STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205143	A. BUILDING _____ B. WING _____	C 03/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMMINGS HEALTH CARE FACILITY	**5 CROCKER STREET HOWLAND, ME 04448**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 3/5/24, an unannounced visit was conducted at Cummings Health Care Facility for the purpose of completing the investigation complaint #ME00045703 and facility reported incident #ME00045772. It was determined that Cummings Health Care Facility was in past non-compliance with 483.25(d) -also known as F689 within 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities	F 000	Past noncompliance: no plan of correction required.	
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to provide necessary assistance to prevent accidents by failing to ensure that a two-person mechanical lift assist was provided during transfer for 1 of 1 resident (Resident#1 [R1]) reviewed for an incident with injury. This fall resulted in R1 falling during an improper transfer from bed to shower chair and R1 sustaining a fractured left arm and left ankle. Findings: On 3/5/24, R1's clinical record was reviewed. The record indicated R1 was diagnosed with dementia, weakness, neuropathy, limited mobility,	F 689	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 689	Continued From page 1 and other morbidities. On 12/7/23 at 1:30 p.m., a nurse note indicated: "C.N.A.1 had another staff member tell writer (Registered Nurse [RN]) to come to residents' room immediately. Resident was laying supine on floor by his/her bed, C.N.A.1 stated that one corner of the Hoyer sling came undone and resident fell to the floor hitting his/her left shoulder and leg. Resident complained of severe left leg/shoulder pain." On 12/12/23, the Nurse Practitioner documented in her progress note that R1 fell on 12/7/23 and came back from the Emergency Department (ED) on 12/7/23 with a fractured left humerus(upper arm bone). R1 continued to complain of pain in left leg. On 12/11/23, an x-ray was done and a fractured left ankle was discovered. R1's care plan for December 2023 and current care plan, under the problem of Activity of Daily Living/self performance deficit (initiated 2020) indicated, Resident requires total assist with Hoyer lift by two staff with transfers. A review of the facility Employee Safety policy and procedure, dated 12/7/23, under Employee Instructions: Two staff members must assist at all times during the movement of residents, including using lifting devices and equipment. On 3/5/24 at 10:15 a.m., interview with Registered Nurse (RN). RN stated the following, "I was Charge Nurse that morning. C.N.A.2 came and got me and said R1 had fallen out of the Hoyer lift. I got to the room and R1 was lying on his/her left side across the legs of the Hoyer lift. R1 was in a lot of pain. The Emergency Medical	F 689		

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F 689	Continued From page 2 Technicians (EMT's) arrived but couldn't move him/her due to pain. They waited for a Paramedic to get here, and the Paramedic gave him/her morphine for pain, then transported. C.N.A.1 transferred R1 by herself and she shouldn't have done that. There were other staff here that could have helped her." On 3/5/24 at 10:40 a.m., interview with Certified Nurse Assistant (C.N.A.1). C.N.A.1 stated the following, "I know I shouldn't have transferred her by myself. The other girls were busy and my Charge Nurse said R1 had to have a shower. I could have waited for someone to help me, but my Charge Nurse wanted her to have a shower. I got [redacted] on the Hoyer pad and started to lift R1 up. I was guiding his/her feet over the bed to get to the shower chair and down R1 went." On 3/5/24 at 10:55 a.m., interview with Certified Nurse Assistant (C.N.A.2). C.N.A.2 stated the following, "I have never Hoyered a resident by myself. The policy says two people and that is how I do it. C.N.A.1 called for me to get the nurse the day R1 fell out of the Hoyer. C.N.A.1 transferred R1 by herself." As a result of this isolated incident, the following corrective actions were initiated between 12/7/23 and 12/12/23: On 12/7/23 (day of incident), the Administrator and Maintenance Supervisor removed the Hoyer lift used in the incident from use and assessed for any malfunction with the lift and parts. Non were found. In addition, the Hoyer lift sling used in the incident was removed from service and all other Hoyer slings were assessed for any damage. On 12/7/23 at 2:45 p.m., at shift change the	F 689		

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F 689	Continued From page 3 Administrator demonstrated to the nursing staff the proper way to use the Hoyer lift. On 12/8/23, the Administrator provided nursing staff with the facility Hoyer lift policy and procedure and a test that they were mandated to complete. On this date, the Administrator demonstrated to the nursing staff the proper way to use the Hoyer lift. On 12/12/23, the Administrator provided nursing staff, that had not attended any previous training, with the facility's Hoyer transfer policy and procedure and test. The Administrator demonstrated to the nursing staff the proper way to use the Hoyer lift. On 3/5/24 at 9:50 a.m., in an interview with the DON, she stated that all the C.N.A.'s and nurses reviewed the Hoyer lift transfer policy and took a written test. She stated that after C.N.A.1 was trained, she was observed/audited doing Hoyer transfers and other staff were randomly audited as well.	F 689		