STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075313	A. Building B. Wing	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gladeview Health Care Center	60 Boston Post Rd Old Saybrook, CT 06475

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** Based on review of the clinical record, facility documentation, facility policy and interviews for one (1) of three (3) residents (Resident #3) reviewed for transfers, the facility failed to transfer the resident with equipment appropriate for the resident's standing ability. The findings include: Resident # 3's diagnoses included absence of right leg above the knee, history of falling, primary osteoarthritis of the right hand and anxiety disorder. The Resident Care Plan (RCP) dated 9/30/24 identified that Resident #3 had an alteration in physical mobility and independence with daily activities with interventions that included Physical Therapy (PT) and Occupational Therapy (OT) treatment per order and to transfer the resident with assist per orders. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #3 had a Brief Mental Interview for Mental Status (BIMS) of fourteen (14) indicative of intact cognition and required moderate assistance with bed mobility and transfers. A physician's order dated 10/1/24 directed staff assistance of two (2) for bed to wheelchair and wheelchair to bed transfers and identified that Resident #3 was non-ambulatory. Although a facility incident report was unavailable statements regarding a concern about a transfer from NA #3, NA #5 and RN #1 were provided regarding an incident while trying to transfer with Resident #3 on 10/10/25. Statement from NA #3 dated 10/10/24 at 6:41 PM identified that on 10/10/24 at 5:50 PM, she was in the dining room and was asked to help transfer Resident #3. The statement reported that when she went into Resident #3's room with the other staff member, and because the resident had fallen earlier in the shift she requested that the other NA (NA #5) go get another staff to assist them, but NA #5 instead returned with sit-to-stand lift (Sara lift). She reported that while standing the resident up in the lift, the resident's foot moved away from the lift and his/her knee moved, stating they then sat the resident back into the chair and the Nursing Supervisor (RN #1) was called. She identified that when RN #1 arrived, Resident #3's family was yelling that the NA's were killing the resident and another NA (NA #7) was sent in to assist and the resident was then placed in bed. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Statement from NA #5 dated 10/10/24 identified that Resident #3's family requested that she transfer him/her from the wheelchair to the bed. She reported that she asked another staff member (NA #3) to assist her in lifting the resident from the wheelchair to the bed, stating they were unsuccessful, so she left to get another NA to assist them. She identified that she was unable to find assistance so she brought in the Sara lift, thinking it would be helpful, and they hooked the resident up to the lift and asked him/her to stand as it was lifting, to which the resident agreed. NA #5 reported that as they were lifting the resident, his/her foot slipped to the side and the resident stated that he/she was losing strength, and he/she started sliding down. She identified that they then lowered the lift into the wheelchair, but that he/she wasn't completely sitting in the wheelchair. Interview with NA #7 on 2/26/25 at 12:42 PM identified that on 10/10/24 the Nursing Supervisor (RN #1) had approached him and requested that he assist the other staff with a transfer of Resident #3. He reported that when he entered the room, Resident #3's family member was in distress about the transfer, and although he could not remember all the details, he remembered Resident #3 sitting partly in the wheelchair, still attached to the Sara lift (sit-to-stand mechanical lift) with his/her upper body slouching forwards between the handlebars of the lift. Interview with PT #1 (Director of Rehab) and OT #1 on 2/26/25 at 12:59 PM identified that Resident #3's functional abilities fluctuated day to day, as well as his/her motor planning and cognition. They identified that if the resident had already been exhibiting signs of weakness and was unable to stand with an assist of two (2) staff, the staff should not have used the Sara lift because the resident requiresfour limbs (resident is a right leg amputee) and the ability to stand to safely be transferred with the Sara lift. Interview with RN #1 on 2/26/25 at 4:03 PM and review of statement dated 10/15/24 identified that she was in the dining room assisting another resident when Person #1 ran in and started yelling about a resident falling, stating she followed him/her into Resident #3's room and Person #1 yelled, They're killing him/her. RN #1 reported that when she entered the room, two (2) NA's were standing beside Resident #3, who was attached to the Sara lift and it appeared as if his/her left leg gave out, stating he/she was in a sitting position but was on the edge of the wheelchair. She identified that the resident did not fall but the staff was unable to get him/her further onto or off the wheelchair and the NA's were unable to explain what had happened, so she reported she left the room to get another NA (NA #7) to assist them, stating all three (3) NA's (NA #3, NA #5 and NA #7) were then able to place the Hoyer sling onto the wheelchair and transfer Resident #3 safely back to bed. RN #1 identified that she then left a message for the therapy department requesting an evaluation on Resident #3's transfer status, as it appeared the resident was too weak to use the sit-to-stand (Sara lift), notified the APRN and obtained a new order for laboratory testing, notified the family and printed safety reminder signs for the resident's bathroom and bedroom. Interview with the DNS on 2/26/25 at 1:28 PM identified that agency NA's are expected to be educated and have the skills to use mechanical lifts prior to working in the facility, stating that she expects for them to follow the plan of care and be able to transfer the residents with the mechanical lifts (Hoyer and Sara lift) and should ask the facility staff if they have any questions or need assistance with the equipment. She was unsure if the staff should have used the Sara lift with Resident #3, but identified that staff can always downgrade the resident's transfer status if needed, but cannot upgrade their status. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's order dated 10/11/24 directed that Resident #3 was a Hoyer lift and staff assistance of two (2) for bed to wheelchair and wheelchair to bed transfers and identified that Resident #3 was non-ambulatory. Although attempted, interviews with NA #3 and NA #5 were not obtained. Although requested, a facility policy for the Sara lift was not provided.