STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075402	A. Building B. Wing	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mansfield Center for Nursing and Rehabilitation	100 Warren Circle Storrs Mansfield, CT 06268

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review of facility documentation, review of facility policy, and interviews, for one of six sampled residents (Resident #33) reviewed for accidents and required a mechanical lift for transfers, the facility failed to ensure the resident was assessed by a registered nurse following an incident that occurred during a transfer with the mechanical lift. The findings include: Resident #33's diagnoses included Alzheimer's disease, aphasia, muscle weakness and chronic kidney disease. The annual MDS assessment dated [DATE] identified Resident #33 had intact cognition, did not display behaviors, required maximal assistance with bed mobility, upper body dressing and was dependent on care for lower body dressing and toileting hygiene. The assessment further identified the resident did not ambulate, utilized a wheelchair and was dependent on staff for mobility. The care plan dated 8/21/24 identified Resident #33 had an activities of daily living (ADL) self-care performance deficit due to Alzheimer's/dementia. The care plan interventions directed a transfer status of [NAME] (which is a sit to stand mechanical lift) or Hoyer lift (which is a mechanical lift) if unable with assist of two (staff), back to bed with Hoyer at night, and toilet transfer status of Sara lift assist of two if able otherwise back to bed with the Hoyer lift. The care plan also identified Resident #33 had limited physical mobility related to Alzheimer's dementia and osteoarthritis with interventions that included physical therapy and/occupational therapy referrals as ordered and as needed. The Nurse Aide care card for the month of October 2024 identified Resident #33 required the assistance of two staff with the use of the Sara lift and for the Hoyer lift. The acute care hospital's Discharge summary dated [DATE] identified Resident #33 had bruising and tenderness to the left proximal tibia and an x-ray indicated an oblique left proximal tibia fracture. It further noted the resident was placed in a long leg splint and to follow-up with orthopedic surgery. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's reportable event report and investigation dated 10/9/24 at 9:30 AM identified Resident #33 complained of having pain in the left leg with increased warmth and swelling to the area. In addition, an order was received to have an x-ray performed which indicated a left lower leg fracture involving the proximal tibia and fibula with minimal callus and mild displacement. An order was given to send the resident to the emergency department for further evaluation. The report identified that at the hospital the resident was noted to have a fracture of the left tibia, and placed in a long leg splint, non-weight bearing until follow-up with orthopedic surgery. The facility noted the injury was of unknown origin. NA #2's written statement dated 10/9/24 identified she washed and got Resident #33 ready to be transferred to the wheelchair, the resident was strapped to the lift, the resident's feet were placed on the lift platform, everything was on correctly and ready to lift. The statement further identified she noticed the resident's left foot fell off the lift platform, and the resident told her that his/her leg got weak. The statement further noted NA #2 identified that she lowered the resident down and went to get the nurse. In a second statement from NA #2 obtained via telephone on 10/15/24 by the former DNS (RN #3) identified Resident #33's left foot slipped off the Sara lift and the resident kneeled on the left knee slightly and the Charge Nurse (LPN #2) assisted the nurse aide in transferring the resident back to bed. Interview with NA #2 on 4/3/25 at 2:20 PM identified she worked the 7:00 AM to 3:00 PM shift on 10/7/24. NA #2 identified that in the morning she assisted Resident #33 to sit on the edge of the bed to transfer him/her using the Sara lift to the wheelchair. She further identified that while the resident was connected to the Sara lift and in the process of the transfer, she noticed that the resident's left foot had slipped off the foot support/platform. She then locked the machine (Sara lift) and went in the hallway to get the nurse (LPN #2). The nurse came and asked the resident if she had any pain and assisted her in transferring the resident to the bed with the Sara lift then they used the Hoyer lift to transfer the resident from the bed to the wheelchair. NA #2 identified that she was aware that Resident #33 required assistance from two staff to use the Sara lift, however, she transferred the resident by herself as there was nobody available to assist with the transfer. LPN #2's written statement dated 10/9/24 identified on 10/7/24 around 9:30 AM she was called by NA #2 to Resident #33's room. On arrival LPN #2 observed Resident #33 hooked up on the Sara lift with his/her leg bent behind the resident, and the resident was unable to complete the transfer. She further identified that immediately the resident was safely transferred back to bed with the assistance of two. The statement further identified that Resident #33 appeared calm, denied pain or discomfort, no visible bruises, lacerations or swelling was noted, and the resident was able to move extremities without pain. Review of Resident #33's clinical record failed to identify a registered nurse assessment or nurses note following an incident which occurred on 10/7/24 during a transfer using the Sara lift. