STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225040	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Julian J Levitt Family Nursing Home	770 Converse Street Longmeadow, MA 01106

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 44129 Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who required the use of a Hoyer lift (mechanical mobility aid that supports a person's body weight to allow movement from one surface to another), the Facility failed to ensure his/her environment was as free of incidents/accidents as possible, when on 11/19/24, Certified Nurse Aide (CNA) #3 and CNA #4, who had set up and prepared him/her for transfer out of bed, did not properly set up (position of the legs/base) the Hoyer lift, as they transferred Resident #1 the lift started to tip over sideways, Resident #1 was lowered to the floor by staff during the incident, and the Hoyer lift completely tipped over landing on the floor next to the resident. Findings include: Review of the Battery Operated Patient Lift Owners manual (specific to the Hoyer lifts the Facility utilized), provided to the surveyor by the Facility, indicated the following instructions to transfer a person from bed: - Open the base (legs) and move the lift slowly towards the patient and position the spreader bar (the area where the Hoyer sling, that holds a patient, attaches to the lift), over the patient's chest. - Lower the cradle to a point where the sling's loops can reach the cradle's hooks and attach the sling to the cradle hooks. - Lift the patient above the bed by using the hand control. - Pull lift away from the bed and rotate the patient so they are facing the back of the lift. - Close the base (legs) and slowly move patient over the wheelchair (wheelchair wheels must be locked) or commode, opening the base for stability. - Then lower the patient onto the surface by pressing the down button. Review of the Facility's Competency titled, Skill Performance - Mechanical Lift indicated the following step: (continued on next page)

