STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105618	A. Building B. Wing	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regents Park of Winter Park	558 N Semoran Blvd Winter Park, FL 32792

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36489 Based on interview, and record review, the facility failed to immediately notify the physician and resident representative of a change in condition regarding a fracture for 1 of 2 residents reviewed for falls, out of a total sample of 8 residents, (#3). Findings: Review of the medical record revealed resident #3, a [AGE] year-old female, was admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included multiple sclerosis, breast cancer, secondary bone cancer, muscle contractures of her left hip, both knees, and right ankle, and a post-fall sacral fracture. Review of the Order Recap Report for the period 11/01/24 to 12/31/24 revealed an order from resident #3's attending physician, dated 12/10/24, for x-rays of her left ankle and both hips. Resident #3's Radiology Results Report revealed x-rays of her left ankle, left hip, and right hip were done on 12/11/24 at 6:10 PM. Interpretation of the x-rays by a radiologist showed the resident had a fracture at the upper end of the left femur or thigh bone. The document was electronically signed by the radiologist on 12/11/24 at 8:28 PM. Review of a Situation, Background, Appearance, Review and Notify (SBAR) Communication Form revealed resident #3's primary care clinician was notified of her left hip fracture on 12/12/24 at 6:20 AM, approximately 12 hours after the test was completed. The SBAR form indicated the facility received an order to send the resident to the hospital Emergency Department via emergency medical services. Review of Progress Notes revealed no documentation on 12/11/24 by resident #3's assigned nurse, Registered Nurse (RN) G, regarding the completion of her x-rays or acknowledgement of the results. A Narrative Note dated 12/12/24 at 6:20 AM, indicated the Director of Nursing (DON) notified an Advanced Practice Registered Nurse of the x-ray results of a left hip fracture and she received an order to send resident #3 to the hospital for evaluation. The note revealed the DON informed RN G of the order and tasked him with notifying the resident's representative, her daughter. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/12/24 at 10:28 AM, the Cambridge Unit Manager (UM) confirmed resident #3's radiology results were available since about 8:30 PM on 12/11/24 but the physician was not notified until the next morning, 12/12/24, at about 6:20 AM. She explained the radiology provider usually faxed radiology reports to the facility and would call to make verbal notification if there was a positive result. The UM stated the physician on call, the resident, and the representative should immediately be notified of abnormal findings. She confirmed the assigned nurse did not enter any documentation in the medical record on the x-ray technician's visit or any follow up related to obtaining or viewing the results. The UM stated she was not aware of the finding of a left hip fracture until the DON informed her earlier this morning. On 12/12/24 at 12:19 PM, the facility's Medical Director verified his expectation was nurses would immediately notify the ordering physician regarding a positive or abnormal diagnostic test result. On 12/13/24 at 9:06 AM, the DON validated resident #3's x-ray result of a left hip fracture was available to nurses on 12/11/24 at 8:28 PM when the document was uploaded to the electronic medical record. She explained in the early morning on 12/12/24, she was at home reviewing residents' test results, new physician orders, and the 24-hour report when she noted the radiology report that showed resident #3 had a left hip fracture. The DON stated she realized the physician had not been notified so she called the facility and discussed the result with RN G. She confirmed she expected nurses to monitor for pending diagnostic test results at the beginning of the shift, during the shift, and prior to leaving. The DON stated resident #3's physician and daughter should have been notified of her condition immediately after the x-ray results were available. On 12/13/24 at 2:59 PM, RN G confirmed he was assigned to resident #3 on 12/11/24. He explained he worked on the 3:00 PM to 11:00 PM and the 11:00 PM to 7:00 AM shifts. RN G verified the x-ray technician completed the resident's x-rays at 6:19 PM according to his personal nursing report sheet. He stated the radiology provider did not call the facility, and he did not check the electronic medical record for the results during his 16-hour shift. RN G explained sometimes the Nursing Supervisor would check for pending test results, but he was not aware of resident #3's results until the DON called him on 12/12/24 in the early morning while he was passing morning medications. RN G acknowledged he should have checked for the result during his shifts. He said, It was my responsibility. I was supposed to follow up. Review of the facility's policy and procedure for Notification of Changes, implemented in November 2020, revealed the facility would promptly inform the resident, consult the physician, and notify the resident's representative when there was a change in condition such as an accident, significant change in physical status, or the need to alter treatment or initiate a new treatment.

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36489 Based on observation, interview, and record review, the facility failed to protect the residents' right to be free from neglect to prevent a fall with major injury (#3); and neglected to implement care directives to promote safety during a transfer procedure, (#2), for 2 of 7 residents reviewed for mechanical lift use, out of a total sample of 8 residents. On 11/22/24 at approximately 5:00 PM, the facility failed to prevent resident #3, a vulnerable, physically impaired resident, from suffering a fall and fracture. The resident's plan of care indicated she required assistance from two staff members for transfers with a full body mechanical lift, but her assigned Certified Nursing Assistant (CNA) attempted the task single-handedly. During the transfer between the shower chair and her bed, one of the sling's loops detached from the lift while the resident was suspended in the air, and she fell to the floor. Resident #3 landed on her head and back, suffered excruciating pain, and was hospitalized with diagnoses of blunt head trauma and a fracture of the sacrum or tailbone. On re-admission to the facility, resident #3 complained of acute left hip pain, and after three weeks of persistent pain, she was subsequently diagnosed with a left hip fracture and required re-hospitalization . After the fall, resident #3 developed a fear of using the mechanical lift and chose to remain in bed, which affected her quality of life by limiting participation in her usual routine and activities of choice. On 12/10/24 at approximately 11:00 AM, the facility failed to ensure staff accessed and implemented the plan of care for resident #2, a physically impaired resident, to promote his safety during a mechanical lift transfer. The resident's assigned CNA neglected to review the CNA care plan or kardex prior to the procedure and attempted to transfer him from the bed to a chair with a sit-to stand lift, instead of a full body lift as required. Resident #2 had noticeable weakness and poor balance, but the CNA did not pause the transfer to validate his transfer status and thereby placed him at high risk for an adverse outcome as he was unable to stand. The facility's failure to provide appropriate care and services for mechanical lift transfers contributed to resident #3's fall and fracture and placed resident #2 and all 48 residents who required mechanical lifts for transfers at risk for serious injury/impairment/death. These failures resulted in Immediate Jeopardy starting on 11/22/24. The facility's Director of Nursing and Regional Nurse Consultant were notified of the Immediate Jeopardy on 12/13/24 at 3:05 PM, and provided the Immediate Jeopardy templates. The Immediate Jeopardy was determined to be removed on 12/11/24 after verification of the immediate actions implemented by the facility. The scope and severity of the deficiencies was decreased to D, no actual harm, with potential for more than minimal harm, that is not Immediate Jeopardy. The census at the start of the survey was 105. Findings: Cross reference F689 and F726. