STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075158	A. Building B. Wing	01/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New London Sub-Acute and Nursing	90 Clark Lane Waterford, CT 06385

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for one (1) of three (3) residents (Resident #1) reviewed for accidents, the facility failed to ensure the resident was safely transferred in the mechanical lift resulting in minor injuries on two (2) separate occasions. The findings include: Resident #1 had diagnoses including morbid obesity, chronic pain, muscle weakness, difficulty in walking, localized edema to the bilateral lower extremities and depression. The Resident Care Plan (RCP) dated 2/17/22 identified that Resident #1 had an alteration in Activities of Daily Living (ADLs) related to difficulty walking and generalized weakness post hospitalization for dyspnea (shortness of breath), pulmonary edema (excess fluids in the lungs), Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD) and lymphedema (swelling cause by a lymphatic system blockage) with interventions that included providing assistance as needed and Physical Therapy (PT) and Occupational Therapy (OT) to evaluate and treat per physician's order. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Mental Interview for Mental Status (BIMS) of fifteen (15) indicative of intact cognition and required moderate assistance with transfers. A physician's order dated 2/23/22 directed that Resident #1 was a Hoyer (mechanical) lift with an assist of two (2) staff for transfers. a) A nurse's note dated 4/30/22 at 12:30 PM identified that at 11:15 AM Resident #1 was observed laying on the floor next to the Hoyer lift. The note identified that staff identified that they were transferring the resident with the Hoyer lift and while making a turn, the lift started to tip, and they were unable to prevent the resident and Hoyer lift from tipping over. The resident was alert and oriented following the incident and he/she stated that they hit their head as well as complaining of pain to the right leg. The resident sustained a scrape to the right great toe but no other open areas or bruising was noted on assessment. The APRN was notified and due to the resident being on Eliquis (blood thinner), the resident was transferred to the Emergency Department (ED) at 11:30 AM for evaluation. (continued on next page)

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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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility Accident & Investigation (A & I) documentation identified that on 4/30/22 at 11:15 AM, Resident #1 was being lowered into the chair and began to shift his/her weight resulting in the Hoyer lift tipping and the staff was unable to stabilize the machine due to the resident's weight resulting in both the resident and the Hoyer lift falling to the floor, subsequent to the incident, Resident #1 was made an assist of three (3) staff for transfers with the Hoyer lift. Review of hospital documentation dated 4/30/22 identified that Resident #1 was seen in the ED stating that he/she was being transferred from bed to a chair when he/she was 'dropped', complaining of left sided pain. The resident reported that he/she did hit their head but denied loss of consciousness. Imaging was completed of the left shoulder, left ankle and the head with no fractures or abnormalities identified. Review of Resident #1's body weights identified that he/she was 433.8 pounds (lbs) on 4/29/22. Observation on 1/13/25 at 2:00 PM identified that the facility had a standard Hoyers and a Bariatric Hoyer. Interview and review of statement with NA #6 on 1/13/25 at 1:22 PM identified that she assisted NA #8 in transferring Resident #1 from the bed to the shower chair with the Hoyer lift on 4/30/22. She reported that the resident was secured in the Hoyer sling and when they started to lift him/her with the Hoyer, Resident #1 started to wiggle their left leg and the Hoyer started rocking and although they attempted to stop it from tipping, they were unable to stop the Hoyer from tipping due to the residents weight and the resident fell on his/her left side alongside the Hoyer machine which also fell on its side with the top hook falling on the resident's left thigh. She identified that although not mentioned in her statement and she was unsure if she had been asked by RN #3 (previous DNS), the resident was in the correct bariatric Hoyer sling, the legs at the base of the Hoyer machine were opened (to help with stabilization) and stated they did not pull the resident by the Hoyer pad instead of using the handlebars on the machine. She reported that she was unable to recall if there had been any hazards (water, cords) on the floor that could have caught up the wheels and made pushing the Hoyer lift difficult. She identified that she checked the Hoyer lift machine specifications after the incident and stated it said it could be used with residents up to 600 lbs. NA #6 stated she believed they did everything correct with the transfer of Resident #1 that day and did not believe that any errors on their part led to the incident. Interview with Resident #1 on 1/13/25 at 2:09 PM identified that on 4/30/22, NA #6 and NA #8 started to connect the loops on the Hoyer sling to the machine when one of the NA's (NA #6) stated, You're not using the right Hoyer machine, he/she is supposed to have the bigger one and the other NA (NA #8) replied back stating, It will be fine, I'll be quick. She reported that she did not shift her weight or move her legs during the Hoyer transfer. Additionally, she reported that no one had asked her what had happened following the incident, including RN #3, stating she would have reported to them that the staff reported that they were using the incorrect Hoyer lift. