STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225273	A. Building B. Wing	06/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carleton-Willard Village Retirement & Nursing Ctr	100 Old Billerica Road Bedford, MA 01730

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 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. Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who required two staff members assistance with the mechanical sling lift for all transfers, the Facility failed to ensure he/she was free from neglect, when on 06/03/25 Certified Nurse Aide (CNA) #1, although she was aware of facility policy and that Resident #1 required an assist of two staff persons for transfers with a mechanical sling lift, CNA #1 transferred Resident #1 by herself, and he/she fell from lift on to the floor. CNA #1 also did not immediately report the fall to nursing so Resident #1 could be assessed for potential injury prior to being moved, but instead physically picked Resident #1 up off the floor by herself and put him/her back into bed. Once Resident #1 was back in bed, she still did not report the incident to nursing. Over two and a half hours later, Resident #1 was found to be bleeding from a cut on back of his/her head, had bruising on his/her back and left hip area, was complaining of severe back and left shoulder pain, was transferred to the Hospital Emergency Department (ED) and was diagnosed with several fractured ribs, fractured left scapula, several spinal fractures, bilateral subdural bleeds, a head laceration, and other internal injuries. Findings include: The Facility Policy, titled Resident Abuse Prevention Program, dated as revised 10/14/22, indicated: - The Facility would ensure that every resident was free from all forms of abuse, including neglect. -Abuse was defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting in physical harm, pain, or mental anguish. Abuse also included the deprivation by an individual, including a caretaker, of goods or services. The term willful meant the individual must have acted deliberately. -Neglect was defined as the failure of the Facility, its employees or service providers to provide services to a resident that were necessary to avoid physical harm, pain, mental anguish, or emotional distress. This included cases of indifference or disregard for resident care, comfort, or safety that resulted in or could have resulted in physical harm, mental anguish, or emotional distress. Review of the Facility's Incident Investigation Summary, undated, indicated the following: (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-On the morning of 06/03/25, some time between 07:05 A.M., and 07:20 A.M., Certified Nurse Aide (CNA) #1 attempted to transfer Resident #1 from his/her bed to his/her reclining wheelchair via the mechanical sling lift, and during the transfer Resident #1 fell from the sling onto the floor. -CNA #1 did not notify anyone that Resident #1 had fallen, and instead manually picked Resident #1 up from the floor, then placed him/her back in bed. -CNA #1 noticed blood on the back of Resident #1's head but did not report it to any other staff member. Resident #1 was admitted to the Facility in July 2023, diagnoses included Parkinson's disease, Alzheimer's disease, osteoarthritis, osteoporosis, and peripheral neuropathy. Review of Resident #1's Activities of Daily Living Care Plan, dated as reviewed on 05/14/25, indicated Resident #1 required assistance of two staff members using the mechanical sling lift for all transfers. Review of Resident #1's Nurse Progress Note, dated 06/03/25, indicated that at 07:30 A.M., Nurse #1 heard Resident #1 groaning, he/she said he/she had pain in his/her back, and Nurse #1 administered his/her scheduled pain medication. The Note indicated that when Nurse #1 reassessed Resident #1, around 20 minutes later at 07:50 A.M., he/she was still complaining of back pain, so Nurse #1 applied a hot pack to his/her back. The Note indicated Resident #1 was fed breakfast in bed [by CNA #1], and Nurse #1 returned to his/her room twice during the breakfast meal to assess his/her pain. The Note indicated that at 10:00 A.M., Unit Secretary #1 alerted Nurse #1 that Resident #1 had blood on his/her pillow, and that Unit Manager #1, the Director of Nurses (DON) and Nurse Practitioner (NP #1) were all notified, responded, and NP #1 ordered for Resident #1 to be transferred to the Hospital ED. Review of Resident #1's Emergency Department After Visit Summary, dated 06/03/25, indicated he/she had a witnessed fall from the mechanical sling lift at the Facility, and he/she was diagnosed with the following: -Bilateral subdural fluid collections (a collection of blood between the dura mater (the tough outer layer of the meninges) and the surface of the brain. This condition typically occurs after a head injury and can be life-threatening due to the pressure it exerts on the brain) that measured 3 millimeters (mm) on the right and 5 mm on the left. -Left first and second nondisplaced (bones were broken, but remained in their original position) rib fractures. -Left second, third, fourth, and fifth acute rib fractures including significant displacement and flail segments (a condition that occurs when three or more adjacent ribs are fractured in two or more places, allowing that segment of the thoracic wall to displace and move independently of the rest of the chest wall. In flail chest, a segment of the chest wall separates from the rest and moves in the opposite direction from the rest of the chest wall when a person breathes. This condition can result in damage to the lungs or other organs.) (continued on next page)

