

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366043	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2024
NAME OF PROVIDER OR SUPPLIER Carlisle Manor Health Care Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 730 Hillcrest Drive Carlisle, OH 45005	

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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41271</p> <p>THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NONCOMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY.</p> <p>Based on closed medical record review, hospital visit summary review, facility self-reported incident and investigation review, and staff interview, the facility failed to ensure residents were safely transported on and off the facility vehicle.</p> <p>Actual harm occurred on 06/05/24 when Resident #91, who was in a wheelchair, sustained a fall resulting in multiple fractures including a fracture to his left leg and fractures to his ribs on the left side when staff were assisting him off the facility bus. A space/gap was identified between the ramp platform and the bus and the resident's wheelchair turned and got stuck in there and the resident flipped out of his chair on to the ramp. The resident complained of pain as a result of the fall with injury and was subsequently transported to the emergency room for evaluation and treatment of his injuries. This affected one resident (#91) of four residents reviewed for safety concerns. The facility census was 45.</p> <p>Findings include:</p> <p>Review of the closed medical record for Resident #91 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included presence of an artificial knee joint, altered mental status, type two diabetes mellitus, and chronic pain.</p> <p>Review of the plan of care dated 04/16/19 revealed Resident #91 was at risk for experiencing pain/discomfort related to a long history of opioid use. Resident #91 received narcotic analgesic medication routinely for a long history of knee pain. Resident #91 received corticosteroid injections as needed. Interventions included administering pain medication as ordered and observing side effects and effectiveness, complete pain assessments, and observe for pain every shift.</p> <p>Review of the plan of care dated 05/03/19 revealed Resident #91 had a potential risk for falls related to a history of frequent falls. He has low tolerance and was very easily fatigued. He received narcotic analgesic and psychotropic medications routinely. He had fluctuations in cognition. Intervention includes ensuring Dycem to wheelchair to reduce risk of sliding, assist with transfers as needed, and use a Hoyer lift as needed for transfers.</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 Resident #91's annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 12 out of 15 indicating moderate cognitive impairment for daily decision-making abilities. Resident #91 was noted to be free of bilateral upper or lower impairments and required the use of a wheelchair for mobility.</p> <p>Review of a witnessed fall investigation dated 06/05/24 created by Registered Nurse (RN) #126 revealed the nurse was notified Resident #91 had slipped out of his wheelchair when State tested Nursing Assistant (STNA) was attempting to assist the resident off the bus. Upon observation, Resident #91 was lying on his back complaining of left side back pain and tearful stating left knee pain. Nurse Practitioner (NP) #500 made aware. Immediate (STAT) X-ray of pelvis, bilateral hips and left knee was ordered. Vital signs revealed blood pressure at 120/70 millimeter of mercury (mmHg), pulse at 89 beats per minute, respiration at 18 breaths pre minute, oxygen saturation at 95 % room air, and temperature at 98.2 degrees Fahrenheit. Abrasion noted to the left knee measuring 6.0 centimeter (cm) in length by 0.6 cm in width and area was cleansed with normal saline, pat dry and a dry dressing applied. Resident #91 stated that he slid out of the chair.</p> <p>Review of the completed Skin Observation dated 06/05/24 at 4:00 P.M. revealed Resident #91 was noted to have an abrasion to his left front knee, measurements obtained, and treatment implemented.</p> <p>Review of a Pain Evaluation dated 06/05/24 at 4:10 P.M. for Resident #91 revealed the resident was complaining of pain noted to his left front knee. Pain was also noted using non-verbal pain rating indicating the resident's pain hurt a little more. Non-pharmacological interventions were attempted but not effective. Pain medication was administered.</p> <p>Continued review of investigation revealed an Interdisciplinary note dated 06/05/24 that revealed the family and Medical Director were made aware of the incident. New orders were obtained to cleanse the area to knee with normal saline cover with a clean dry dressing. Resident #91 was sent to the emergency room for evaluation. Fracture noted to left leg and ribs. Family made aware, medical director made aware. Statements provided state that Resident #91 slid forward out of his wheelchair on the bus ramp. Staff education provided.</p> <p>Review of the facility's timeline of events dated 06/05/24 revealed:</p> <p>At 3:00 P.M., Resident #91 fell while getting off the bus on the bus ramp.</p> <p>At 3:05 P.M., STNA with Resident #91 made sure that the resident was in a safe position and then came in to get nursing staff.</p> <p>At 3:10 P.M., Nursing staff came to assess Resident #91 and vital signs obtained.</p> <p>At 3:12 P.M., Assistant Director of Nursing (ADON) notified Power of Attorney (POA) of incident.</p> <p>At 3:15 P.M., Hoyer lift was taken outside and assisted Resident #91 back into his wheelchair.</p> <p>At 3:25 P.M., Resident #91 was assisted back to bed, nurse on the floor assessed skin and pain level, dressing applied to left knee and pain medication was administered.