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with RN #3 (previous DNS) on 1/13/25 at 2:39 PM identified that when she investigated the 4/30/22 accident, the staff involved reported that the resident shifted his/her weight while suspended up in the Hoyer lift and she attributed the tipping of the lift to the weight redistribution due to the resident's excess bodyweight. She reported that she was unable to recall the details of the incident and was unsure if she had asked the staff involved if they had used the correct Hoyer machine (there was a bariatric hoyer for Resident #1 and other Hoyers available in the facility), correct Hoyer pad, if the legs of the Hoyer machine were opened during the transfer and if any hazards were in the way of the machine, but stated she should have and she was unsure why the details weren't documented. Review of NA #8's statement dated 4/30/22 identified that she was controlling the Hoyer machine and NA #6 was assisting her. She reported that they had the resident suspended over the shower chair and the next thing she knew the Hoyer machine flipped and the resident was on the floor and she was unable to explain what had happened. Although attempted, an interview with NA #8 was not obtained. b. The 5-day Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Mental Interview for Mental Status (BIMS) of 15 (fifteen) indicative of intact cognition and was dependent on staff for assistance with transfers. The Resident Care Plan (RCP) dated 7/22/24 identified that Resident #1 required assistance with Activities of Daily Living (ADLs) with interventions that included providing an assist of two (2) to three (3) for transfers with a bariatric Hoyer lift. A nurse's note dated 8/23/24 at 3:05 PM identified that she (ADNS) was called to Resident #1's room to assess the resident. The resident was observed to be sitting in a chair and staff reported that they were transferring the resident to the chair with the Hoyer lift when the Hoyer slightly tipped resulting in the Hoyer bar hitting the resident on the right side of the face and in the chest. A slight abrasion was noted to the right eyelid with scant bleeding and swelling was noted and a purple, tender bruise was noted to the midline/ right chest. The resident complained of moderate pain (four out of ten) and Tylenol (pain reliever) was administered. Physical Therapy (PT) and three (3) NA's transferred the resident back to bed per his/her request, the physician was notified directed that a STAT (immediate) chest x-ray and facial x-ray be obtained and to apply ice to the affected areas as needed. Review of the facial and chest x-ray's dated 8/23/24 did not identify any fractures. Review of the facility Accident & Investigation (A & I) documentation identified that on 8/23/24 at 1:30 PM while NA #1, NA #2 and NA #3 were transferring the resident to the chair, the Hoyer lift tipped, resulting in the bar hitting the resident on the face and chest. It identified that the resident was then lowered into the chair and assessed by the RN. The A & I documentation identified that staff education was provided on the use of the Hoyer lift, and the Hoyer lift was inspected and found to be in proper working order. Review of Resident #1's body weights identified that he/she was 471 pounds (lbs) on 8/23/24. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Person #3 (Hoyer lift customer service representative) on 1/13/25 at 9:28 AM identified that the bariatric lift that Resident #1 was using was appropriate for up to 700 lbs. He/she reported that the only way to tip the Hoyer lift is if staff are pulling on the resident and the Hoyer pad instead of pushing the lift with the handlebars or if the base of the lift is in the narrow position and the legs are not opened to stabilize the weight of the resident. He/she identified that when trying to turn the lift and maneuver out of a tight position, the casters (wheels) can be difficult to push and pull due to a resident's weight but reported that staff should only use the handlebar and never pull the resident or the pad, as it can put the machine off balance and cause it to tip. Person #3 identified that his/her company does not provide education on the Hoyer lift, but that a manual comes with the lift. Interview with Resident #1 on 1/9/25 at 10:53 AM identified that on 8/23/24 while transferring him/her to the chair with the Hoyer lift, they pulled the Hoyer pad to position him/her above the chair, the Hoyer lift started to tip and the main upwards bar hit him/her in the face and on the chest. The resident identified that he/she sustained bruising and bleeding to