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. Review of the medical record revealed resident #3, a [AGE] year-old female, was admitted to the facility on [DATE]. She was transferred to the hospital on 11/22/24, readmitted on [DATE], and returned to the hospital on 12/12/24. Her diagnoses included multiple sclerosis, breast cancer, secondary bone cancer, muscle contractures of her left hip, both knees, and right ankle, muscle wasting and atrophy of the shoulders, post-fall sacral fracture, and a left hip fracture. Review of the Minimum Data Set (MDS) Quarterly assessment with assessment reference date (ARD) of 10/23/24 revealed resident #3 had functional limitation in range of motion due to impairment of all extremities and used a wheelchair for mobility. Resident #3 was dependent on staff for transfers between the chair and bed, and into and out of the shower. The MDS Discharge assessment-return anticipated, with ARD of 11/22/24, revealed resident #3 had an unplanned discharge to an acute care hospital on 11/22/24. The MDS assessment indicated she had one fall since admission/entry, re-entry, or the prior assessment, which resulted in a major injury. Review of the medical record revealed resident #3 had a care plan for activities of daily living (ADL) self-care performance deficit related to multiple sclerosis, impaired mobility, and contractures. The document was created on 4/03/15 and revised on 2/23/24. The goal was resident #3 would have her ADL needs met by staff. The interventions included instructions for CNAs to perform chair/bed and shower transfers with a total body mechanical lift operated by two staff. A care plan for risk for complications of osteoporosis with a history of a fracture, initiated on 4/03/15 and revised on 11/28/24, revealed a goal that resident #3 would remain free of injury. The interventions included educate the resident and caregivers on safety measures needed to reduce the risk for falls and report signs of a fracture and pain to the physician. Review of the CNA care plan or kardex for resident #3 revealed instruction for two CNAs to perform transfers with a full body mechanical lift. On 12/10/24 at 3:02 PM, the facility's Administrator and Director of Nursing (DON) discussed resident #3's fall. The Administrator explained the incident investigation showed resident #3's assigned CNA performed a mechanical lift transfer without assistance, which was contrary to the facility's policy. The Administrator verified the facility therefore substantiated the incident as neglect. The DON stated she interviewed CNA A by telephone on the day of the incident and had her come into the building the following day to do a re-enactment and demonstrate how the resident fell . She stated CNA A confirmed she performed the mechanical lift transfer by herself and admitted to not following her training. On 12/10/24 at 10:10 AM, resident #3 verified she fell from the mechanical lift when her CNA attempted to transfer her from the shower chair to her bed. She stated the CNA was the only staff present at the time. Resident #3 said, It was not the first time that only one CNA picked me up in the lift. I did not realize it was wrong then, but now I know it is supposed to be two people. Resident #3 stated since the fall she was fearful of using the lift and now had significant left hip pain with movement. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/10/24 at 4:02 PM, CNA B stated she often assisted CNA A to transfer resident #3 with the mechanical lift on shower days. She recalled on the day the resident fell ; she assisted CNA A to transfer her from the bed to the shower chair. CNA B stated she did not accompany them to the shower room, but told CNA A to call her when they were finished so she could assist with transferring resident #3 back to bed. CNA B stated she left to provide care for her assigned residents and when the dinner meal cart arrived, she started to distribute trays. She explained she did not see when CNA A and resident #3 returned from the shower room, and CNA A never asked her to help to transfer the resident back to bed. CNA B stated she was in the unit's day room when CNA A shouted her name three times from resident #3's doorway. She stated CNA A appeared very upset and when she ran to the room to check what happened, she saw resident #3 on the floor. CNA B stated all CNAs were aware a mechanical lift transfer required two people, but CNA A decided to do the wrong thing. In interviews on 12/10/24 at 10:00 AM, and 12/12/24 at 10:45 AM, the Cambridge Unit Manager (UM) confirmed resident #3 required a full body mechanical lift for transfers. She explained the resident fell from the lift on 11/22/24 when the assigned CNA performed a transfer by herself, although the task required two staff. The UM stated resident #3 was hospitalized after the fall, and was diagnosed with a sacral fracture. She confirmed the resident complained of increased pain since re-admission to the facility and now requested almost daily doses of the pain medication Oxycodone, a significant increase compared to before the fall. The UM stated x-rays done yesterday showed resident #3 had a left hip fracture so she was sent to the hospital this morning for evaluation. On 12/13/24 at 9:57 AM, in a telephone interview, resident #3's daughter confirmed since her mother fell during a mechanical lift transfer, she had been experiencing significant pain with movement, particularly when she rolled from side to side. The resident's daughter stated her mother was again in the hospital with a newly diagnosed left hip fracture that likely occurred at the time of the fall from the lift, although it was not diagnosed then. She explained her mother was not a good surgical candidate at this time as she was compromised by multiple clinical conditions including metastatic cancer and multiple sclerosis. Resident #3's daughter acknowledged the combination of the improbability of surgery, increased pain, and fear of using the lift would create limitations that negatively impacted her mother's quality of life. She said, I think they could have done a better job assessing her pain and addressing the cause. I am upset. 2. Review of the medical record revealed resident #2, a [AGE] year-old male, was admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included seizures, muscle wasting and atrophy of both shoulders, unsteadiness on his feet, abnormal posture, and cervical spine fusion. Resident #2 had a nursing care plan created on 10/27/24 for ADL self-care performance deficit related to generalized weakness. An intervention dated 11/24/24 instructed CNAs to perform transfers between the bed and wheelchair and into and out of the shower with a total body mechanical lift operated by two staff. Review of the kardex for resident #2 revealed the instruction for two CNAs to transfer him between the bed and chair with a full body mechanical lift. On 12/10/24 at 9:50 AM, CNA C stated resident #2 was scheduled for a shower today and she would transfer him from his bed to the shower chair with a mechanical lift. A sit-to-stand lift was noted in the hallway near the resident's door. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/10/24 at 11:00 AM, CNA C stated she was ready to transfer resident #2 with assistance from CNA E. The sit-to-stand lift remained outside resident #2's door so CNA C was prompted to check the care directives regarding the resident's transfer needs. She reviewed the nursing care plan for risk for falls, but did not check the care plan for ADLs or view the Kardex with specific transfer instructions. On 12/10/24 at 11:02 AM, CNA C placed the sit-to-stand lift at resident #2's bedside and CNA E assisted with positioning the resident into a seated position on the side of the bed. He was not able maintain an upright position and rocked backwards and fell to the side without CNA E's support. CNA C explained before the resident went to the hospital, he did not use a lift as he was able to stand for transfers with the assistance of two people. She stated since re-admission, he was much weaker and required a mechanical lift. CNA C stated this was her first attempt to get the resident out of bed since his return from the hospital. As CNA C continued to position resident #2 in the sit-to-stand lift for the transfer, CNA E expressed concern, pointed to the lift, and said, Maybe this is not good for him. Staff were aware of the resident's extreme weakness and obvious inability to even sit, and neither CNA stopped the procedure to verify his transfer requirements or report concerns to a nurse. The transfer with the sit-to-stand lift was averted when CNA C discovered the lift's battery was dead. On 12/11/24 at 9:56 AM, the Therapy Director was informed staff attempted to transfer resident #2 from his bed to the shower chair with a sit-to-stand mechanical lift. She reviewed his Physical Therapy notes and explained the resident required maximum assistance for transfers and it was determined that the full body mechanical lift was the appropriate type for CNAs to use. She was informed CNA C mentioned that prior to his hospitalization , the resident could do stand and pivot transfers with two staff. The Therapy Director reiterated resident #2 required maximum assistance for transfers and for the safety of staff and the resident, a full body mechanical lift was the only recommended transfer