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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	-Left small to moderate pneumothorax (a condition where air or gas accumulates in the pleural space, the area between the lungs and the chest wall. This can cause partial or complete lung collapse, leading to chest pain and shortness of breath.) -Left trace hemothorax (a collection of blood in the pleural cavity, which is the space between the chest wall and the lung. It can be caused by an injury.) -Left scapula (shoulder blade) markedly comminuted (broken into more than two pieces), displaced (out of alignment) fracture, extending to the glenoid (socket part of the shoulder.) -Thoracic (middle spine) second and third transverse process (bony protrusion that extends sideways from each vertebra in the spine) acute nondisplaced fractures. -Lumbar (lower spine) second superior endplate mild to moderate height loss (occurs when the bone in the front (anterior) part of a vertebral body collapses and forms a wedge shape) and 3 millimeter (mm) retropulsion (a retropulsed fragment refers to a piece of the vertebra or intervertebral disc material that has been displaced from the vertebral body backward into the spinal canal.) Review of Resident #1's Nurse Practitioner Note, dated 06/04/25, indicated he/she returned to the Facility the evening of 06/03/25, and his/her skin observation revealed the following: -A superficial open area on the back of his/her head measuring 0.5 centimeters (cm.) -Reddish bruising to the left back, buttock, and left upper back along the lateral edge of the scapula. Review of Certified Nurse Aide (CNA) #1's Written Statement, dated 06/03/25, indicated that on 06/03/25 at 07:30 A.M., she attempted to transfer Resident #1 without assistance from another staff member, using the mechanical sling lift. The Statement indicated that during the transfer, the upper left hook of the sling released from the lift, and Resident #1 fell to the floor. The Statement indicated CNA #1 noticed blood on the back of Resident #1's head, manually lifted him/her up from the floor by herself, put him/her back to bed, and did not notify anyone that Resident #1 had fallen. The Statement indicated CNA #1 then left Resident #1's room, went and provided care for another resident, assisted with passing breakfast trays on the unit, and then went back to Resident #1's room to assist with feeding him/her breakfast. Further review of CNA #1's Written Statement indicated that when Unit Manager #1 later questioned her about the blood found on Resident #1's pillow, she initially denied knowing anything had happened, but later admitted that Resident #1 had fallen. During a telephone interview on 06/10/25 at 08:55 A.M., Certified Nurse Aide (CNA) #1 said she normally worked full time the 03:00 P.M., to 11:00 P.M., shift on the Resident #1's unit, and had picked up the 07:00 A.M. to 03:00 P.M., shift on 06/03/25. CNA #1 said that on 06/03/25 around 7:30 A.M., she attempted to transfer Resident #1 using the mechanical sling lift without assistance from another staff member, and during the transfer the sling released from the lift, and Resident #1 fell around four feet straight down to the floor. (continued on next page)

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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	CNA #1 said she physically lifted Resident #1 up from the floor by herself and placed him/her back in bed. CNA #1 said she did not think his/her injuries were serious, that she did not report the fall to anyone, and left Resident #1's room, and went to provide care for another resident. CNA #1 said she was aware that it was the facility's policy for two staff members to assist with mechanical sling lift transfers and knew that Resident #1 required two assists for transfers. CNA #1 also said she knew it was important to immediately notify a nurse when a resident fell and before moving the resident, but she did neither of them because she knew she was in trouble. CNA #1 said she was not aware that Resident #1 was bleeding from the back of his/her head, and said she only wrote that in her Written Statement because the Director of Nurses told her to. During an interview on 06/10/25 at 02:58 P.M., CNA #2 said she was the lead CNA for the unit, and on 06/03/25 at 06:40 A.M., she conducted her usual walking rounds on the unit and saw that Resident #1, who was usually washed and dressed by the 11:00 P.M., to 07:00 A.M., shift was in bed and fully dressed. CNA #2 said that between 07:15 A.M., and 07:20 A.M., she noticed Resident #1's bedroom door was slightly open and the mechanical sling lift was in the room. CNA #2 said when she entered the room to offer to help transfer Resident #1, he/she was no longer wearing a shirt, the mechanical lift sling pad was not positioned under him/her and was instead hanging from lift by the two top clips. CNA #2 said CNA #1 was in the bathroom washing something in the sink but she did not see what it was, and said CNA #1 told her that Resident #1's shirt had gotten dirty. CNA #2 said she noticed a few drops of blood on Resident #1's top sheet but thought maybe he/she had a nosebleed, and then left the room, because she thought CNA #1 was not ready to get Resident #1 up out of bed at that time. During an interview on 06/10/25 at 01:06 P.M., Nurse #1 said that on 06/03/25 at 07:00 A.M., she gave CNA #1 report, told her to start her assignment with Resident #1, and to get her when she was ready to transfer him/her, since Resident #1 required two staff members for transfers via the mechanical sling lift. Nurse #1 said she went to