the areas and that the areas were tender for a while following the incident. Interview with NA #1 on 1/9/25 at 12:43 PM identified that NA #2, NA #3 and herself were present at the time of the incident regarding Resident #1 on 8/23/24. She reported that they had provided incontinent care and put the bariatric Hoyer pad under the resident and then opened the legs of the lift and started lifting the resident in the air. She identified that they started to pull the lift out and positioned it over the chair when the lift started to tip, they were unable to stabilize it, and it subsequently hit the resident on the face and chest. She reported that the resident did not fall, and they were able to finish lowering him/her into the chair. She identified that she was unable to identify any errors that they made resulting in the Hoyer lift to tip. Interview with NA #2 on 1/9/25 at 12:59 PM identified that the legs of the Hoyer lift were opened as they prepared to lower the resident into the chair. She reported that they pulled the back of the Hoyer pad to position the resident over the chair and the machine started to tip and the arm of the Hoyer lift hit the resident in the face and chest. She reported that she was unaware that pulling the Hoyer pad could cause the Hoyer lift to tip when the legs were opened on the lift. Interview with NA #3 on 1/9/25 at 1:05 PM identified that NA #1 and NA #2 requested her help with the transfer of Resident #1 on 8/23/24. She reported that on 8/23/24 she assisted NA #1 and NA #2 by pulling Resident #1's Hoyer pad to get him/her to move, as they were unable to get the Hoyer lift to roll and move in the direction they were trying to go with only one person pulling and pushing the lift by the handlebar. She reported that the lift could not bare the resident's weight so they all had to push him/her, stating she knew they shouldn't have pulled the resident by the Hoyer pad but that it was the only way to move the resident and get him/her out of bed. She identified that she didn't directly tell anyone that she had difficulty with the bariatric Hoyer lift, as all the staff communicated that they had the same problem. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the ADNS on 1/9/25 at 11:59 AM identified that she was unable to identify what caused the Hoyer lift machine to tip onto Resident #1 on 8/23/24, stating that although she did not ask the staff during her investigation if the legs at the base of the machine were open at the time of the transfer, she stated that the resident was obese and she believed the staff did everything they should have done in relation to the transfer and that she was unsure if the incident could have been prevented. Additionally, she reported that the staff involved was educated on the spot, PT inspected the Hoyer lift with no irregularities noted and education related to the Hoyer lift had been started on 8/1/24 and was ongoing throughout the month of August 2024. Interview with the DNS and ADNS on 1/13/25 at 9:50 AM identified that they were unable to conclude how the Hoyer lift tipped onto Resident #1 on 8/23/24 reporting that's why they initiated immediate education, watched NA #1, NA #2 and NA #3 transfer the resident back to bed after the incident and had therapy inspect the Hoyer lift. They identified that they also made education booklets on how to safely transfer residents with a Hoyer lift and placed them on each unit. Interview with the DNS, ADNS and Administrator on 1/13/25 at 12:00 PM identified that Resident #1 was safely transferred on both the 4/30/22 and 8/23/24 incidents stating that ideally if the facility does everything correctly an incident should not occur but reported that they were unable to identify that the resident had been transferred incorrectly in both incidents. Interview with the DNS and Administrator on 1/13/25 at 3:49 PM identified that they were unaware that staff had pulled the resident by the Hoyer pad on 8/23/24 due to difficulties in maneuvering the Hoyer lift, stating that through prior education staff had not communicated they were having difficulties with only pushing the resident by the handlebar on the Hoyer lift. They identified that had they known, they could have implemented another staff for assistance. Although attempted, a re-interview with NA #1 was not obtained. The Hoyer policy identified that the Hoyer lift should be used for residents who are too heavy to move or who are not able to be transferred by other means, be sure to clear the path of the Hoyer lift before moving the resident. Review of the Accidents and Incidents Investigation policy dated 6/2023 directed, in part, that the investigation is initiated to define causative/contributing factors and institute preventative measures to avoid further occurrences as part of the Quality Assurance Performance Improvement process. An accident is defined as any unexpected or unintentional incident which may result in injury or illness to a resident. An incident is defined as any occurrence not consistent with the routine operation of the facility or normal care of the patient. An incident can involve a staff member, malfunctioning equipment, or observation of a situation that poses a threat to safety or security.