

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365625	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/08/2025
NAME OF PROVIDER OR SUPPLIER  Altercare of Bucyrus Center Fo		STREET ADDRESS, CITY, STATE, ZIP CODE  1929 Whetstone Street Bucyrus, OH 44820	

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)
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48568</b></p> <p>THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY.</p> <p>Based on medical record review, staff interview, review of the fall investigation and witness statements, review of the hospital records, review of facility lift inspections, review of the manufacturer recommendations for use, and review of facility policy, the facility failed to ensure a resident was safely transferred by a mechanical lift that was not inspected per manufactures instructions or identified as defective by facility staff. This resulted in Actual Harm on 01/31/25 when Resident #70 was transferred from the bed to her recliner with the mechanical (Hoyer) lift when the lifts shoulder bolt fell out and Resident #70 dropped to the floor landing on top of the lift legs, from approximately four feet in the air. Resident #70 complained of pain in the right leg and right knee. Subsequently, Resident #70 was sent to the local hospital where she was diagnosed with a tibia fracture. This affected one (#70) of three residents reviewed for accident hazards. The facility census was 66.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #70 revealed an admitted [DATE]. Diagnoses included cerebral palsy, heart failure, hypercapnia, hypoxemia, esophageal stenosis, contracture of muscle in right lower leg, and on 01/31/25 she was diagnosed with a displaced bicondylar fracture of the right tibia.</p> <p>Review of the care plan dated 02/17/22 revealed Resident #70 was at risk for falls and injuries with interventions to utilize a stand-up lift for transfers.</p> <p>Review of the Annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #70 was cognitively intact and was dependent upon staff for activities of daily living. Resident #70 was also dependent on staff for transfers from bed to chair, tub/shower, and rolling left and right.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the progress note dated 01/31/25 at 2:35 P.M., revealed Resident #70 was being lifted by the mechanical (Hoyer) lift when the part that the sling attached to snapped off. Resident #70 fell to the floor on top of the mechanical lift legs. A red area was observed across Resident #70's lower abdomen. Resident #70 complained about her right leg hurting and stated that it hurt a little before the incident. Resident #70 was assisted by five people and placed back into bed. The intervention in place was for a Hoyer lift audit per the Director of Nursing (DON).</p> <p>Review of the fall investigation revealed on 01/31/25 at 2:35 P.M. Resident #70 fell while staff were transferring her via Hoyer lift from her bed to recliner. Two staff members were present, but during the transfer, the hang bar fell off of the Hoyer lift and the resident fell to the floor. An assessment showed a light red area across her lower abdomen and the resident was alert after the fall. Resident #70 was medicated for pain, an X-ray was ordered, and Resident #70 was subsequently sent to the emergency room . The resident's health care provider and resident representative were notified. The immediate safety measure taken was a post fall assessment that revealed the need to audit the Hoyer lifts. Hoyer lift audits were to be added to Resident #70's care plan.</p> <p>Review of the fall investigation timeline revealed on 01/31/25 at 2:35 P.M. two staff members were maneuvering the mechanical (Hoyer) lift, and the hanger bar became detached from the boom which resulted in Resident #70 landing on the floor in front of the recliner. Certified Nursing Assistant (CNA) #44 notified the charge nurse and Medical Director (MD) #222 immediately. The charge nurse and MD #222 responded to Resident #70's room and completed an assessment of the resident. A red area was noted to the resident's abdomen and Resident #70 stated her right knee was hurting a little prior to the incident. MD #222 did not identify any injuries at the time. Resident #70 was assisted into bed by MD #222 and five other staff members with the sling that was still under the resident. The DON removed the Hoyer lift from service. Staff provided care to Resident #70 and Resident #70 requested to be placed in her recliner. She was transferred to the reclining chair via a different and operational Hoyer lift with the assistance of two staff members. On 01/31/25 at 3:16 P.M., Resident #70 was medicated with Tylenol for a complaint of right knee pain. On 01/31/25 at approximately 4:00 P.M. to 4:15 P.M., the DON checked on Resident #70 and asked if she was hurting. Resident #70 patted her right knee and stated it