

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075135	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/13/2024
NAME OF PROVIDER OR SUPPLIER Masonicare Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 22 Masonic Avenue Wallingford, CT 06492	

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)
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47826</p> <p>Based on clinical record reviews, facility documentation, facility policies and interviews for one (1) of three (3) sampled residents (Resident #1) who were dependent on staff for transfers, the facility failed to properly transfer a resident which ultimately resulted in a fall with a laceration to the head and subdural hematoma. The findings include:</p> <p>Resident #1's diagnoses included dementia, difficulty walking, and generalized muscle weakness.</p> <p>The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 had a BIMS score of two (2) indicating short and long-term memory recall deficits and was dependent on staff for turning and repositioning when in bed and transfers getting in and out of the bed and chair.</p> <p>The Resident Care Plan dated 8/3/24 identified Resident #1 had a self-care deficit and was at risk for falls due to impaired balance, dementia, and poor safety awareness. Interventions directed assistance of two (2) with bed mobility and mechanical lift transfers.</p> <p>The nurse's note dated 10/16/24 at 12:00 PM identified the Nursing Supervisor, Registered Nurse (RN) #1, heard a loud noise from Resident #1's room at approximately 11:30 AM. The note indicated while Resident #1 was being transferred from the bed to the wheelchair the Hoyer lift strap disconnected, and Resident #1 fell to the ground striking their head on the Hoyer lift. The note identified the physician assistant was at the bedside to evaluate, Resident #1 had an open area to the back of the head and a bump on the head, there was a moderate amount of blood from the site, 911 was called and Resident #1 was sent to the hospital.</p> <p>The nurse's note dated 10/16/24 at 4:13 PM identified the charge nurse, Licensed Practical Nurse, (LPN) #1, was positioning the wheelchair about three (3) feet from the bed and as the nurse aide, Nurse Aide (NA) #1, was in the process of turning the Hoyer lift to place Resident #1 in the wheelchair, the back strap to the Hoyer lift pad came off the lift causing Resident #1 to fall out of the pad and hit his/her head on the Hoyer lift.</p> <p>The hospital record dated 10/16/24 identified Resident #1 sustained a scalp hematoma and a three (3) cm laceration to the right inferior occiput which was repaired with three (3) staples. A CT scan identified bifrontal petechial hemorrhage and a subdural hematoma. The resident was admitted for treatment and neurological monitoring due to multiple comorbidities.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The nurse's note dated 10/21/24 at 9:26 PM identified Resident #1 was readmitted .</p> <p>A physician's progress noted dated 10/22/24 identified Resident #1 was stable with serial CT scans, was diagnosed with bifrontal petechial hemorrhages and subdural hematoma, was at baseline and directed to continue to monitor for worsening symptoms.</p> <p>Review of the facility's summary report dated 10/22/24 indicated Resident #1 was being transferred out of the bed to the wheelchair to go to the dining room. According to staff interviews and return demonstration utilizing the hoier lift, the nurse aide, (NA) #1 holding the remote in her hand while maneuvering the mechanical lift, inadvertently hit the remote button which caused the sling to recline back which caused the strap to come off the hook.</p> <p>Interview with the Nurse Educator, RN #2, on 11/13/24 at 12:25 PM identified Resident #1's transfer was to be done with two (2) staff using a Hoyer Lift. RN #2 identified the proper transfer technique was to be done by two (2) staff working together as a team. A staff member stands on either side of the bed and assists the resident onto the lift pad and then the staff attach the top and bottom straps to the lift and ensure they are secure. Next, one (1) person assumes the role of the machine operator and the other person assumes the role of the guide or spotter of the resident's body. The guide would place their hands on the resident or sling during the transfer to ensure the resident remains in the proper position while the lift is being moved. The operator controls the machine by manipulating the machine up and off one surface and then moves to the proper position to the next surface and then lowers the resident. RN #2 identified NA #1 had been retrained on 3/15/24 and 4/16/24 for improper transfers prior to the incident on 10/16/24.</p> <p>Interview with the 7AM-3PM charge nurse, Licensed Practical Nurse, (LPN) #1, on 11/13/24 at 1:25 PM identified on 10/16/24, NA #1 asked her to assist in the transfer of Resident #1 and when she entered the room Resident #1 was already positioned on the lift sling and the straps were attached to the lift. The staff utilized the correct sling size for Resident #1. LPN #1 indicated while she was positioning and holding onto the wheelchair, NA #1 began operating the lift and Resident #1 fell on to the floor. LPN #1 identified the expectation would have been for her to have had her hands on Resident #1 to assist in guiding the resident to the chair, but NA #1 moved Resident #1 too fast before she could get into the position to assist Resident #1.</p> <p>Interview with the Administrator and Director of Nursing (DON) on 11/13/24 at 2:00 PM identified that if a lift pad were to start to slide the staff responsible to guide the resident would be responsible to assist the resident. Both the Administrator and Director of Nursing identified the facility's investigation determined the cause of the fall was when NA #1 continued to hold the remote-controlled device in her hand while maneuvering the mechanical lift, inadvertently hit the remote button which caused the sling to recline back, and this caused the strap to come off the hook. The DON stated NA #1 was no longer employed at the facility due to ongoing issues with proper transfer techniques.</p> <p>Attempts to interview NA #1 were unsuccessful.</p>		