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

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Position lift over resident in bed (or in front of resident if in chair). Spread open and lock mechanical lift feet. - Guide lift away from starting point (bed or chair) - Position resident over bed or chair - First assist repositions themselves to support resident in sling, use sling loops to ensure correct potion as resident is lowered into chair (or bed). Review of the Facility Investigation, dated 11/19/24, which included written statements provided by staff, indicated that on 11/19/24 at 8:15 A.M., after Resident #1 received morning personal care, he/she was in the Hoyer lift, the lift tipped over and he/she was lowered to the ground. Resident #1 was admitted to the Facility in February 2024, diagnoses included Dementia and recent fall resulting in a Subdural Hematoma (pool of blood between the brain and it's outermost covering), Subgleal Hematoma (blood accumulation between the skull and scalp) and Subarachnoid Hemorrhage (bleeding in the space between the brain and the tissue covering the brain). Review of Resident #1's Quarterly Minimum Data Set (MDS) Assessment, dated 10/12/24, indicated he/she had severe cognitive impairment and was dependent on staff for chair/bed-to-chair transfers. Review of Resident #1's ADL Care Plan, reviewed and renewed with his/her October 2024 MDS, indicated he/she was dependent on two staff members for transfers and utilized a Hoyer lift. Review of Resident #1's Care Kardex (used by the CNAs to determine individual care needs) indicated he/she required assistance of two staff members with a mechanical lift (Hoyer). Review of a Nursing Progress Note written by Nurse #1, dated 11/19/24 at 8:58 A.M., indicated Resident #1 was receiving care in the morning with two CNAs (CNA #3 and CNA #4) present while he/she was in the Hoyer lift. The lift tipped over and the Resident #1 was lowered to the ground by the CNAs, and no injuries were observed. During an interview on 01/08/25 at 2:21 P.M., Nurse #1 said on the morning of 11/19/24 at approximately 8:15 A.M., another staff nurse notified her that Resident #1 was on the floor. Nurse #1 said when she arrived to Resident 1's room, CNA #3, CNA #4, and his/her spouse were present, the wheelchair (which was empty) was facing her, the Hoyer lift was lying sideways on the floor, and Resident #1 was seated on the floor leaning against the wheelchair. Nurse #1 said she assessed Resident #1 by obtaining his/her vital signs and performed a physical and a neurological assessment. Nurse #1 said she determined Resident #1 had no injuries and was not exhibiting signs or symptoms of pain. Nurse #1 said CNA #3 and CNA #4 reported to her that Resident #1 had not hit his/her head, and he/she was safely transferred into his/her wheelchair. Nurse #1 said after the incident, the Executive Director, along with CNA #3 and CNA #4 attempted a re-enactment. Nurse #1 said based on that re-enactment it was determined that the CNAs had failed to widen the base legs of the Hoyer lift, and once the CNAs attempted to move Resident #1 into his/her wheelchair, the weight shift caused the Hoyer lift to tip, that the CNAs were unable to stabilize the Hoyer lift, so they had no choice but to lower Resident #1 to the floor for his/her safety. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse #1 said that when residents are being lifted and lowered while in the Hoyer lift, the legs (base) should be in an open position to provide balance and stability. During an interview on 01/09/25 at 9:45 A.M., which included review of her written Witness Statement, CNA #3 said that on 11/19/24 at approximately 8:15 A.M., she and CNA #4 utilized a Hoyer lift to attempt to transfer Resident #1 out of bed to his/her wheelchair. CNA #3 said that when they started to move Resident #1 into his/her wheelchair, she was behind him/her guiding his/her upper body and CNA #4 was next to him/her near his/her legs, the Hoyer tipped sideways toward CNA #4 and actually hit her (CNA #4) in the face. CNA #3 said she and CNA #4 grabbed a hold of the Hoyer sling Resident #1 was seated in, lowered him/her to the floor, and the Hoyer lift ended up sideways on the floor, as well. CNA #3 said that she and CNA #4 made a mistake by not opening the Hoyer legs. The surveyor asked CNA #3 if she knew she was supposed to widen the Hoyer lift legs, but that she did not realize that was supposed to be done. CNA #3 said she thought that the reason to open and close the legs at the base of the Hoyer was to fit the Hoyer lift around objects such as larger wheelchair wheels. During an interview on 01/09/25 at 10:15 A.M., which included review of her written Witness Statement, CNA #4 said that on 11/19/24 at approximately 8:15 A.M., she and CNA #3 were using a Hoyer lift to transfer Resident #1 from his/her bed to his/her wheelchair. CNA #4 said CNA #3 was behind Resident #1 and that she was near his/her leg and as they were moving him/her, the Hoyer began to tilt sideways and while tilting, it hit her face. CNA #4 said that she and CNA #3 decided it would be safer to lower Resident #1 to the floor, and when they lowered him/her down, the Hoyer lift fell down sideways. CNA #4 said that when she and CNA #3 transferred Resident #1, they did not have the legs (base) to the Hoyer lift in the open position, and was unaware that having the legs open while lifting and lowering a resident was required for balance and safety. During an interview on 01/08/25 at 3:10 P.M, Unit Manager #1 said she was told CNA #3 and CNA #4 lowered Resident #1 to the floor on 11/19/24 at 8:15 A.M. because the Hoyer lift tilted sideways due CNA #3 and CNA #4 failing to open the Hoyer lift legs (base) causing a weight shift resulting in the Hoyer lift to tip. During an interview on 01/09/25 at 9:50 A.M., the Occupational Therapist (OT) said in order to operate a Hoyer lift safely, the (base) legs must be in the open position prior to and while lifting a resident, and should be open when lowering a resident back down (to the destination surface), and that the widened base provides stability and balance to the Hoyer lift, preventing it from tipping over in the event of a weight shift. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/09/25 at 1:30 P.M., the Director of Rehabilitation said that she could not speak to the incident on 11/19/24 at 8:15 A.M., when Resident #1 was lowered to the floor by CNA #3 and CNA #4, as she was not involved in the related investigation. The Director of Rehabilitation with the surveyor, reviewed the Hoyer lift owner manual that indicated the base (the legs) should be open prior to lifting and prior to lowering a resident. The Director of Rehabilitation said reasoning behind having the base open was to provide a wider base of support for increased stability, and keeping the legs in the narrow position could render the Hoyer lift unstable and a weight shift could cause the Hoyer lift to tip. The Director of Rehabilitation further said that because of this, the Hoyer legs/base should be open when lifting and lowering a patient. During an interview on 01/09/25 at 2:35 P.M., the Director of Nursing (DON) said she was not working on 11/19/24 when Resident #1 was lowered to the floor by CNA #3 and CNA #4, but said however that the Executive Director and another staff member, along with CNA #3 and CNA #4 re-enacted the incident shortly after it occurred. The DON said that all clinical staff, which included certified nurse aides were provided education and competencies related to mechanical lift transfers upon hire and annually. During an interview on 01/09/25 at 3:15 P.M., the Executive Director (ED) said on 11/19/24, she received a call that Resident #1 had experienced an incident where he/she was lowered to the floor. The ED said that she, along with one of the nurse managers went up to the unit and had CNA #3 and CNA #4 re-enact what they did. The ED said the CNAs showed her how the wheelchair was positioned near the bed and how they transferred Resident #1 from the bed to the chair (by going over the wheelchair arm rest). The ED said she asked them if they were sure they had opened the legs, and said the CNAs told her they were sure they were open but said they were unsure at what point in the process the Hoyer base legs were open or closed. On 01/09/24, the Facility was found to be in Past Non-Compliance and provided the surveyor with a plan of correction which addressed the area of concern as evidenced by: A) On 11/19/24, Resident #1 was immediately assessed by nursing for injuries, none were noted and he/she did not voice any complaints of pain. B) On 11/19/24, and 11/21/24 the Director of Rehabilitation and the Staff Development Coordinator re-educated CNA #3 and CNA #4 regarding Hoyer lift usage which included a written competency and return demonstration. C) On 11/20/24, Resident #1 was re-assessed by Rehabilitation staff to determine if he/she required alternative seating. D) On 11/20/24, 11/21/24 and 11/22/24, the Staff Development Coordinator and the Director of Rehabilitation provided in-person education to all clinical staff titled, Full Body Mechanical Lift which included competencies with demonstration. E) On 11/19/24, the Staff Development Coordinator provided education to all clinical staff titled, Hoyer Transfer Protocol which indicated until further notice all Hoyer lift transfers required two CNAs and one Nurse be present to ensure the Hoyer lift base is opened for stability while lowering a resident into a wheelchair. The Education included a written page from the Hoyer lift owners manual that highlighted the following: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Pull lift away from the bed and rotate the patient so they are facing the back of the lift - Close the base and slowly move patient over the wheelchair, opening the base for stability. F) On 11/20/24 and ongoing, the Rehabilitation department is screening all residents in the Facility that require a total mechanical lift to ensure appropriate Hoyer sling size, appropriate seating and auditing/observing clinical staff during Hoyer transfers to ensure correctness and safety is maintained. G) On 11/20/24 and ongoing, the Rehabilitation department, Nurse Managers, and Staff Nurses are conducting random audits to ensure mechanical lift transfers are carried out appropriately and safely. H) On 11/20/24 an Ad-Hoc Quality Assurance Performance Improvement (QAPI) meeting was held. The Facility leadership team developed a plan of correction related to the deficient practice. The Project Leader is the Executive Director, Key Area for Improvement - Hoyer Transfers. I) Effectiveness of this plan will be reviewed during Monthly QAPI meetings until further notice. J) Director of Nursing and Executive Director will be responsible for overall compliance.