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Nursing Supervisor (RN #1) on 4/8/25 at 11:48 AM identified she had not done an assessment, nor had she written a nurse's note based on what the charge nurse had told her that had occurred. She indicated that LPN #2 indicated that Resident #33 was having difficulty transferring using the Sara lift and that she had to assist with the transfer. She further identified that LPN #2 indicated Resident #33 was unable to bear weight on his/her leg, so she recommended that the resident be screened for a physical therapy evaluation as the resident struggled with the transfer which was not uncommon for this population. RN #1 identified when she reported to work on 10/9/24 and found out the resident had a fracture, she then went to LPN #2 to find out what happened when LPN #2 expressed that Resident #33's knee almost touched the platform/foot support during the transfer and had to assist with getting the resident back in to the bed/chair, she could not recall if it was the bed/chair. RN #1 identified that had she been made aware of all the circumstances, she would have assessed the resident, wrote a note, initiated an accident report and notified the provider. Interview with the Charge Nurse (LPN #2) on 4/8/25 at 1:44 PM identified she told the nursing supervisor about what had happened during the transfer wherein the resident's leg was bent towards his/her back, and she had assisted the nurse aide with the Sara lift to transfer the resident back to bed. LPN #2 indicated that she expressed to the nursing supervisor that when the resident was back in bed, she removed his/her pants to check the leg for any bruising, Resident #33 denied pain, no sign of deformity, had no grimacing and was then transferred to wheelchair using a Hoyer lift. The resident had no further complaints throughout the shift. LPN #2 added that the next morning Resident #33 complained of pain in the left lower extremities, swelling and a little redness was noted, so she informed the nursing supervisor on duty. LPN #2 indicated that she was not sure if RN #1 had gone to see the resident or had written a note. LPN #2 identified looking back at the incident she should have written a note and started the accident/incident report on 10/7/24, as the resident was a two-person assist with transfers using the Sara lift. Interview with the Administrator, and the DNS on 4/9/25 at 1:39 PM identified that based on what occurred during the transfer, it would be considered an incident, which would indicate that a nursing assessment and note should have been initiated. Review of the Accident/Incident policy and procedure identified staff will notify the nursing supervisor/licensed nurse when an incident occurs. The policy further identified the licensed nurse, or the supervisor will complete and document the evaluation of the resident's condition. This evaluation is to include but is not limited to vital signs and neuro signs if applicable, type of injury with location on body, include measurements if the injury is a skin tear or bruise, evaluation of pain, range of motion of all extremities.

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(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 - 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 clinical records, review of facility documentation, review of facility policy, and interviews, for two of six sampled residents (Residents #13 and #47) reviewed for accidents, the facility failed to ensure the required staff assistance was utilized during the use of the mechanical lift, and for one of six sampled residents (Resident #33) the facility failed to ensure the required staff assistance was in place during a mechanical lift transfer and failed to ensure the resident was attached to the lift correctly, which resulted in an accident and injury. The findings include: 1. Resident #13 was admitted to the facility in January 2025 with diagnoses that included metabolic encephalopathy, dementia, and renal failure. The admission MDS assessment dated [DATE] identified Resident #13 had intact cognition, functional limitation in range of motion of the bilateral upper extremities, utilized a wheelchair for mobility, was dependent on staff for toileting hygiene, toileting and transfers from the bed to the wheelchair, and was always incontinent of bowel and bladder. The physician's order dated 3/17/25 directed Resident #13 be transferred with the assistance of two staff members. The care plan dated 1/31/25 identified Resident #13 had a deficit in Self Care Function with interventions that direct 2 staff for bathing/showering, 2 staff for dressing, and 2 staff for toileting. Observation on 4/9/25 at 9:40 AM identified NA#7 and NA#6 utilizing the mechanical lift to transfer Resident #13 from the bed (a seated position) to the bathroom, to be seated on the toilet. Both NA#6 and NA#7 completed the transfer. Resident #13 was seated on the toilet and disconnected from the lift. NA#7 directed NA#6 to call him when she was finished with care and left the room. NA#6 completed care and dressed the resident in the bathroom with the door closed. Observation on 4/9/25 at 9:55 AM