was sore, along with her left side. The DON assessed the resident's left side with no abnormal findings. The DON assessed the resident's right knee, and no bruising, deformities, or swelling was identified. Resident #70 was able to lift her right leg off the chair at that time. On 01/31/25 at 4:30 P.M., the DON verified that all other mechanical lifts were in proper working order. On 01/31/25 at 4:50 P.M., Resident #70 complained of increased right knee pain. Orders were received for X-rays of the right knee, right rib, and thoracic lumbar. The mobile X-ray company was notified of the new X-ray orders. On 01/31/25 at 5:57 P.M. a new order was received to discontinue Tylenol 350 milligrams (mg) daily and initiate Tylenol 1,000 mg three times a day and Oxycodone 5 mg every four hours as needed. On 01/31/25 at 9:17 P.M. Resident #70 was given Tylenol 1,000 mg. On 01/31/25 at 9:18 P.M. Resident #70 was given Oxycodone 5 mg for right knee pain. On 01/31/25 at 10:30 P.M. Resident #70 was sent to the ER due to an increase in knee pain and medications were not effective. On 02/01/25 at 7:09 P.M., Resident #70 returned to the facility.</p> <p>Review of the witness statement of CNA #14 dated 01/31/25 revealed she and CNA #44 were using the weighted Hoyer lift to place Resident #70 back in her recliner. The lift was raised safely enough to clear the bed. The bolt holding the weight box and metal loops snapped off and Resident #70 fell to the floor but did not hit her head. Resident #70 revealed only her left leg/knee was hurting. When Resident #70 fell , CNA #14 was getting into position to pull her back into her recliner. CNA #44 was positioning the lift to approach the recliner, and the Hoyer was in front of the recliner.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the witness statement of CNA #44 dated 01/31/25 revealed CNA #44 and another aide [CNA #14] were using the Hoyer to transfer Resident #70 to her chair. In the process, CNA #44 heard a loud noise and Resident #70 fell to the floor and landed on the legs of the Hoyer.</p> <p>Review of the witness statement of Resident #70 transcribed by the DON dated 01/31/25 revealed the lift broke apart and she fell . Resident #70 stated she had soreness to her left side and right leg.</p> <p>Review of the progress note dated 01/31/25 at 4:50 P.M., revealed Resident #70 complained of pain in the right knee becoming more intense. A new order was received for an X-ray of the right knee, right rib, and thoracic lumbar area.</p> <p>Review of the progress note dated 01/31/25 at 5:57 P.M., revealed Resident #70 received a new order for Tylenol 1,000 mg three times a day and Oxycodone 5 mg every four hours as needed. The resident and her emergency contact were notified.</p> <p>Review of the progress note dated 01/31/25 at 11:00 P.M., revealed Resident #70 was sent to the hospital at approximately 10:30 P.M. Resident #70 complained of severe pain to her right knee related to her fall that occurred earlier. An X-ray was ordered, but Resident #70 stated she could not wait any longer for the X-ray. The nurse administered Tylenol and the as-needed Oxycodone 5 mg. The medications were not effective for Resident #70. The resident's physician, power of attorney (POA) and DON were notified.</p> <p>Review of the progress note dated 02/01/25 at 9:34 A.M. revealed the emergency room (ER) called to update the facility on Resident #70's status. Resident #70 was noted in the ER with a fractured tibia. Resident #70 was to see orthopedic services.</p> <p>Review of the hospital notes dated 02/01/25 revealed Resident #70 had a right medial tibial plateau fracture. The notes further revealed the resident received an orthopedic consult on 02/01/25 and they recommended nonoperative treatment due to her non-ambulatory status.</p> <p>Review of the progress note dated 02/01/25 at 7:09 P.M. revealed Resident #70 returned to the facility from the hospital. Resident #70 was to be non-weight bearing and was to wear a brace to the right leg for six weeks.</p> <p>Review of the care plan updated 02/03/25 revealed Resident #70 was at risk for falls and injuries with a new intervention for Hoyer lift audits.</p> <p>Interview on 03/18/25 at 3:15 P.M. with CNA #14 revealed Resident #70 needed to use her bed pan and like normal, she was safely lifted with the Hoyer into her bed, and it was also the Hoyer that weights were taken with. She then was going to be lifted back to her recliner. Resident #70 was pulled up by the lift and the button was pressed to open up the lift's legs. CNA #14 stated the bolt that holds up the straps that they hooked everything to, snapped. She revealed the lift unit had been working all day and first shift did not have issues with the lift.