| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365081 | A. Building<br>B. Wing | 12/16/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Three Rivers Healthcare Center | 7800 Jandaracres Drive<br>Cincinnati, OH 45248 |

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|---|---|
| F 0689<br><br>Level of Harm - 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** 35770<br><br>THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY.<br><br>Based on medical record review, review of hospital records, resident interview, staff interview, and review of the facility policy, the facility failed to properly transfer a resident using a mechanical lift (Hoyer) and the assistance of two staff per the resident's care plan. Actual harm occurred on 10/28/24 when Certified Nursing Assistant (CNA) #35 completed a hands-on pivot transfer of Resident #11 from the bed to the wheelchair without the assistance of additional staff or use of a gait belt. Resident #11 sustained a fall to the floor during the transfer which resulted in a left femur fracture. This affected one (Resident #11) of three residents reviewed for falls. The facility census was 115 residents.<br><br>Findings include:<br><br>Review of the medical record for Resident #11 revealed an admitted [DATE] with diagnoses including cerebral infarction, chronic respiratory failure, morbid obesity, cardiac murmur, and scoliosis.<br><br>Review of the Minimum Data Set (MDS) assessment for Resident #11 dated 10/14/24 revealed the resident had mild cognitive deficits and required extensive assistance of staff with activities of daily living (ADLs).<br><br>Review of the care plan for Resident #11 dated 04/09/24 revealed the resident had an ADL self-performance deficit and required staff assistance related to hemiplegia, chronic respiratory failure, obesity, spinal stenosis, multiple cardiac diagnoses, and overall medical condition. Interventions included the resident was totally dependent with transfers and required the assistance of two or more staff with transfer and the resident required the use of a mechanical lift (Hoyer) with two-person support.<br><br>Review of a nursing note for Resident #11 dated 10/28/24 timed at 11:50 A.M. revealed CNA #35 notified Licensed Practical Nurse (LPN) #42 that Resident #11 was on the floor. LPN #42 assessed Resident #11 who complained of left leg pain which the resident rated as eight on a scale of 1 to 10 with 10 being the worst pain. LPN #42 notified Nurse Practitioner (NP) #41 who gave an order to send Resident #11 to the hospital via emergency medical services (EMS) for an evaluation.<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 - Actual harm<br><br>Residents Affected - Few | Review of a nursing note for Resident #11 dated 10/28/24 timed at 6:16 P.M. revealed the hospital reported to LPN #42 that Resident #11 had a fractured leg femur and would be sent back to facility on 10/28/24.<br><br>Review of the Interdisciplinary Team (IDT) follow-up note for Resident #11 dated 10/29/24 revealed the resident had a fall with injury related to staff assisting the resident to the floor when the resident's legs became weak during transfer.<br><br>Review of the results for the computed tomography (CT) scan of the left femur without contrast for Resident #11 dated 10/28/24 timed at 4:28 P.M. revealed the resident had a mildly displaced fracture of the distal femur.<br><br>Review of a written statement per Resident #11dated 10/28/24 revealed the resident reported that on 10/28/24 a young girl came into her room, and she was no bigger than the resident and the girl tried to get the resident up into a chair, but the resident's legs gave out.<br><br>Review of a written statement per CNA #35 dated 10/28/24 revealed Resident #11 was sitting on the edge of the bed with her legs off the side of the bed. CNA #35 attempted to do a pivot transfer of Resident #11 from the bed to the chair and during the transfer the resident's legs gave out. Further review of the statement revealed CNA #35 then placed her arms under the resident's arms and lowered the resident to the floor.<br><br>Review of a written statement per LPN #42 dated 10/28/24 revealed the nurse was administering medications and conversing with Unit Manager (UM) #36 when CNA #35 alerted the nurses that Resident #11 was on the floor. When LPN #42 entered Resident #11's room, the resident was on the floor. CNA #35 stated she slid Resident #11 down her leg and lowered the resident to the floor because the resident's legs started getting weak. LPN #42 then assessed the resident and notified Nurse Practitioner (NP) #41.<br><br>Review of an email sent from the Administrator to Regional Director of Clinical Operations (RDCO) #40 dated 10/28/24 timed at 4:57 P.M. revealed the Administrator was reaching out to inform that Resident #11 was improperly transferred by an aide on 10/28/24 which resulted in left leg pain and NP #41 requested that Resident #11 be sent out 911. From the hospital it was determined Resident #11's hip was fractured. The Administrator had completed the following: an in-service and a final write up (disciplinary action) for CNA #35, full house education started on transfers, root cause analysis, statements collected from staff, staff notified the Medical Director and NP #41, and the Administrator notified Resident #11's guardian of the incident.