method. On 12/12/24 at 12:19 PM, the facility's Medical Director stated he was very familiar with resident #3's medical issues which included multiple sclerosis and breast cancer with bone metastasis. He explained recent diagnostic tests showed metastatic lesions in both hips. The Medical Director stated the CNA's decision to transfer the resident by herself was inexcusable as she was very frail and already at high risk for fractures due to her diagnoses. He stated his expectation was for all staff to handle resident #3 delicately, like an egg. The Medical Director confirmed he was made aware CNAs attempted to transfer resident #2 with the wrong type of mechanical lift a couple days ago, because they did not check the care directives. He stated he was dumbfounded as all staff were re-educated on transfers with mechanical lifts after resident #3 fell a few weeks ago. The Medical Director emphasized the importance of CNAs following care directives to ensure residents were transferred appropriately and safely. Review of the facility's policy and procedures for the prohibition of Abuse, Neglect and Exploitation, revised on 11/16/23, revealed the facility would protect the health, welfare, and rights of each resident. The policy defined neglect as failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. The document indicated the facility would provide ongoing oversight and supervision of staff to ensure the abuse and neglect prohibition policy was implemented. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the policy and procedures for Comprehensive Care Plans, revised on 7/27/22, revealed the facility would develop and implement a comprehensive care plan to meet residents' needs according to assessment findings and identify services to be furnished to attain the highest practicable well-being. Review of the facility's policy and procedures for Safe Resident Handling/Transfers, revised on 11/29/22, revealed the facility would ensure residents were handled and transferred safely to minimize risks for injury and promote a safe, secure and comfortable experience for the resident. The guidelines revealed the interdisciplinary team (IDT) would evaluate and assess each resident's mobility needs to determine the type of lifting equipment or other transferring/handling aids to be used. The document read, Two staff members must be utilized when transferring residents with a mechanical lift.Staff members are expected to maintain compliance with safe handling/transfer practices.Resident lifting and transferring will be performed according to the resident's individual plan of care. The resident sample was expanded to include five additional residents who required a full body mechanical lift for transfers. Review of immediate actions to remove the Immediate Jeopardy implemented by the facility revealed the following, which were verified by the survey team: * On 11/22/24, the evening shift Nursing Supervisor immediately placed the mechanical lift and sling out of service. * On 11/22/24, the CNA who failed to follow correct procedure for use of mechanical lift using two staff members was immediately suspended. * On 11/22/24, the Weekend Nursing Supervisor began education and skills validation with 13 of 24 CNAs duty on the day, evening and night shifts. * On 11/23/24, an Ad Hoc Quality Assurance and Performance Improvement (QAPI) meeting was held with the facility's Administrator, Director of Nursing, and Medical Director to review the initial incident. * On 11/24/24 through 11/25/24, the Therapy Director completed resident transfer status evaluations on current residents. Any updates were placed in the kardex and care plans. * On 11/24/24 through 11/25/24, the MDS coordinator completed care plan/kardex reviews to ensure appropriate transfer status was on care plan/kardex for current residents. * On 11/25/24, the MDS Coordinators completed a quality review of current residents for MDS accuracy related to transfer status. Corrections were made as identified. Quality reviews were then completed on current resident care plans and kardexes to ensure accurate transfer status were listed. Corrections were made when identified. * On 11/23/24, the Maintenance Director inspected all mechanical lifts and slings for any malfunctions and no concerns were identified. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	* On 11/23/24 through 11/27/24, current nursing staff were educated on mechanical lift usage and competencies were performed by the Director of Nursing, Staff Development Coordinator, and Nurse Managers. Occupational and Physical Therapy staff were educated on mechanical lift usage. Of 91 total nursing staff, 80 total current nursing staff received education, and 11 total nursing staff members were to receive education prior to next shift worked. Of 27 total Occupational and Physical Therapy staff, 26 total current therapy staff received education, and 1 total therapy staff member was to receive education prior to next shift worked. There are no contracted licensed nurses or CNAs currently on staff. Any contracted nurses or CNAs who are placed at the facility on assignment will receive the above education prior to starting their shift through an agency orientation packet. * On 11/24/24 through 11/27/24, current facility staff were educated on abuse, neglect and exploitation by the Administrator, Director of Nursing, Staff Development Coordinator, and Nurse Managers. Of 171 total staff, 171 current staff received education. There are no staff members who require education prior to next shift worked, and no contracted licensed nurses or CNAs on staff. Any contracted nurses or CNAs who are placed at the facility on assignment in the future will receive the above education prior to starting their shift through an agency orientation packet. * On 11/23/24, an Ad Hoc QAPI meeting was completed with the Medical Director, Administrator, and DON. The topics of the incident, abuse and neglect, use of mechanical lifts, mechanical lift competencies, updating care plans/kardex, and following care plans/kardex were discussed. * On 11/25/24, an Ad Hoc QAPI meeting was held with the Medical Director, Administrator, DON, Staff Development Coordinator, IDT members, and Nurse Managers to review the 4-Point Plan and Investigation. * On 11/26/24, an Ad Hoc QAPI meeting was held with the Medical Director, Administrator, DON and IDT members to include the Director of Rehabilitation, to review the 4-Point Plan, Root Cause Analysis, and progression of investigation. * On 12/07/24, an Ad Hoc QAPI meeting was held with the Medical Director, Administrator, DON and IDT team to include the Director of Rehabilitation, to review the 4-Point Plan progress, quality reviews, and conclusion of investigation. * On 12/10/24, the Unit Manager corrected the assigned CNA on the proper way to transfer resident #2 and showed her the transfer status on the kardex. The CNA was suspended pending investigation and re-educated on checking the kardex prior to transfers. * On 12/10/24, nursing staff re-education on how to view kardex for transfer status was initiated with return demonstration required. Of 92 nursing staff members, 43 total nursing staff were re-educated. Other staff will be educated prior to the beginning of their next shift by the Director of Nursing or designee, and 49 nursing staff members will be educated prior to the beginning of their next shift. * On 12/10/24, nursing staff competencies were initiated by the Director of Nursing or designees. Of 92 nursing staff members, 43 total nursing staff were re-educated. Other staff will be educated prior to the beginning of their next shift, by the Director of Nursing or designee, and 49 nursing staff members will be educated prior to the beginning of their next shift. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	* On 12/11/24, an Ad Hoc QAPI meeting was held with the Medical Director, Administrator, DON, and IDT team to include Director of Rehabilitation, to discuss areas of concern that were identified during the complaint survey that started on 12/10/24 and additional steps the facility is taking to re-educate staff. * On 12/12/24, an Ad Hoc QAPI meeting was held with the Medical Director, Administrator, DON, and IDT team to include Director of Rehabilitation, to go over kardex education, discuss quality monitoring tools, root cause of concerns, and clarify areas of concerns. Interviews conducted on 12/13/24 with 19 total facility staff who represented the nursing, therapy, and housekeeping departments revealed they were knowledgeable of the facility's policy and procedure to prohibit abuse and neglect. Interviews conducted with nursing staff, including 12 CNAs, two Registered Nurses, and two Licensed Practical Nurses, revealed they received education on the Safe Resident Handling/Transfers policy and procedures, and the requirement to access and review the nursing care plan or CNA kardex as appropriate, to identify the type of mechanical lift and number of staff required for transfers. Staff validated they performed return demonstrations.