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Telephone interview on 03/18/25 at 4:05 P.M. with CNA #44 revealed she did not think the facility kept lift equipment maintained, and she did not see a maintenance man that often. CNA #44 revealed the day the fall occurred, Resident #70 was being transferred to her chair. As CNA #44 was opening the legs to the hoyer she heard a snap and saw Resident #70 fall to the floor. After this occurred, a bunch of people came and transferred her to her bed.</p> <p>Telephone interview on 03/20/25 at 12:51 P.M. with Licensed Practical Nurse (LPN) #199 revealed she was called into Resident #70's room after the fall. Resident #70 was on the floor on top of the Hoyer lift legs and the part that everything hooked up to, broke off of the machine. LPN #199 assessed Resident #70 and asked if she was in pain and Resident #70 said no. LPN #199 immediately went and got MD #222. LPN #199 asked MD #222 to assess Resident #70 before she touched her. MD #222 assessed Resident #70 and stated they could get her up. LPN #199 wanted to send Resident #70 out, but MD #222 said they could get her up. LPN #199 did not know how far the fall from the Hoyer lift was and she would have been more comfortable sending Resident #70 out.</p> <p>Interview on 03/19/25 at 11:28 A.M. with the DON revealed that maintenance looked at the lift units monthly. Since the incident happened, the lifts had been evaluated weekly. She stated floor staff only looked at basics of the lift, like if anything was loose or not working properly. The DON revealed the U-shaped piece with a bolt in it, failed and the shoulder bolt and mounting bracket were bent out. She stated the hanger bar with the weight box fell off too. The DON reiterated that the shoulder bolt and mounting bracket was what failed and the hanger bar was still fine.</p> <p>Interview on 03/19/25 at 5:13 P.M. with the DON revealed a medical company came in every six months and evaluated the mechanical lifts. The DON also revealed maintenance was looking at them weekly for the next four weeks and then they would go back to monthly. The DON revealed she was leading an all staff meeting when the Hoyer fall incident occurred with Resident #70. The DON revealed staff were transferring the resident with the Hoyer lift and as they were opening the legs, the shoulder bolt fell out and Resident #70 fell to the floor in her sling along with the hanger bar, as the hanger bar fell on top of her. An aide came out and got a nurse and MD #222 to assess the resident, and the lift was taken out of commission immediately. The DON revealed she went and checked all the other lifts for loose bolts, bent metal or anything not working properly and there were no issues with the other lifts. The DON revealed staff received training on lifts as part of their orientation and lifts were discussed at almost every staff meeting. She stated for example, the 04/04/24 agenda was related to proper use of mechanical lifts and Hoyer pads, the 05/23/24 agenda was related to proper lift use, the 09/05/24 agenda was related to how Resident Council talked about the use of Hoyer lifts and the guidelines were discussed as well as Hoyer pad issues, the 11/25/24 agenda was related to using a mechanical lift properly, the 12/03/24 agenda was related to proper mechanical lift procedure, and the 01/31/25 agenda was related to a discussion on proper use of a Hoyer lift.</p> <p>Interview on 03/20/25 at 11:06 A.M. with the Administrator revealed monthly inspections on lifts were completed by maintenance coordinators.</p> <p>Observation 03/19/25 at 11:46 A.M. of the Invacare Reliant 600 Hoyer lift that failed, with the Administrator and DON present, revealed the shoulder bolt itself was not cracked or broken, but the mounting bracket was observed severely bent.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the manufacturer's Invacare Reliant 600 RPL600-2 user manual revealed regular maintenance of patient lifts and accessories were necessary to assure proper operation. Review of the maintenance safety inspection checklist in the user manual revealed the institution was to conduct monthly inspections/adjustments to the hardware, hanger bar supports, bolted joints, pivot joints, and hardware on the mast, boom, and base as well as checking for bends or deflections. Further review of the manual revealed casters and axle bolts, the hanger and eye of the boom, pivot points and fasteners, lubrication, hanger bar hooks and mounting brackets, and the mast pivot bolt required inspections every six months. The user manual also stated that all parts of the patient lift were made of the best grades of steel, but metal to metal contact would wear after considerable use.</p> <p>Review of the resident lift work history report from January 2024 to March 2025 revealed resident mobile lifts were inspected every month, except for January 2025. The inspection prior to the incident was dated 12/31/24 and it revealed that the mobile lifts were inspected. The documentation did not mention if there were issues or if the lift passed or failed the inspection, just that they were inspected.