STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365587	A. Building B. Wing	07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Abbyshire Place Health and Rehabilitation Center L	311 Buckridge Road Bidwell, OH 45614

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** 28923 Based on record review, review of the facility's fall investigation, review of a self-reporting incident (SRI) and for an allegation of neglect and the facility's related investigation, observation, staff interview, family interview and policy review, the facility failed to ensure a resident with cognitive impairment, who was at risk for falls and had a history of falls, received the appropriate level of supervision to prevent him from falling in the facility's enclosed patio area. This affected one (Resident #65) of three residents reviewed for falls. Findings include: Review of Resident #65's medical record revealed he was admitted to the facility on [DATE]. His diagnoses included a history of a pubis (pelvic) fracture (05/2024), heart failure, chronic obstructive pulmonary disease (COPD), osteoarthritis (OA), orthostatic hypotension, muscle weakness, vertigo, atrial fibrillation, unspecified dementia, and macular degeneration. He resided on the facility's North unit until he was moved to the secured memory care unit on 07/19/24. Review of Resident #65's fall risk assessment dated [DATE] revealed the resident was at risk for falls. His fall risk factors included occasional confusion, history of one to two falls in the past three months, intermittent incontinence, minimal unsteadiness with balance/ ambulation needing supervision or contact guard assist (hands on assist), poor safety awareness where he attempted to self-transfer or ambulate when not recommended to do so, impulsiveness, taking medications that increased his risk for falls, and diagnoses that predisposed him to falls. Review of Resident #65's quarterly Minimum Data Set (MDS) assessment completed on 06/03/24 revealed the resident had clear speech and was usually able to make himself understood. He had minimal difficulty in hearing and was usually able to understand others. His vision was adequate, without the use of corrective lenses. His cognition at the time of the assessment was severely impaired. He was known to have verbal behaviors directed at others but was not known to reject care. A wheelchair was indicated to be a mobility device he used, and he did not have any functional limitations in his range of motion. Supervision or touching assistance was needed with going from a sitting to lying position and lying to sitting on the side of the bed. Moderate assistance was needed with sit to stand and chair to chair transfers. Ambulation did not occur. (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 #65's care plans revealed he had a care plan in place for an activities of daily living (ADL) self-care deficit related to increased weakness and decreased mobility. The care plan was initiated on 05/15/24. The interventions included transferring the resident with a two-person physical assist using a gait belt and rollator walker. Further review of Resident #65's care plans revealed he also had a care plan for being at risk for falls related to the diagnoses of OA, orthostatic hypotension, generalized muscle weakness, a history of falls, vertigo, low back pain, spinal stenosis, and sciatica. The care plan was last revised on 10/25/23. The goal was for him to have less falls during the review period. The interventions included placing an alarm on the patio door. That intervention was added on 07/01/24. The use of a mesh barrier across the patio door to deter residents from going out was added on 07/18/24. Review of Resident #65's progress notes revealed a nurse's note dated 06/30/24 at 12:13 P.M., that indicated the resident went outside on the patio and slid out of his wheelchair. He sustained an abrasion to the top of his head and left outer elbow. Dycem (non-slip pad) was applied to his wheelchair. Further review of the progress notes revealed a nurse's note dated 07/17/24 at 7:08 P.M. by Registered Nurse (RN) #100 that indicated a state tested nurse aide (STNA) went to the Buckeye room (lounge area by the North nurses' station that had an exit door to the enclosed patio) and saw Resident #65 lying on the patio floor on his right side. The STNA called out for help. The resident was assisted back to his wheelchair and his skin was assessed. He was noted to have an abrasion to his right elbow. Review of the facility's fall investigation for Resident #65's fall on 07/17/24 revealed the resident's fall occurred at 5:10 P.M. RN #100 was the staff member that completed the fall investigation form and indicated the location of the fall was outside. The resident had been seen at the nurses' station approximately ten minutes prior to the fall. The fall investigation indicated the resident's daughter had been in agreement with the resident sitting outside, when the weather was nice. It did not specify if the daughter wanted him to be supervised while he was outside. Immediate action taken included adding a mesh barrier across the patio door to deter the resident from going out unsupervised. The patio door was indicated to remain alarmed. Predisposed physiological factors to the fall included him being confused, having gait imbalance, having impaired memory, and weakness. Predisposing situation factors included active exit seeking and ambulating without assistance. