| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225781 | A. Building<br>B. Wing | 05/27/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Seven Hills Pediatric Center | 22 Hillside Avenue<br>Groton, MA 01450 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>Based on records reviewed and interviews, for one of three sampled residents (Resident #1) who required the use of a mechanical ceiling lift for all transfers, the Facility failed to ensure that his/her safety was adequately maintained a during a transfer, when on 04/22/26, prior to moving Resident #1 from his/her wheelchair to his/her bed, Certified Nurse Aide (CNA) #1 did not completely secure all the loops (straps) of the lift pad to the overhead mechanical lift, and when she elevated Resident #1 in the lift, one of the straps (loops) became detached and his/her right side started to slip out of the lift pad, CNA #1 lowered him/her to the floor and Resident #1 hit his/her head on the floor.Findings include:Review of the Facility's policy, titled, Falls and Fall Risk, Managing, dated 2001, indicated that a fall is defined as unintentionally coming to rest on the ground, floor, or lower level.Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 04/29/26, indicated that on 04/22/26 at around 4:30 P.M., CNA #1 was transferring Resident #1 from his/her wheelchair to his/her bed with the overhead mechanical lift when Resident #1 started to slip out of the lift pad. The Report indicated that CNA #1 immediately lowered Resident #1 to the floor and called for a nurse. The Report indicated that Resident #1 was observed to be lying on the floor on his/her right side with the lift sling (pad) still underneath him/her. The Report indicated that Resident #1 had a small area of swelling on his/her right eyebrow, and a small amount of bleeding from his/her lip, but no other injuries noted.Review of the Facility's Post Fall Investigation Report, dated 04/29/26, indicated that CNA #1 was in the process of transferring Resident #1 with the overhead mechanical lift, and thought she had fully attached all of the lift pad (sling) loops (straps) to the lift before she began to lift him/her up from the wheelchair. The Report indicated that when CNA #1 moved Resident #1's wheelchair out of the way, she noticed that the top right loop (strap) of the pad had not been completely attached to the mechanical lift and that Resident #1 was slipping out of the lift pad while in the elevated position. The Report indicated that CNA #1 immediately lowered Resident #1 to the floor with the mechanical lift. The Report indicated that Resident #1 did not sustain any injuries except for a small amount of bleeding from his/her lip, and small area of swelling on his/her right eyebrow. The Report indicated that CNA #1 did not ensure that the top loop (strap) of the mechanical lift pad (sling) had been completely attached to the lift, and when she (CNA #1) raised Resident #1 with the lift, he/she began to slip out of the lift pad.Resident #1 was admitted to the Facility in May 1973, diagnoses included cerebral palsy (neurological disorder that affects movement, muscle tone, posture, and balance) and a seizure disorder.Review of Resident #1's Quarterly Minimum Data Set Assessment, dated 04/17/26, indicated he/she was dependent on staff for all care.Review of Resident #1's Physical Therapy (support needed) Care Plan, reviewed and renewed with the Quarterly Minimum Data Set Assessment, dated 04/17/26, indicated that he/she required assist of one staff person for transfers with the overhead (ceiling) mechanical lift.Review of a Nurse Practitioner's Note, dated 04/22/26, indicated that Resident #1 had a fall from the overhead mechanical lift and was noted to have a small amount of lip bleeding and a small bump above his/her right eyebrow.During a telephone interview on 05/27/27at 2:07 P.M., (which included a review of her written witness statement, dated 04/22/26), CNA #1 said that on 04/22/26, while she was transferring Resident #1<br>(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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | from his/her wheelchair to his/her bed, the upper right side loop (strap) of the lift pad became detached from the mechanical lift when she lifted Resident #1 up out of his/her wheelchair, and moved it (wheelchair) out from underneath Resident #1. CNA #1 said she immediately lowered Resident to the floor with the mechanical lift. CNA #1 said she was unable to catch Resident #1 before he/she hit his/her head on the floor. CNA #1 said she thought she had fully secured all loops (straps) to the overhead lift before she lifted him/her up out of the wheelchair, but she must not have since the right upper loop (strap) came undone during the transfer.During a telephone interview on 05/27/26 at 1:28 P.M., Nurse #1 said that on 04/22/26, after CNA #1 called him into Resident #1's room, he saw him/her lying on the floor with the mechanical lift sling pad underneath him/her. Nurse #1 said Resident #1 had a small area of swelling over his/her right eyebrow, and a little blood on his/her lip, but no other injuries.During an interview on 05/27/26 at 2:25 P.M., the Assistant Director of Nurses (ADON) said she had CNA #1 reenact the incident with the overhead mechanical lift and determined that CNA #1 had not fully secured the upper right loop (strap) of the mechanical lift pad to the lift which caused Resident #1 to begin slipping out of the top right corner of the lift pad once CNA #1 lifted him/her from the wheelchair. The ADON said CNA #1 had moved the wheelchair out of the way once she had lifted Resident #1 from it (wheelchair), and that is when Resident #1 began to slip out of the mechanical lift pad causing him/her to hit his/her head on the floor as (CNA #1) lowered him/her to the floor. The ADON said that other than a small area of swelling on Resident #1's right eyebrow area and a little blood on his/her lip, he/she did not sustain any injuries. The ADON said this incident was a result of user error, and that CNA #1 should have double-checked to make sure she had fully attached all mechanical lift pad loops (straps) to the lift, but she had not.During an interview on 05/27/27 at 2:47 P.M., the Director of Nurses (DON) said that after she completed their investigation, she determined that CNA #1 had not fully secured the mechanical lift pad loops (straps) to the lift, which caused the right side loop (strap) of the lift pad to come loose (detached) from the lift once CNA #1 had raised Resident #1 up from the wheelchair. The DON said they revised the Facility's Mechanical Lift Policy to include annual reeducation for all nursing staff.On 04/27/26, the Facility was found to be in Past Noncompliance and presented the Surveyor with a plan of correction, with an effective date of 05/07/26, which addressed the area(s) of concern as evidenced by:A. On 04/22/26, Resident #1 was immediately evaluated, found to have no significant injuries, and remained at the Facility. Resident #1's overhead mechanical lift and lift sling were inspected by the Therapy Department and found to have no issues.B. On 04/22/26, CNA #1 reenacted the transfer incident with Resident #1 for the DON and/or designee, and it was determined that CNA #1 had not fully attached all of the mechanical lift pad loops (straps) to the lift, which caused Resident #1's right upper body to slip out from the pad during the transfer.C. On 04/23/26, the Therapy Department reeducated and completed a mechanical lift competency skills check for CNA #1.D. On 4/23/26, the Therapy Department audited all mechanical lift slings for integrity and correct size.E. On 04/23/26, the DON revised the mechanical lift policy to include yearly reeducation for all nursing staff.F. On 04/23/26 through 04/28/26, the Therapy Department educated all nursing staff on the revised mechanical lift policy.G. On 04/23/26 through 05/01/26, the Therapy Department completed mechanical lift competencies with all nursing staff.H. On 04/23/26, an Ad Hoc Quality Assurance Performance Improvement (QAPI) meeting was held to develop and institute a corrective action plan, and results will be reviewed at monthly QAPI meetings to determine compliance.I. On 05/06/26, the DON and/or designee began observational audits of mechanical lift use by nursing staff which will continue weekly for four weeks, bi-weekly for two weeks, and then monthly for three weeks or until substantial compliance is met.J. The DON and/or Designee are responsible for overall compliance. |