</p> <p>Review of the contracted medical equipment company lift evaluation on 02/13/25 revealed two lifts passed the evaluations and four lifts failed the calibration and safety tests. The lifts that failed were taken out of commission. The contract company also performed the same evaluation on 05/29/24 where four lifts passed the safety and calibration tests and on 11/13/24 where five lifts passed the evaluation.</p> <p>Review of the Administrator email correspondence sent to the DON, Maintenance Coordinator #80, [NAME] President of Nursing Operations #225, Regional Plant Maintenance Director #226, and Regional Nurse Consultant #227, after a conversation with their contracted lift company, dated 02/26/25 at 3:37 P.M. revealed, Here is what I received from Medical Equipment. While here, he stated it is common for the screws to come loose. The lift is poorly designed, and the screws need tightened all the time. It only takes 5 threads for the screw to come loose. Based on his observation, the screw came loose, and the pressure from the scale, and resident being moved in the Hoyer, the screw gave way, and the bolt fell out causing the resident to fall.</p> <p>Review of the Hoyer Lift policy dated 2024 revealed it was the facility's policy to utilize a Hoyer lift when transferring a resident in accordance with professional standards of nursing practice.</p> <p>As a result of the incident, the facility took the following actions to correct the deficient practice as of 03/14/25:</p> <p>On 01/31/25, the DON placed the broken lift out of commission.</p> <p>On 01/31/25, the DON checked all of the other facility lifts for loose bolts, bent metal or anything not working properly. No issues were noted.</p> <p>On 01/31/25, the DON educated all staff during the all staff meeting on Hoyer lifts and proper use. The education discussed the amount of staff it takes to operate a lift, that the emergency power button is for emergencies, and the new process to wash and clean the slings as well as assessing the lifts for damage prior to use.</p> <p>On 02/04/25, a new maintenance man [Maintenance Coordinator #80] was hired.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 02/05/25 the facility rented two lifts.</p> <p>On 02/06/25, 02/09/25, and 02/10/25, the DON provided all direct care staff education on identifying possible safety hazards with mechanical lifts specifically regarding breaks, casters, the boom, sling clips, bolts, and [NAME] pins. The education also included for staff to look for any potential hazards in the sling such as frayed edges and ripping in the material and being aware of how to respond if any hazard was identified.</p> <p>On 02/10/25, the Administrator provided education to all leadership regarding how the mechanical lifts would be audited weekly for four weeks and as needed to check for hazards and ensure they were in working order. Once the weekly audits were completed, mechanical lifts would be checked monthly and as needed. Processes were reviewed for auditing lifts, the use of checklists, hazards to look for, and what to do when/if hazards were found.</p> <p>On 02/10/25, the DON provided education to Maintenance Coordinator #80 regarding how the lift audits would be completed weekly for four weeks, then monthly and as needed.</p> <p>On 02/13/25, an outside contracted medical equipment company audited the facility's lifts. Five lifts failed the evaluation. The lifts were taken out of commission and removed from use. One of the five lifts was a sit-to-stand machine which the facility stated they did not use.</p> <p>On 02/13/25, Regional Plant Maintenance Director #226 was educated regarding the requirement for monthly lift inspections.</p> <p>On 02/26/25, the Quality Assurance Performance Improvement (QAPI) Committee met and discussed safety and monitoring for all lifts and lifts being audited weekly for safety for four weeks and then monthly. The committee also discussed that a new lift was purchased and delivered on this day.</p> <p>On 02/11/25 and 02/28/25, the facility purchased two new lifts. The lifts were received on 02/26/25 and 03/05/25.</p> <p>On 03/07/25, the Maintenance Director or designee completed the weekly audits of all mechanical lifts for four weeks and as needed to ensure that all mechanical lifts were in proper working order on 02/13/25, 02/20/25, 02/28/25, and 03/07/25.</p> <p>On 03/14/25, the DON, or designee(s), completed interview audits with staff on identifying possible safety hazards with a mechanical lift on all shifts three times a week on alternating shifts for four weeks then as needed on 02/17/25, 02/19/25, 02/21/25, 02/24/25, 02/26/25, 02/28/25, 03/03/25, 03/05/25, 03/07/25, 03/10/25, 03/12/25, and 03/14/25.</p> <p>This deficiency represents non-compliance investigated under Master Complaint Number OH00162693 and Complaint Number OH00162620.</p>		