STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365215	A. Building B. Wing	09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Suburban Healthcare and Rehabilitation	20265 Emery Rd North Randall, OH 44128

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 - Minimal harm or potential for 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** 37100 Based on medical record review, resident interview, staff interview, and facility policy review, the facility failed to timely report and investigate a resident incident. This affected one (Resident #76) of three residents reviewed for incidents. The census was 112. Findings Include: Resident #112 was admitted to the facility on [DATE]. Her diagnoses were cerebral infarction, dysarthria and anarthria, cognitive communication deficit, need for assistance, difficulty in walking, cerebral infarction, end stage renal disease, obstructive sleep apnea, hypertensive chronic kidney disease (stage V), chronic embolism and thrombosis, congestive heart failure, type II diabetes, hypothyroidism, morbid obesity, anemia, and hemiplegia and hemiparesis. Review of her minimum data set (MDS) assessment, dated 09/14/24, revealed she was cognitively intact. Review of Resident #112 occupational therapy notes, dated 08/20/24 but not written until 08/27/24, revealed patient complete opposition exercises, table top activities for grasp, heat with passive range of motion. Patient let go of two pound free weight and it rolled down leg and therapist tried to push away. Therapist asked if she was ok, and did not state she was having pain. Review of Resident #112 medical records, including progress notes, care plans, skin assessments, and investigation documentation, dated 08/20/24 to 08/22/24, found no evidence that this incident/accident was reported to the nursing staff or that a full assessment of Resident #112 leg was completed to ensure no injury was present. Review of Resident #112 progress notes, dated 08/23/24, revealed a nurse spoke with the facility physician and received an order for x- ray of Resident #112 left ankle. This was in response to Resident #112 complaining of left ankle/foot pain, level eight out of ten. Review of Resident #112 x-ray documentation, dated 08/23/24, revealed on 08/23/24, there is a nondisplaced fracture noted of the distal tibia of unknown acuity. The ankle mortise and talar dome appear normal. There is soft tissue swelling. Recommended clinical correlation. Axial imaging may be performed for further evaluation. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #112 orthopedic appointment documentation, dated 08/29/24, revealed Resident #112 did not have a fracture but soft tissue injury; she was ordered to wear a boot and return for observation/review in one month. Interview with Resident #112 on 09/27/24 at 1:45 P.M. confirmed she had an incident in the therapy room where she dropped a free weight dumbbell on her ankle/foot. She confirmed it hurt. She stated no one ever did a full assessment of her ankle. The therapist asked if she was ok and moved the weight, but did not do a full assessment. She confirmed she did not tell anyone how painful her ankle/foot was after the incident, but she stated, they should have known by my facial expressions. Interview with Therapist #200 on 09/27/24 at 2:05 P.M. confirmed Resident #112 dropped a two pound dumbbell on her left foot/ankle. She stated there was no redness or tenderness to her ankle, and Resident #112 was not complaining of pain. She confirmed she did not report the incident to anyone else, and did not document the incident until 08/27/24. She confirmed she did not document a skin/injury assessment as well. She confirmed that with an incident like this, she should have written an incident report and reported it to nursing at the time it happened. Review of facility Change in Condition policy, undated, revealed the facility shall notify the resident, his or her attending physician, and representative of changes in the resident's medical/mental condition and/or status. The nurse supervisor/charge nurse will notify the resident's attending physician or on-call physician when there has been an accident or incident involving the resident, a discovery of injuries of an unknown source, and a significant change in the resident's physical/emotional/mental condition. A significant change of condition is a decline or improvement is a decline or improvement in the resident's status that will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions. Unless otherwise instructed by the resident, the nurse supervisor/charge nurse will notify the resident's family or representative when the resident is involved in any accident or incident that results in injury including injuries of an unknown source or there is a change in the resident's physical, mental, or psychosocial status. Except in medical emergencies, notification will be made within 24 hours of a change occurring in the resident's medical/mental condition or status. The nurse supervisor/charge nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status as necessary.