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** 36489 Based on observation, interview, and record review, the facility failed to follow its policies and procedures and accepted standards of practice to prevent an avoidable fall from a full body mechanical lift (#3); and ensure use of the appropriate type of mechanical lift to meet assessed needs (#2), for 2 of 7 residents reviewed for mechanical lift use, out of a total sample of 8 residents. On 11/22/24 at approximately 5:00 PM, the facility failed to prevent resident #3, a vulnerable, physically impaired resident, from suffering a fall and fracture. The resident's plan of care indicated she required assistance from two staff members for transfers with a full body mechanical lift, but her assigned Certified Nursing Assistant (CNA) attempted the task single-handedly. During the transfer between the shower chair and her bed, one of the sling's loops detached from the lift while the resident was suspended in the air, and she fell to the floor. Resident #3 landed on her head and back, suffered excruciating pain, and was hospitalized with diagnoses of blunt head trauma and a fracture of the sacrum or tailbone. On re-admission to the facility, resident #3 complained of acute left hip pain, and after three weeks of persistent pain, she was subsequently diagnosed with a left hip fracture and required re-hospitalization . After the fall, resident #3 developed a fear of using the mechanical lift and chose to remain in bed, which affected her quality of life by limiting participation in her usual routine and activities of choice. On 12/10/24 at approximately 11:00 AM, the facility failed to ensure staff accessed and implemented the plan of care for resident #2, a physically impaired resident, to promote his safety during a mechanical lift transfer. The resident's assigned CNA neglected to review the CNA care plan or kardex prior to the procedure and attempted to transfer him from the bed to a chair with a sit-to stand lift, instead of a full body lift as required. Resident #2 had noticeable weakness and poor balance, but the CNA did not pause to validate his transfer status which thereby placed him at high risk for an adverse outcome as he was unable to stand. The facility's failure to adhere to plans of care related to providing the required number of staff to operate a mechanical lift and failure to use the appropriate type of lift contributed to resident #3's fall and fracture, and placed resident #2 and all 48 residents who required mechanical lifts for transfers at risk for serious injury/impairment/death. These failures resulted in Immediate Jeopardy starting on 11/22/24. The facility's Director of Nursing and Regional Nurse Consultant were notified of the Immediate Jeopardy on 12/13/24 at 3:05 PM, and provided the Immediate Jeopardy templates. The Immediate Jeopardy was determined to be removed on 12/11/24 after verification of the immediate actions implemented by the facility. The scope and severity of the deficiencies was decreased to D, no actual harm, with potential for more than minimal harm, that is not Immediate Jeopardy. The census at the start of the survey was 105. Findings: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Cross reference F600 and F726. 1. Review of the medical record revealed resident #3, a [AGE] year-old female, was admitted to the facility on [DATE]. She was transferred to the hospital on 11/22/24, readmitted on [DATE], and returned to the hospital on 12/12/24. Her diagnoses included multiple sclerosis, breast cancer, secondary bone cancer, muscle contractures of her left hip, both knees, and right ankle, muscle wasting and atrophy of the shoulders, post-fall sacral fracture, and a left hip fracture. Review of the Minimum Data Set (MDS) Quarterly assessment with assessment reference date (ARD) of 10/23/24 revealed resident #3 had clear speech, was able to express her ideas and wants, and had no comprehension issues. The resident's Brief Interview for Mental Status (BIMS) score was 15/15 which indicated she was cognitively intact. The MDS assessment revealed resident #3 exhibited no behavioral symptoms and did not reject evaluation or care that was necessary to achieve her goals for health and well-being. She had functional limitation in range of motion due to impairment of all extremities and used a wheelchair for mobility. Resident #3 was dependent on staff for transfers between the chair and bed, and into and out of the shower. The MDS Discharge assessment-return anticipated, with ARD of 11/22/24, revealed resident #3 had an unplanned discharge to an acute care hospital on 11/22/24. The MDS assessment indicated she had one fall since admission/entry, re-entry, or the prior assessment, which resulted in a major injury. Review of the medical record revealed resident #3 had a care plan for activities of daily living (ADL) self-care performance deficit related to multiple sclerosis, impaired mobility, and contractures. The document was created on 4/03/15 and revised on 2/23/24. The goal was resident #3 would have her ADL needs met by staff. The interventions included instructions for CNAs to perform chair/bed and shower transfers with a total body mechanical lift operated by two staff. A care plan for risk for complications of osteoporosis with a history of a fracture, initiated on 4/03/15 and revised on 11/28/24, revealed a goal that resident #3 would remain free of injury. The interventions included educate the resident and caregivers on safety measures needed to reduce the risk for falls and report signs of a fracture and pain to the physician. Review of the CNA care plan or kardex for resident #3 revealed the instruction for two CNAs to perform transfers with a full body mechanical lift. Review of the Physical Therapy Plan of Care dated 9/25/24 revealed resident #3 was referred for therapy services to address further deterioration in range of motion of her hips, knees, and ankles. The document indicated she required total assistance for transfers and got out of bed three times weekly to a high-back recliner wheelchair. The Initial Physical Therapy assessment showed resident #3 was dependent on staff for transfers and read, Resident does none of the effort to complete the activity.assistance of 2 or more helpers is required for the resident to complete the activity. A Situation, Background, Appearance, Review and Notify (SBAR) Communication Form dated 11/22/24 revealed resident #3 had a fall and complained of level 10/10 pain in the back of her head. The document indicated RN D notified the resident's primary care clinician and her daughter of the accident. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a Narrative Note written on 11/22/24 by Registered Nurse (RN) D, the 3:00 PM to 11:00 PM Nursing Supervisor, revealed resident #3 fell while being transferred from the chair to her bed with a full body mechanical lift, and was sent to the hospital. Review of the Order Recap Report for November and December 2024 revealed resident #3 had a physician order with an effective date of 11/22/24, to send her to the Emergency Department for evaluation after a fall. Review of the hospital record revealed resident #3 had computed tomography (CT) scans of her head, neck, and spine on 11/22/24 for complaints of a headache and neck pain after a she fell out of [mechanical] lift. The result showed no acute intracranial abnormality, but the resident had a small scalp contusion on the left side of the back of her head. A CT scan of the lumbar spine, dated 11/22/24, was done for a complaint of back pain, and the result showed resident #3 sustained an acute fracture along the anterior sacrum at the S2 level. An x-ray of her pelvis done on 11/22/24 was described as a significantly limited evaluation that could not exclude an acute impacted left hip femoral neck fracture. A follow-up CT scan for further evaluation was recommended by the radiologist. Review of the CT scan of the resident' pelvis dated 11/22/24 showed no acute abnormality. The hospital record included resident #3's History & Physical dated 11/23/24, which showed assessment findings including fall from a mechanical lift, lower back pain, headache, blunt head trauma, and acute closed fracture of the anterior sacrum. Review of the Admit/Readmit Screener & Baseline Care Plan dated 11/27/24 revealed on re-admission to the facility from the hospital, resident #3 was alert and oriented to person, place, time, and situation. The document showed resident #3 reported she had experienced frequent, moderate left hip pain over the last five days and the nurse noted the resident said, My left hip hurts. The document revealed the resident described her hip pain as worse with movement and alleviated by the pain medication Oxycodone. The Order Recap Report for November and December 2024 included orders dated 11/27/24 to re-admit resident #3 for long term care services and observe for pain every shift. Resident #3 had physician orders dated 11/28/24 for two tablets of Acetaminophen (pain reliever) 325 milligrams (mg) every four hours as needed for mild pain, Baclofen (muscle relaxer) 10 mg once daily for back pain, and Oxycodone (Opioid pain reliever) 5 mg as needed for pain. Review of a Health Note dated 11/28/24 revealed resident #3 was assessed by a clinical provider on re-admission to the facility. The note indicated she had acute pain due to trauma and complained of left hip pain with movement. A Skin/Wound Note dated 12/02/24 revealed resident #3 continued to complain of pain with left hip movement. Review of the medical record revealed a physician order dated 12/10/24 for diagnostic x-rays of the resident's left ankle, and both femurs (thigh bones) for report of pain. A Radiology Results Report dated 12/11/24 revealed resident #3 had x-rays of her left ankle, left hip, and right hip. Interpretation of the x-rays showed the resident had a fracture at the upper end of her left femur. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of an SBAR Communication Form revealed resident #3's primary care clinician was notified of her left hip fracture on 12/12/24 at 6:20 AM. The form indicated the facility received an order to send the resident to the hospital Emergency Department via emergency medical services. On 12/10/24 at 10:00 AM, the Cambridge Unit Manager (UM) confirmed resident #3 fell from the full body mechanical lift and sustained a sacral fracture. She stated after completing the resident's shower, CNA A transported her back to her room in the shower chair. The UM explained CNA A used the mechanical lift to transfer the resident from the chair to her bed, noted one of the straps on the sling came loose, and had to lower her to the ground. The UM confirmed transfers with full body mechanical lifts required two staff members to be present. On 12/10/24 at 10:10 AM, resident #3 verified she fell from the mechanical lift during a transfer between the shower chair and her bed. She stated the CNA was the only staff member in the room at the time. Resident #3 used her hand to demonstrate that she was above the current height of the bed. She said, I was up in the air. I suddenly, quickly fell flat to the floor. I hit the back of my head and back. I was shocked. I did not realize what happened because it was so fast. She stated she felt as if she slipped out of the sling. The resident stated she was in a lot of pain after she landed on the floor. She explained she still had pain whenever she rolled from one side to another, especially on the left side. Resident #3 expressed fear of using the mechanical lift since the incident and stated in the three weeks since her fall, she got out of bed only once with assistance from two or three strong men, who transported her to a doctor's appointment. She confirmed she had not been transferred by CNAs since she fell . The resident stated before the incident, she enjoyed getting out of bed on some days, just to get into her wheelchair and move around the room. On 12/10/24 at 10:48 AM, Physical Therapy Assistant (PTA) F explained resident #3 was going to be transferred from her bed to the wheelchair for the first time since re-admission. She stated she would be present to reassure resident #3 during the procedure. PTA F confirmed resident #3 complained of pain in her left hip during morning care, and she positioned her legs with a pillow to relieve the pain. On 12/10/24 at 10:52 AM, CNAs C and E placed the sling underneath resident #3 in bed and attached the loops to the spreader bar of the full body mechanical lift. During the transfer procedure, the resident complained of left hip pain and had an apprehensive expression. When resident #3 was seated in the wheelchair, CNA E repositioned her left leg and foot and the resident cried out, grimaced, and continued to tell staff her left hip hurt. On 12/10/24 at 3:02 PM, the Administrator confirmed the facility's incident investigation showed resident #3 fell during a mechanical lift transfer performed by CNA A. She verified CNA A did not follow the facility's policy and procedures for mechanical lift transfers which indicated these types of transfers always required two staff members. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/10/24 at 3:37 PM, RN D verified she was the evening shift Nursing Supervisor on 11/22/24. She recalled she was on the Bristol unit at about 5:00 PM when someone urgently grabbed her and said she was needed on the Cambridge unit. RN D stated she rushed to the room as directed and saw resident #3 on the floor near the foot of her bed. She stated the mechanical lift was at the foot of the roommate's bed and the shower chair was close to the door. RN D explained it appeared as if CNA A had rolled the lift across the room with the resident in it. She stated the sling was on the floor under the resident who still had towels wrapped around her body. RN D stated she assessed resident #3, noted she was in pain, and discovered a lump on the back of her head. She confirmed she arranged for the resident to go to the hospital for further evaluation. On 12/11/24 at 10:27 AM, the Therapy Director validated for at least the last three years, resident #3 was dependent on two staff for transfers as she required a full body mechanical lift. The Therapy Director stated the resident enjoyed therapy sessions and usually came to the gym. She was informed resident #3 was now fearful of the mechanical lift and chose to remain in bed. The Therapy Director reviewed resident #3's treatment notes and confirmed she did not see documentation regarding any treatments in the gym since the fall. The Therapy Director confirmed resident #3 sometimes liked to get out of bed and propel herself in the wheelchair in her room. On 12/12/24 at 10:45 AM, the Cambridge UM explained prior to her fall from the mechanical lift, resident #3 had chronic pain issues related to her metastatic cancer, but her pain levels worsened after the fall. The UM reviewed the resident's Medication Administration Record (MAR) for October through December 2024 and confirmed the document showed increasing pain levels and more frequent use of Oxycodone for pain management. She verified prior to the fall from the mechanical lift, resident #3 requested only one dose of Oxycodone 5 mg in October 2024 and three doses in November 2024. The UM stated after the fall, the resident received Oxycodone on 11/30/24 for a pain level of 8. She verified the MAR showed in December 2024 resident #3 received Oxycodone 5 mg almost daily, as eight doses were administered over a 10-day period for pain levels that ranged from 4 to 8 on a 0 to 10 scale. On 12/12/24 at 12:19 PM, the facility's Medical Director stated the Administrator and Director of Nursing (DON) informed him of resident #3's fall from the mechanical lift. He described the CNA's decision to utilize the mechanical lift without assistance as inexcusable since she was frail and already at high risk for fractures due to her diagnosis of metastatic bone cancer. On 12/13/24 at 9:57 AM, in a telephone interview, resident #3's daughter stated during the weeks since re-admission from the hospital her mother experienced significant pain. She explained every time staff rolled her mother from side to side, she screamed or cried out in audible distress. The resident's daughter stated the facility eventually did x-rays and discovered her mother had a left hip fracture. She stated she visited her mother in the hospital early this morning and the orthopedic surgeon explained hip replacement/repair surgery was the solution, but not currently a realistic option, due to her mother's multiple health issues. The resident's daughter said, She's fine if she's not rolling or they're not transferring her, but that would make her be in bed all the time, and mostly in the same position. She is very nervous about the lift now.combination of fear and pain. She explained before the fall, her mother did things around her room, went to the therapy gym, and occasionally attended bingo with her roommate. The daughter acknowledged there would be restrictions on her mother's usual activities if she could not have surgery and had to remain in bed. She acknowledged her mother's contractures made positioning for diagnostic tests challenging, and the orthopedic surgeon felt the left hip fracture was related to the fall from the mechanical lift on 11/22/24 but was not diagnosed at that time. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. Review of the medical record revealed resident #2, a [AGE] year-old male, was admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included seizures, muscle wasting and atrophy of both shoulders, unsteadiness on his feet, abnormal posture, and cervical spine fusion. Review of the MDS Medicare 5-day assessment with ARD of 11/25/24 revealed resident #2 had functional limitation in range of motion due to impairment of one lower extremity. The MDS assessment indicated the resident was dependent on staff for transfers between the bed and wheelchair. Resident #2 had a nursing care plan created on 10/27/24 for ADL self-care performance deficit related to generalized weakness. An intervention dated 11/24/24 instructed CNAs to perform transfers between the bed and wheelchair and into and out of the shower with a total body mechanical lift operated by two staff. A care plan for risk for falls and fall related injury, created on 10/27/24 had the goal that resident #2's risk for falls and injuries would be minimized. The interventions included assist with transfers as needed, cue for safety awareness, and encourage use of the call light for assistance with standing/transferring. Review of the kardex for resident #2 revealed the instruction for two CNAs to perform transfers with a full body mechanical lift was noted in the section for ADL Level of Assistance. Review of the Physical Therapy Evaluation & Plan of Treatment dated 12/03/24 revealed at baseline, resident #2 required maximum assistance from two staff for transfers. He was referred to physical therapy due to exacerbation of decreased strength, functional mobility, and transfer ability, and reduced ADL participation. The document indicated his static sitting balance was poor and he was unable to maintain balance without moderate to maximal assistance. The evaluation showed the resident had intermittent, aching right knee pain, at a level 5/10. Review of the Occupational Therapy Evaluation & Plan of Treatment dated 12/03/24 revealed resident #2 had reduced bilateral upper extremity strength, reduced safety awareness, and decreased activity tolerance. The evaluation indicated the resident had poor sitting balance at baseline. On 12/10/24 at 11:00 AM, CNA C stated she was ready to get resident #2 out of bed and into the shower chair to transport him to the shower room. A sit-to-stand lift, instead of the full body lift noted in the medical record, was in the hallway outside the resident's room. CNA C was prompted to check the electronic kardex regarding the resident's transfer status. She accessed the nursing care plan instead of the kardex and reviewed an intervention for fall prevention related to encouraging the resident to use his call light to obtain assistance with standing and transferring. After reading the nursing care plan, CNA C stated the resident was able to stand for transfers. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A few minutes later on 12/10/24 at 11:02 AM, CNA C placed the sit-to-stand lift at resident #2's bedside and assisted by CNA E, she initiated the transfer procedure. With substantial effort, both CNAs assisted resident #2 to sit on the side of his bed with his feet dangling above the base of the lift. The resident exhibited extreme weakness and poor balance as he repeatedly rocked backwards and from side to side. Due to his poor trunk control, CNA E had to keep her left hand and arm on or around the resident's shoulders to prevent him from falling as he could not support himself in a sitting position. CNA C explained resident #2 was weaker since his recent re-admission from the hospital. Next, she placed the sling behind the resident's upper back and under his arms and attached it to the lift. CNA E positioned the resident's arms and hands to hold on to the frame of the lift while CNA C instructed him to position his feet on the platform in preparation to stand. The resident attempted to follow the instruction but as he gripped the lift tightly with both hands, he continued to sway backwards and to the side. CNA E expressed concern, pointed to the lift, and said, Maybe this is not good for him. However, CNA C persevered. She pressed the button on the remote to lift resident #2 from his seated position but was not able to perform the transfer with the inappropriate lift as the battery was dead. CNA C left the room to retrieve another battery while CNA E returned resident #2 to a supine position in bed. A couple minutes later, CNA C stood at the nurses' station while the Cambridge UM looked at the computer screen. On 12/10/24 at 11:08 AM, CNA C walked towards resident #2's room with a full body mechanical lift. The Cambridge UM was informed CNAs C and E had been about to transfer resident with the wrong type of lift as the staff did not check the kardex for instructions prior to the task. On 12/11/24 at 2:46 PM, the Clinical Reimbursement Director confirmed it was very important for CNAs to follow the care directives developed by members of the interdisciplinary team (IDT) based on their assessment findings. She verified on admission on 10/28/24, resident #2's baseline care plan showed he was not able to stand. The Clinical Reimbursement Director reviewed the resident's comprehensive care plan and kardex and validated both documents showed the intervention for two staff to transfer him with a total mechanical lift. She stated resident #2 was never assessed as appropriate for sit-to-stand lift transfers. On 12/11/24 at 9:56 AM, the Therapy Director stated resident #2's re-admission evaluation by Physical Therapy on 12/02/24 showed he still required maximum assistance for transfers. She explained through a collaborative process, it was determined that CNAs should use the full body mechanical lift to transfer resident #2. The Therapy Director validated use of a sit-to-stand lift was not an appropriate choice for this resident. She explained the facility's goal was to promote safety for residents and staff, and the transfer attempted by CNAs C and E would not have been safe for resident #2 or the CNAs. On 12/12/24 at 12:19 PM, the Medical Director was informed of concerns related to the likelihood of an adverse outcome for resident #2 when staff attempted a mechanical lift transfer without accessing care directives and selected the wrong type of lift. The Medical Director confirmed the resident's attending physician had already made him aware of the issue and he was dumbfounded. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's policy and procedures for Safe Resident Handling/Transfers, revised on 11/29/22, revealed the facility would ensure residents were handled and transferred safely to minimize risks for injury and promote a safe, secure and comfortable experience for the resident. The document indicated mechanical lifts were a safer alternative to manual lifting for staff and residents. The guidelines revealed the IDT would evaluate and assess each resident's mobility needs to determine the type of lifting equipment or other transferring/handling aids to be used. The document read, Two staff members must be utilized when transferring residents with a mechanical lift.Resident lifting and transferring will be performed according to the resident's individual plan of care. Review of the Facility Assessment Tool, dated 7/29/24, revealed facility staff would provide general care and services such as assistance with mobility and fall prevention. The document indicated the facility would offer specific care including bathing, showers, and transfers, and person-centered care such as the prevention of abuse and neglect and identification of risks and hazards. The resident sample was expanded to include five additional residents who required a full body mechanical lift for transfers. Review of immediate actions to remove the Immediate Jeopardy implemented by the facility revealed the following, which were verified by the survey team: * On 11/22/24, the evening shift Nursing Supervisor immediately placed the mechanical lift and sling out of service. * On 11/22/24, the CNA who failed to follow correct procedure for use of mechanical lift using two staff members was immediately suspended. * On 11/22/24, the Weekend Nursing Supervisor began education and skills validation with 13 of 24 CNAs duty on the day, evening and night shifts. * On 11/23/24, an Ad Hoc Quality Assurance and Performance Improvement (QAPI) meeting was held with the facility Administrator, Director of Nursing, and Medical Director to review the initial incident. * On 11/24/24 through 11/25/24, the Therapy Director completed resident transfer status evaluations on current residents. Any updates were placed in the kardex and care plans. * On 11/24/24 through 11/25/24, the MDS coordinator completed care plan/kardex reviews to ensure appropriate transfer status was on care plan/kardex for current residents. * On 11/25/24, the MDS Coordinators completed a quality review of current residents for MDS accuracy related to transfer status. Corrections were made as identified. Quality reviews were then completed on current resident care plans and kardexes to ensure accurate transfer status were listed. Corrections were made when identified. * On 11/23/24, the Maintenance Director inspected all mechanical lifts and slings for any malfunctions and no concerns were identified. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	* On 11/23/24 through 11/27/24, current nursing staff were educated on mechanical lift usage and competencies were performed by the Director of Nursing, Staff Development Coordinator, and Nurse Managers. Occupational and Physical Therapy staff were educated on mechanical lift usage. Of 91 total nursing staff, 80 total current nursing staff received education, and 11 total nursing staff members were to receive education prior to next shift worked. Of 27 total Occupational and Physical Therapy staff, 26 total current therapy staff received education, and 1 total therapy staff member was to receive education prior to next shift worked. There are no contracted licensed nurses or CNAs currently on staff. Any contracted nurses or CNAs who are placed at the facility on assignment will receive the above education prior to starting their shift through an agency orientation packet. * On 11/24/24 through 11/27/24, current facility staff were educated on abuse, neglect and exploitation by the Administrator, Director of Nursing, Staff Development Coordinator, and Nurse Managers. Of 171 total staff, 171 current staff received education. There are no staff members who require education prior to next shift worked, and no contracted licensed nurses or CNAs on staff. Any contracted nurses or CNAs who are placed at the facility on assignment in the future will receive the above education prior to starting their shift through an agency orientation packet. * On 11/23/24, an Ad Hoc QAPI meeting was completed with the Medical Director, Administrator, and DON. The topics of the incident, abuse and neglect, use of mechanical lifts, mechanical lift competencies, updating care plans/kardex, and following care plans/kardex were discussed. * On 11/25/24, an Ad Hoc QAPI meeting was held with the Medical Director, Administrator, DON, Staff Development Coordinator, IDT members, and Nurse Managers to review the 4-Point Plan and Investigation. * On 11/26/24, an Ad Hoc QAPI meeting was held with the Medical Director, Administrator, DON and IDT members to include the Director of Rehabilitation, to review the 4-Point Plan, Root Cause Analysis, and progression of investigation. * On 12/07/24, an Ad Hoc QAPI meeting was held with the Medical Director, Administrator, DON and IDT team to include the Director of Rehabilitation, to review the 4-Point Plan progress, quality reviews, and conclusion of investigation. * On 12/10/24, the Unit Manager corrected the assigned CNA on the proper way to transfer resident #2 and showed her the transfer status on the kardex. The CNA was suspended pending investigation and re-educated on checking the kardex prior to transfers. * On 12/10/24, nursing staff re-education on how to view kardex for transfer status was initiated with return demonstration required. Of 92 nursing staff members, 43 total nursing staff were re-educated. Other staff will be educated prior to the beginning of their next shift by the Director of Nursing or designee, and 49 nursing staff members will be educated prior to the beginning of their next shift. * On 12/10/24, nursing staff competencies were initiated by the Director of Nursing or designees. Of 92 nursing staff members, 43 total nursing staff were re-educated. Other staff will be educated prior to the beginning of their next shift, by the Director of Nursing or designee, and 49 nursing staff members will be educated prior to the beginning of their next shift. (continued on next page)

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	105618	A. Building B. Wing	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regents Park of Winter Park	558 N Semoran Blvd Winter Park, FL 32792

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	* On 12/11/24, an Ad Hoc QAPI meeting was held with the Medical Director, Administrator, DON, and IDT team to include Director of Rehabilitation, to discuss areas of concern that were identified during the complaint survey that started on 12/10/24 and additional steps the facility is taking to re-educate staff. * On 12/12/24, an Ad Hoc QAPI meeting was held with the Medical Director, Administrator, DON, and IDT team to include Director of Rehabilitation, to go over Kardex education, discuss quality monitoring tools, root cause of concerns, and clarify areas of concerns. Interviews conducted on 12/13/24 with 16 facility staff including 12 CNAs, two Registered Nurses, and two Licensed Practical Nurses who represented all shifts revealed they were knowledgeable of the facility's mechanical lift transfer policy and the requirement to access and review the nursing care plan or CNA kardex as appropriate, to identify the type of mechanical lift and number of staff required for transfers. Staff validated they performed return demonstrations.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36489 Based on observation, interview, and record review, the facility failed to validate that Certified Nursing Assistants (CNAs) possessed and demonstrated appropriate competencies and skills to meet identified needs based on assessments, and followed directives in the plans of care for 2 of 7 residents reviewed for mechanical lift transfers, out of a total sample of 8 residents, (#2 and #3), and for all residents who required assistance with transfers. Findings: 1. Review of the medical record revealed resident #3, a [AGE] year-old female, was admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included multiple sclerosis, breast cancer, secondary bone cancer, muscle contractures of her left hip, both knees, and right ankle, and a post-fall sacral fracture. Review of the Minimum Data Set (MDS) Quarterly assessment with assessment reference date (ARD) of 10/23/24 revealed resident #3 had a Brief Interview for Mental score of 15/15, which indicated she had no cognitive impairment. The MDS assessment showed the resident had functional limitation in range of motion due to impairments of all extremities and used a wheelchair for mobility. She was dependent on staff for transfers between the bed and wheelchair and into and out of the shower. The document showed she had no falls since admission/entry, re-entry, or the prior assessment. Resident #3 had a nursing care plan initiated on 4/03/15 for activities of daily living (ADL) self-care performance deficit related to multiple sclerosis, impaired mobility, and contractures. The goal was staff would anticipate and meet her ADL needs. An intervention dated 2/12/24 instructed CNAs to perform chair/bed and shower transfers with a total body mechanical lift operated by two staff. Review of the CNA care plan or kardex for resident #3 revealed the nursing care plan intervention regarding transfers was transcribed accurately. The instruction for two CNAs to perform transfers with a full body mechanical lift was noted in the section for ADL Level of Assistance. Review of a Narrative Note dated 11/22/24 revealed resident #3 fell during a mechanical lift transfer between the chair and her bed. The progress note indicated she was transferred to the hospital where she was diagnosed with a sacral fracture and blunt head trauma. On 12/10/24 at 10:10 AM, resident #3 verified she fell from the mechanical lift when her CNA attempted to transfer her from the shower chair to her bed. She stated the CNA was the only staff present at the time. Resident #3 said, It was not the first time that only one CNA picked me up in the lift. I did not realize it was wrong then, but now I know it is supposed to be two people. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/10/24 at 3:02 PM, the facility's Administrator and Director of Nursing (DON) discussed resident #3's fall. The Administrator explained the incident investigation showed resident #3's assigned CNA did not ask for assistance and used the mechanical lift to perform the transfer by herself. The Administrator stated according to CNA A, the loop of one shoulder strap detached from the lift and she had to lower resident #3 to the floor. The DON recalled she interviewed CNA A who admitted she performed the mechanical lift transfer without the help of another CNA. The DON stated she reminded CNA A she participated in skills fair competencies a few days before which included training on the requirement for two staff to perform all mechanical lift transfers. The DON stated since resident #3's fall, she and the Unit Managers (UMs) conducted random surveillance of staff during mechanical lift transfers to ensure there were two CNAs present. Review of the post-incident Staff Education Summary (undated) revealed licensed nurses, CNAs, and therapy staff completed mechanical lift training with required competencies, and audits would be done to ensure compliance. The document indicated education for CNAs included instructions to .review the transfer status of their assigned residents to ensure that no changes have occurred. They were reminded to look at the kardex. 