall on 1/16/25 after her elopement.
*Her Wander Guard was discontinued per doctor's order and was removed from resident 1.

5. Interview on 1/21/25 at 2:20 p.m. with certified nursing assistant (CNA) H regarding resident 1's above elopement revealed:
*CNA H indicated she had seen the resident at the end of the hallway with her walker but did not know if she was a resident or a visitor due to not having worked for the past 2 days prior.
*She indicated that she was working in the 400 hallway that day and typically works in the 100-200 hallway.
*She indicated that there was a red light up above the emergency exit doors, that would blink when the door was activated, and the alarm would sound.
*She faintly heard the alarm and noticed the red light above the door blinking.
*She looked out the window but did not see anyone. She did not open the door as she

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F 684	Continued From page 3 thought she needed a code to open it and to shut the alarm off. *CNA H stated she then reported to RN K that the alarm was going off and that she had looked out the window and did not see anyone but did not open the door. *RN K then had gone down the hallway to see why the alarm went off, CNA H went to answer residents' call lights and did not know what RN K had done. *Another staff member asked her if she had seen resident 1, as she was missing. That was when she realized that resident 1 was likely the person she had seen at the end of the hallway. *CNA H indicated about 10 to 15 minutes after she had notified RN K a "Code White Unknown" was announced. *She was suspended around 8:30 a.m. after the day of the elopement pending the investigation. 6. Interview on 1/21/25 at 4:34 p.m. with MS E revealed: *The facility had video surveillance cameras on some entrance/exit doors. *There were monitors available for nursing staff to view those at the nurses' stations. *A door alarm panel (shows what door has been opened) was at the nurse's station for the one hundred and two hundred halls. *Nursing staff would sit at the 400 hall nurses' station, there was no door alarm panel there. *A panel for the door alarms in the 400 hall was expected to be installed by a vendor in two weeks. 7. Interview on 1/21/25 at 5:07 p.m. with executive director (ED) A revealed: * RN K's employment was terminated. He stated, "She had been here a long time and should have	F 684		

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known what to do and did not do it."
*He stated the facility was performing one code white drill daily for seven days with alternating shifts.
*Staff were to announce "Code white unknown" if it was unknown of who the resident was or include the resident's name if known.
*All staff were expected to aid in these drills.
*All residents must be accounted for before the code would be cleared.

8. On 1/22/25 at 11:53 a.m. with ED A and MS E regarding the camera footage investigation of resident 1's elopement revealed:
*Resident 1 left the facility through the 400 hall back door at 6:53 a.m. on 1/16/25.
*At 6:55 a.m. CNA H walked down the hall by the door the alarm indicated but did not look out the window or open the door. She had looked at a resident's room across the hallway.
*At 6:57 a.m. RN K walked down the hall to the keypad on the wall next to the back door, entered the code for the alarm to stop sounding and did not look out the window or open the door.
*ED A verified the camera footage revealed neither CNA H or RN K had visually looked out the window or opened the door to see if someone had left the facility.

9. On 1/22/25 at 11:55 a.m. interview with MS E regarding resident 1's above incident revealed:
*When he arrived to the facility for work he saw a police officer speaking to someone outside but was unaware if the individual was a resident of the facility at that time.
*The police officer was with that individual when MS E entered the facility and asked the staff if they were missing a resident.
*A Code White Unknown was called immediately.

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F 684	Continued From page 5 *He returned outside where resident 1 and the police officer were and informed him that resident 1 resided at their facility. *Resident was then escorted back to the facility by the police officer. The provider's implemented actions to ensure the deficient practice does not reoccur was confirmed on 1/22/25 after a review of the provider's performance improvement plan revealed: *"Director of nursing (DON) or designee and /or (MDS) [minimum data set] coordinator reevaluated residents at risk for wandering and effectiveness of wander-guard for resident safety." *"All nursing staff on all shifts received education on wandering, elopement, and resident safety from the DON or designee. Any staff on leave will receive education on their next scheduled workday prior to their shift." *"DDCO [divisional director of clinical operations] reviewed all elopement evaluations to ensure timely evaluation." *"The facility's policies and procedures regarding elopement and wandering residents was reviewed by ED, DNS [director of nursing services], and IDT [interdisciplinary team] completed on 1/16/25." *"All staff education on the elopement procedure was completed ED, DNS or designee on 1/16/25." *"Elopement binder was reviewed and is up to date completed on 1/16/25." *"New hires will receive education on wandering, elopement, and resident safety by the DON, director of social services, or designee completed on 1/16/25 and ongoing." *"Elopement drill conducted and on-going daily x 1 week then weekly for the next four weeks. After	F 684		

