STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365077	A. Building B. Wing	06/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monterey Care Center	3929 Hoover Road Grove City, OH 43123

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** THIS IS AN INCIDENCE OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on medical record review, review of facility incident report, resident and staff interview, and facility policy review, the facility failed to ensure a resident was safely transferred by a mechanical lift. This resulted in Actual Harm on 05/27/25 when one staff attempted to transfer Resident #103 from the wheelchair to the bed with the mechanical lift and the strap to the lift pad tore and Resident #103 dropped to the floor. Resident #103 was observed by staff to have one missing tooth, and one tooth was broken in half at the time of the incident. Resident #103 was sent to the hospital and returned to the facility with no other injuries noted. The resident has a follow up appointment with the emergency dentist. This affected one resident (#103) of three residents reviewed for mechanical lift transfers. The facility census was 117. Findings Include: Resident #103 was admitted to the facility on [DATE]. His diagnoses included but were not limited to absence of right leg and left leg above knee, multiple sclerosis, disorder of muscle, muscle wasting, morbid obesity, legal blindness, schizoaffective disorder, paraplegia, and weakness. Review of his Minimum Data Set (MDS) assessment, dated 03/04/25, revealed he was cognitively intact and dependent on staff for transfers. Review of Resident #103's care plan, dated 11/19/24, revealed a care area of Resident #103 having an activity of daily living (ADL) deficit. An intervention within this care plan revealed he needed two-person assistance due to having to use a mechanical lift for transfers. Review of Resident #103 Incident Report and Progress Notes, dated 05/27/25, confirmed that Resident #103 was being transferred from his wheelchair to his bed via mechanical lift. It was confirmed that Resident #103 was being transferred by CNA #148 alone; she did not have a second nursing staff with her while performing the transfer. During the transfer, the mechanical lift pad strap broke on one side, causing Resident #103 to fall from the mechanical lift to the floor. Resident #103 was assessed by the nurse for injury and found that he had one tooth missing and another tooth was broke in half. He was sent to the emergency room for further evaluation. In review of the findings, the facility confirmed CNA #148 should have had a second staff person with her while transferring Resident #103, and there should have been a better assessment of the mechanical lift pad prior to using it; which contributed to Resident #103 fall. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview with Resident #103 on 06/04/25 at 9:30 A.M. confirmed he fell from the lift about a week ago. He confirmed there was only one staff member transferring him in the mechanical lift. He stated he wasn't sure why she was doing that, because all staff know he is a two-person transfer. He confirmed he fell to the ground while he was in the air, and knocked one tooth out and broke a second tooth due to the fall. He confirmed he went to the emergency room after the fall to ensure there were no further injuries. Interview with Director of Nursing (DON) on 06/04/25 at 12:10 P.M. confirmed they completed an investigation regarding the fall/accident that occurred with Resident #103 on 05/27/25. She confirmed CNA #148 was transferring Resident #103 via mechanical lift by herself, when she should have had a second staff person with her. She also confirmed there was evidence the mechanical lift pad failed/broke, which contributed to Resident #103 falling to the ground while in the air during the transfer. She confirmed they immediately started the quality assurance process to ensure an incident like this did not occur again. Interview with CNA #148 on 06/04/25 at 1:40 P.M. via telephone confirmed she transferred Resident #103 by herself. She confirmed she should not have done that. She confirmed the front part of the mechanical lift pad failed as well, which contributed to Resident #103 falling to the ground. She was unsure if the pad hooks broke or if they came off the lift itself, but after Resident #148 fell, she noticed that one side of the lift pad was no longer attached to the mechanical lift. Review of facility Hoyer Lift/Mechanical Lift policy, dated 05/13/24, revealed it is the responsibility of the RN, LPN, and/or STNA to follow manufacturer's guidelines. Please utilize two staff members. To transfer a patient/resident back to bed, you should attach the hooks to the sling. Be sure the hooks are placed so that they are facing away from the patient/resident. Bring the lift into position over the resident. Be sure the lift is in the low position and the legs of the lift are spread appropriately to balance the lift. Attach the hooks to the sling. Be sure the hooks are placed so that they are facing away from the patient/resident. Instruct the resident to fold both arms over his or her chest if possible. Using the crank/power button, raise the resident from the chair. Assist the resident in guiding his/her legs. Move the lifter away from the chair. Be sure the resident is turned in such a manner that the resident is facing you. Do not pull the resident backwards. Position lift over the bed. Lower the resident into the center of the bed. Remove the hooks from the lift. Remove the hooks from the sling. Remove the sling from under the resident. Remove the lift. Position the resident in a comfortable position that promotes good body alignment. Place the call light within easy reach of the resident. The deficient practice was corrected on 06/03/25 when the facility implemented the following corrective actions: • On 05/28/25, Director of Nursing (DON) or designee assessed all residents who use a mechanical lift for injuries. • On 05/28/25, DON or designee audited all mechanical lift pads for safety and functionality. Those that were deemed unsafe were discarded and new pads were issued. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	• On 05/28/25, DON or designee audited the mechanical lift assessments and care plans reviewed; of all residents who utilize a mechanical lift and updates were made as necessary. • From 05/27/25 to 05/29/25, DON or designee educated all nursing staff except for five as needed nursing staff who have not worked since the incident. The education included operating a mechanical lift in a safe/proper manner and assessing/removing mechanical lift pads if they are deemed unsafe. None of the five nursing staff who have not received education will work in the facility until the education has occurred. The following nursing staff were interviewed on 06/04/25 and confirmed they received education and were aware of the proper procedures to follow regarding mechanical lifts: Unit Manager #155, CNA #148, CNA #103, and CNA #225. Observation completed on 06/04/25 with CNAs #103 and #225 performing a resident transfer via mechanical lift safely and appropriately. • On 05/28/25, all laundry staff were re-educated by Housekeeping and Laundry Manager #110 about inspecting/ assessing/removing mechanical lift pads if they are deemed unsafe. The following laundry staff were interviewed on 06/04/25 and confirmed they received education and were aware of the proper procedures to follow regarding mechanical lift pads: Laundry Staff #250. • On 05/29/25, Certified Nursing Aide (CNA) #148 was provided education by DON about using a mechanical lift with two staff and assessing the mechanical lift pads to ensure they are safe. She also received a final written warning as discipline by DON and Administrator. • On 05/30/25, DON ensured all nursing staff except for five as needed nursing staff who have not worked since the incident, received and passed competency training regarding the proper assessment of mechanical lift pads and properly transferring a resident within the mechanical lift. None of the five nursing staff who have not received education will work in the facility until the education has occurred. • Starting 05/29/25, nursing managers/designees will assess mechanical lift pads at least three times weekly for four weeks, and then on a monthly basis there after. Audits were completed on the following dates: 05/29/25, 05/30/25, 05/31/25, 06/01/25, 06/02/25, 06/03/25, and 06/04/25 with no negative findings. • (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Starting 06/03/25, all laundry staff will complete a daily assessment/review of mechanical lift pads taken to the laundry room, to review their condition and remove if they are deemed to be unsafe. This will continue indefinitely. Audits were completed on the following dates: 06/03/25 and 06/04/25 with no negative findings. This deficiency represents non-compliance investigated under complaint number OH00166132.