identified NA#6 operating the mechanical lift independently without assistance to transfer Resident #13 out of the bathroom and into the wheelchair which was located in the room next to the bed. Interview on 4/9/25 at 10:04 AM with NA#6 identified she has worked at the facility since 9/2024 and identified she is a full-time employee. NA#6 further identified that she looks at the care card to identify what type of care the resident needs and indicated that all residents required two staff members when utilizing the sit to stand mechanical lift. Interview on 4/9/25 at 10:24 AM with RN#1 identified that all of the staff is aware that mechanical lift transfers require the assistance of two staff members. Interview on 4/9/25 at 12:39 PM with the ADNS identified that NA competencies are done annually and as needed and that all nurses' aides are aware that two staff members are required when utilizing the mechanical lift. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview on 4/9/25 at 2:15 PM with the Administrator and RN#4 identified that the facility policy identifies that mechanical lift transfers require the assistance of 2 staff members. The policy on use of the mechanical lifts identified that two staff members must be involved in the transfer of a resident with the mechanical lift. 2. Resident #33's diagnoses included Alzheimer's disease, aphasia, muscle weakness and chronic kidney disease. The annual MDS assessment dated [DATE] identified Resident #33 had intact cognition (BIMS of 13), required maximal assistance with bed mobility, and upper body dressing, required total assistance with lower body dressing and toileting hygiene. The assessment further identified Resident #33 did not ambulate, utilized a wheelchair and was dependent on staff for mobility. The care plan dated 8/21/24 identified Resident #33 had an activities of daily living (ADL) self-care performance deficit due to Alzheimer's/dementia. The care plan interventions directed: transfer status of [NAME] (which is a sit to stand mechanical lift) or Hoyer lift (which is a total mechanical lift) with assist of two (staff), back to bed with Hoyer at night, and toilet transfer status of Sara lift assist of two if able otherwise back to bed with the Hoyer lift. The care plan also identified Resident #33 had limited physical mobility related to Alzheimer's dementia and osteoarthritis. Review of the Nurse Aide care card instructions in effect for the month of October 2024 identified the need for two staff with the use of the Sara lift and the Hoyer lift. The physician's orders for the month of October 2024 directed Acetaminophen (Tylenol) tablet 650 milligrams (mg), administer two tablets orally in the morning for pain. Review of the medication administration record identified that on 10/8/24, the resident was administered Tylenol 650 mg at 10:07 AM for complaint of discomfort in addition to his/her regularly scheduled Tylenol. The nurse's note dated 10/8/24 at 10:46 AM written by RN #5 identified Resident #33 had pain in the left knee, tibia and fibula area with some increased warmth and swelling. The note further identified that APRN #1 was notified, and an x-ray was ordered. APRN 1's progress note/assessment via telehealth visit dated 10/8/24 identified Resident #33 reported left knee pain and the inability to help with Sara lift transfer as usual. The note further identified that per nursing the left knee had slight edema, a negative [NAME] sign, was warm to the touch without erythema and an x-ray of the knee was ordered. The x-ray results dated 10/8/24 identified the resident had a fracture of the left tibia and fibula. It further noted that the resident had mild degenerative changes and diffuse osseous demineralization. (continued on next page)

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	075402	A. Building B. Wing	04/10/2025

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The nurse's note dated 10/9/24 at 12:30 AM identified the x-ray results were positive for fracture of the left tibia/fibula and that an order was obtained to send the resident to the hospital emergency department. Review of the hospital discharge paperwork dated 10/9/2024 identified bruising and tenderness in the left proximal tibia and an x-ray was performed in the emergency department which showed an oblique left proximal tibia fracture. The leg was splinted with instructions to follow up with orthopedic surgery. The facility's reportable event report and investigation dated 10/9/24 at 9:30 AM identified Resident #33 complained of having pain in the left leg, with increased warmth and swelling to the area. In addition, an order was received to have an x-ray performed which indicated a left lower leg fracture involving the proximal tibia and fibula with minimal callus and mild displacement, and an order was received to send the resident to the emergency department for further evaluation. The report further identified the hospital identified a fracture of the left tibia, placed a long leg splint, and noted the resident a status of non-weight bearing until follow-up with orthopedic surgery. The facility submitted the report to the state survey agency with the classification as an injury of unknown origin, the reportable event report did not acknowledge the incident with the Sara lift that occurred on 10/7/25. The reportable event report identified a written statement by NA #2 dated 10/9/24 that identified she