Resident #1's room at 07:30 A.M. and could hear Resident #1 groaning even with the door closed. Nurse #1 said she went into Resident #1's room, saw CNA #1 standing next to his/her bed, and Resident #1 was complaining of back pain. Nurse #1 said she told CNA #1 to feed Resident #1 in bed that morning, medicated him/her with his/her scheduled pain medication and applied a warm pack to his/her back. Nurse #1 said she returned to Resident #1's room twice while CNA #1 was feeding him/her breakfast to assess his/her pain. Nurse #1 said CNA #1 did not report that there was any sort of incident or fall that had occurred at all. Nurse #1 said she did not know something had happened to Resident #1 until 10:00 A.M., when Unit Secretary #1 told her there was blood on his/her pillow. Nurse #1 said when she went to check on what Unit Secretary #1 reported, she said there were two pillows with blood on them, that one pillow had an area of blood located on the corner of it that was around five inches wide and four inches long, and the second pillow had an area of blood in the center of it that was around six inches long and four inches wide, surrounded by smaller spots of blood. Nurse #1 described the blood as bright red and fresh. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Although Nurse #1 went into Resident #1's room to assess him/her at least three different times (07:30 A.M., at the start of the breakfast meal sometime between 8:00 A.M. -8:30 A.M., and, again at 08:50 A.M.), while CNA #1 was in the room, and despite Nurse #1 assessing Resident #1 for pain, and specifically asking CNA #1 how he/she was doing, CNA #1 never told Nurse #1 about Resident #1's fall out of the mechanical sling lift. CNA #1 never told Nurse #1 that she picked Resident #1 up off the floor and put him/back bed, or reported to Nurse #1 that he/she was bleeding from the back of his/her head. During an interview on 06/10/25 at 12:07 P.M., Family Member #1 said that on 06/03/25 at 09:30 A.M., he was on a video call with Resident #1 when he noticed what appeared to be blood behind his/her head on his/her pillow, and he/she complained of left shoulder pain, which was unusual. Family Member #1 said he called the unit desk and asked Unit Secretary #1 to check on Resident #1. Family Member #1 said Resident #1 had advanced dementia and could not speak up for him/herself. Family Member #1 said he was most disturbed by the fact that CNA #1 had left Resident #1 in bed for well over two hours, in pain, without any care and without letting anyone know what had happened to him/her. During an interview on 06/10/25 at 03:22 P.M., Unit Manager #1 said that on 06/03/25 at 10:00 A.M., Nurse #1 told her that Resident #1 was bleeding, and said she immediately went to assess Resident #1. Unit Manager #1 said there was blood on two pillows, and she and Nurse #1 tried to roll Resident #1 over to assess him/her, but could not because he/she moaned in pain and said, that hurts. Unit Manager #1 said she was able to briefly see the back of Resident #1's head, said it was raw and there was fresh blood in his/her hair. Unit Manager #1 said while she and Nurse #1 were assessing Resident #1, CNA #1 came to the room. Unit Manager #1 said she asked CNA #1 if anything had happened to Resident #1 and said CNA #1 said no, and also denied knowing that Resident #1 had blood on his/her pillow. Unit Manager #1 said there was also blood observed on the floor in Resident #1's room, that CNA #1 was asked if she knew about the blood on the floor, that CNA #1 said she knew about the blood on the floor but had not reported it, and said why would I? Unit Manager #1 said later that day she reviewed CNA #2's written statement that indicated she had seen some blood spots on Resident #1's sheet and of CNA #1 washing something in Resident #1's bathroom sink. Unit Manager #1 said she went to Resident #1's personal laundry hamper and found his/her shirt, which was sopping wet with water and it had a faint blood stain around the upper back and collar areas. During an interview on 06/10/25 at 08:04 A.M., The Director of Nurses (DON) said it was Facility policy that two staff members were required for all mechanical sling lift transfers, and that all resident falls were to be reported to the nurse immediately and before the resident was moved. The DON said CNA #1 did not follow Facility policies, which resulted in Resident #1's injuries and a significant delay in care. The DON said CNA #1 initially denied that anything had happened to Resident #1, but later admitted to the incident, admitted that she knew Resident #1 was bleeding, and that she had not reported it to anyone. The DON said as a result Resident #1 went over two hours without being assessed by nursing, therefore necessary care and treatment was delayed. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 06/10/25, 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) 06/03/25, The Facility conducted an Ad-Hoc Quality Assurance Performance Improvement meeting, which indicated the Facility Leadership developed an action plan to correct the deficient practice, ensure that residents were free from falls involving the mechanical sling lift devices, and that all resident falls are reported to the nurse immediately. B) 06/03/25, The Assistant Director of Nurses (ADON)/designee educated all licensed staff and CNAs of the Facility policy and the requirement to always have two staff members present for all mechanical sling lift transfers. C) 06/03/25, The ADON/designee educated all licensed staff and CNAs of Facility policy and the requirement not to move a resident following a fall until a nurse has assessed