| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 366299 | A. Building<br>B. Wing | 12/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Centerburg Pointe | 4531 Columbus Road<br>Centerburg, OH 43011 |

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) |
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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47569<br><br>THIS IS AN INCIDENCE OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY.<br><br>Based on record review, staff interviews, review a facility investigation, review of hospital documentation and facility policy review the facility failed to use a mechanical lift sling pad correctly resulting in a fall from a mechanical lift. This affected one resident (Resident #73) of two residents reviewed for accidents. The facility census was 71.<br><br>Findings Include:<br><br>A review of Resident #73's medical record revealed admitted [DATE] with diagnoses including but not limited to respiratory failure with ventilator dependency, tracheostomy, dysphagia, chronic obstructive pulmonary disease (COPD), and high blood pressure.<br><br>A review of Resident #73's admission fall risk assessment revealed Resident #73 was at risk for falls related to impaired mobility.<br><br>A review of Resident #73's admission [NAME] Data Set (MDS) dated [DATE] revealed Resident #73 had moderate cognitive impairment and was dependent on staff for all care and Activities of Daily Living (ADL) tasks including transfers using a mechanical lift.<br><br>A review of Resident #73's baseline care plan dated 10/02/24 revealed Resident #73 required a mechanical lift, and two staff assistance for all transfers.<br><br>A review of Resident #73's physician orders dated 10/01/24 to 10/10/24 revealed an order dated 10/02/24 for blood thinning medication Eliquis 5 milligram (mg) given by mouth twice daily for deep vein thrombosis (DVT). Further review revealed an order dated 10/02/24 for the use of a mechanical lift for transfers.<br><br>A review of Resident #73's progress notes revealed:<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 10/10/24 at 7:00 P.M. authored by Licensed Practical Nurse (LPN) #234 revealed at approximately 6:40 P.M. LPN #234, Certified Nursing Assistant (CNA) #276 and Respiratory Therapist (RT) #505 were assisting Resident #73 transfer from wheelchair to the bed using a mechanical lift (hoyer). Resident #73 had been elevated out of the wheelchair, CNA #276 moved the wheelchair from under Resident #73 and RT #505 was maintaining the ventilator tubing, prior to the hoyer lift being unlocked and moved towards the bed, Resident #73 rolled to the right side of the lift sling and continued rolling out of the top right side of the lift sling, landing on her right shoulder and right side of her face. Resident #73 fell approximately 4.5 feet to the floor from the elevated lift sling. LPN #234 completed a head-to-toe assessment of Resident #73, noting an abrasion on the top of the right shoulder. LPN #234 notified the physician and received a new order to send Resident #73 to the hospital for further evaluation. Resident #73's family member was present during the fall and accompanied Resident #73 to the hospital.<br><br>On 10/11/24 at 1:17 A.M., authored by Registered Nurse (RN) #404, revealed hospital nurse stated Resident #73 had no acute injury and advised Resident #73 would be returning to the facility on ce transportation was available.<br><br>On 10/11/24 at 12:28 P.M., authored by the Director of Nursing (DON), revealed Resident #73 was dependent for transfers and utilized a hoyer lift. Resident #73 had sustained a fall from the hoyer lift during a transfer on 10/10/24 at 6:40 P.M. Resident #73 was sent to the hospital for further evaluation and was admitted back to the facility on [DATE] at 4:30 A.M. with no acute injury results on the X-ray and computed tomography (CT) from the fall on 10/10/24.<br><br>A review of Resident #73's hospital documents dated 10/10/24 to 10/11/24 revealed a CT of Resident #73's head revealed no acute intracranial abnormality, only small right posterior parietal scalp swelling. Further review revealed portable chest radiograph (Xray) results revealed Resident #73's stable tracheostomy and a stable small left pleural effusion There were no acute abnormalities noted.<br><br>A review of the fall investigation dated 10/10/24 completed by the DON revealed during Resident #73's transfer from the wheelchair to the bed using a mechanical lift (hoyer) Resident #73 appeared to have shifted in the sling causing her to slide out of the top right side of the sling. Upon investigation by the DON on 10/11/24, the sling which had been used during the transfer was examined and found to be a cross-strap sling which would require the leg straps to be crossed between the resident's legs. This type of sling was not appropriate for use with Resident #73. Resident #73 required a full body lift sling.