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of SRI #249803 for an allegation of neglect with date of discovery of 07/17/24 revealed the initial source of the allegation was from a visitor/ family member and the involved resident was Resident #65. The alleged/ suspected perpetrator was facility staff or other care provider. The resident's relevant condition included dementia, heart failure, pleural effusion, COPD, and orthostatic hypotension. He was not able to provide meaningful information regarding the incident when interviewed. A narrative summary of the incident revealed Resident #65 was found on the patio, where he had fallen from his wheelchair. While staff were assisting him, his daughter came in and began screaming at the staff. The staff were trying to communicate to her that the resident had only been outside for less than ten minutes. A mesh barrier was placed across the patio door to deter the resident from going onto the patio unsupervised. The patio was enclosed with no way to exit. The patio door was alarmed to let staff know when a resident got outside. A body check was completed with a small abrasion noted to the elbow being the only injury the resident sustained. The facility's investigation was ongoing, and no conclusion/ disposition had been made at that time regarding the facility's conclusion of the allegation. Review of a witness statement obtained from RN #120 (the nurse assigned to Resident #65's hall on 07/17/24) dated 07/17/24 revealed she was not in the building when Resident #65 fell . Staff were aware she was on break. When she returned into the facility, she was notified by the South nurse (RN #115) of the resident's fall. Review of an undated written statement by RN #115 revealed she was at the medication cart passing evening medication at 5:00 P.M. to the residents on the South Hall. She was alerted by staff (STNA #125) that Resident #65 fell on the back patio. Upon entering the back patio area, the resident was noted to be lying on his right side. While the nurse was assessing the resident for injuries, the resident's daughter arrived and became agitated while yelling at the staff, this needs to stop. The daughter was yelling and cursing about the staff not doing their jobs. The nurse explained to the daughter that the resident was not under her care, and she was unaware of the resident's care/needs. Review of a written statement from RN #100 revealed she went to assist a resident at 5:03 P.M. When she walked past the Buckeye room, Resident #65 was sitting by the table in his wheelchair. After walking out of the other resident's room, staff had notified her of what happened with Resident #65 falling. Review of a written statement from STNA #125 revealed she was on her way to empty the linen cart and looked down at her watch and saw it was 5:00 P.M. She then saw Resident #65 sitting in front of the North nurses' station. She proceeded to grab the linen cart and went down to empty it. She hurried because dinner trays were coming. When she arrived back onto the hallway, she replaced the linen cart and went to grab a pop from the vending machine (located in the Buckeye room). When she looked out the door, she saw Resident #65 on the ground. She looked down at her watch and it was 5:10 P.M. She went and yelled for STNA #150 to assist and then went to get the nurse (RN #115). During all of that, the daughter came running behind them and was screaming at them. It was hard for them to hear anything because the call lights were going off and the TV in the Buckeye room was loud. Review of a written statement by STNA #150 revealed at 5:00 P.M. she used the North Hall staff restroom and saw Resident #65 sitting in the hall between the nurses' station and the staff restroom. She came out of the restroom, saw that the trays were on the hall and started passing the dinner trays. At 5:10 P.M., STNA #125 yelled at her from the Buckeye room, and she sprinted there to find Resident #65 lying on the ground. STNA #125 went and got the nurse (RN #115). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a written statement by STNA #175 revealed at 5:00 P.M., while she was walking past the Buckeye room to answer a call light, she observed Resident #65 in the Buckeye room watching TV. She proceeded to go answer the call light that was going activated. She assisted the other resident with changing him and getting him ready for dinner. When she came out, she saw STNA #125, STNA #150, and RN #115 out on the back porch. STNA #125 and RN #115 assisted Resident #65 into his chair. She then assisted with getting the resident back to his room. The resident's daughter was yelling at staff and was yelling at her in the hallway while being in her face. The aide informed the daughter that she was assisting another resident and would not have been able to hear the door alarm to the patio. On 07/22/24 at 1:47 P.M., the door alarm to the enclosed patio area off of the Buckeye room was checked for proper function and to see how the alarm was transmitted. The facility's Director of Nursing (DON) assisted with checking the door and with describing how it worked. The patio door had a small alarm in the right upper corner of the door with two small, white plastic pieces that made up the alarm. One piece was on the door and the other was on the door frame so when the two pieces became disengaged, an audible alarm would sound. The alarm sounded like a doorbell making a ding-[NAME] sound while it was open. Once the door closed the alarm would stop. There was a box at the North nurses' station across from the Buckeye room that transmitted the audible alarm. The alarm was not overly loud and did not require staff to respond to the door in order to silence the alarm. On 07/22/24 at 1:49 P.M., an interview with STNA #125 confirmed she was working when Resident #65 fell in the patio area on 07/17/24. She confirmed her written statement was accurate and she could not hear the door alarm go off while she was in another resident's room at the time of the fall. On that day, they had to redirect the resident frequently, as he was exit seeking through that back patio door most of the day. She stated it was hard to keep an eye on one individual, when they had 30 residents to take care of. The resident required an extensive