<br><br>Interview on 12/04/24 at 4:01 P.M. with Resident #11 confirmed that when she was transferring with the assistance of one staff, her legs gave out, and she just fell . Resident #11 stated she did not fall out of the Hoyer lift, and that on 10/28/24, CNA #35 came in by herself and tried to transfer her to the wheelchair and she fell .<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Interview on 12/10/24 at 1:34 P.M. with CNA #35 confirmed she was not the aide assigned to Resident #11 on 10/28/24. CNA #35 stated another aide had asked her to get Resident #11 up in the wheelchair. CNA #35 stated she had seen other aides using a single-person pivot transfer for Resident #11 and she was unaware that Resident #11 was to be transferred by Hoyer lift with two staff assist. CNA #35 stated that while she was pivoting Resident #11 to the wheelchair the resident froze and would not move anymore. Resident #11 then stated her legs were going to go out, so the aide slowly lowered Resident #11 down to the ground and quickly hollered for UM #36 for assistance. UM #36 assessed Resident #11, and the resident started crying stating her leg hurt. CNA #35 stated she did not know Resident #11 was supposed to be transferred via the Hoyer (mechanical) lift, and the aide did not look at the Kardex (care plan) or ask anyone how the resident was supposed to be transferred.<br><br>Interview on 12/10/24 at 4:08 P.M. with RDCO #40 confirmed Resident #11 should be transferred per two staff using a mechanical lift, and CNA #35 should have had another staff member assisting with the transfer.<br><br>Review of the facility policy titled Plan of Care Overview dated 2017 revealed it was the policy of the facility to provide resident centered care that met the psychosocial, physical, and emotional needs and concerns of the residents. Safety was a primary concern for the residents, staff, and visitors.<br><br>The deficiency was corrected on 11/27/24 when the facility implemented the following corrective actions:<br><br>On 10/28/24, LPN #42 assessed Resident #11 with findings of left leg pain.<br><br>On 10/28/24 at 11:50 A.M., LPN #22 notified NP #41 of Resident #11's leg pain and gave an order to send the resident to the hospital via nine-one-one (911) emergency transport.<br><br>On 10/28/24 at 12:00 P.M., UM #26 notified the Administrator of Resident #11's fall.<br><br>On 10/28/24 at 4:45 P.M., the hospital called and reported to facility nurse, LPN # 22, that Resident #11 has sustained a fracture to the distal end of left femur.<br><br>On 10/28/24 at 4:50 P.M., the Administrator notified Resident #11's guardian of the fracture to the resident's left femur.<br><br>On 10/28/24 at 5:00 P.M., the Director of Nursing (DON) conducted an audit for all residents that required two staff members' assistance regarding care concerns related to mechanical lifts.<br><br>On 10/28/24 at 5:15 P.M., UM #26 initiated assessments of residents that required two staff assist including mechanical lifts for transfers to ensure no injuries occurred during transfers.<br><br>On 10/28/24 at 5:30 P.M., the Administrator and the DON provided one-on-one education to CNA #35 on the Kardex, following the resident's plan of care, and mechanical lift transfers.<br><br>On 10/28/24 at 6:00 P.M., Therapy Director (TD) #51 completed a transfer competency with CNA #35.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | On 10/28/24 at 6:10 P.M., the DON completed education with all licensed nurses, therapists, and aides on the Kardex, following the resident's plan of care, and mechanical lift transfers.<br><br>On 10/28/24 at 7:40 P.M., Resident #11 returned to the facility with an order for a follow-up appointment with an orthopedic surgeon. Registered Nurse (RN) #53 completed a head-to-toe assessment and pain assessment for Resident #11.<br><br>On 10/28/24 at 7:55 P.M., RN #53 notified NP #41 of Resident #11's new diagnoses of closed fracture of distal end of left femur.<br><br>On 10/29/24 at 2:02 P.M., the Quality Assurance and Performance Improvement (QAPI) Committee met to review the incident involving Resident #11 with NP #41 present. Resident #11's care plan was updated to include pain management, ADLs, and falls. The DON was to initiate ongoing monitoring on 10/30/24.<br><br>On 10/29/24 at 2:25 P.M., the DON notified Resident #11's guardian of the plan of care updates and the resident's guardian was in agreement.<br><br>On 10/29/24 at 5:20 P.M., MDS Nurse #54 completed a review and updated all care plans for residents identified as requiring two staff assist and/or mechanical lift for transfers.<br><br>On 10/30/24, the DON/designee to conduct audits of transfers to be completed three times weekly for four weeks and then weekly for four weeks to ensure transfers were occurring as indicated on the resident care plan/Kardex.<br><br>Review of facility audits of transfers completed beginning 10/30/24 through 11/27/24 revealed there were no further identified concerns.<br><br>This deficiency represents noncompliance investigated under Complaint Number OH00159597. |