</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>At 3:45 P.M., Medical Director notified, new order received to obtain STAT X-ray of bilateral hips and left knee.</p> <p>At 4:00 P.M., NP #500 was notified when she arrived at the facility.</p> <p>At 4:45 P.M., NP #500 assessed Resident #91.</p> <p>At 5:15 P.M. Family was notified by the ADON and NP#500 that the resident wanted to go to the emergency room for evaluation and was very adamant that he did not want to stay here.</p> <p>At 5:45 P.M.-6:00 P.M. Resident #91 left the facility.</p> <p>Review of the statement dated 06/05/24 created by Transporter #28 revealed Transporter #28 was helping to unload residents off the bus, Activity Director #48 and Transporter #28 were coming back from an outing and the Activity Director was taking another resident inside when Transporter #28 put the lift up and then proceeded to unhook Resident #91 from the locked belts and seat belt. Transporter #28 then unlocked Resident #91's wheelchair; and moved him into the front facing position. Resident #91 was grabbing onto the back of the seat handles and the lift bar, before Transporter #28 could see what was going on, his wheelchair got stuck on the lift and Resident #91 landed on his left side. Resident #91 denied hitting his head.</p> <p>Review of an undated statement created by Licensed Practical Nurse (LPN) #82 revealed at approximately 3:00 P.M., LPN #82 was notified by STNA (Transporter #28) that Resident #91 fell out of his chair onto the bus ramp. Upon arriving outside to the bus, LPN #82 noted Resident #91 was laying on his right side on the bus ramp. Resident #91 stated that he fell out of his chair, and he was complaining of left knee pain. STNA (Transporter #28) stated she was getting Resident #91 onto the ramp and his wheelchair caught the ramp's lip, and he slid out of his chair onto his buttock onto the legs of the wheelchair and then slid out to the ramp on his left side. This STNA (Transporter #28) stated she made sure the resident was in a safe position before she came in to get help. LPN #82 assessed Resident #91 and noted an abrasion to his left knee, vital signs were 120/70 mmHg, heart rate at 89 beats per minute, respiration at 18 breaths per minutes, oxygen saturations at 95% room air, temperature at 98.2 degrees F, and pain was noted to be a 5 out of 10 on the numeric pain scale, and pupils were equal, round, and reactive to light and accommodation (PERRLA). Resident #91 stated pain is in his left leg mainly in the left knee. Resident #91 responded appropriately. Staff assisted resident back to wheelchair via Hoyer lift with no complications, then back to his bed. Once Resident #91 was back to bed, the floor nurse administered resident medication including ordered pain medication. NP #500 notified. Power of Attorney (POA) notified. POA and NP #500 agreed to obtain in house STAT X-ray to bilateral hips and left knee. STAT X-ray ordered at approximately 3:45 P.M. Under further assessment from NP #500 at approximately 4:45 P.M., Resident #91 stated that he was in pain and that he wanted to go to the emergency room for evaluation. POA was notified and Resident #91 was sent to the emergency room. Resident #91 left the facility at approximately 5:45 P.M.-6:00 P.M.</p> <p>Review of Resident #91's hospital summary record dated 06/05/24 revealed a clinical impression including periprosthetic fracture around internal prosthetic left knee joint, closed nondisplaced fracture of medial malleolus of the left tibia, and closed fracture of the distal end of the left ulna.</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 statement created by LPN #22 dated 06/06/24 revealed when LPN #22 walked out the front door of the facility, Resident #91 was lying with his head towards the building and bilateral lower extremities (BLE) was towards the bus in supine position. Staff slightly rolled resident to left side, placed a Hoyer pad under him, rolled slightly to the right side, placed Hoyer pad in the center of him. Staff placed the Hoyer lift around the resident and lowered it down to the resident and the ramp, placed the correct straps on the residents Hoyer pad to gently lift the resident up. Staff placed the wheelchair in the correct position and transferred him into the wheelchair via Hoyer lift with no further incidents noted. Resident #91 was then brought inside by staff.</p> <p>Review of the statement created by Admissions #98 dated 06/06/24 revealed that on 06/05/24 around 3:00 P. M. STNA #28 came into the office and requested assistance. She said Resident #91 had fallen out of his wheelchair and was on the lift. The nurse went outside with other staff. LPN #82 and floor nurses assessed Resident #91. He was lying on the lift; the lift was on the ground. His head was lying towards the end of the lift, with his feet towards the bus lying more on his right side, with complaints of pain to his left leg and hip area. The mechanical lift was brought out to the bus, the Hoyer pad was removed from his wheelchair to be placed under him. He was mechanically transferred into his wheelchair and taken back to his room. NP #500 visited with Resident #91 to assess his level of pain and injuries.</p> <p>Review of the statement created by Receptionist #38 dated 06/06/24 revealed that Receptionist #38 was a witness on 06/05/24. Resident #91 had a fall; however, she did not actually witness the fall. Receptionist #38 saw Resident #91 on the lift on the ground with nursing staff and the Administrator and they were assessing him and using a Hoyer lift to get him up safely.