STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305081	A. Building B. Wing	04/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Birch Healthcare Center	62 Rochester Hill Road Rochester, NH 03867

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 - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 47129 Based on interview and record review, it was determined that the facility failed to ensure that staff use equipment properly during transfers, resulting in a fall with a fracture for 1 of 1 residents reviewed for accidents (Resident Identifier #1). Finding include: Review on 4/16/24 of Resident #1's nurse's note dated 3/25/24 revealed that Staff A (Registered Nurse) heard a loud noise in Resident #1's room. Upon entering, Resident #1 was on the floor. The Licensed Nursing Assistants (LNAs) informed Staff A that Resident #1 slid off the Hoyer pad while being lifted. Resident #1 was complaining of back pain. Resident #1 was sent to the hospital for further evaluation. Resident #1 returned to the facility from the hospital and the hospital nurse reported that Resident #1 had a first lumbar (L1) fracture. Review on 4/16/24 of Resident #1's diagnostic imaging reports from the hospital dated 3/25/24 revealed that the indication for the diagnostic imaging was for fall and trauma. Further review of the diagnostic imaging reports revealed that Resident #1 was found to have an acute L1 compression fracture and a tiny avulsive fracture to the dorsal aspect of the right talar neck (right foot). Interview on 4/16/24 at 10:46 a.m. with Staff B (LNA) revealed that on 3/25/24 while Staff B and Staff C (LNA) were Hoyering Resident #1 from the bed to the chair, Staff B noticed the strap was slipping, Resident #1 was tilted and Staff B guided Resident #1 to the floor. Resident #1 landed on [pronoun omitted] right side. Staff B stated that after the incident, it was identified that the top Hoyer pad strap was twisted. Interview further revealed Staff B would use any Hoyer pad found in the resident's room or get one from stock but was not aware residents were assessed for Hoyer pad size. Staff B would use his/her judgement based on what size he/she needed. Interview on 4/16/24 at 11:07 a.m. with Staff D (LNA) revealed that he/she was unaware that there were specific Hoyer pads for specific residents and used what was available. Interview on 4/16/24 at 11:15 a.m. with Staff E (LNA) revealed that he/she visualized what size Hoyer pad to use based on the size of the resident and was not aware residents were assessed for Hoyer pad size. (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
	305081	A. Building B. Wing	04/16/2024

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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	Interview on 4/16/24 at 11:16 a.m. with Staff F (Unit Manager) revealed that if it was determined that a resident required lift assistance an assessment would be done to determine what size Hoyer pad to use based on the resident's weight. Review on 4/16/24 of Resident #1's device/transfer evaluation dated 3/13/24 revealed that Resident #1's transfer/mobility assessment indicated Resident #1 met the criteria for total mechanical lift (for example Hoyer lift) and Resident #1's sling size was an extra large. Review on 4/16/24 of Resident #1's weight records revealed a weight of 153 pounds dated 3/1/24. Review on 4/16/24 of the manufacturer's instructions for the Proactive Medical Products: Full Body Sling revealed .Features and Benefits: Sling size can vary significantly depending on the patients' weight and girth . Patient Sling Guide: It is very important to use the correct sized sling and make sure it is fitted properly prior to lifting .Limited Life Warranty .Useful life of this product is size months from date of purchase under normal use .Size and Weight Range Guide .Small (S): 75-150lbs [pounds] 59[inches]-64, Medium (M): 125-200lbs 63-68, Large (L): 175-300lbs 67-72, Extra Large (XL): 275-500lbs 71-76, Extra Extra Large (XXL): 350-600lbs Determine PRN . Review on 4/16/24 of the manufacturer's instructions for the Lumex: LF 1090 Bariatric Patient Lift revealed: . WARNING: Ensure that lifting sling loops are correctly attached to the hooks to prevent the patient from sliding or falling out of the sling, which could result in personal injury . Review on 4/16/24 of the facility's policy titled Safe Resident Handling/Transfers revised 11/29/23, revealed . 14. Staff will perform mechanical lifts/transfers according to the manufacturer's instructions for use of the device . Interview on 4/17/24 at 8:30 a.m. with Staff G (Director of Nursing) confirmed the above findings. Staff G stated that it was identified that Resident #1 was in the wrong Hoyer sling on the day of the incident.