STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185208	A. Building B. Wing	12/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carmel Manor	100 Carmel Manor Road Fort Thomas, KY 41075

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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interview, record review, review of the facility's investigation, and review of the facility's policies, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 23 sampled residents, Resident (R) 7.The findings include:Review of the facility's policy titled, Accidents and Supervision, no date, revealed it stated, The resident environment will remain as free of accident hazards as is possible. Each resident will receive adequate supervision and assistive devices to prevent accidents.Review of the facility's policy titled, Resident Care-Safe Resident Handling/Transfers, dated 10/01/2024, revealed it stated, It is the policy of this home to ensure that residents are handled and transferred safely to prevent or minimize risk for injury and provide and promote a safe secure and comfortable experience for the resident while keeping the employees safe in accordance with current standards and guidelines. The policy also revealed two staff members must be used to transfer residents with a mechanical lift. Review of R7's Face Sheet revealed the facility admitted the resident on 08/17/2023 with diagnoses of end stage renal disease (ESRD), diabetes, and depression.Review of R7's quarterly Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 07/17/2025, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of 15 out of 15, indicating intact cognition.Review of R7's Care Plan, dated 06/30/2025, revealed R7 had an Activities of Daily Living (ADL) self-care performance deficit related to weakness, with an intervention for transfers requiring a mechanical lift with two staff assistance.Review of R7's Investigation, dated 08/02/2025, revealed the incident with R7 occurred on 08/01/2025 at 7:56 PM. Further review revealed a witness statement, with no date or time listed, by Certified Nurse Aide (CNA) 16 that stated CNA16 was asked to assist with R7. Per the statement, CNA16 reported when he entered R7's room, R7 was up in the Hoyer [a mechanical lift used to transfer residents from one surface to another]. Additional review revealed a witness statement from R7, with no date or time listed. Per the statement, R7 reported she was left in the air in the Hoyer lift, while CNA14 and CNA15 left to get assistance from CNA16.During an interview on 09/18/2025 at 9:02 AM with R7, she stated both aides (CNA14 and CNA15) walked out of her room while she was suspended in the air in the Hoyer lift on 08/01/2025.During an interview on 09/17/2025 at 6:11 PM with CNA16, he stated that 08/01/2025 was a rough day. He stated he was working with two aides that did not normally work in his area, and they refused to do any weights or any showers. He stated he was in the middle of doing his rounds, and the aides came to him and told him that R7 was requesting him. He stated when he entered R7's room, along with CNA15, he saw R7 in the air in the Hoyer lift. He stated he did not recall any staff member being in there with her. He stated he assisted R7 to her chair, and CNA15 continued to argue with R7 before leaving the room. He stated he reported the incident to Director of Nursing (DON) 2 at the time.During an interview on 09/17/2025 at 4:33 PM with CNA14, she stated R7's complaint was false, and she was terminated for the accusations. CNA14 stated, No residents were left in a Hoyer lift on my shifts.During an interview on 09/17/2025 at 6:21 PM with CNA15, she stated when she walked out to ask CNA16 for assistance, she left CNA14 in the room. CNA15 denied walking out of R7's room, leaving R7 alone in the Hoyer lift.During an interview on 09/17/2025 at 2:56 PM with Director of Nursing (DON) 2, she stated the R7 (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Investigation determined CNA14 and CNA15 did leave R7 in the Hoyer lift and walked out of her room. She stated, based on this, they were both terminated, CNA15 on 07/31/2025 and CNA14 on 08/13/2025. She stated two staff members should be with a resident anytime a Hoyer lift was being used for the resident's and staff's safety. During an additional interview on 09/19/2025 at 3:23 PM with DON2, she stated her expectation was for staff to follow the manufacturer's guidelines for equipment, to be checked off on competency skills, and be able to perform tasks appropriately while maintaining the safety of the residents. During an interview on 09/19/2025 at 2:04 PM with the Administrator, she stated she was aware of gaps and deficits with the facility staff. She stated she would expect the facility to identify concerns and improve the process of onboarding to ensure staff had 100 percent competencies. She stated that was important for resident safety.