</p> <p>Review of the statement dated 06/06/24 created by Activities Director #48 revealed that on 06/05/24, they had come back from an outing, approximately 3:00 P.M. Activities Director #48 and Transportation #28 were on the outing. They had unloaded a resident off the lift, and Activities Director #48 went inside with the other resident to take her back to her room. When she came back out to the bus, Resident #91 was on his back on the lift and the lift had been lowered to the ground.</p> <p>Review of the statement created by Social Worker #128 revealed Transporter #28 came to the front door and asked for help to assist with Resident #91, Social Worker #128 observed him lying on the lift with a pillow under his head. Staff all helped with getting a lift and getting him back into his wheelchair. Nursing ordered a STAT x-ray for him.</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 an undated statement created by RN #126 revealed she was located in the admissions office speaking with LPN #82 when Transporter #28 came through the front door stating Resident #91 was on the ground. Upon assessment after exiting the front door, Resident #91 was observed lying on his back with his head towards the end of the ramp. Resident #91 stated his leg hurts. Unable to obtain blood pressure due to cuff malfunction. All other vital signs within normal limits. Transporter #28 advised resident did not hit his head. A call was placed to POA who declined for resident to be sent to the emergency room . All available staff assisted residents to turn side to side to place the Hoyer pad under the resident. Resident #91 was assisted back into the wheelchair via Hoyer. Resident #91 was taken to his room and assisted into bed via Hoyer lift. Upon assessment Resident #91 was noted with a 6 cm in length by 0.6 cm in width abrasion to the left knee. Area was cleansed with normal saline, pat dry and foam dressing applied. Small hematoma noted to left knee. Routine Norco (pain medication) administered at this time. LPN #82 was advised to obtain X-rays, orders placed in electronic charting system and X-ray provider contacted. NP #500 in facility and confirmed she was aware of the incident. At approximately 5:30-ish P.M., received call from NP #500 to send to the emergency room to evaluate and treat. Resident #91 sent to local ER via squad. Report called in to the ER and advised of incident.</p> <p>Interview on 06/28/24 at 10:42 A.M. with the DON revealed she was not at the facility when this incident with Resident #91 occurred but per her understanding staff was either assisting Resident #91 on or off the bus via wheelchair and using the buses wheelchair ramp. There was a very small space/gap between the ramp platform and the bus and the resident's wheelchair somehow turned and got stuck in there and the resident flipped out of his chair on to the ramp. Resident #91 did sustain fractures and the family felt best for the resident to reside at a different facility (following the incident), so the resident was discharged .</p> <p>Interview on 06/28/24 at 1:30 P.M. with Transporter #28 revealed the facility bus had just returned from an activity outing and she was assisting residents back into the facility. Resident #91 was still on the facility van so she made sure the van's wheelchair lift was up so she could assist the resident off the van. She stated she grabbed the resident's wheelchair handles and turned the wheelchair and proceeded to push the wheelchair off the van and onto the lift. The lift has a handrail on both sides and while she was pushing Resident #91's wheelchair onto the lift, he grabbed hold of the railing and proceeded to try and pull himself onto the van lift. There was a gap between the van and the lift and when she was turning the wheelchair, the wheels on the chair were sideways and got stuck in the gap. Due to the wheelchair wheels being stuck in this gap and Resident #91 pulling himself with the lift railing, he pulled himself right out of his wheelchair and onto the wheelchair lift. Transporter #28 stated she then made sure the resident was safe and lowered the lift to the ground so she could go get assistance.</p> <p>Interview on 06/28/2024 at 3:00 P.M. with Activity Director #48 revealed she was the one driving the bus the day this incident with Resident #91 occurred. She stated they had just gotten back from a group outing (going out to eat). Activity Director #48 claimed she was assisting residents off the bus and another staff member came out to assist. She was taking a resident into the facility and the other staff member was in the process of assisting Resident #91 off the bus via wheelchair and the bus wheelchair lift. Before she could come back out, she heard everyone saying the Resident #91 fell out of his wheelchair and they were going out to help get him back up. Upon returning to the bus, she said the bus wheelchair lift was on the ground level and Resident #91 was laying with his head away from the van side door and his legs were facing towards the van's side door.</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>The deficient practice was corrected on 06/06/24 when the facility implemented the following corrective actions:</p> <p>On 06/05/24 the facility Administrator notified the Medical Director of actions taken. No additional orders or recommendations received.</p> <p>On 06/06/24, all staff education was given by Regional Nursing Director #600 for falls, notification, transportation, abuse and neglect, and safe transfers.</p> <p>On 06/06/24, all staff that transfer residents via bus were educated by Activity Director #48 with return demonstration.</p> <p>Audits performed with every transport, 1-2 transports daily for the month of July 2024, then weekly for the month of August 2025, September 2024, and October 2024.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00154902.</p>