STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365436	A. Building B. Wing	06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mother Angeline McCrory Manor	5199 East Broad Street Columbus, OH 43213

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 Note: The nursing home is disputing this citation.	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** 33019 Based on record review, review of hospital reports, review of facility investigation, and interview, the facility failed to ensure a safe and proper wheelchair transport resulting in a fall. This affected one resident (#7) of three residents reviewed for falls. The facility census was 113. Findings include: 1. Medical record review revealed Resident #7 was admitted to the facility on [DATE] with diagnoses including dementia, chronic kidney disease, protein-calorie malnutrition, weakness, failure to thrive, and atrial fibrillation. Review of the fall risk assessment, dated 05/03/24, revealed Resident #7 was determined to be at an increased risk for falls. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment, dated 04/08/24, revealed the resident was severely cognitively impaired. The assessment further revealed the resident was dependent on staff for activities of daily living and mobility. The resident's mobility device was a wheelchair. Review of the Care Plan dated 12/22/17 revealed the resident had the potential for falls related to weakness, abnormal gait/mobility, dementia, history of falling, neuropathy, hypotension, and psychotropic medication use with interventions including to apply Dycem to wheelchair and recliner as tolerated. Further review of the Care Plan dated 03/13/18 revealed Resident #7 was at risk for decline in activities of daily living (ADLs) status and has an ADL self-care performance deficit related to weakness, abnormal gait/mobility, non-ambulatory status, and dementia with interventions including the resident uses a wheelchair when out of bed, usually dependent on staff to propel. Review of a nursing progress note, dated 05/03/24 at 8:50 P.M., revealed the resident was status post fall with observation revealing the left side of forehead was swollen and bleeding. The area was cleansed with normal saline and pressure was applied to the area to stop the bleeding. Hospice was notified, 911 was called and the resident was transferred to the hospital. Review of the Falls- Incident Accident Checklist and the Fall Investigation, dated 05/03/24, did not reveal that the fall intervention for a Dycem to be applied to the seat of the wheelchair was in place at the time of the fall. (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 Note: The nursing home is disputing this citation.	Review of State-tested Nursing Assistant (STNA) #48's Witness Statement, dated 05/03/24, revealed staff was pushing the resident to her room when the resident slid off the wheelchair and down to the floor. The resident hit the left side of her head. Staff immediately notified the nurse who came and took the resident's vital signs and did everything else. Review of Licensed Practical Nurse (LPN) #46's Witness Statement, dated 05/03/24, revealed STNA #48 informed the nurse that Resident #7 had slid out of her wheelchair and had fallen while being transferred in her wheelchair. The nurse observed the resident lying face down with a swollen and bleeding area noted to the resident's left forehead. The resident was crying from pain with distress and the hospice nurse and 911 were called. The resident was taken to the emergency room (ER) for evaluation. Review of a nursing progress note, dated 05/08/24, revealed the interdisciplinary team (IDT) met to discuss the fall on 05/03/24 at 8:00 P.M. The STNA was escorting Resident #7 to her room when the resident slid forward out of her wheelchair. The STNA immediately notified the nurse. Bleeding was noted to the left forehead and a clean, dry dressing was applied. The STNA and nurse assisted the resident from the floor with a gait belt. Pain was noted to the resident's head. Resident was sent to the ER for evaluation and treatment. The intervention initiated was to make sure footrests are in place with resident transfers. Review of the Emergency Department (ED) Note, dated 05/03/24 at 11:14 P.M., revealed the resident was examined in the ED following a fall with a closed head injury and skin avulsion. Computed tomography (CT) scans of the head and spine revealed no acute abnormalities. Bacitracin was the treatment administered. The resident was discharged back to the skilled nursing facility. Review of a nursing progress noted dated 05/06/24 at 1:10 P.M., revealed there was a skin tear to Resident #7's left forehead resulting from the fall on 05/03/24. The area measured 1.5 centimeters (cm) by 2.0 cm by 0.1 cm with treatment in place. Review of a nursing progress note, dated 05/06/24 at 1:10 P.M., revealed a nurse, Administrator, and hospice social worker met with Resident #7's family members who had concern regarding the resident falling over the weekend and being sent to the emergency room (ER) as her code status was do not resuscitate-comfort care only. The family was told that the floor nurse used her nursing judgement due to the inability to stop the resident's abrasion from bleeding. All scans were negative for any subdural hematoma or brain bleed. The resident returned to the facility and neurological checks were resumed. The resident's family were informed that the new intervention following the fall was for the use of the leg rest on the wheelchair. Interview on 06/04/24 at 12:30 P.M. with the Assistant Director of Nursing (ADON) (the Director of Nursing was not present in the facility during the survey) revealed on 05/03/24 the resident was sitting in the common area and the STNA was transporting her back to her room. The wheelchair's footrest was not in use and the resident put her foot down and slid down the wheelchair onto the floor, sustaining a skin tear to her head. The ADON confirmed there was no evidence of any documentation that a Dycem was applied to the seat of Resident #7's wheelchair at the time of the fall. The ADON further confirmed this was a fall intervention listed on the resident's care plan. This deficiency represents non-compliance investigated under Master Complaint Number OH00153793 and Complaint Number OH00153715.