them. D) 06/03/25, The ADON/designee educated all licensed staff and CNAs of Facility policy and the requirement to report all incidents involving residents immediately so a nurse can assess the resident and prevent further injuries. E) 06/05/25, The Inspection Report indicated the mechanical sling lift manufacturing company inspected all the Facility's mechanical sling lift devices and determined they were all in good working order. F) 06/06/25, The Mechanical Lift Sling Inspection attestations, signed by the Unit Managers, indicated the Facility's lift slings were inspected by and found to be intact without tears or fraying straps, and the fasteners were intact without cracks. G) The Staff Educator/designee conducted an audit to determine that all licensed staff and CNAs had a competency completed within the last year on mechanical sling lift transfers. H) 06/09/25, The Service Report indicated the mechanical sling lift manufacturing company conducted annual maintenance on the Facility's mechanical sling lift devices. I) 06/09/25, Department Managers educated all Facility staff that all staff in all departments were required to immediately report any noticed change in a resident condition, falls, anything out of the ordinary such as blood, to the nurse on duty or Unit Manager. J) 06/09/25, The Point of Care Audit Tool indicated Unit Managers conducted observations of staff performance of mechanical sling lift transfers. K) The DON/designee will conduct follow up audits consisting of visual observations of all licensed and CNA staff performances using the mechanical sling lift for transfers, and immediate re-education will be conducted as needed. L) The Unit Managers/designee will conduct weekly observations on all shifts of staff performance of five mechanical sling lift transfers for four weeks, and immediate re-education will be conducted as needed. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	M) The Facility will continue to monitor compliance at monthly and quarterly Quality Assurance Meetings. N) The Director of Nurses and/or designee are responsible for ongoing compliance.

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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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on records reviewed and interviews, for one of three sampled residents (Resident #1), whose comprehensive plan of care interventions indicated that he/she required the assistance of two staff members with the mechanical sling lift for all transfers, the Facility failed to ensure that staff consistently implemented and followed interventions related to transfers per his/her plan of care. On 06/03/25, Certified Nurse Aide (CNA) #1 attempted to transfer Resident #1 without the assistance from any other staff member, during the transfer the left upper clip on the mechanical sling lift became disconnected and Resident #1 fell to the floor. Resident #1 was transferred to the Hospital Emergency Department (ED) for evaluation and was diagnosed with several fractured ribs, fractured left scapula, several spinal fractures, bilateral subdural bleeds, a head laceration, and other internal injuries. Findings include: The Facility Policy, titled Baseline and Comprehensive Person-Centered Care, dated as revised 06/01/24, indicated the Facility would develop and implement a comprehensive person-centered plan of care for each resident that included services to maintain or attain their highest practicable, physical, mental, and psychosocial well-being. The Facility Policy, titled, Transfer Utilizing a Mechanical Lift, dated as revised September 2023, indicated two licensed or certified staff were needed to do a Mechanical Lift transfer, and one of the staff members would have their hands on the resident during the transfer. A mechanical sling lift (often referred to as a Patient Lift or Hoyer Lift) is a device that allows caregivers to safely transfer an individual between a bed, wheelchair, shower chair, or another surface. A sling lift is comprised of a base on casters, a boom, and a cradle that supports the sling. Resident #1 was admitted to the Facility in July 2023, diagnoses included Parkinson's disease, Alzheimer's disease, osteoarthritis, osteoporosis, and peripheral neuropathy. Review of Resident #1's Activities of Daily Living Care Plan, dated as reviewed on 05/14/25, indicated Resident #1 required assistance of two staff members with the use of the mechanical sling lift for all transfers. The Facility's Incident Investigation Summary, undated, indicated that on the morning of 06/03/25, some time between 07:05 A.M., and 07:20 A.M., Certified Nurse Aide (CNA) #1 attempted to transfer Resident #1 from his/her bed to his/her reclining wheelchair via the mechanical sling lift, and during the transfer Resident #1 fell from the sling and onto the floor. Review of Resident #1's Nurse Progress Note, dated 06/03/25, indicated Resident #1 was noted to be groaning, said he/she had pain in his/her back, and Nurse Practitioner (NP) #1 ordered for Resident #1 to be transferred to the Hospital Emergency Department for evaluation. Review of Resident #1's Emergency Department After Visit Summary, dated 06/03/25, indicated he/she had a witnessed fall from the mechanical sling lift at the Facility, and was diagnosed with the following: (continued on next page)