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| F 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35770<br><br>Based on medical record review, observation, staff interview, and the resident interview, the facility failed to maintain an adequate supply of food during tray service and failed to follow the facility menu. This affected four (Residents #12, #18, #19, and #20) of four residents observed for meal service. The facility census was 115 residents.<br><br>Findings include:<br><br>Review of the medical record for Resident #12 revealed an admitted [DATE] with diagnoses including alcohol dependence, respiratory failure, depression, psychoactive substance abuse, anxiety, chronic pain, and insomnia.<br><br>Review of the Minimum Data Set (MDS) assessment for Resident #12 dated 09/01/24 revealed the resident had no cognitive deficits and required supervision with activities of daily living (ADLs).<br><br>Review of the medical record for Resident #18 revealed an admitted [DATE] with diagnoses including diabetes, heart failure, epilepsy, colon cancer, and sleep apnea.<br><br>Review of the MDS for Resident #18 dated 10/30/24 revealed the resident had mild cognitive deficits and required supervision with activities of daily living.<br><br>Review of the medical record for Resident #19 revealed an admitted [DATE] with diagnoses including diabetes, morbid obesity, agoraphobia, tachycardia, and anxiety.<br><br>Review of the MDS for Resident #19 dated 10/06/24 revealed the resident had no cognitive deficits and required supervision with ADLs.<br><br>Review of the dietary assessment for Resident #19 dated 03/08/23 revealed pork chops were listed as a disliked food.<br><br>Review of the medical record for Resident #20 revealed an admitted [DATE] with diagnoses including diabetes, depression, convulsions, obesity, and anxiety.<br><br>Review of the MDS for Resident #20 dated 11/09/24 revealed the resident had no cognitive deficits and was totally dependent on staff for ADL care.<br><br>Review of the dietary assessment for Resident #20 dated 01/08/24 revealed pork was listed as a disliked food.<br><br>Observation on 12/02/24 at 1:45 P.M. of meal service for Residents #12 and #18 revealed the lunch ticket listed double chocolate brownie for lunch, but there was no brownie on either tray. Resident #12's ticket indicated the resident should receive eight ounces of chocolate milk on his tray, but there was no milk on the tray.<br><br>(continued on next page) |

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| F 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Interview on 12/02/24 at 1:58 P.M. with Certified Nursing Assistant (CNA) #30 confirmed Residents #12 and #18 did not receive brownies on their meal trays and Resident #12 did not receive chocolate milk on the meal tray as indicated by the meal tickets. CNA #30 confirmed residents frequently had missing food items on their trays, and the trays frequently did not include the items listed on the meal tickets.<br><br>Interview on 12/02/24 at 2:03 P.M. with one [NAME] #20 and Kitchen Aides ([NAME]) #21 and #29) confirmed the facility did not have a kitchen manager.<br><br>Interview on 12/02/24 at 2:04 P.M. with [NAME] #20 confirmed for the lunch meal on 12/02/24 the kitchen ran out of brownies so not all residents received brownies as indicated on the facility menu.<br><br>Observation on 12/04/24 at 1:25 P.M. with [NAME] #20 of the tray line service revealed the service had to be stopped for 10 to 15 minutes due to running out of cabbage with 21 residents left to serve. During tray line the kitchen also ran out of chicken breast which was a substitute ordered for Residents #19 and #20 both of whom had pork listed as a disliked food. Resident #19 was given one chicken breast and a pork chop as a replacement for the second chicken breast. Resident #20 was given a cheeseburger to replace the chicken breast.<br><br>Interview on 12/04/24 at 1:30 P.M. with [NAME] #20 confirmed the kitchen staff ran out of cabbage and chicken during the lunch meal services on 12/04/24.<br><br>Interview on 12/04/24 at 3:15 P.M. with Resident #19 confirmed the kitchen never followed her menu choices and she usually had to send her food back.<br><br>Interview on 12/04/24 at 3:20 P.M. with Resident #20 confirmed she did not eat pork but did not like the cheeseburgers made by the facility. Resident #20 confirmed on 12/04/24 the facility sent her a cheeseburger instead of sending her a chicken breast which was supposed to be the alternate selection for residents who didn't eat pork. Resident #20 confirmed she frequently didn't eat the food because it was not what she ordered, and she would ask the aides to take the food out of her room.<br><br>This deficiency represents noncompliance investigated under Complaint Number OH00159757 and Complaint Number OH00159544. |