

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225394	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/27/2024
NAME OF PROVIDER OR SUPPLIER Woburn Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 18 Frances Street, #3095 Woburn, MA 01801	

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)
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>37342</p> <p>Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who required the use of a Hoyer lift (mechanical device, person is placed in a specialized sling for transfer from one surface to another) for all transfers, the Facility failed to ensure staff maintained his/her safety, when on 9/09/24 during a transfer using the Hoyer lift, the sling was not properly attached to the Hoyer lift by the Certified Nurse Aides (CNAs) performing the transfer, Resident #1 fell from the lift sling to the floor, was noted to be bleeding from his/her head, was transferred to the Hospital Emergency Department (ED), where he/she was diagnosed with multiple injuries including a closed head injury, scalp laceration, fractures to his/her left leg, and was admitted for treatment.</p> <p>Findings include:</p> <p>The Facility Policy, titled Safe Resident Handling/Transfers, dated as revised 02/2024, indicated staff would ensure the residents were handled and transferred safely to prevent or minimize the risk for injury and to provide a safe, secure, and comfortable experience for the resident. The Policy indicated all residents required safe handling when transferred to prevent or minimize the risk of injury to themselves and the employees that assist them.</p> <p>The Facility Policy, titled Accidents and Supervision, dated as revised 02/2023, indicated the resident environment would remain as free of accident hazards as possible.</p> <p>The Facility Protocol, titled Hoyer Lift Education, undated, indicated the Hoyer Lift spreader bar used slings with loops which allowed for positioning adjustments to be made by selecting the different colored loops. The Protocol indicated that before transferring, all sling positioning loops would be checked to ensure they were all attached, and each corresponding color must match. The Protocol indicated the Hoyer sling was designed to be positioned under the resident, and each connecting strap had different length loops, which were color coordinated to the opposite side and must match to ensure stability.</p> <p>Resident #1 was admitted to the Facility in May 2019, diagnoses included dementia, anxiety, and generalized muscle weakness.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Nurse Progress Note, dated 09/09/24, indicated that at 07:15 A.M., Nurse #1 was alerted that Resident #1 had fallen from the Hoyer lift during a transfer, and was bleeding from his/her head. The Progress Note indicated Resident #1 was transferred to the Hospital Emergency Department for evaluation.</p> <p>Review of the Hospital Discharge Summary, dated 09/11/24, indicated Resident #1 was transferred from the Facility on 09/09/24 after a fall out of the Hoyer Lift, and was diagnosed with a subarachnoid hemorrhage (bleeding in the space between the brain and tissue covering the brain), scalp laceration, left calcaneus (heel bone) fracture, and left distal fibula (long bone in the lower leg) fracture.</p> <p>Review of the Facility's Internal Investigation Summary, dated 09/10/24, indicated the Regional Nurse and Facility leadership conducted a reenactment of the incident, and discovered that the sling had not been properly placed on the Hoyer Lift, which caused Resident #1 to fall to his/her left and onto the floor.</p> <p>During an interview on 09/27/24 at 08:51 A.M., the Staff Development Coordinator (SDC) said all nursing staff had been educated and were required to complete competencies on the use of the Hoyer Lift, which included the need for the sling loops, when attached to the lift hooks, that the colors of each loop needed to match. The SDC said CNA #1 and CNA #2 should have connected the sling correctly, by using the same colored loops on each hook, but had not.</p> <p>Review of the Competencies, dated 07/22/24, indicated Certified Nurse Aide (CNA) #1 and CNA #2 were both observed and determined to be competent performing transfers using the Hoyer lift, which included proper attachment of the sling.</p> <p>During a telephone interview on 09/27/24 at 03:38 P.M., Certified Nurse Aide (CNA) #1 said that on 09/09/24, she and CNA #2 used the Hoyer lift to transfer Resident #1 from his/her bed to the reclining wheelchair. CNA #1 said she and CNA #2 talked about which color loops they were using while they were connecting the sling loops to the Hoyer lift. CNA #1 said she could not recall if she looked at the color of loops on all of the hooks to compare one side to the other, to see if they were the same. CNA #1 said she operated the Hoyer lift from Resident #1's left side while CNA #2 guided his/her feet. CNA #1 said as they started to lift and transfer him/her, Resident #1 started yelling, was turning him/herself in the sling and fell out from the left side of the sling onto the floor, striking his/her head.</p> <p>During an interview on 09/27/24 at 11:24 A.M., Certified Nurse Aide (CNA) #2 said that on 09/09/24, he and CNA #1 used the Hoyer lift to transfer Resident #1. CNA #2 said he was guiding Resident #1's feet and when he let go to position the reclining chair, Resident #1 turned his/her body to the left and fell out from the Hoyer sling on to the floor. CNA #2 said Resident #1's legs were stuck in the sling so he unhooked one of the bottom loops to free his/her legs. CNA #2 said he did not unhook any of the other loops.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 09/27/24 at 09:40 A.M., the Regional Nurse said the Hoyer sling that was used to transfer Resident #1 has four connection points on either side and said each connection point has color coordinated loops which indicate the length of the connection point. The Regional Nurse said that immediately after the incident on 09/09/24, when Resident #1 fell from the Hoyer sling, she and nursing leadership inspected the Hoyer with the sling still hooked up as it was left by CNA #1 and CNA #2. The Regional Nurse said through this reenactment, it was determined that the loops on each side of Resident #1 were not attached equally, which caused Resident #1 to fall out from the left side of the sling.</p> <p>On 09/27/24, 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:</p> <p>A) 09/09/24, Ad-Hoc Quality Assurance Performance Improvement (QAPI) meeting was held, and Action Plan meeting minutes indicated the Facility leadership team met and developed a plan of correction related to the deficient practice.</p> <p>B) 09/09/24, The Hoyer lift was immediately taken out of service until it was inspected by the Maintenance Director.</p> <p>C) 09/09/24, The Regional Nurse, Administrator, SDC, and Director of Maintenance reviewed the manufacturer guidelines for the mechanical lift and sling involved in the incident.</p> <p>D) 09/10/24, A re-creation of the event was conducted by the Regional Nurse and SDC using pictures of the Hoyer with the sling attached as it was at the time of the incident, and they determined the sling was not properly connected to the Hoyer lift at the time of the incident.</p> <p>E) 09/11/24, The Director of Maintenance performed routine maintenance on the Hoyer lift.</p> <p>F) 09/11/24, The QAPI team decided to simplify the use of Hoyer lift slings, and determined use of only the six-point connection slings was going to be the standard practice moving forward.</p> <p>G) 09/16/24, CNA #1 and CNA #2 were re-educated by the SDC on the Facility Protocol titled, Hoyer Lift Education.</p> <p>H) 09/16/24, The Medical Equipment Invoice indicated that the Facility ordered 12 new, Hoyer lift slings, and staff have been in-serviced, educated and trained on use of the new lift slings.</p> <p>I) 09/20/24, The Education Inservice Record Sign in Sheet indicated nurses and CNAs were re-educated to the Facility Protocol titled, Hoyer Lift Education by the SDC.</p> <p>J) 09/09/24 through 09/20/24 The Director of Nurses and SDC completed audits and observations of staff performance of 72 Hoyer lift transfers.</p> <p>K) Observations of Hoyer lift transfers will be completed five times a week by the Director of Nursing and/or designee, for 30 days, and need to continue observations will be evaluated by leadership team.</p> <p>(continued on next page)</p>		

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