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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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Bilateral subdural fluid collections (a collection of blood between the dura mater (the tough outer layer of the meninges) and the surface of the brain. This condition typically occurs after a head injury and can be life-threatening due to the pressure it exerts on the brain) that measured 3 millimeters (mm) on the right and 5 mm on the left. -Left first and second nondisplaced (bones were broken, but remained in their original position) rib fractures. -Left second, third, fourth, and fifth acute rib fractures including significant displacement and flail segments (a condition that occurs when three or more adjacent ribs are fractured in two or more places, allowing that segment of the thoracic wall to displace and move independently of the rest of the chest wall. In flail chest, a segment of the chest wall separates from the rest and moves in the opposite direction from the rest of the chest wall when a person breathes. This condition can result in damage to the lungs or other organs.) -Left small to moderate pneumothorax (a condition where air or gas accumulates in the pleural space, the area between the lungs and the chest wall. This can cause partial or complete lung collapse, leading to chest pain and shortness of breath.) -Left trace hemothorax (a collection of blood in the pleural cavity, which is the space between the chest wall and the lung. It can be caused by an injury.) -Left scapula (shoulder blade) markedly comminuted (broken into more than two pieces), displaced (out of alignment) fracture, extending to the glenoid (socket part of the shoulder.) -Thoracic (middle spine) second and third transverse process (bony protrusion that extends sideways from each vertebra in the spine) acute nondisplaced fractures. -Lumbar (lower spine) second superior endplate mild to moderate height loss (occurs when the bone in the front (anterior) part of a vertebral body collapses and forms a wedge shape) and 3 millimeter (mm) retropulsion (a retropulsed fragment refers to a piece of the vertebra or intervertebral disc material that has been displaced from the vertebral body backward into the spinal canal.) Review of Resident #1's Nurse Practitioner Note, dated 06/04/25, indicated he/she returned to the Facility the evening of 06/03/25, and his/her skin observation revealed the following: -A superficial open area on the back of his/her head measuring 0.5 centimeters (cm.) -reddish bruising to the left back, buttock, and left upper back along the lateral edge of the scapula. During a telephone interview on 06/10/25 at 08:55 A.M., (which included a review of her written statement, dated 06/03/25), Certified Nurse Aide (CNA) #1 said she normally worked full time on the 03:00 P.M., to 11:00 P.M., shift on the Resident #1's unit, and had picked up the day (07:00 A.M. to 03:00 P.M.) shift on 06/03/25. CNA #1 said at the time of the incident, she had been working at the facility for around two years, and had received education and training on mechanical sling lift transfers, and the need to review resident care plans before providing care. (continued on next page)

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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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	CNA #1 said that she was familiar with Resident #1, and his/her plan of care, and that she knew Resident #1 required two staff members assistance for transfers with the mechanical sling lift. CNA #1 also said she knew it was Facility policy that two staff members were required to assist with all mechanical sling lift transfers. CNA #1 said she never asked another staff member to help her transfer Resident #1. CNA #1 said that on 06/03/25 around 07:30 A.M., she attempted to transfer Resident #1 out of bed using the mechanical sling lift without getting assistance from another staff member. CNA #1 said during the transfer the upper left hook on the sling released from the lift and Resident #1, who was still suspended up in the sling around four feet off the floor, fell straight down to the floor. During an interview on 06/10/25 at 01:06 P.M., Nurse #1 said that on 06/03/25 at 07:00 A.M., she gave CNA #1 report, told her to start her assignment with Resident #1, and to get her when she was ready to transfer him/her. Nurse #1 said she reminded CNA #1 that Resident #1 required two staff members for transfers via the mechanical sling lift. Nurse #1 said CNA #1 never came to get her to assist with Resident #1's transfer out of bed, so she had no idea CNA #1 had tried to transfer Resident #1 by herself and that he/she fallen out of the lift sling. During an interview on 06/10/25 at 02:58 P.M., CNA #2 said she was the lead CNA for the unit, and on 06/03/25 at 06:40 A.M., she conducted her usual walking rounds on the unit and saw that Resident #1, who was usually washed and dressed by the 11:00 P.M., to 07:00 A.M., shift was in bed and fully dressed. CNA #2 said that between 07:15 A.M., and 07:20 A.M., she noticed Resident #1's bedroom door was slightly open and the mechanical sling lift was in the room. CNA #2 said when she entered the room to offer to help CNA #1 with transferring Resident #1, noticed that the mechanical lift sling pad was not positioned under him/her and was instead hanging from lift by the two top clips. CNA #2 said she left the room, because she thought CNA #1 was not ready to get Resident #1 up out of bed at that time. Review of the facility staffing schedule for Resident #1's unit for 6/03/25 during the day shift, indicated there were 33 residents on the unit, nursing staff consisted of the Unit Manager, two licensed nurses, five CNA's and one additional CNA that was on orientation. During an interview on 06/10/25 at 08:04 A.M., The Director of Nurses (DON) said CNA #1 had been working