2. Review of the medical record revealed resident #2, a [AGE] year-old male, was admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included seizures, muscle wasting and atrophy of both shoulders, unsteadiness on his feet, abnormal posture, and cervical spine fusion. Review of the MDS Medicare 5-day assessment with ARD of 11/25/24 revealed resident #2 had functional limitation in range of motion due to impairment of one lower extremity. The MDS assessment indicated the resident was dependent on staff for transfers between the bed and wheelchair. Resident #2 had a nursing care plan created on 10/27/24 for ADL self-care performance deficit related to generalized weakness. An intervention dated 11/24/24 instructed CNAs to perform transfers between the bed and wheelchair and into and out of the shower with a total body mechanical lift operated by two staff. Review of the CNA care plan or kardex for resident #2 revealed the nursing care plan intervention regarding transfers was transcribed accurately. The instruction for two CNAs to perform transfers with a full body mechanical lift was noted in the section for ADL Level of Assistance. On 12/10/24 at 11:00 AM, CNA C stated she was ready to get resident #2 out of bed and into the shower chair to transport him to the shower room. A sit-to-stand lift, instead of the full body lift noted in the medical record, was in the hallway outside the resident's room. CNA C was prompted to check the electronic Kardex regarding the resident's transfer status. She logged into the resident's electronic medical record and noted two buttons, side by side, for the care plan and kardex. CNA C selected the care plan button which pulled up the detailed nursing care plan. She scrolled through the focus areas and interventions and stopped at the nursing care plan for risk for falls, which indicated resident #2 should be encouraged to use his call light to obtain assistance with standing and transferring. After CNA C read the nursing care plan she incorrectly stated the resident was able to stand for transfers. She did not review the nursing care plan for ADLs that included transfer instructions or select the kardex tab with specific transfer instructions for CNAs. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/10/24 at 11:02 AM, CNA C entered resident #2's room and explained he was recently readmitted from the hospital. She stated before the resident went out to the hospital, he was able to stand up and transfer with the assistance of two staff, not a mechanical lift, but was now too weak to do this. CNA C stated this was her first attempt to get the resident out of bed after re-admission. She stood at resident #2's bedside, and assisted by CNA E, initiated the sit-to-stand lift procedure. Although resident #2 exhibited extreme weakness and poor balance, neither CNA stopped the procedure to review the kardex or report concerns to a nurse. As she prepared to lift the resident from the edge of the bed to a standing position, CNA C discovered the lift's battery was dead. On 12/10/24 at 11:08 AM, the Cambridge UM confirmed resident #2 should be transferred with a full body mechanical lift. When she explained CNA C misunderstood the transfer instructions, she was informed CNA C did not verify the resident's required transfer method in the kardex prior to attempting the task. On 12/10/24 at 11:21 AM, the Regional Nurse Consultant, Clinical Reimbursement Director, DON, and the Cambridge UM were informed CNA C had to be prompted to check the care plan prior to transfer, and when she accessed the electronic plan of care, she reviewed the nursing care plan rather than kardex. They were told the CNA did not accurately identify the location of resident #2's transfer instructions. The Clinical Reimbursement Director interjected that to her knowledge, CNAs should not have access to the nursing care plan. On 12/10/24 at 11:24 AM, the Clinical Reimbursement Director reviewed resident #2's care directives on the tablet used by CNA C. She verified there were two possible sources of information available to CNAs, the nursing care plan and the kardex. On 12/11/24 at 2:46 PM, the Clinical Reimbursement Director acknowledged she was now aware CNAs had access to the detailed nursing care plan as well as the kardex. She explained the kardex was a simplified version of the care plan and contained specific, task-oriented instructions for CNAs. She confirmed the comprehensive care plan had extensive interventions for all disciplines. The Clinical Reimbursement Director stated it was very important for CNAs to follow the care directives included in the kardex. She reviewed resident #2's care plans and stated he always required a full body mechanical lift since admission and had never been deemed appropriate for a sit-to-stand lift or other type of transfer. On 12/13/24 at 12:31 PM, the DON stated after resident #3's fall from the mechanical lift during a transfer attempted by a single CNA, the facility verbally re-educated staff on neglect related to failure to follow resident care instructions. She acknowledged staff were not required to complete a post-test or any other activity to validate comprehension of the education provided. The DON stated CNAs were told to look at kardexes prior to caring for residents. She confirmed the facility's management team did not require demonstration of this skill nor identify that CNAs had issues with locating or using the kardex. The DON said, We had no idea that a care plan tab was there. Not sure why it was not mentioned to me if others knew it was there. She stated her understanding was all new CNAs were taught about the kardex and required to demonstrate its use in orientation. The DON explained the Staff Educator, who no longer worked at the facility, was responsible for educating CNAs on the kardex, so she could not say why the care plan tab went unreported. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/12/24 at 12:19 PM, the facility's Medical Director confirmed he was aware of the concerns related to CNAs' failures to adhere to protocols for use of mechanical lifts and verification of transfer status in the plan of care. He stated he was surprised, especially about the incident with resident #2 since staff were re-educated after resident #3's fall. The Medical Director was informed of concerns related to CNAs' knowledge regarding accessing the kardex. He stated there was apparently additional work to be done to ensure staff cared for residents according to instructions in the plan of care. Review of a Competency Validation form for CNA A (dated 11/20/24) revealed she demonstrated competency in the use of a mechanical lift for transfers. The form listed indications for the use of a total lift and cautions including use number of staff designated to safely complete the transfer [and] report any resident change in condition to your supervisor. However, there was no checklist attached to the validation form to show CNA A performed all required steps of the procedure. Review of Competency Validation forms for CNA C (dated 11/20/24) and CNA E (dated 11/24/24) revealed both staff demonstrated competency with use of the mechanical total or full body lift. The attached step-by-step checklist did not show a requirement for CNAs to check the kardex and verify transfer instructions prior to using the lift. Review of the Skills Fair November 2024 packets for CNAs A, C, and E revealed the topics included stand and pivot transfers with the assistance of one or two staff and transfers with a full body or total lift. None of the packets contained a competency checklist for use of the sit-to-stand mechanical lift. The job description for Certified Nursing Assistant, dated April 2020, revealed essential duties and responsibilities included .transfer residents, utilizing appropriate assistive devices. The job description for the Director of Nursing, dated August 2021, revealed the DON would manage the overall operations of the Nursing Department to ensure excellent care for all residents. The DON's essential duties and responsibilities included staff training and staff development, ensuring the provision of appropriate departmental in-service education programs, and direct the performance and delivery of nursing and resident care services. Review of the Facility Assessment Tool, dated 7/29/24, revealed facility staff would provide general care and services such as assistance with mobility and fall prevention. The document indicated the facility would offer specific care including bathing, showers, and transfers, and person-centered care such as the prevention of abuse and neglect and identification of risks and hazards. The Facility Assessment Tool revealed education and/or in-services for CNAs would be provided annually, semi-annually, and as needed on topics including activities that constitute neglect. Nursing staff would demonstrate competency in person-centered care and ADLs at the time of hire, semi-annually, and as needed.