Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 09/27/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365600	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lost Creek Rehabilitation and Nursing Center	804 South Mumaugh Road Lima, OH 45804

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 35035

Based on observation, medical record review, resident and staff interviews, review of hospital documentation, revealed of fall investigations, review of manufacturer's guidelines, and review of a facility policy, the facility failed to ensure residents dependent for transfers and activities of daily living were kept free from falls. This resulted in actual harm when Resident #10 sustained a fall during a mechanical lift transfer on 06/12/24 which was being completed by one staff member and Resident #2 sustained a fall on 06/07/24 when the resident was left unattended in bed after it was elevated to perform incontinence care. Consequently, Resident #10 suffered a fractured left femur requiring surgery and Resident #2 suffered fractures to both femurs. This affected two (#2 and #10) of three residents reviewed for falls. The census was 41.

Findings include:

1. Review of Resident #10's medical record revealed the resident was admitted to the facility on [DATE]. Diagnoses included wedge compression of vertebrae, obesity, chronic obstructive pulmonary disease, and embolisms.

Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #10 had mildly impaired cognition and was an extensive assist with transfers.

Review of Resident #10's care plans revealed a focus for falls. Interventions dated 11/03/23 included to anticipate needs, keep the call light within reach, educate the resident on safety, follow fall protocols, therapy evaluation, review information post fall and attempt to determine cause of falls, record root cause of falls, and alter or remove potential causes if possible. A revised intervention dated 06/06/24 included the use of a walker for ambulation and transfers.

Further review of Resident #10's care plans revealed there were no revised interventions added to the care plans regarding lifts used for transfers post fall on 06/12/24.

Review of Resident #10's physical therapy notes dated 04/15/24 revealed the therapist documented the resident required a maximum heavy assist with two staff for a stand lift bed-chair with the wheelchair for proper technique and safety. There were no other assessments for lifts or equipment noted in the medical record.

