

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/30/2025  
FORM APPROVED  
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>205099</b> |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                               |                                                                                                                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>05/14/2025</b> |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>RUMFORD COMMUNITY HOME</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                            |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>11 JOHN F KENNEDY LANE</b><br><b>RUMFORD, ME 04276</b> |                                                                                                                          |                                                                    |                            |
| (X4) ID<br>PREFIX<br>TAG                                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                            |  | ID<br>PREFIX<br>TAG                                                                                | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |                                                                    | (X5)<br>COMPLETION<br>DATE |
| F 000                                                             | INITIAL COMMENTS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                            |  | F 000                                                                                              |                                                                                                                          |                                                                    |                            |
| F 689<br>SS=G                                                     | <p>On 5/14/25 an unannounced on site visit was conducted at Rumford Community Home to investigate complaint #ME00051519. It was determined that Rumford Community Home was cited at past non-compliance with 42 CFR Part 483, Subpart B - Requirements for Long Term Care Facilities.</p> <p>Free of Accident Hazards/Supervision/Devices<br/>CFR(s): 483.25(d)(1)(2)</p> <p>§483.25(d) Accidents.<br/>The facility must ensure that -<br/>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and</p> <p>§483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents.<br/>This REQUIREMENT is not met as evidenced by:<br/>Based on record review, facility policies, review of a reportable incident form, and interviews the facility failed to ensure that a resident was free from injury when the facility staff failed to properly transfer a resident causing the resident to sustain a laceration on the nose and several lacerations with hematomas to the head for 1 of 13 residents requiring a mechanical lift for transfers. (Resident #1)</p> <p>Findings:<br/><br/>On 5/5/25, The Division of Licensing and Certification received a facility Reportable Incident Form indicating that on 5/4/25 at 1:50 p.m. Resident #1 was being transferred out of bed to a Broda chair using a mechanical lift</p> |                                                                            |  | F 689                                                                                              | <p>Past noncompliance: no plan of correction required.</p>                                                               |                                                                    |                            |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

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| F 689                                                             | <p>Continued From page 1</p> <p>(hoyer). The legs of the hoyer lift were not opened and the hoyer lift fell over sideways while the resident was in the sling. The resident fell to his/her left side onto the floor resulting in a laceration to the back of the head and the bridge of his/her nose.</p> <p>Review of nurses note dated 5/4/25 at 2:42 p.m., stated, This nurse was called to resident's room. Resident was laying on [his/her] left side on the floor and the staff was in the process of standing the hoyer lift back up. Per staff resident was being transferred into [his/her] broda chair. The legs of the hoyer were not open and the hoyer lift tipped over sideways with the resident in it. Resident noted to have a small laceration on the bridge of [his/her] nose. [He/she] also has a 8cm (centimeter) x 7cm welt on the left side of [his/her] head. There is a 0.5cm laceration in the center of the welt. Also noted is a 0.5cm laceration on the back of [his/her] head. Resident alert and answering questions appropriately. Offers no complaint of pain or discomfort. Able to move all extremities. Lacerations cleansed with wound cleanser and left open to air.</p> <p>Review of Physician order dated 5/5/25 stated, "Hematoma to left side of head and posterior head: monitor q (every) shift, notify provider of any new or worsening sx (symptoms)- HA (headache), nausea, vomiting, confusion."</p> <p>Resident #1's care plan initiated on 8/16/23 stated, he/she has ADL self-care performance deficit related to Dementia and requires extensive assists with bathing, grooming, personal hygiene and bed mobility. Interventions include the resident requires total assist via hoyer lift with 2 staff.</p> | F 689                                                                      |                                                                                                                          |  |                                                                    |

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| F 689                                                             | <p>Continued From page 2</p> <p>On 5/14/25 at 12:17 p.m., during an interview, the Certified Nurses Aid (CNA #5) stated she assisted 2 other CNA's and the Licensed Practical Nurse get Resident #1 off the floor using the hooyer lift and into his/her Broda chair. When she entered the room the hooyer lift was on its side and the legs were in the closed position stating, "the first thing I said, oh the legs are closed, you're supposed to have them open".</p> <p>On 5/14/25 at 1:16 p.m., during an interview, the Licensed Practical Nurse (LPN) stated CNA #7, a witness, reported that the hooyer legs were closed during the transfer.</p> <p>On 5/15/25 at 1:21 p.m., during a telephone interview, CNA #7 confirmed she was assisting CNA #3 with the hooyer transfer for Resident #1 with CNA #3 operating the hooyer. CNA #7 stated, "we were going to the chair that we had placed and when she went to try to open the legs, it was like a manual hooyer, you have to pull it, like physically to open the legs. So, basically when she went to go do that, it kind of made the balance off centered and that's when the hooyer fell." The surveyor asked if Resident #1 was lifted out of the bed and transferred over to the broda chair with the hooyer legs in the closed position. CNA #7 stated, "it wasn't until we got to the chair that she was trying to open them."</p> <p>Mechanical lift Policy effective 4/2004, revision date 5/6/2025 states "The base legs of the lift will be locked in the maximum open position. The base legs must be always locked for stability and resident safety when lifting and transferring a resident".</p> | F 689                                                                      |                                                                                                                          |  |                                                                    |

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| F 689                                                             | Continued From page 3<br>On 5/14/25 at 2:45 p.m., the above was<br>confirmed with the Administrator.<br><br>As a result of the facility's investigation, the<br>following corrective actions were initiated:<br>Immediate education on mechanical lift safety to<br>staff involved in the incident<br>Hoyer lifts were inspected and removed from<br>service if needed<br>Resident #1's care plan was reviewed and<br>revised on 5/9/25<br>Nursing staff completed education on mechanical<br>lift safety including videos, in person training and<br>tests<br>New hoyer lifts were ordered<br>Facility conducted an investigation with root<br>cause analysis.<br>Audits in place for hoyer use observations and<br>results will be brought to QAPI. | F 689                                                                      |                                                                                                                          |  |                                                                    |