STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365072	A. Building B. Wing	12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Anna Maria of Aurora	889 North Aurora Road Aurora, OH 44202

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47570 Based on closed record review, interview and review of facility policy, the facility failed to provide adequate assistance/supervision and develop and implement a comprehensive, individualized and effective fall prevention program for Resident #91 to prevent falls with injury and failed to ensure the resident was adequately and timely assessed post fall. Actual harm occurred beginning on 09/27/24 when Resident #91, who was at high risk for falls, had a history of multiple falls and was cognitively impaired with poor safety awareness, sustained a witnessed fall resulting in injury in the rehab gym when Physical Therapy Assistant (PTA) #432 walked away from Resident #91 during treatment to get equipment and the resident fell while being left unattended. On 09/30/24 (three days after the fall), Resident #91's wife alerted staff to bruising to the resident's rib area. An x-ray was ordered revealing multiple rib fractures. On 10/05/24 Resident #91 sustained a fall when he stood up from his wheelchair while being left unattended by staff and fell to the ground fracturing his right wrist requiring treatment in the hospital emergency room to obtain a cast to his right wrist. This affected one resident (#91) of three residents reviewed for falls. The facility census was 89. Findings include: Review of the closed medical record for Resident #91 revealed the resident was admitted to the facility on [DATE] with diagnoses including fracture of femur with routine healing, sleep behavior disorder, fracture of radius, disorder of bone density and structure, restlessness, multiple fractures of the ribs left side, orthopedic aftercare, pulmonary hypertension, dementia, repeated falls, atrial fibrillation, age related macular degeneration and Parkinson's disease. The resident was discharged to another facility on 10/24/24. (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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the Minimum Data Set (MDS) 3.0 admission assessment dated [DATE] revealed Resident # 91 was admitted to the facility on [DATE] from a general hospital. Resident #91 was usually able to make self-understood and usually able to understand others and had impaired vision. Resident #91 had long term memory problems and short-term memory problems and moderately impaired decision-making skills. The assessment revealed the resident required moderate assistance to roll left and right in bed, was dependent on staff to sit on the side of the bed, lie back in bed, transfer from the bed to the chair and transfer on and off the toilet. Resident #91 did not attempt to walk ten feet. Resident #91 was continent of bladder. The assessment also noted Resident #10 had a fall history prior to admission. Review of the Fall Risk Evaluation dated 09/10/24 revealed Resident #10 was a high risk for falls. Review of the plan of care initiated of 09/11/24 revealed Resident #91 had a self-care deficit on admission from a recent hospitalization for a fall with left femur neck fracture for which he had a surgical nailing performed. Due to cognitive deficits, the resident often forgot to use the walker and had frequent falls. The care plan revealed the resident required increased assistance with care related to impaired mobility, pain and severe cognition deficits, combative and resistant with care. Resident #91 also had a plan of care for being at high fall risk related to impaired mobility, pain, severe cognition deficits, increased potential for lethargy, increased agitation, combative and resistant with care, poor safety awareness, psychoactive and opioid medication use, repeated falls at home, behaviors and Parkinson's disease. Fall interventions included administer pain medication as needed, anticipate and meet residents needs, keep call light in reach and encourage use, bed in low position, call daughter or wife when having unsafe behaviors, fall risk evaluation upon admission, quarterly and as needed, monitor changes in balance and safety awareness, monitor for lethargy, pressure alarm to bed, provide assistance as needed with activity of daily living (ADL), physical therapy and occupational therapy evaluation and treatment to increase independence with transfer and mobility, and short string personal alarm to wheelchair. Review of a nursing progress note dated 09/22/24 at 5:59 P.M. authored by Registered Nurse (RN) #392 revealed staff heard resident's alarm