(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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #10's physician orders dated June 2024 revealed no physician ordered interventions for prevention of falls were noted in the records. Review of Resident #10's progress notes dated 06/13/24 at 10:58 A.M., late entry, revealed the resident had a fall witnessed by a nurse aide. Per the note, the resident fell to her knees onto the floor while being assisted with a sit-to-stand lift. Resident #10 was lowered to the floor and complained of pain to the left knee and left hip. Resident #10 was assessed by the nurse and emergency medical services (EMS) were called with the resident being sent to the hospital on 06/12/24 at 9:00 P.M. Review of Resident #10's fall investigation revealed on 06/12/24 at 8:30 P.M., the nurse aide was transferring Resident #10 back to bed using a sit-to-stand mechanical lift. Per the investigation, the nurse aide was in the room with the resident and her family member. The nurse aide documented the resident slid out of the stand lift and fell to floor. Per the nurse aide's written interview, the nurse aide had taken the resident to the shower room, bathed her, and was transferring the resident back into bed from a wheelchair using the sit-to-stand lift. The nurse aide attempted to stop Resident #10 from falling, but was unable to, and lowered her to the ground. The nurse aide called for help and two nurses responded. Per the nurse aide's written interview, EMS was called, and the resident was transported to the hospital. Review of Resident #10's hospital paperwork dated 06/12/24 revealed the resident was admitted to the emergency room (ER) on 06/12/24 at 9:04 A.M. when the first set of vital signs were recorded in the documentation. Per the documentation, Resident #10 sustained a left distal femur fracture which required surgery to repair the fracture and the resident was returned to the facility on [DATE]. Interview on 06/25/24 at 2:00 P.M. with Resident #10 revealed there was one nurse aide with her in the bathroom on 06/12/24, the day of her fall. Resident #10 stated she was brought back to her room and the nurse aide was using the sit-to-stand lift to get her back into bed from the wheelchair. Resident #10 stated she was weak, her foot slipped on the floor during the transfer, and the nurse aide could not keep her from falling to her knees on the floor. Resident #10 stated she could not recall who the nurse aide was, but stated there was only one nurse aide assisting her with her bathing and transfer. Resident #10 stated she suffered a broken bone in her leg and had surgery to repair it. Interview on 06/25/24 at 7:55 P.M. with Licensed Practical Nurse (LPN) #200 revealed the nurse was present in the building at the time Resident #10 fell on [DATE]. Per LPN #200, she heard the nurse aide calling for help to Resident #10's room and stated she and another nurse responded quickly to the room. LPN #200 stated the resident was lying on the floor and the nurse aide was holding her to prevent her from falling further and hurting herself more. Per LPN #200, the nurses began to assess Resident #10 for injuries and the resident stated her leg hurt. LPN #200 stated a staff member called EMS and the resident was transferred to the hospital within one hour of the fall. LPN #200 verified there was to be two staff members performing the transfers with lifts and at the time of Resident #10's fall there was only one nurse aide in the room providing care and using the lift. Interview on 06/26/24 at 2:30 P.M. with Assistant Director of Nursing (ADON) #275 and Regional Nurse #595 verified the facility fall policy revealed all lifts are to be used by two staff members. Regional Nurse #595 stated the nurse aide who witnessed Resident #10's fall was following the manufacturer's guidelines and not the facility's policy. During a follow-up interview on 06/27/24 at 9:20 A.M. with Regional Nurse #595 and ADON #275 verified there was no full clinical assessment of Resident #10's condition and suitability to use the sit-to-stand lift per manufacturer's guidelines. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the facility policy titled, Lifting Machine Using a Mechanical, dated 07/2017, revealed per the policy at least two nursing assistants are needed for all transfers using a lift. Review of the manufacturer's guideline dated 11/2014, for the mechanical sit-to-stand lift used during Resident #10's fall on 06/12/24, revealed per the guidelines, prior to using the lift each resident must have a full clinical assessment and his/her condition and suitability must be completed by a qualified person. 2. Review of Resident #2's medical record revealed the resident was admitted to the facility on [DATE]. Diagnoses included chronic respiratory failure with hypoxia, dysphagia, impulse disorder, intellectual disabilities, and cognitive communication deficit. Review of the comprehensive MDS assessment dated [DATE] revealed Resident #2 had impaired cognition and was dependent for assistance with activities of daily living (ADLs). Review of Resident #2's care plans dated 10/31/19 revealed Resident #2 was at risk for falls. Interventions include to keep the call light within reach, keep personal items within reach, perimeter mattress to the bed, and maintain the bed in a low position. An intervention was added to the revised care plan on 06/08/24 for staff to take the bedside table out of the room with books and hat and return after care had been provided. Review of Resident #2's fall investigation dated 06/07/24 revealed one nurse aide was providing care for Resident #2 and raised the bed to waist level. Per the investigation, the nurse aide turned to leave the room and was in the doorway to retrieve the lift in the hallway, when the resident reached out of his bed for items on his bedside table and fell out of the bed landing on his face down on the floor. Per the investigation, the resident sustained femur fractures to bilateral legs. Observation on 06/25/24 to 06/27/24 at random times throughout the survey revealed Resident #2 was wearing bilateral leg braces. Interview on 06/25/24 at 5:00 P.M. with Resident #2 revealed the resident did not recall specific details regarding the fall. Resident #2 stated he fell out of bed and hurt his legs but could not give details on the incident. Resident #2 stated his legs were uncomfortable and hurt sometimes. Resident #2 denied pain at the time of the interview. Interview on 06/25/24 at 6:50 P.M. with LPN #200 revealed, per the nursing report, there was one nurse aide in Resident #2's room providing care when the resident rolled out of the bed and sustained the fractures to his legs. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview on 06/26/24 at 4:00 P.M. with Regional Nurse #595 and ADON #275 verified State tested Nurse Aide (STNA) #350 raised Resident #2's bed to provide incontinence care to the resident and did not lower the bed prior to leaving the room. ADON #275 stated STNA #350 was close to the bed when she turned to go out to the hallway to ask for another staff to help her with the lift. ADON #275 stated, per the fall investigation, the lift was in the hallway at the time of the incident and verified the resident did reach out of the bed to his bedside table, which was out of reach, fell out of the waist high raised bed, and sustained the bilateral femur fractures. ADON #275 verified Resident #2's care plans and the interventions were not followed by STNA #350 at the time of the fall. This deficiency represents non-compliance investigated under Master Complaint Number OH00155120, Complaint Number OH00155118, Complaint Number OH00154905, and Complaint Number OH00154469.