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F 684	Continued From page 6 four weeks IDT to determine whether to continue drills on a week by week or month by month completed on 1/16/25 and ongoing." *"Risk management completed on the incident by DNS and was signed off and approved by the ED completed on 1/16/25 and ongoing." *"A quality assurance performance improvement (QAPI) performance improvement project (PIP) was implemented to review and interpret all audit findings. All findings will be discussed at the monthly QAA [quality assessment assurance] meeting for a minimum of three months or until the pattern of compliance is maintained completed on 1/16/25." *"Resident involved in the incident to be referred to locked memory care unit for additional care opportunities completed on 1/16/25." *"Care plans updated and reviewed on residents that are identified as potential elopement risks by DNS/designee and SSD [social services director] completed on 1/16/25." *"All exit doors were checked by vendor to ensure all doors working as intended completed on 1/16/25." *"New panel for door alarms on the 400 will be installed per vendor estimated time of arrival two weeks (no panel on that hall at this time) completion to be on 1/31/25.' *"Review/modify current policies as applicable to ensure appropriate procedures are in place to prevent harm/potential harm completed on 1/16/25." *"QAPI plan: all new residents will be screened prior to and on admission to assess for elopement risk." -"Increased elopement drills to ensure staff are proficient in handling an occurrence ongoing." *"The DNS or designee will do a random audit of all residents identified at risk for elopement to	F 684		

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F 684	Continued From page 7 ensure wander-guard is functioning, elopement binder is up to date, elopement evaluation is completed timely and care plan is updated completed on 1/16/25 and ongoing." *Record review of a sample of resident care plans after 1/16/25 showed they were following their new and updated policies. *Observations and staff interviews revealed the staff understood the education provided and the revised processes. Based on the above information, past non-compliance at F684 occurred on 1/16/25, and based on the provider's implemented corrective action for the deficient practice confirmed on 1/22/25, the non-compliance is considered past non-compliance.	F 684		
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 South Dakota Department of Health (SD DOH) facility-reported incident (FRI) review, observation, interview, record review, and manufacturer's operator's instructions review the provider failed to ensure *The safety of one of one sampled resident (2) who had to be lowered to the floor while in a sit-to-stand lift (a mechanical lift that requires the	F 689	1. Unable to correct deficient practice noted during survey for resident 2. All lifts repaired or put out of service that were noted during survey. 2. The ED and DNS reviewed the manufacturer guidance on utilizing the lifts. The DNS or designee educated all nursing staff on the proper use of the lifts and proper utilization of the safety straps by 2/14/2025. All staff not educated will be educated prior to their next working shift. The ED educated maintenance on 1/23/2025. 3. The DNS or designee will audit 4 lift transfers weekly times 4 weeks and monthly times two months to ensure transfers are done in a safe manner per manufacturers guidance. The ED or designee will audit all lifts weekly times four weeks and monthly times two months to ensure they are in working order and maintained. The ED, DNS or designee will bring the results of these audits to the monthly QAPI for further review and recommendation to continue or discontinue the audits.	2/14/2025

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F 689	Continued From page 8 person to be able to partially bear weight on at least one leg when assisted from a seated position to a standing position) while being transferred. *While transferring resident 2 from the commode to the recliner two of two certified nurse aides (CNA) (D and L) utilizing the sit-to-stand lift did not adjust the safety strap of the sling. *Six of eight sit-to-stand lifts were used and maintained per the manufacturer's operator instructions. Findings include: 1. Review of the provider's 1/12/25 SD DOH FRI regarding resident 2 revealed: *On 1/11/25 at 9:30 p.m. while CNA C was attempting to transfer him with the sit-to-stand lift she lowered him to the floor because he was not able to maintain a safe standing position. *He required two staff to assist him with transfers while using the sit-to-stand lift. *The sit-to-stand leg strap was not used during that transfer. *His Brief Interview for Mental Status (BIMS) assessment score was 14, which indicated he was cognitively intact. -He was his own responsible party and did not want his mother called. *He was assessed and had no injuries. *The physician was notified. 2. Interview on 1/21/25 at 2:06 p.m. with CNA H and CNA I regarding the use of mechanical lifts revealed: *Some residents who used the mechanical sit-to-stand lift for transfers required the assistance of one staff and some required the assistance of two staff. *Some residents had a lift sling stored in their	F 689		