washed and got Resident #33 prepared for the transfer to his/her wheelchair, she placed the straps around the resident's torso, and attached the straps to the lift, placed the resident's feet on the lift platform, The statement further identified that during the transfer from the bed to the wheelchair, she noticed one of the resident's feet fell off the lift, and the resident told her that his/her leg was weak. The documentation further noted NA #2 lowered the resident down and went to get the nurse. The reportable event report investigation further identified that on 10/15/24 The DNS (former) spoke to NA #2 who identified that Resident #33's left foot slipped off the lift platform, causing the resident to kneel on the left knee. Interview with NA #2 on 4/3/25 at 2:20 PM identified that in the morning she assisted Resident #33 to sit on the edge of the bed to transfer him/her using the Sara lift to the wheelchair. She further identified that while the resident was attached to the Sara lift via the straps and in the process of transferring the resident she noticed that the resident's left foot slipped off the Sara lift platform. She noted that she locked the Sara lift and went in the hallway to get the nurse (LPN #2). LPN #2 came and asked the resident if she had any pain and assisted NA #2 in transferring the resident to the bed with the Sara lift. She further noted that they used the Hoyer lift to transfer the resident from the bed to the wheelchair. NA #2 identified that she was aware that Resident #33 required assistance from two staff to use the Sara lift, however, she transferred the resident by herself because there was nobody available to assist with the transfer. LPN #2's written statement dated 10/9/24 identified on 10/7/24 around 9:30 AM she was called by NA #2 to Resident #33's room. She noted that on arrival to the room she observed Resident #33 hooked up on the Sara lift and noted the left leg was bent behind the resident and was not on the lift platform (where the feet should be placed). She further identified that immediately the resident was safely transferred back to bed with assistance of two and noted Resident #33 appeared calm, denied pain or discomfort, had no visible bruises, lacerations or swelling and was able to move extremities without pain. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview with the Charge Nurse (LPN #2) on 4/3/25 at 2:35 PM identified she was the nurse on duty on 10/7/24 for the 7:00 AM to 3:PM shift. LPN #2 identified she was taking care of another resident in a nearby room when NA #2 called her to come to Resident #33's room. She identified that when she entered the room, Resident #33 had the lift pad around her upper torso with the straps attached to the lift, but the resident was hanging freely from the lift with the knees not touching the padding on the lift where the knees are supposed to touch to support the resident, her left leg was also bent back and was not on the lift platform. LPN #2 further noted that NA #2 was in the process of transferring the resident from the bed to the wheelchair. LPN #2 identified that the leg straps (supports) were not in place (as they should be) around the resident's lower legs. LPN #2 further identified that the resident required two staff to assistance with the transfer and that NA #2 had not requested assistance. Additionally, LPN #2 identified that she notified the nursing supervisor of the incident. Interview with LPN #2 on 4/8/25 at 1:44 PM identified that on 10/8/24 Resident #33 complained of pain in the left lower extremity. LPN #2 noted that the left lower extremity was noted with swelling and redness. She identified that she notified the nursing supervisor on duty and x-rays were ordered. LPN #2 further identified Resident #33 should absolutely have the lift leg support straps in place when using the Sara lift. The physical therapy (PT) note dated 10/9/24 at 2:44 PM by PT #2 identified Resident #33 was referred to PT due to significant decline in his/her transfer abilities that was noted on 10/8/24, and the resident was found to have a deformity of the left lower extremity with increased edema to the left lower extremity and was sent out for x-rays which revealed a fracture of the left fibula/tibia. Interview with MD #1 (Orthopedic Surgeon) on 4/9/25 at 9:26 AM identified Resident #33 was seen in the office due to a fracture and based on the x-ray results, and his examination of the resident, he identified Resident #33 had an acute fracture. He further noted that the accident with the Sara lift could definitely have caused the fracture, and because of the resident's dementia, the response to pain may be atypical and the resident may not remember what occurred. Interview with the Physical Therapist (PT #1) on 4/8/25 at 8:33 AM identified that if the resident transfer status fluctuates between the use of a Sara lift and Hoyer lift then the leg straps should be utilized. PT #1 further identified if the leg straps on the Sara lift are not used as indicated and secured it can cause injuries to the resident. PT #1 further identified that if the leg straps on the Sara lift are used and secured properly, a resident's leg would not slip off the platform/foot support. PT #1 added that when using the Sara lift with Resident #33, two staff members are needed to prevent the resident from getting hurt and for safety. PT #1 added that two staff members are needed in Sara lift transfers as one staff would aid in positioning residents who are unable to position themselves in a seated position to be connected to the Sara lift and guide the resident during the transfer while the other staff manages the Sara lift. Interview with the Staff Development Nurse (RN #2) on 4/7/25 at 10:56 AM identified that two staff members are required when using the mechanical lift as one staff operates the machine/lift and the other staff guides the resident, and legs support straps are to be utilized during the transfers as it is a part of the training. Interview with the current DNS and the Administrator on 4/9/25 at 1:39 PM identified that NA #2 was an agency staff and was provided with education following the incident. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the [NAME] 3000 (Sara lift) instructions for use manual identified that the foot support is used for positioning before and supporting the resident's feet during raising and transferring. In addition, the lower leg straps accessory is used to ensure that the lower parts of the resident's legs stay close to the knee support as they pass around the knee supports, then around the resident's lower calves. Also to ensure that the straps are firm but comfortable for the resident. In addition, the manual further identified in the warning section that the residents' feet shall always remain in full contact with the foot support and when raising, check to ensure that the resident's feet do not lift from the foot support. Review of the policy and procedure for Sara lift (partial weight bearing/standing lift) identified a mechanical lifting device is utilized to safely move a patient/resident from bed to chair or to the commode/bathroom and two staff are utilized to perform the procedure unless it is specified by physical therapy that the transfer can be completed with one person assisting. The policy and procedure for using the Sara lift in part, identify to place the resident's feet onto the foot support, adjust the resident's leg so that they are in full contact with the knee support of the lift, attach sling to the lift at the designated spots and attach the support strap to the resident's legs for safety. 3. Resident #47's diagnoses included dementia, type 2 diabetes, anemia and hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side. The quarterly MDS assessment dated [DATE] identified Resident #47 had severe cognitive impairment, had no behaviors, was dependent for hygiene, lower body dressing, and bed mobility. The assessment further identified Resident #47 did not ambulate, utilized a wheelchair and was dependent on staff for mobility. The care plan dated 2/9/25 identified Resident #47 had an ADL self-care performance deficit related to cognitive impairment /history of CVA with left sided hemiplegia. Care plan interventions included transfer with two staff assist using the Sara lift (sit to stand lift). The Nurse Aide care card instruction for April 2025 identified Resident #47 required the assistance of two 2 staff members when using the Sara lift. Observation on 4/2/25 at 12:19 PM identified Resident #47 seated in his/her adaptive wheelchair located on the right-side of the resident's bed. NA #5 wheeled the resident to the end of the bed facing the entrance door of the room. NA #5 positioned the Sara lift in front of the resident, then applied the sling to Resident #47 followed by attaching the sling to the Sara lift followed by applying the leg support straps and she ensured the resident placed his/hand on the support grips. NA #5 then utilized the control to raise the resident up, then transferred the resident to the bathroom and lowered the resident to the toilet seat. Interview with NA #5 on 4/2/25 at 1:06 PM identified the care card indicated Resident #47 required two staff members for transfers with the Sara lift. NA #5 further identified that she should have had a second staff member with her during the transfer, but she transferred the resident by herself. She added that when she first started orientation on the unit, she was trained and told by staff that Resident #47 only needed one person to use the Sara lift for transfers. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview with the DNS on 4/2/25 at 3:10 PM identified that two staff members are required to use the Sara lift. The DNS reviewed Resident #47's care plan and indicated that he/she required two people when utilizing the Sara lift. Interview with the Staff Development Nurse (RN #2) on 4/7/25 at 10:56 AM identified that staff are trained to use two staff members when using the Sara lift. RN #2 further identified she provided education and/competency to the nurses' aides including NA #5 in December of 2024. She noted that during the transfer, one staff member operates the lift, and one staff member provides hands on guidance to the resident. Interview with the Physical Therapist (PT #1) on 4/8/25 at 8:25 AM identified Resident #47 requires two staff members for transfers using the Sara lift. PT #1 noted that when using the Sara lift for this resident that two staff members are needed to prevent the resident from getting hurt and for safety, as one staff member operates the Sara lift, and the other staff member guides the resident and ensures the resident is positioned properly. The Mechanical Lift policy identified two staff members must be involved in the transfer of a resident with the Mechanical Lift.