STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366235	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fair Haven Shelby County	2901 Fair Road Sidney, OH 45365

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. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interviews, review of a facility investigation, and review of facility policy, the facility failed to ensure a resident was properly transferred from a recliner chair to a bed by a Hoyer (mechanical Lift). This resulted in Actual Harm when the Hoyer lift tipped over during transfer by Certified Nursing Assistant (CNA) #200 and Resident #55 hit her face on the floor. Resident #55 sustained facial fractures, a subdural hematoma (bleeding between brain and outer covering), and a facial laceration that required medical transport by helicopter and hospital admission. This affected one (#55) of three residents reviewed for accidents. The census was 65. Findings include: Review of Resident #55's medical record revealed an admission date of 08/09/19. Diagnoses included hypertension, chronic fatigue, bladder cancer, osteoarthritis, and major depressive disorder. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #55 was cognitively intact and dependent on staff for transfers. Review of the care plan initiated 08/09/19 revealed Resident #55 was at risk for falls related to weakness, decreased mobility, and chronic fatigue. Resident #55 had impaired activities of daily living (ADLs) self-performance and required a Hoyer lift for all transfers. Review of physician orders revealed an order dated 03/12/25 for Hoyer lift for all transfers. Review of progress notes dated 06/26/25 at 4:00 P.M. revealed the nurse was notified by a CNA that she needed assistance. Upon entry, Resident #55 was observed laying on her back and bleeding from an unknown area. The nurse called out for help from other nurses and the nurse called emergency services (911). The nurse assisted Resident #55 to spit out blood. Resident #55's oxygen saturation level was checked until emergency services staff (EMS) arrived. Review of hospital documentation dated 06/26/25 through 07/02/25 revealed Resident #55 suffered multiple facial fractures, a subdural hematoma, and an eight centimeter (cm) facial laceration between eyes to nose requiring sutures. Resident #55 was transported by medical helicopter from a local hospital's emergency room (ER) to a trauma center where she remained until discharge on [DATE]. Review of the facility's investigation revealed per a written statement by CNA #200, CNA #200 was transferring Resident #55 back into bed without assistance on 06/26/25 at 3:42 P.M. when the Hoyer lift tipped over and Resident #55 landed on the floor. CNA #200 reported Resident #55 grabbed the top of the Hoyer lift during transport before it tipped. CNA #200 noticed Resident #55 was bleeding and went to get a nurse. Resident #55 was talking and alert. Resident #55 fell on her left side. Further review of the investigation revealed witness statements were taken from nursing staff that assisted with Resident #55's post-fall until EMS arrived. There was not any documentation of the Hoyer lift being inspected for any defects post Resident #55's fall. Observation on 08/12/25 at 4:29 P.M. of the Hoyer lift that was used by CNA #200 on 06/26/25 revealed a sticker dated last inspection of 04/06/22 and was due for inspection April 2023. The Director of Nursing (DON) was present during the observation and confirmed both dates. Interview with the DON on 08/13/25 at 9:23 A.M. revealed there is not a check-off for agency staff before they are able to use the Hoyer lifts. A maintenance slip was not filled out to check the Hoyer for any defects post Resident #55's fall. The DON was unsure if maintenance performed scheduled maintenance checks of Hoyer lifts. The cause of the Hoyer lift tipping over was not determined. CNA #200 reported that Resident #55 was grabbing the top of Hoyer during transfer. CNA #200 was not an employee of the facility and worked through a staffing agency. Interview with Resident #55 on 08/13/25 at 10:02 A.M. revealed she did not remember very much of the fall event. Resident #55 stated there should have been two people transferring her and there was only one. Resident #55 was told there was a lot of blood when she fell. Resident #55 had residual effects from the fall and reported sometimes it was like looking through a screen in her left eye. Observation of Resident #55 during the interview revealed a scar on the left side of her face between her left eye and nose. Interview with CNA #110 and CNA #150 on 08/13/25 at 1:13 P.M. revealed two staff members are required when transferring residents by a Hoyer. Interview with Environmental Service Director (ESD) #170 on 08/13/25 at 2:00 P.M. revealed he does not inspect Hoyer lifts on a regular schedule. ESD #170 does not inspect any medical equipment and was not certified in medical equipment inspection. ESD #170 looked at the Hoyer lift post Resident #55 fall on 06/26/25 and checked for any obvious concerns. ESD #170 did not check the Hoyer lift functions or stability. Phone interview with CNA #200 on 08/13/25 at 3:26 P.M. revealed she worked at the facility through a staffing agency. The facility had not given her any instructions on how to operate the Hoyer lift prior to transferring Resident #55 on 06/26/25. It was the first time using that Hoyer lift and it was her first time transferring Resident #55. CNA #200 did not have any other