STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225233	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brandon Woods of Dartmouth	567 Dartmouth Street South Dartmouth, MA 02748

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40702 Based on records reviewed and interviews for one of three sampled residents (Resident #1) who required the use of a mechanical lift with the assistance of two staff members for transfers, the Facility failed to ensure his/her environment was free of accident hazards, as is possible, when on 10/02/24, as nursing staff attempted to transfer Resident #1 from a chair into his/her bed with the use of a mechanical lift, after positioning him/her in the mechanical lift sling required for use with a mechanical lift, as they started to lift him/her, one of the straps (looped end of sling pad that staff manually connect to the lift) became detached from the mechanical lift causing Resident #1 to slide out of the lift sling, he/she landed on the floor on his/her left side and immediately complained of left hip and knee pain. Finding Include: The Facility Policy titled Lifting Machine, Using a Mechanical, dated as revised July 2017, indicated the purpose of the procedure was to establish the general principles of safe lifting using a mechanical lifting device and that it was not a substitute for manufacturer's training or instructions. The Policy indicated that step four in the procedure in use of a mechanical lift included prepare the environment: -clear an unobstructed path for the lift machine; -ensure there is enough room to pivot; -position the lift near the receiving surface; and -place the lift at the correct height The Policy further indicated that step twelve and step thirteen in the procedure in use of a mechanical lift included: -make sure the sling is securely attached to the clips and that it is properly balanced -check to make sure the resident's head, neck, and back are supported (continued on next page)

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	-before resident is lifted, double check the security of the sling attachment -examine all hooks, clips, or fasteners -check the stability of the straps -ensure that the sling bar is securely attached and sound -lift the resident two inches from the surface to check the stability of the attachments, the fit of the sling and the weight distribution Resident #1 was admitted to the Facility in November 2020 diagnoses included atrial fibrillation (irregular heartbeat), muscle weakness, difficulty in walking, hypothyroidism, hypertension, and heart failure. Review of Resident #1's Fall Assessment, dated 07/05/2024, indicated that he/she was assessed by nursing as being at an increased risk for falls. Review of the Annual Minimum Data Set (MDS), dated [DATE], indicated Resident #1 had severe cognitive impairment and was dependent for chair/bed-to-chair transfers with the assistance of two or more staff members. Review of Resident #1's Care Plan related to Self-Care Deficit, reviewed and renewed with his/her July 2024 MDS, indicated he/she was dependent on the completion of all Activities of Daily Living (ADL) care by staff. Review of Resident #1's Resident Care Kardex, (used as a reference guide for Certified Nurse Aides (CNA's), dated 08/09/24, indicated that he/she required the use of a mechanical lift with the assistance of two staff members for transfers. Review of the Facility's Internal Investigation Report, dated 10/02/24, indicated that on 10/02/24 at 11:45 A. M. Nurse #1, CNA #1, and Hospice Aide #1 were transferring Resident #1 from a Geri-chair (recliner) to his/her bed using the mechanical lift. The Report indicated CNA #1 positioned the mechanical lift in front of Resident #1, then Hospice Aide #1 hooked the left side sling hooks to the lift and Nurse #1 hooked the right side sling hooks to the lift. The Report indicated that CNA #1 began raising Resident #1 up in the mechanical lift with the controller (remote) at which point Hospice Aide #1 removed the Geri-chair out from under Resident #1. The Report further indicated, CNA #1 moved Resident #1's feet on the left side of the mechanical lift and the lower left hook strap came undone [disconnected] from the mechanical lift. The Report indicated that Resident #1 fell on to the floor on his/her left side, and he/she complained of lower back and left leg pain. The Report indicated that Resident #1 was assessed by Nurse #1 with no apparent or visible injuries, and he/she was manually transferred into his/her bed. The Report indicated that Resident #1 was then assessed by the NP who gave an order to obtain X-rays of his/her left hip and knee. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's Nurse Practitioner Note, dated 10/02/24, indicated that Resident #1 was seen as requested by nursing due to status post fall out of mechanical lift. The Note indicated per nurse (later identified as Nurse #1) Resident #1 did not have loss of consciousness (LOC), no head strike, and no visible injuries. The Note indicated that Resident #1 reported pain in his/her left hip radiating down to left knee and to obtain X-rays of his/her left hip and knee, monitor vitals, complete neurological checks per Facility policy and if he/she has abnormal vitals or worsening in condition, may send him/her to the Hospital Emergency Department (ED) and notify the provider. During an interview on 10/22/24 at 2:38 P.M., (which included review of her written statement), Certified Nurse Aide (CNA) #1 said on 10/02/24, she helped transfer Resident #1 from the Geri-chair to his/her bed. CNA #1 said she operated the mechanical lift, placed it in front of the Geri-chair then lowered the lift so Nurse #1 and Hospice Aide #1 could hook the sling pad to the lift. CNA #1 said Nurse #1 hooked the right side sling straps and Hospice Aide #1 hooked the left side sling straps to the lift. CNA #1 said she visually observed that all four sling straps were secured on the lift. CNA #1 said she announced, we are going up then started raising Resident #1 up with the mechanical lift and Hospice Aide #1 pulled the Geri-chair out from under Resident #1. CNA #1 said Nurse #1 had turned away because she was making room for the Geri-chair and when Hospice Aide #1 pulled the Geri-chair backward, the lower left sling strap came undone, Resident #1 slid off the sling pad and he/she fell on the floor landing on his/her left side. CNA #1 said that they had visually looked at the sling straps but, they should have double checked placement of the sling straps by pulling down on them to ensure they were secure on the mechanical lift before transferring Resident #1. During an interview on 10/22/24 at 1:17 P.M., (which included review of her written statement), Hospice Aide #1 said she was at the Facility on 10/02/24 and assisted Nurse #1 and CNA #1 to transfer Resident #1 from the Geri-chair into his/her bed. Hospice Aide #1 said CNA #1 was controlling the mechanical lift and placed the lift in front of Resident #1's Geri-chair. Hospice Aide #1 said she hooked the upper and lower left side sling straps to the lift and Nurse #1 hooked the upper and lower right side sling straps to the lift. Hospice Aide #1 said Nurse #1 then looked at all four sling straps and she (Nurse #1) said we are ready? Hospice Aide #1 said that CNA #1 started to raise Resident #1 up with the mechanical lift, then she and Nurse #1 pulled the Geri-chair out from under Resident #1 and Nurse #1 moved the Geri-chair out of the way. Hospice Aide #1 said as CNA #1 moved Resident #1's feet towards the left side of the lift, the lower left sling strap came off the lift and Resident #1 slid off the sling pad onto the floor. Hospice Aide #1 said that after all four sling straps were hooked to the lift, that she, Nurse #1, and CNA #1 had not done a double check to make sure the sling straps were secured to the mechanical lift. (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 10/17/24 at 12:28 P.M., (which included review of her written statement), Nurse #1 said on 10/02/24 she, CNA #1, and Hospice Aide #1 were transferring Resident #1 from the Geri-chair to his/her bed. Nurse #1 said CNA #1 was controlling the mechanical lift and said she (Nurse #1) hooked the right upper and lower sling straps to the lift and Hospice Aide #1 hooked the left side sling straps to the lift. Nurse #1 said they all did a visual second check that all four lift straps were hooked to the lift and said CNA #1 then announced, we are going up! Nurse #1 said as Resident #1 was being lifted by the mechanical lift she turned away to make room for the Geri-chair that the Hospice Aide #1 was moving out from under Resident #1. Nurse #1 said she turned, grabbed the Geri-chair, moved it, and said as she turned back around, she saw Resident #1 fall to floor, landing on his/her left side. Nurse #1 said she immediately assessed Resident #1 and asked CNA #1 and Hospice #1 if he/she had hit his/her head and they replied no. Nurse #1 said Resident #1 had no visible signs of injury, but he/she was uncomfortable, so they manually transferred him/her to the bed. Nurse #1 said she re-assessed Resident #1 after he/she was put