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F 689	Continued From page 9 room and others shared a sling that was stored on the lift. *The care plan and "special instructions" in the resident's electronic medical record that indicated which type of lift, the size sling required, and the number of staff required to transfer each resident. *The "pocket care plan" was a paper they carried that indicated how each was to be resident transferred. *They both had attended a training "maybe a week ago" regarding transferring residents with the mechanical lifts. 3. Observation and interview on 1/21/25 at 2:20 p.m. with resident 2, CNA D, and CNA L in resident 2's room revealed: *Resident 2 was seated on the commode to the left of his recliner. *He was wearing a lift sling around his back that was attached to the sit-to-stand lift. There was a second sling draped over the lift. -The safety strap was not tight around his midsection. *CNA D and CNA L then transferred resident 2 to his recliner using the sit-to-stand lift without adjusting the strap on the sling. *CNA L removed the lift sling worn by resident 2, hung that sling on the back of his door, and exited the room with CNA D. -CNA L said she knew which sling to use for resident 2 by the color of the sling's handle and because it was stored in his room. Continued observation and interview on 1/21/25 at 2:25 p.m. with resident 2 revealed: *He confirmed that the strap around his midsection had been very loose. -He stated, "Sometimes they tighten the strap and sometimes they don't."	F 689		

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F 689	Continued From page 10 *He recalled that he had "slid out" of the sit-to-stand lift "about a week ago." -The "fall" had occurred at night. -There was one staff with him at that time, "maybe [CNA C]." -He stated, "It was not attached right." -He confirmed that he had not been injured and stated he "went down slow." *At times one or two staff assisted him when transferring him with the sit-to-stand lift. *He had to use the full-body lift (a mechanical lift and sling used to lift a person's full body) after the fall and stated, "I hate that thing." *He had begun working with physical therapy after the above incident so that he could return to using the sit-to-stand lift. 4. Interview on 1/21/25 at 2:50 p.m. with CNA L revealed: *Resident 2 had needed the full-body lift "at one time," but had been working with therapy to use the sit-to-stand. *She knew which lift and sling to use and how many staff were needed to assist resident 2 because it was on his care plan. *She received facility training "maybe last Friday" on transferring residents with the mechanical lifts. *She stated the lift sling had padding that should be under the belt and the belt should be tightened. -She could not recall if she had tightened the belt when she transferred resident 2 during the above observed transfer that day. 5. Interview on 1/21/25 at 2:55 p.m. with CNA D regarding the above observed transfer with resident 2 that day revealed: *Resident 2 required the full-body lift for transfers with nursing staff.	F 689		

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F 689	Continued From page 11 *Resident 2 had been working with therapy. -The therapist assisted in transferring resident 2 onto the commode with the sit-to-stand lift. --The therapist had cleared them to transfer resident 2 off the commode that day. *She stated that the lift sling belt should be tight, "but it loosens as they stand." *CNA D could not recall if the belt had been tight when she transferred resident 2 off the commode. -She stated, "He already had the sling on." 6. Interview on 1/21/25 at 3:06 p.m. with physical therapist PT M revealed: *He had been working with resident 2 because of concerns after his recent fall from the sit-to-stand lift. *It had been unclear if there was a mechanical problem with the lift or if the fall occurred as a result of "user error." *He had been trialing lifts, assessing safety, and providing education to staff during transfers with resident 2. *The facility had sit-to-stand lifts capable of lifting 400 and 500 pounds. *He had approved the CNAs to use a 500-pound capacity lift for the above observed transfer that day with resident 2. -Resident 2 weighed between 366 and 375 pounds. *Two or three other lifts slowly descended with resident 2 in the standing position, which increased his risk of falling. *He thought maintenance supervisor (MS) E had been checking the lifts and had been in contact with the lift vendor about any issues. *He had educated staff today (1/21/25) when putting resident 2 on the commode. -He expected the padding on the lift sling to be	F 689		

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F 689	Continued From page 12 underneath the strap and the strap to be snug. 7. Interview on 1/21/25 at 3:53 p.m. CNA N revealed: *Some of the lifts would not maintain the standing position and would slowly lower the resident back down while she had tried to transfer them. -She had switched the lift batteries to see if that would help, but it had not helped. *Most of the lifts go up to 400 or 500 pounds, but the "older lifts" were not used with heavier residents because they could not hold as much weight. 8. Interview on 1/21/25 at 4:23 p.m. with MS E revealed: *He was aware of staff concerns about some lifts that lowered with a resident in the lift. -He was told it had been only with resident 2. *He completed monthly inspections of the lifts and any required maintenance. -Inspections and maintenance were tracked on TELS (maintenance electronic work order system). -He used the lift serial numbers to identify the lifts and track the maintenance performed on them. -Each lift was inspected for a list of items including the motor and several other areas. -He stated, "There hasn't been anything mechanically wrong with the lifts." *The weight capacity was labeled on the side of each lift. *The lift manufacturer representative had provided advice on possible problems that had been looked into. *He expected staff to notify him of needed repairs or broken equipment through the TELS system. *When lifts required repair, they were "taken out of service."	F 689		