assistance of two staff for transfers and was not able to ambulate. He had declined the past couple of months and was more confused now than he had been. He used to be allowed to go outside a couple of months ago and usually did that at the front porch where the office staff and other residents could see him. Since it had been hot outside, the resident's daughter did not want him outside. He was not allowed to be out unattended due to his increased confusion. She denied there had been a functioning problem with the door alarm, as it worked as it should. It was just hard to hear, if you were away from the nurse's station and down the hall in a resident's room. On 07/22/24 at 1:58 P.M., an interview with STNA #150 confirmed she was working on 07/17/24, when Resident #65 fell in the patio area. The resident required maximum assistance of two staff for transfers. She considered him to be at risk for falls, and he was known to have fallen prior to the fall on 07/17/24. She described him as being confused. He had displayed exit seeking behaviors before. They had to constantly redirect him and that had not been the first time the patio door alarm had sounded. She confirmed she had seen the resident sitting in the hallway between the nurses' station and the staff's restroom as was written in her statement. She further confirmed he was no longer there when she came out of the restroom. She started passing the dinner trays and then notified by STNA #125 that Resident #65 had fallen on the patio. She denied she had heard the doorbell alarm go off at the patio door. If they were down the hall or in a resident's room, they were not able to hear the alarm. They could not hear it if they were in the restroom either. She did not feel the patio door alarm was an effective intervention, due to them not always being able to hear it. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/22/24 at 2:10 P.M., an interview with RN #100 revealed she was Resident #65's assigned nurse when he fell on [DATE]. She reported the resident was a fall risk and had fallen quite a few times while in the facility. She described him as being very confused and required frequent redirection. She confirmed he had previously fallen in the patio area on 06/30/24, before the fall on 07/17/24. They placed the doorbell alarm on the patio door following that previous fall. She denied she heard the door alarm go off when the resident exited through the patio door to access the enclosed patio area. She was assisting another resident in their room towards the end of the hall near the secured unit doors. When she came out of the room, she was told what had happened. She did not feel the doorbell alarm on the patio door was effective as a fall prevention intervention, unless they were sitting at the nurse's station or in the nearby area. She confirmed the resident should not have been out in the patio area unattended. On 07/22/24 at 2:19 P.M., an interview with RN #120 revealed Resident #65 was a fall risk and had a history of falls. She described him as being very unsteady and required extensive assistance of two staff for transfers. His cognitive status had declined, and he was confused most of the time. He was not fully aware of his limitations. He used to sit outside by himself, but the power of attorney (POA) made it known she did not want him sitting outside by himself anymore. If he did go outside, he should be supervised. His fall interventions included the use of the door alarm to the patio door. She confirmed that intervention was in place before the 07/17/24 fall. She reported, when they were down the hall or in another resident's room, that door alarm to the patio door was hard to hear. On 07/22/24 at 2:26 P.M., an interview with Resident #65's daughter/ POA revealed she found the resident in the patio area, and it was the third time. He had been found out there alone, and after the first time, she asked the facility to put an alarm on the patio door so the staff would know when he went out there. She reported after they put the door alarm on that door it happened again. The staff said they could not hear the alarm when they were down the hall. She confirmed she had told the facility he could go outside, when it was nice weather, if someone was out there with him. With it being so hot outside, she asked that they not allow him out there. On 07/22/24 at 2:40 P.M., an interview with the DON was completed to review Resident #65's fall on 07/17/24. She acknowledged the staff were reporting it was hard for them to hear the door alarm that was on the patio door when they were down the hall or in a resident's room. She further acknowledged the patio door alarm only sounded while the door was open. With it being hard to hear and only sounding when the door was open, it was not effective in preventing Resident #65's fall on 07/17/24. She confirmed that was not the first fall he had out there, as he fell while in the enclosed patio area on 06/20/24. She further confirmed the doorbell alarm on the patio door was their fall prevention intervention for his fall on 06/30/24. Review of the facility's policy on Fall Management Guidelines issued on 12/13/23 revealed the purpose of the policy was to provide guidelines to assist with fall risk identification and fall management of residents in the facility. Fall management goals included reducing the risk of falls by intervening in modifiable risk factors. Factors included in the fall risk evaluation included mental status, history of falling in the last three months, balance while standing, transferring and/or walking, and safety awareness. The resident's care plan and interventions would be reviewed and revised as indicated for the individual needs of the resident and effectiveness of the interventions. This deficiency represents non-compliance investigated under Self-Reported Incident, Control Number OH00155927.