go off from the end of the hallway. Resident attempted to stand from the recliner in the lounge area and sank to the floor. Review of the facility document titled Resident Incident Report, dated 09/22/24 and authored by RN #392, revealed Resident #91 had a witnessed fall in the TV lounge at 4:30 P.M. The resident was last toileted at 2:30 P.M. and was sitting in a recliner watching a Brown's game on TV. The resident stated he got up to go to the office and fell . The witness was Registered Nurse (RN) #392. The incident description indicated the resident stood from the recliner, his legs went out and he sat on the floor on his bottom. An alarm was ringing but the RN could not get to the resident in time. An assessment of the resident was completed with no complaints of pain or abnormal vital signs. Additional comments on the document included the resident had a large group of family in to visit who had just left and he fell . The Certified Nurse Practitioner (CNP) was notified with no new orders. The immediate intervention was a short-string personal alarm to chair. Review of the witness statement dated 09/22/24 and authored by Licensed Practical Nurse (LPN) #309 revealed LPN #309 was in another room assisting staff with a transfer when an alarm started to sound. Another nurse, who also was helping assist, looked out of the room and saw Resident #91 standing up. Both nurses headed toward Resident #91 who was found sitting on his bottom saying help. No staff were present with Resident #91 prior to this fall. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of physician's orders dated 09/23/24 revealed an order for a short string personal alarm, check placement and function every shift to alert staff of transfers. Review of the facility document titled Steel Valley portable x-ray, dated 09/25/24, revealed a left shoulder x-ray was completed and results indicated no acute fractures noted. Review of the Physical Therapist Summary of Skill progress note dated 09/26/24 written by Physical Therapist (PT) #433 revealed Resident #91 needed skilled interventions and training in safe sit to stand and stand to sit mobility. Minimal assist/contact guard assist was needed for sit to stand and stand pivot with front wheeled walker and a Nustep (a piece of specialized equipment which is a recumbent cross-trainer used for low-impact exercise) for 23 minutes to work on strength per therapy goals. Review of the facility document titled Physical Therapy Treatment Encounter Note, dated 09/27/24, revealed transfer training was being provided to increase functional task performance to and from the wheelchair with use of a front wheeled walker and verbal cues for hand placement with contact guard assist to minimal assist to promote prior level of function with decreased fall risk. An additional comment revealed near the end of the therapy session Resident #91 stood from his wheelchair and lost his balance falling onto his right side. The physical therapy assistant (PTA) was across the room and not close enough to help although (the employee) did call out (to the resident) to sit. However, Resident #91 did not (follow the verbal command) due to cognitive deficits. The note included nursing was notified and the resident was assessed with no injuries. Review of the facility document titled Resident Incident Report, dated 09/27/24, revealed Resident #91 had a witnessed fall in the rehab gym at 10:00 A.M. The resident had a personal alarm in place at the time of the fall. The resident was witnessed by PTA #432 to stand up from his wheelchair, leaning to his right side and fell on to his right side and shoulder. The resident had no complaints of pain, no abrasions or contusions. He was at baseline mentation; no abnormal vitals and the physician and family were notified. Interventions included two persons assist and direct attendance during therapy. Review of the witness statement dated 09/27/24 and authored by PTA #432, revealed immediately prior to the fall Resident #91 was sitting in his wheelchair in the therapy gym with his personal alarm in place. PTA #432 who was working with the resident walked across the room away from the resident to get the Nustep set up and after turning to walk back saw Resident #91 stand up from his wheelchair without holding on to anything, lost his balance then fell on to the floor onto his right upper and lower extremities. The resident had on non-skid socks and no injury was noted. Review of a nursing note dated 09/27/24 at 10:03 A.M. written by LPN #320 revealed nursing was notified by therapy that Resident #91 stood up on his own in the gym and fell to the right side. The fall was witnessed by two therapists. Review of a facility Incident Report dated 09/30/24 revealed bruises were found by Resident #91's spouse. Bruises were evaluated to left rib cage and scattered bruises to hand. Resident complained of pain to left shoulder. Treatment included an x-ray of the ribs. Interventions included discussing with wife a one-on-one sitter for Resident #91. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of medical record nursing note dated 09/30/24 revealed Resident #91 was seen by the CNP who ordered left rib x-ray status post fall. Purple bruising and mild pain noted to area. Review of facility document titled Steel Valley portable x-ray dated 09/30/24 revealed Resident #91 had his left ribs x-rayed and the results were an acute displaced left posterior 7th, 8th and possible 9th rib fracture. Review of the CNP note dated 10/01/24 revealed Resident #91 had closed fractures of multiple ribs on the left side with improving ecchymosis (bruising). Pain was being controlled with routine Tylenol and narcotic pain medication as needed. A lidocaine patch was added for pain. The resident was seen sitting in his chair without complaint of pain. The note included staff to ensure fall precaution. Review of the facility document titled Resident Incident Report, dated 10/05/24 revealed Resident #91 had a witnessed fall in the dining area at 3:44 P.M. The resident had a personal alarm in place and stated he was looking for his office. The incident description indicated Resident #91 was trying to get up several times throughout the shift. The Certified Nursing Assistant (CNA) placed him in his wheelchair and pushed him to the table. Resident #91 kept trying to stand up and kept unlocking his wheelchair. Next thing he fell on to the floor. After the fall his right hand was bruised, and right wrist was swollen, and he had complained of pain with touch/range of motion. The physician and family were notified. The immediate intervention was to move the resident to a more supervised location. Review of medical record nursing note dated 10/05/24 at 3:39 P.M. revealed Resident #91 fell . Resident #91 stood up from his wheelchair. Resident #91 stated he was in pain. An x-ray was order to the right hand and right wrist. Review of facility document titled Steel Valley portable x-ray dated 10/05/24 revealed Resident #91 had an x-ray of right wrist that revealed an acute distal radial fracture and osteopenia. Review of medical record nursing note dated 10/06/24 at 12:24 A.M. revealed Resident #91 x-ray result of right wrist was reported to the CNP and a new order was obtained to send Resident #91 to the emergency room for evaluation. Review of medical record nursing note dated 10/06/24 at 4:32 A.M. revealed Resident #91 came back to the facility from the hospital with a soft fiberglass cast on his right wrist which was to be on for one week. The note included the resident would need a hard cast and clinic shoulder immobilizer. A follow up appointment was needed with orthopedics. A cat scan of the head was done with no new orders. Review of the CNP note dated 10/07/24 revealed Resident #91 had a closed fracture of the distal end of the right radius with routine healing and unspecified fracture morphology after falling over the weekend with right wrist pain. Pain was controlled with routine Tylenol, narcotic pain medication as needed and lidocaine patch. The note included the facility was to ensure fall precaution. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the witness statement dated 10/07/24 authored by CNA #348 revealed Resident #91 was attempting to get out of his recliner (on 10/05/24) so CNA #348 moved him to his wheelchair and pushed him to the dining room table with a snack. He appeared confused and slightly aggressive, and he was dry. The chair alarm was present, and he had on non-skid socks. CNA #348 documented the fall was unwitnessed by her, as she observed him on the floor. Review of the investigation worksheet, dated 10/07/24, revealed Resident #91 had a witnessed fall on 10/05/24. Resident #91 said he was looking for the office. Contributing factors were non-compliance, being resistive to care and confusion. The investigation summary revealed the resident's personal alarm was sounding, he stood up from his chair took one step and fell . Staff had requested he sit down when he stood. Interventions ordered in response to this fall included a medication review, review by the interdisciplinary team, and a private duty sitter. Interview on 12/04/24 at 6:33 A.M. with Nurse Unit Manager (NUM)# 346 verified Resident #91 fell in the dining room, the TV lounge and in the therapy room during his