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F 689	Continued From page 13 *Recently some lifts have been replaced. 9. Phone interview on 1/21/25 at 5:30 p.m. with CNA C regarding the incident on 1/11/25 involving resident 2 revealed: *She worked from 10:00 p.m. to 6:00 a.m. that night. *Two CNAs and one nurse were responsible for the residents in the 100 and 200 hallways that night. *She had used a sit-to-stand lift and had attempted to transfer resident 2 alone. -She had not fastened the leg strap behind his legs. -She could not recall if she had tightened the mid-body lift sling strap as he stood. *She had used the "smaller lift" and he had been near that lift's weight capacity. *She recalled he stood up and then slid down, and she tried to place him in his wheelchair and called for the nurse. *The nurse arrived as she lowered him to the floor. *She could not recall if the lift had started to lower him down that time but stated that some lifts would not stay up. *Resident 2 did not need to be transferred on her shift very often and she did not know he required two staff to assist him. *She stated she should have checked the care plan and the special instructions to know how he transferred. *She received training on mechanical lift transfers when she was hired, annually, and again after that incident. 10. Observation and interview on 1/22/25 at 8:48 a.m. with resident 3 and CNA P during a transfer with the sit-to-stand lift revealed:	F 689		

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F 689	Continued From page 14 *Resident 3's lift sling was stored in her room and staff used one specific lift for her. *Resident 3 put on her lift sling and tightened the strap herself. *Resident 3 stated a metal clip where the sling attached to the lift was missing and had been for "a long time." *She had not told anyone about the broken clip. *CNA P stated she had not noticed the broken clip but would notify maintenance using the TELS system. 11. Observation on 1/22/25 at 9:00 a.m. throughout the facility of the sit-to-stand lifts revealed: *Lifts 960816, 706010794, and 70609707 were missing one of two metal clips where the sling attached to the lift. *Lift 41522 was missing one of two rubber clips where the sling attached to the lift and had been identified as an "older lift" that lowered residents when in the standing position. *Lift 905968 was missing one of two metal clips where the sling attached to the lift and had been identified as a "newer lift" that lowered residents when in the standing position. *Lift 41644 was missing two of two rubber clips where the sling attached to the lift and had been identified as an "older lift" that lowered residents when in the standing position. 12. Observation and interview on 1/22/25 at 9:45 a.m. with MS E revealed he: *Confirmed the above-listed lifts were missing those clips. *Had checked for the presence of the clips during the monthly lift inspections. *Had not been notified of the lift's missing parts. *Expected staff that used the lifts would notify him	F 689		

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F 689	Continued From page 15 through the TELS system if parts were missing. 13. Interview on 1/22/25 at 9:11 a.m. with director of nursing (DON) B regarding resident 2 revealed: *She had expected resident 2 to have been transferred with two staff and the sit-to-stand lift the day he was lowered to the floor. *She had been notified of the incident immediately after it occurred. *She initiated staff education and mechanical lift competency checklists with all caregiver staff. *There was no current performance improvement plan (PIP) involving the use of mechanical lifts or resident falls. -She planned to initiate a PIP regarding falls at the next quality assurance performance improvement (QAPI) meeting on 1/30/25. *She had not conducted any audits regarding the use or condition of the sit-to-stand lifts. *She expected the leg strap to be used on resident 2 and all residents other than resident 3 who had been assessed for risk versus benefit, educated and signed a form that indicated she chose not use the leg strap. *Resident 2 had needed a full-body lift after the above incident and had been working with therapy to determine if he could safely use the sit-to-stand lift again. *PT M cleared resident 2 to return to being transferred with the sit-to-stand lift today (1/22/24) with the assistance of two staff. *The care plan had been updated to reflect those changes. 14. Review of resident 2's electronic medical record revealed: *His weight was 365 pounds. *His "special instructions" indicated "Transfers: stand aid with 2 assist."	F 689		