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An interview on 12/10/24 at 10:38 A.M. with the DON confirmed Resident #73 had fallen from the hoyer lift sling during a transfer on 10/10/24 at 6:40 P.M. Resident #73 did not sustain any acute injury from the fall, only an abrasion to the top of right shoulder. The DON stated during the investigation following Resident #73's fall it was determined the root cause of the fall from the hoyer lift sling was due to improper use of a cross- strap lift sling. The DON stated on 10/11/24 she had examined the sling which had been used during Resident #73's transfer, once the sling had been laid out on the floor, the DON realized the sling was actually a cross-strap lift sling which required lower straps to be crossed between the resident's legs and then hooked to the lift bar. The DON determined the lower straps of the cross-strap lift sling must not have been crossed during the transfer. Resident #73 required the use of a full body lift sling. The DON further stated an audit was completed for any cross-strap lift slings in circulation. The DON then removed all cross-strap slings that were in circulation, this was completed on 10/11/24. The DON and the Unit Managers conducted clinical staff education and competencies for dependent residents utilizing a mechanical lift (hoyer) for transfers. The education was initiated on 10/10/24 and completed on 10/11/24.<br><br>An interview on 12/10/24 at 1:11 P.M. with CNA #276 revealed Resident #73 had been up in the wheelchair for the day on 10/10/24 and Resident #73 had requested to go back to bed. LPN #234 and RT #505 were also assisting CNA #276 in the transfer. CNA #276 stated once Resident #73 had been elevated out of the wheelchair, CNA #276 moved the wheelchair from under Resident #73 and turned back to the hoyer lift when Resident #73 began sliding out of the top right side of the lift sling, landing on right shoulder and right side of her face. CNA #276 stated the four lift sling straps had been secured to the lift bar prior to the transfer.<br><br>An interview on 12/10/24 at 1:42 P.M. with LPN #234 revealed she was assisting CNA #276 with Resident #73's transfer and RT #505 was also in the room helping maintain Resident #73's ventilator tubing during the transfer. LPN #234 stated the lift sling straps had been hooked securely to the lift bar prior to the transfer of Resident #73. The brakes were locked on the hoyer lift and the wheelchair. CNA #276 had moved the wheelchair from underneath Resident #73, Resident #73 appeared to shift or move in the sling causing her to slide out of the top right side of the sling onto the floor striking her right shoulder and the right side of her face. LPN #234 notified other staff members of the need for assistance, notified the physician and called Emergency Medical Services (EMS). LPN #234 performed a head-to-toe assessment of Resident #73 and noted an abrasion to the top of her right shoulder. Resident #73 was able to communicate absence of pain and was able to move all extremities. Resident #73's family member was present during the transfer.<br><br>Attempts to reach RT #505 were made during the survey however, unsuccessful.<br><br>An observation on 12/10/24 at 2:10 P.M. revealed there were no cross-strap lift slings in the clean linen closet or in the laundry facilities.<br><br>Review of the facility's policy titled, Mechanical Lift Policy dated 01/07/22 revealed, A mechanical lift may be used for transferring residents that cannot be safely transferred by themselves or with staff assistance. Slings will be inspected for any damage with each use. If the sling has any evidence of damage or fraying of the straps, the sling will be removed from circulation and disposed of.<br><br>The deficiency was corrected on 10/11/24 when the facility implemented the following corrective actions:<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 10/10/24 a head to toe assessment was completed by LPN #234 for Resident #73 with an abrasion noted to the top of her right shoulder. The physician was notified and Resident #73 was sent to the hospital for further evaluation. The resident returned and did not have any injuries aside from the abrasion that did not require additional treatment.<br><br>On 10/10/24 Resident #73's care plan was reviewed with no corrections required.<br><br>On 10/10/24 all like residents (24 residents) requiring the use of a mechanical lift for transfers medical records were reviewed for accuracy, there were no corrections required.<br><br>On 10/10/24 clinical staff education and competencies conducted by the DON and Unit Managers were initiated for proper use of mechanical lifts during transfers. The staff educated included 35 CNAs, 8 RNs, and 13 LPNs. The education and competencies were completed on 10/11/24.<br><br>On 10/10/24 the DON audited all lift slings in the facility and removed all cross-strap slings from circulation.<br><br>On 10/10/24 an ad hoc (immediate, unscheduled) Quality Assurance Performance Improvement (QAPI) meeting was conducted with the following in attendance: the Administrator, the DON, the Assistant DON and the Medical Director. The subject of the meeting covered a resident fall from the hoyer lift due to improper use of a lift sling.<br><br>On 10/10/24 the DON initiated audits of all lift slings which were conducted weekly for four weeks and then monthly for two months with the audits being completed on 12/02/24.<br><br>As of 12/10/24 there have been no further falls occurring from transfers with the use of a mechanical lift.<br><br>This deficiency represents non-compliance investigated under Complaint Number OH00159887. |