at the facility for two years, and that per her employee file, all of CNA #1's mandatory trainings which included but was not limited to facility policy's, abuse, neglect, provision of ADL care, safety, and mechanical lifts had been completed and were up to date. The DON said CNA #1 should have had another staff member with her for Resident #1's transfer on 06/03/25, but did not, and as a result Resident #1 fell and sustained serious injuries. The Director of Nurses (DON) said all mechanical lift transfers must be conducted with two staff members. On 06/10/25, 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) 06/03/25, The Facility conducted an Ad-Hoc Quality Assurance Performance Improvement meeting, which indicated the Facility Leadership developed an action plan to correct the deficient practice, ensure that residents were free from falls involving the mechanical sling lift devices, and that all resident falls are reported to the nurse immediately. (continued on next page)

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	225273	A. Building B. Wing	06/10/2025

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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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	B) 06/03/25, The Assistant Director of Nurses (ADON)/designee educated all licensed staff and CNAs of the Facility policy and the requirement to always have two staff members present for all mechanical sling lift transfers. C) 06/03/25, The ADON/designee educated all licensed staff and CNAs of the Facility policy and the requirement not to move a resident following a fall until a nurse has assessed them. D) 06/03/25, The ADON/designee educated all licensed staff and CNAs of the Facility policy and the requirement to report all incidents involving residents immediately so a nurse can assess the resident and prevent further injuries. E) 06/05/25, The Inspection Report indicated the mechanical sling lift manufacturing company inspected all the Facility's mechanical sling lift devices and determined they were all in good working order. F) 06/06/25, The Mechanical Lift Sling Inspection attestations, signed by the Unit Managers, indicated the Facility's lift slings were inspected by and found to be intact without tears or fraying straps, and the fasteners were intact without cracks. G) The Staff Educator/designee conducted an audit to determine that all licensed staff and CNAs had a competency completed within the last year on mechanical sling lift transfers. H) 06/09/25, The Service Report indicated the mechanical sling lift manufacturing company conducted annual maintenance on the Facility's mechanical sling lift devices. I) 06/09/25, Department Managers educated all Facility staff that all staff in all departments were required to immediately report any noticed change in a resident condition, falls, anything out of the ordinary such as blood, to the nurse on duty or Unit Manager. J) 06/09/25, The Point of Care Audit Tool indicated Unit Managers conducted observations of staff performance of mechanical sling lift transfers. K) The DON/designee will conduct follow up audits consisting of visual observations of all licensed and CNA staff performances using the mechanical sling lift for transfers, and immediate re-education will be conducted as needed. L) The Unit Managers/designee will conduct weekly observations on all shifts of staff performance of five mechanical sling lift transfers for four weeks, and immediate re-education will be conducted as needed. M) The Facility will continue to monitor compliance at monthly and quarterly Quality Assurance Meetings. N) The Director of Nurses and/or designee are responsible for ongoing compliance.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - 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. Based on records reviewed and interviews for one of three sampled residents (Resident #1), who required two staff member assistance using the mechanical sling lift for all transfers, the Facility failed to ensure he/she was provided with the necessary level of staff assistance to maintain his/her safety and prevent an incident/accident resulting in significant injuries. On the morning of 06/03/25, Certified Nurse Aide (CNA) #1 attempted to transfer Resident #1 without another staff member present to assist her, and during the transfer the upper left clip of the sling unattached from the lift, and Resident #1 fell around four feet onto the floor. Resident #1 was transferred to the Hospital Emergency Department (ED) and was diagnosed with several fractured ribs, fractured left scapula, several spinal fractures, bilateral subdural bleeds, a head laceration, and other internal injuries. Findings include: The Facility Policy, titled, Transfer Utilizing a Mechanical Lift, dated as revised September 2023, indicated two licensed or certified staff were needed to do a Mechanical Lift transfer, and one of the staff members would have their hands on the resident during the transfer. A mechanical sling lift (often referred to as a Patient Lift or Hoyer Lift) is a device that allows caregivers to safely transfer an individual between a bed, wheelchair, shower chair, or another surface. A sling lift is comprised of a base on casters, a boom, and a cradle that supports the sling. Resident #1 was admitted to the Facility in July 2023, diagnoses included Parkinson's disease, Alzheimer's disease, osteoarthritis, osteoporosis, and peripheral neuropathy. Review of Resident #1's Activities of Daily Living Care Plan, dated as reviewed on 05/14/25, indicated Resident #1 required assistance of two staff members using the mechanical