admission with resultant fractures to his ribs and right wrist. NUM #346 stated Resident #91 was non-compliant and combative and he was known to get up at any time. NUM #346 revealed awareness of Resident #91 having falls at home prior to admission. Interview on 12/04/24 at 11:25 A.M. with PTA # 432 with Administrator #431 present revealed Resident #91 needed a gait belt for walking. PTA #432 stated Resident #91's baseline was maximum (staff) assist moving from wheelchair to standing position and the resident was not able to walk. Therapy provided daily treatments and Resident #91 needed contact guard minimum assistance to stand from sitting. During the interview, PTA #432 revealed (on 09/27/24) Resident #91 was sitting in his wheelchair by the four-step fixture located near the entrance door in the therapy gym. PTA #432 stated Resident #91 remained seated in the wheelchair while she walked 20 feet to retrieve the NuStep equipment. PTA #432 verified Resident #91 stood up while she was away from the resident, Resident #91 lost his balance, but PTA #432 stated she was not close enough to keep Resident #91 from falling. PTA #432 verified a hand must be on Resident #91 with contact assistance. Interview on 12/04/24 at 3:35 P.M. with Resident #91's wife revealed during the resident's stay she would stay overnight to monitor Resident #91 from falling. The day of Resident #91's last fall in the facility on 10/05/24 resulted in the resident sustaining a broken wrist. She stated on this date, she had informed the nurse she was leaving Resident #91 for an hour, and he fell after she left. She stated she requested the x-ray of Resident #91's hand after the fall on 10/05/24. She stated in addition, she had found the bruising on Resident #91 on 09/30/24 (from the fall that occurred on 09/27/24) and requested the x-rays to be taken. The x-rays on 09/30/24 revealed the resident had broken ribs. During the interview Resident #91's wife showed the surveyor pictures she had taken on 09/30/24 of a large bruise over the resident's rib area and multiple scattered bruises to Resident #91's right hand after he fell on [DATE]. Interview on 12/06/24 at 2:17 P.M. with CNA #348 revealed on 10/05/24 Resident #91 was agitated, so she placed the resident at a table in his wheelchair to eat a snack. CNA #348 stated she believed Resident #91 would be safe alone and stepped away without notifying another nurse. CNA #348 stated Resident #91 then stood to up on his own and fell . CNA #348 verified Resident #91 required monitoring at all times to prevent falls. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview on 12/06/24 at 3:21 P.M. with RN #392 revealed she worked the night of 09/22/24 and witnessed Resident #91 fall. RN #392 stated the night Resident #91 fell , the rehab unit had a new admission that required three people to transfer the resident to bed. RN #392 was assisting with the new admission transfer with other staff when she heard Resident #91's alarm sound. RN #392 stated she was at the other end of the hall and could not run to Resident #91 fast enough to prevent his fall. Interview on 12/09/24 at 11:10 A.M. with the Director of Nursing (DON) revealed she did not have clinical oversight of the fall investigations because NUM #346 was in-charge of the fall investigations, so the DON was only involved in the post-fall interdisciplinary meeting. She stated she did not observe bruising to Resident #91's body. The DON stated on 09/22/24 Resident #91 had been sitting in a recliner then sat down from his recliner onto the floor. The DON verified he did fall onto his right side on 09/27/24 in the therapy gym. The DON stated Resident #91's falls were caused by Resident #91's agitation and staff had to repeat often for him to stay seated. The DON stated nursing staff were aware Resident #91's wife also had to repeatedly tell the resident to remain seated, but the resident could not understand to remain seated because of his dementia. When the resident fell on [DATE] the DON revealed nursing staff knew Resident #91's wife was not in the facility to watch him as he had been placed at a table to have a snack. Review of facility policy titled Falls Policy and Procedure, undated, revealed residents were assessed for fall risk factors and the facility strived to reduce the risk of falls and injuries by implementing the Falls Policy and Procedure. Residents are assessed for fall risk factors. The interdisciplinary team worked with the resident and family to identify and implement appropriate interventions to prevent falls or injuries. This deficiency represents non-compliance investigated under Complaint Number OH00159706.