STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225584	A. Building B. Wing	06/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Avenue Health Center	146 Park Avenue Arlington, MA 02174

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 0656 Level of Harm - Minimal harm or potential for actual harm 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), who per staff interviews has always been transferred via two person assist with the use of a mechanical lift, the Facility failed to ensure his/her comprehensive person-based plan of care related to transfer status indicated his/her dependence on the use of a mechanical lift device, that included interventions, goals and outcomes.Findings include:The Facility Policy, titled Comprehensive Person-Centered Care Plans, dated as revised in March 2022, indicated the comprehensive person based care plan would describe the services that were to be furnished to the resident.The Facility Policy, titled Safe Lifting and Movement of Residents, dated as revised July 2017, indicated nursing staff would document resident transferring and lifting needs in the care plan.Resident #1 was admitted to the Facility in March 2023, diagnoses included progressive multiple sclerosis (an autoimmune disease that affects the central nervous system, leading to damage of the myelin sheath that protects nerve fibers, resulting in a range of physical and cognitive symptoms).Review of Resident #1's Activities of Daily Living (ADL) Care Plan, dated as reviewed and revised with his/her Quarterly Minimum Data Set (MDS) assessment, dated 06/04/26, indicated he/she was dependent for and required assistance for all transfers.Further review of Resident #1's ADL Care Plan indicated there was no documentation to support that he/she required two staff members assistance and the use of the mechanical lift for all transfers.During a telephone interview on 06/22/26 at 3:33 P.M., Certified Nurse Aide (CNA) #1 said Resident #1 was always transferred using the mechanical lift and two staff members to assist.During a telephone interview on 06/22/26 at 10:40 A.M., CNA #2 said Resident #1 was always transferred using the mechanical lift and two staff members to assist.During an interview on 06/22/26 at 3:17 P.M., Nurse #1 said Resident #1 was always transferred using the mechanical lift and two staff members to assist.During an interview on 06/22/26 at 11:41 A.M., Nurse #2 said Resident #1 was always transferred using the mechanical lift and two staff members to assist.During an interview on 06/22/26 at 08:05 A.M., The Director of Nurses (DON) said Resident #1's ADL Care Plan should have included details of his/her transfer status including the use of the mechanical lift and number of staff required for transfers but did not.

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 0689 Level of Harm - 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** Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who required the use of a mechanical lift with transfers, the Facility failed to ensure his/her safety was maintained during a mechanical lift transfer to prevent an incident/accident resulting in serious injury. On [DATE], during a transfer the mechanical lift stopped functioning with Resident #1 suspended up in the air in lift sling, staff tried to physically move the mechanical lift to position him/her over the bed, Resident #1's body began to sway in the lift sling, and his/her head struck the bedrail. Resident #1 sustained a head laceration, was transferred to the Hospital Emergency Department for evaluation and he/she required five staples to close the wound. Findings include:The Facility Policy, titled Safe Lifting and Movement of Residents, dated as revised [DATE], indicated staff responsible for direct resident care would be trained in the use of mechanical lift devices, and only staff with documented training on the safe use and care of the machines and equipment used in the Facility would be allowed lift or move residents.A Mechanical 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.The Facility Policy, titled Using a Mechanical Lifting Machine, dated as revised [DATE], indicated staff would ensure that the lift's battery was charged and ensure the emergency release feature was functioning prior to initiating a lift transfer.Review of the Owner's Manual for the F550 Floor Lift, dated as revised [DATE], indicated the Mechanical Lift was equipped with an emergency lowering system which could be used to safely lower the resident in the event of a power failure.Review of the Report submitted by the Facility via the Health Care Facilities Reporting System (HCFRS), dated [DATE], indicated that during a mechanical lift transfer, the mechanical lift malfunctioned, resulting in Resident #1's head striking the bedrail and him/her sustaining a laceration.Review of Resident #1's Emergency Department Hospital Discharge summary, dated [DATE], indicated he/she was diagnosed with a scalp laceration and required five staples to close the wound.Review of Resident #1's Nurse Progress Note, dated [DATE], indicated he/she returned from the Hospital Emergency Department to the Facility and had received five staples to the laceration on his/her head.Resident #1 was admitted to the Facility in [DATE], diagnoses included progressive multiple sclerosis (an autoimmune disease that affects the central nervous system, leading to damage of the myelin sheath that protects nerve fibers, resulting in a range of physical and cognitive symptoms).During a telephone interview on [DATE] at 3:33 P.M., Certified Nurse Aide (CNA) #1 said that on [DATE] at 05:30 P.M. she and CNA #2 were transferring Resident #1 from his/her reclining wheelchair to his/her bed using the mechanical lift device. CNA #1 said once Resident #1 was suspended above the reclining wheelchair, the mechanical lift stopped working.CNA #1 said she then attempted to physically move the lift to position Resident #1 over his/her bed, but she was unable to close the legs of the lift, because the battery was dead. CNA #1 said as she moved the lift with Resident #1 suspended up in the air over the bed, the open legs of the lift prevented good alignment with the bed. CNA #1 said Resident #1 was unable to hold up his/her own head, which was hanging downward in the sling, and as the sling moved, his/her head struck the bedrail on the right side of his/her head during the transfer and he/she began bleeding.CNA #1 said she was not aware that there was an emergency release system on the mechanical lift, and said she would have used it and lowered Resident #1 back into his/her chair safely when the battery died on the lift.During a telephone interview on [DATE] at 10:40 A.M., CNA #2 said that on [DATE] at 5:30 P.M. she was assisting CNA #1 transfer Resident #1 from his/her wheelchair to his/her bed when, in the middle of the transfer, the lift's battery died with Resident #1 suspended up in the air.CNA #2 said she moved the wheelchair out of the way while CNA #1 attempted to move the mechanical lift and Resident #1, who was suspended up in the lift sling by the bed, and during that movement, Resident (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	#1's head struck the bedrail and began to bleed. CNA #2 said she worked at the Facility through a staffing agency, and although she had experience using mechanical lifts, she had not had any training by this Facility on the use of mechanical lifts. CNA #2 said she did not think to look for an emergency release on the lift to safely lower Resident #1 back into his/her wheelchair.During an interview on [DATE] at 3:17 P.M., Nurse #1 said that on [DATE] at 5:30 P.M. he was called to Resident #1's room by CNA #2. Nurse #1 said he immediately went to Resident #1's room and observed that he/she was suspended over his/her bed in the mechanical lift sling and was bleeding from the back of his/her head. Nurse #1 said he applied pressure to the wound while Nurse #2 called 911, and Resident #1 was transferred to the Hospital Emergency Department. Nurse #2 said, prior to Emergency Medical Services (EMS) arriving, CNA #1 and CNA #2 somehow lowered Resident #1 down onto his/her bed but said he was not sure how they did it.During an interview on [DATE] at 09:17 A.M., The Staff Development Coordinator (SDC) said she was unable to provide any documentation to support CNA #1 and CNA #2 were trained on the use of the mechanical lift. On [DATE] at 09:20 A.M. The SDC and the Surveyor observed the Mechanical Lift together on the unit. The SDC said she was not aware that the mechanical lift had an emergency release lever on the piston which lowered the boom (where the sling straps are hooked to and connected to the lift) in the event of a power failure.During an interview on [DATE] at 08:05 A.M., the Director of Nurses (DON) said there should have been documented competencies for all staff for the use of the mechanical lift prior to use of the lift. The DON said she did not know if instructions related to the mechanical lifts emergency release system was part of the education provided to staff for use of the mechanical lift. The DON said staff should have used the emergency release to safely lower Resident #1 back down into his/her wheelchair when the battery died.