sling lift for all transfers. The Facility's Incident Investigation Summary, undated, indicated that on the morning of 06/03/25, some time between 07:05 A.M., and 07:20 A.M., Certified Nurse Aide (CNA) #1 attempted to transfer Resident #1 from his/her bed to his/her reclining wheelchair via the mechanical sling lift, and during the transfer Resident #1 fell from the sling and onto the floor. Review of Resident #1's Nurse Progress Note, dated 06/03/25, indicated that at 07:30 A.M., Nurse #1 heard Resident #1 groaning, he/she said he/she had pain in his/her back, and Nurse #1 administered his/her scheduled pain medication. The Note indicated that when Nurse #1 reassessed Resident #1, around 20 minutes later at 07:50 A.M., he/she was still complaining of back pain, so Nurse #1 applied a hot pack to his/her back. The Note indicated Resident #1 was fed breakfast in bed [by CNA #1], and Nurse #1 returned to his/her room twice during the breakfast meal to assess his/her pain. The Note indicated that at 10:00 A.M., Unit Secretary #1 alerted Nurse #1 that Resident #1 had blood on his/her pillow, and that Unit Manager #1, the Director of Nurses (DON) and Nurse Practitioner (NP #1) were all notified, responded, and NP #1 ordered for Resident #1 to be transferred to the Hospital ED. Review of Resident #1's Emergency Department After Visit Summary, dated 06/03/25, indicated he/she had a witnessed fall from the mechanical sling lift at the Facility, and he/she was diagnosed with the following: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Bilateral subdural fluid collections (a collection of blood between the dura mater (the tough outer layer of the meninges) and the surface of the brain. This condition typically occurs after a head injury and can be life-threatening due to the pressure it exerts on the brain) that measured 3 millimeters (mm) on the right and 5 mm on the left. -Left first and second nondisplaced (bones were broken, but remained in their original position) rib fractures. -Left second, third, fourth, and fifth acute rib fractures including significant displacement and flail segments (a condition that occurs when three or more adjacent ribs are fractured in two or more places, allowing that segment of the thoracic wall to displace and move independently of the rest of the chest wall. In flail chest, a segment of the chest wall separates from the rest and moves in the opposite direction from the rest of the chest wall when a person breathes. This condition can result in damage to the lungs or other organs.) -Left small to moderate pneumothorax (a condition where air or gas accumulates in the pleural space, the area between the lungs and the chest wall. This can cause partial or complete lung collapse, leading to chest pain and shortness of breath.) -Left trace hemothorax (a collection of blood in the pleural cavity, which is the space between the chest wall and the lung. It can be caused by an injury.) -Left scapula (shoulder blade) markedly comminuted (broken into more than two pieces), displaced (out of alignment) fracture, extending to the glenoid (socket part of the shoulder.) -Thoracic (middle spine) second and third transverse process (bony protrusion that extends sideways from each vertebra in the spine) acute nondisplaced fractures. -Lumbar (lower spine) second superior endplate mild to moderate height loss (occurs when the bone in the front (anterior) part of a vertebral body collapses and forms a wedge shape) and 3 millimeter (mm) retropulsion (a retropulsed fragment refers to a piece of the vertebra or intervertebral disc material that has been displaced from the vertebral body backward into the spinal canal.) Review of Resident #1's Nurse Practitioner Note, dated 06/04/25, indicated he/she returned to the Facility the evening of 06/03/25, and his/her skin observation revealed the following: -A superficial open area on the back of his/her head measuring 0.5 centimeters (cm.) -reddish bruising to the left back, buttock, and left upper back along the lateral edge of the scapula. During a telephone interview on 06/10/25 at 08:55 A.M., (which included a review of her written statement, dated 06/03/25), Certified Nurse Aide (CNA) #1 said she normally worked full time on the 03:00 P.M., to 11:00 P.M., shift on the Resident #1's unit, and had picked up the day (07:00 A.M. to 03:00 P.M.) shift on 06/03/25. CNA #1 said at the time of the incident, she had been working at the facility for around two years, and had received education and training on mechanical sling lift transfers. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	CNA #1 said that she was familiar with Resident #1, and knew Resident #1 required two staff members assistance for transfers with the mechanical sling lift. CNA #1 also said she knew it was Facility policy that two staff members were required to assist with all mechanical sling lift transfers. CNA #1 said that on 06/03/25 around 07:30 A.M., she attempted to transfer Resident #1 out of bed using the mechanical sling lift without getting assistance from another staff member. CNA #1 said during the transfer the upper left hook on the sling released from the lift and Resident #1, who was still suspended up in the sling around four feet off the floor, fell straight down to the floor. CNA #1 said she never asked another staff member to help her transfer Resident #1, because they were short staffed. However, review of the facility staffing schedule for Resident #1's unit for 6/03/25 during the day shift, indicated there were 33 residents on the unit, nursing staff consisted of the Unit Manager, two licensed nurses, five CNA's and one additional