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F 689	Continued From page 16 *His care plan indicated, "Toilet Transfer: Total lift with two assists for transfers," and had not been updated to reflect the 1/22/25 lift change. *Fall risk assessments completed on 1/7/24 and 4/15/24 indicated a high risk for falls *A fall risk assessment completed on 1/12/25 indicated a moderate risk for falls. *The care plan did not indicate which sit-to-stand lift was to be used for resident 2. 15. Interview on 1/22/25 at 10:15 a.m. with staff development RN G revealed: *CNA C and CNA D had received education on the proper use of the lifts when hired, annually, and after the incident on 1/12/25. *CNA L was an agency staff employee and, would have received training on the use of lifts through her agency, and had been re-educated and completed her competency at the facility after the incident on 1/12/25. *Staff were trained to ensure the sit-to-stand mid-body lift sling strap was "snug" and tightened as the resident stood and that the leg strap was to be used with all residents unless the care plan stated otherwise. 16. Interview on 1/22/25 at 10:59 a.m. with executive director (ED) A revealed: *Maintenance inspected the mechanical lifts monthly. *He expected the staff that used the lifts to use the TELS system to report mechanical issues with the lifts. -He confirmed that no mechanical lift repair requests had been entered into the TELS system since 11/1/24. -There was one TELS request from today (1/22/25) related to the missing clip on one of the lifts.	F 689		

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F 689	Continued From page 17 17. Observation and interview on 1/22/25 at 11:45 a.m. with resident 2 and PT M during a sit-to-stand transfer revealed: *PT M trained CNA D and CNA R on transferring resident 2 with the sit-to-stand lift. *PT M indicated only one of the lifts could be used with resident 2 because it was the only lift that had consistently held him up. -It was marked with a small black "X" on one side. *The mid-body lift strap was snug around the resident's body and tightened as he stood. -Approximately five to six inches of strap extended out of the buckle. 18. Observation and interview on 1/22/25 at 12:03 p.m. and 2:20 p.m. with DON B of the mechanical sit-to-stand lifts revealed: *The "older" model sit-to-stand lifts "required" a rubber clip where the sling would be attached, and the "new" lifts required metal clips. *Lifts 960816, 706010794, 41522, 41644, and 70609707 had been repaired and now had the required clips. *Lift 905968, identified as a "newer lift" that was missing the required clips and lowered residents when in the standing position was taken out of service. *She was aware that one sit-to-stand lift had been reported as descending when used with resident 2. *She was unaware that staff had concerns about three lifts descending when used with patients identified as "heavier". 19. Review of resident 2's Physical Therapy Treatment Encounter Notes revealed: *On 1/14/25 a note indicated, " ...staff needs to	F 689		

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F 689	Continued From page 18 have education and training in correct use of one [brand name sit-to-stand lift]" and " ...interviews of 2 CNA's reveals that at least one [brand name sit-to-stand lift] loses its ability to maintain the standing position and thus, the pt [patient] is descending from the starting position when transferred ..." *On 1/15/25 a note indicated, "Use of 500# [pound] heavy wt [weight] [brand name sit-to-stand lift] reveals the machine malfunctioning today and lowering pt when it is intended for maintaining the position ..." and "trial of various batteries due to? [question] of low battery [as] possible cause of machine dropping." *On 1/16/25 a note indicated, "Pt has trial of 2 [brand name sit-to-stand lifts] with both losing ability to hold pt once upright in standing," and "demonstration to maintenance supervisor ..." *On 1/17/25 a note indicated a discussion with the maintenance supervisor regarding ..."cause for the machine not holding pt upright as is supposed to be the case with the 2 machines that are rated at 500# and that resident 2's weight was "366.2" pounds. 20. Review of the provider's 1/21/25 TELS Resident Lifts report revealed: *The checklist contained at least 12 areas to inspect that included: -"Check the sling hooks for bends or deflection." -"Inspect all surfaces on the lifts to ensure they are in good repair." *There was no specific inspection of the metal clip listed. *Task completion was "Marked done on-time by [MS E] on 12/31/24." Review of the [brand name sit-to-stand lift] Operator's Instructions revealed:	F 689		

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F 689	Continued From page 19 *The maximum lifting capacity of each lift is "located on the opposite side of the stand mast from the battery receiver." *"All [brand name sit-to-stand lift] equipment must be maintained regularly by competent staff according to the maintenance checklist provided. *"For the safety of the patient, securely fasten the safety strap around the patient's torso. Secure the buckle and pull the strap to tighten." *"Verify the loops are properly hooked inside the "pigtail" and the end of the [brand name sit-to-stand lift] arms and the Safety Catch is in place, blocking the strap from exiting through the pigtail." *"As the patient is being raised, simultaneously tighten the safety strap buckled around their torso." *The "Safety & Maintenance Checklist" included "safety tabs need to be checked to make sure they are in place," with a photograph of the metal clips where the sling attached to the lift.	F 689		