back to bed and said she then asked the NP, who was in-house, to also come assess him/her. Nurse #1 said the NP assessed Resident #1 and ordered stat X-rays of Resident #1's left hip and knee. Nurse #1 said, after the fall, she checked the lower left side sling pad straps and said the stitching on the strap hooks were intact. Nurse #1 said she could not recall if a second check on the placement of the sling straps to the lift had to be done physically. Review of the TELS Logbook Documentation Resident Lifts: Inspect mobile lifts, dated 10/03/24, (completed by Maintenance Director) indicated that all mobile lift safety inspections showed no failures or defaults (no changes from standard configuration, settings or behaviors) with the lifts. During an interview on 10/23/24 at 1:38 P.M., the Maintenance Director said he inspects all mechanical lifts in the Facility monthly for proper working order. The Maintenance Director said on 10/03/24, he inspected the mechanical lift that was used to transfer Resident #1 on 10/02/24 and said there no defaults or failures on the lift, that it was in proper working order. During an interview on 10/17/24 at 4:07 P.M., the Administrator said he was notified on 10/02/24 by the acting Director of Nursing at the time that Resident #1 fell out of the mechanical lift. The Administrator said he started an investigation and said the lower left side hook strap on the sling pad came undone from the mechanical lift while Resident #1 was being transferred. The Administrator said after Resident #1's fall, he inspected the lift sling pad, the stitching on the hook straps were intact and said there was no evidence of failure on the lift sling pad. The Administrator said he could not conclude how the hook strap actual came off (unattached) the mechanical lift, but said the most plausible reason was that the lower left hook strap was not fully secured to the hook portion on the lift. The Administrator said staff are supposed to double check that the hook straps are secure on the mechanical lift before transferring a resident. The Administrator said Nurse #1, CNA #1 and Hospice Aide #1 had not done a second check that the hook straps were secure on the mechanical lift before transferring Resident #1 and that they should have. The Administrator said it is his expectation that all Nurses, CNA's and contracted staff follow the Facility's Policy and process when using a mechanical lift to transfer a resident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/17/24, the Facility was found to be in Past Non-Compliance and presented the Surveyor with a plan of correction which addressed the area(s) of concern as evidenced by: A. On 10/02/24, Resident #1 was assessed by the Nurse and NP, he/she given Motrin for complaints of left hip and knee pain and was monitored for signs and symptoms for a change in condition, B. On 10/03/24, the Administrator conducted a Facility wide audit (which included visual inspections of slings and straps) on all mechanical lift sling pads to ensure they were in good condition (26 pads were inspected, 13 pads were removed, and new pads were purchased). C. On 10/03/24, the Maintenance Director conducted a Facility wide audit (safety inspections) on all mechanical lifts for proper function/working order. D. On 10/04/24, the Unit Managers conducted a Facility wide audit (visual observations) for all residents utilizing mechanical lift for transfers to ensure that transfers were done correctly by staff. E. On 10/02/24, 10/03/24, 10/05/24, 10/09/24, 10/10/24, 10/11/24, and 10/15/24 the Staff Development Coordinator provided education to all Licensed Nursing Staff on mechanical lifts and falls with injury or suspected injury that included: -Double checking the security of the sling attachment prior to the transfer -Lifting Machine, Using a Mechanical and the Mechanical Lift Policy -Falls Policy and Procedure -Safe mobility and transfers -Mechanical lift competencies were completed for Nursing staff F. The Unit Managers will conduct daily mechanical lift transfer audits (visual observations) for seven days, then weekly for four weeks, and then monthly for two QAPI quarters. G. Nursing Management will conduct audits (visual observations) on the mechanical lift pads for any replacements required, weekly for four weeks, then monthly for two QAPI quarters. H. The Administrator and/or designee are responsible for audit results and the findings of the audits will be reviewed at the quarterly QAPI meeting for two meetings. I. The Administrator and/or designee are responsible for overall compliance.