CNA that was on orientation. During an interview on 06/10/25 at 01:06 P.M., Nurse #1 said that on 06/03/25 at 07:00 A.M., she gave CNA #1 report, told her to start her assignment with Resident #1, and to get her when she was ready to transfer him/her. Nurse #1 said she reminded CNA #1 that Resident #1 required two staff members for transfers via the mechanical sling lift. Nurse #1 said CNA #1 never came to get her to assist with Resident #1's transfer out of bed, so she had no idea CNA #1 had tried to transfer Resident #1 by herself and that he/she fallen out of the lift sling. During an interview on 06/10/25 at 02:58 P.M., CNA #2 said she was the lead CNA for Resident #1's unit. CNA #2 said that between 07:15 A.M., and 07:20 A.M., she noticed Resident #1's bedroom door was slightly open and the mechanical sling lift was in the room. CNA #2 said when she entered the room to offer to help CNA #1 with transferring Resident #1, noticed that the mechanical lift sling pad was not positioned under him/her and was instead hanging from lift by the two top clips. CNA #2 said she left the room, because she thought CNA #1 was not ready to get Resident #1 up out of bed at that time. During an interview on 06/10/25 at 03:22 P.M., Unit Manager #1 said that on 06/03/25 at 10:00 A.M., Nurse #1 told her that Resident #1 was bleeding, and said she immediately went to assess Resident #1. Unit Manager #1 said there was blood on two pillows, and she and Nurse #1 tried to roll Resident #1 over to assess him/her, but could not because he/she moaned in pain and said, that hurts. Unit Manager #1 said she was able to briefly see the back of Resident #1's head, said it was raw and there was fresh blood in his/her hair. Unit Manager #1 said while she and Nurse #1 were assessing Resident #1, CNA #1 came to the room. Unit Manager #1 said she asked CNA #1 if anything had happened to Resident #1 and said CNA #1 said No. Unit Manager #1 said CNA #1 was asked if she knew about the blood on Resident #1's floor, that CNA #1 said she knew about the blood on the floor but had not reported it, and said why would I? During an interview on 06/10/25 at 08:04 A.M., The Director of Nurses (DON) said CNA #1 had been working at the facility for two years, and that per her employee file, all of CNA #1's mandatory trainings which included but was not limited to facility policy's, abuse, neglect, provision of ADL care, safety, and mechanical lifts transfers had been completed and were up to date. The DON said CNA #1 should have had another staff member with her for Resident #1's transfer on 06/03/25, but did not, and as a result Resident #1 fell and sustained serious injuries. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 06/10/25, 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) 06/03/25, The Facility conducted an Ad-Hoc Quality Assurance Performance Improvement meeting, which indicated the Facility Leadership developed an action plan to correct the deficient practice, ensure that residents were free from falls involving the mechanical sling lift devices, and that all resident falls are reported to the nurse immediately. B) 06/03/25, The Assistant Director of Nurses (ADON)/designee educated all licensed staff and CNAs of the Facility policy and the requirement to always have two staff members present for all mechanical sling lift transfers. C) 06/03/25, The ADON/designee educated all licensed staff and CNAs of the Facility policy and the requirement not to move a resident following a fall until a nurse has assessed them. D) 06/03/25, The ADON/designee educated all licensed staff and CNAs of the Facility policy and the requirement to report all incidents involving residents immediately so a nurse can assess the resident and prevent further injuries. E) 06/05/25, The Inspection Report indicated the mechanical sling lift manufacturing company inspected all the Facility's mechanical sling lift devices and determined they were all in good working order. F) 06/06/25, The Mechanical Lift Sling Inspection attestations, signed by the Unit Managers, indicated the Facility's lift slings were inspected by and found to be intact without tears or fraying straps, and the fasteners were intact without cracks. G) The Staff Educator/designee conducted an audit to determine that all licensed staff and CNAs had a competency completed within the last year on mechanical sling lift transfers. H) 06/09/25, The Service Report indicated the mechanical sling lift manufacturing company conducted annual maintenance on the Facility's mechanical sling lift devices. I) 06/09/25, Department Managers educated all Facility staff that all staff in all departments were required to immediately report any noticed change in a resident condition, falls, anything out of the ordinary such as blood, to the nurse on duty or Unit Manager. J) 06/09/25, The Point of Care Audit Tool indicated Unit Managers conducted observations of staff performance of mechanical sling lift transfers. K) The DON/designee will conduct follow up audits consisting of visual observations of all licensed and CNA staff performances using the mechanical sling lift for transfers, and immediate re-education will be conducted as needed. L) The Unit Managers/designee will conduct weekly observations on all shifts of staff performance of five mechanical sling lift transfers for four weeks, and immediate re-education will be conducted as needed. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	M) The Facility will continue to monitor compliance at monthly and quarterly Quality Assurance Meetings. N) The Director of Nurses and/or designee are responsible for ongoing compliance.