

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365947	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/21/2025
NAME OF PROVIDER OR SUPPLIER  Ohman Family Living at Holly		STREET ADDRESS, CITY, STATE, ZIP CODE  10190 Fairmount Rd Newbury, OH 44065	

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**</b> 38523</p> <p>Based on closed medical record review, staff interview, policy review, and review of manufacturer's guidelines, the facility failed to ensure Resident #100 was transferred in a safe manner to prevent an injury during a mechanical (Hoyer) lift transfer.</p> <p>Actual Harm occurred on 01/31/25 at approximately 6:49 P.M. when Resident #100, who was dependent on staff for transfers, was injured during a Hoyer lift transfer when staff did not ensure Resident #100 cleared the air mattress's bolsters on the edge of the bed. As a result, the Hoyer lift tipped and struck Resident #100 on the top of the head. Resident #100 was transported to the hospital and diagnosed with a concussion and laceration to the head which required six staples to close the lacerated wound. This affected one resident (#100) of three residents reviewed for safe transfers. The facility identified two additional residents who required the use of a Hoyer lift for transfers on the 500-hallway. The facility census was 90.</p> <p>Findings include:</p> <p>Review of the closed medical record for Resident #100 revealed a re-admitted [DATE] with medical diagnoses including Parkinson's disease with dyskinesia, generalized muscle weakness, and chronic systolic heart failure. Resident #100 discharged from the facility on 02/09/25.</p> <p>Review of Resident #100's care plan revised on 01/27/25 revealed the resident had an activities of daily living (ADL) self-care performance deficit related to Parkinson's weakness, limited mobility, and increased tremors. Listed interventions included transferring the resident using two staff participation using a Hoyer (mechanical) lift and a pressure relief mattress to bed to help reduce pressure on fragile skin. An additional care plan focus revealed Resident #100 was at risk for pressure ulcer development related to limited mobility and incontinence. A listed intervention included applying an air mattress to the resident's bed.</p> <p>Review of Resident #100's Minimum Data Set (MDS) admission assessment dated [DATE] revealed the resident was cognitively intact. The assessment revealed Resident #100 was dependent on staff for transfers and required the use of a manual wheelchair.</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 a progress note dated 01/31/25 at 6:49 P.M. revealed the nurse was notified by two Certified Nursing Assistants (CNAs) that as they were lifting Resident #100 with the Hoyer lift into his bed, the Hoyer lift tipped over, and the top-heavy part struck Resident #100 in the middle of his head, near his hairline and forehead. A large hematoma and bleeding were noted around the area. The physician was notified and gave an order to send Resident #100 out to a local emergency room (ED) for evaluation. A subsequent note timed 7:12 P.M. revealed Resident #100's family was notified of the injury and transfer to the local ED.</p> <p>Review of a skin incident report dated 01/31/25 and timed 7:00 P.M. revealed Resident #100 obtained an injury during a Hoyer lift transfer. The report was prepared by Registered Nurse (RN) #224. RN #224 was notified by two (unnamed) CNAs that during a hoyer lift transfer, once Resident #100 was lowered into the bed, the Hoyer lift tipped over and struck Resident #100's head near his hairline. Resident #100 was bleeding and had a hematoma surrounding the area. Resident #100 was assessed to be at baseline mentation and alertness. The report listed Resident #100 as stating I got hit with the Hoyer lift as he was being transferred. Notifications were completed to the physician and Resident #100's family, and the resident was transferred to a local emergency department (ED) for treatment.</p> <p>Review of an ED After Visit Summary (AVS) dated 01/31/25 revealed Resident #100 was seen in the ED after sustaining a head injury to his scalp. The note listed the resident had received six staples in his head to close the laceration. Listed diagnoses for the ED visit were listed as a head injury and concussion. Resident #100 received a dose of Tylenol (an over-the-counter analgesic) and a tetanus vaccination. Resident #100 returned to the facility in the early morning hours of 02/01/25.</p> <p>Interview on 04/11/25 at 11:00 A.M. with the Director of Nursing (DON) revealed that the resident had previously been treated for moisture-associated skin damage (MASD) during a prior admission, so upon his re-admission on 01/29/25, an air mattress was placed on the resident's bed as a preventative measure. The DON stated after being made aware of Resident #100's Hoyer lift injury, she believed the air mattress contributed to the incident.</p> <p>Interview on 04/11/25 at 4:22 P.M. with CNA #158 revealed her and Agency CNA #227 transferred Resident #100 on 01/31/25 when he sustained an injury from the Hoyer lift. CNA #158 reported the transfer went well until the lift got to the resident's bed. CNA #158 stated the mattress was too tall for the Hoyer lift to clear. The legs of the hoyer lift were open, CNA #158 stated she had control of the Hoyer lift, and Agency CNA #227 was guiding the resident. CNA #158 stated the legs of the Hoyer lift were open, Resident #100 was a taller and bigger man, and was unsure why or how the Hoyer lift tipped. CNA #158 stated she and Agency CNA #227 stopped the Hoyer lift from tipping completely.</p> <p>Interview on 04/11/25 at 4:35 P.M. with RN #224 revealed she was on duty the night Resident #100 was injured during a Hoyer lift transfer. RN #224 reported she did not witness the transfer but was called to the room by an unspecified aide after the transfer and an injury occurred. RN #224 immediately responded to the resident's room and noticed an abrasion to the resident's forehead. She assessed the resident and determined Resident #100 needed to be evaluated at a local ED as he routinely took blood thinners.</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>Interview on 04/11/25 at 4:42 P.M. with Agency CNA #227 revealed she was caring for Resident #100 the night he sustained an injury during a Hoyer lift transfer. Agency CNA #227 and CNA #158 transferred Resident #100 from his wheelchair to his bed. On Resident #100's bed was an air mattress with bolsters (raised edges). Agency CNA #227 recalled the transfer went well until the Hoyer lifting Resident #100 did not clear the bolsters of the mattress. When turning and maneuvering the resident, the Hoyer lift tipped to the side, causing the top part of the Hoyer lift to hit Resident #100's head. Resident #100 started bleeding from where the Hoyer lift made contact with the resident's forehead. The two CNAs lowered Resident #100 into the bed and immediately summoned the nurse on duty.</p> <p>A follow up interview on 04/14/25 with the DON revealed the facility investigated the incident and had attempted to recreate the incident. The DON reported she did a root cause analysis of the incident and determined the root cause of Resident #100's injury was a combination of the resident's weight (last recorded as 262 pounds), the resident not clearing the air mattress bolsters, and movement/positioning of Resident #100 while transferring the resident into bed. Following the incident, Resident #100's mattress was changed from an air mattress with bolsters to a regular pressure-reducing mattress per his request and for improvement of safe transfers between surfaces.</p> <p>Review of the manufacturer's guidelines for the Hoyer lift, dated 2015, revealed the Hoyer lift's maximum capacity was 400 pounds (lbs). The guidelines contained a warning that lifters can tip over, and to keep base widened for stability.</p> <p>Review of the policy Mechanical Lift: Hoyer Lift dated 11/20/24 revealed a mechanical lift is used to facilitate transfers of residents who are unable to bear weight. At least two (2) people are involved during transferring a resident with the lift. The procedure included ensuring the resident is safe and secure.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00162876.</p>		