

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365608	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/08/2024
NAME OF PROVIDER OR SUPPLIER  Aristocrat Berea Healthcare and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  255 Front Street Berea, OH 44017	

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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>35768</p> <p>Based on interview and observations the facility failed to maintain a safe and sanitary resident environment. This affected 68 residents who used the showers (#1, #4, #5, #13, #17, #22, #23, #29, #31, #32, #35, #41, #46, #48, #52, #55, #56, #70, #71, #73, #75, #87, #88, #89, #93, #96, #97, #100, #102, #104, #112, #113, #114, #129, #132, #134, #135, #10, #14, #19, #26, #34, #37, #43, #44, #45, #47, #60, #61, #63, #67, #72, #77, #79, #80, #82, #85, #98, #107, #116, #119, #122, #123, #124, #128, #130, #131, #133, and #137) and 21 residents who ate in the dining room on the third-floor secured unit (#7, #9, #20, #24, #27, #28, #30, #33, #38, #51, #57, #59, #64, #65, #78, #92, #99, #101, #110, #118, and #126). Facility census was 140.</p> <p>Findings include:</p> <p>Interview on 07/31/24 at 9:17 A.M. with Resident #32 who resided on the third-floor unit revealed the shower was nasty. Resident #32 said a resident with a colostomy bag used the shower room leaving feces all over the toilet and shower floor.</p> <p>Observation on 07/31/24 at 9:30 A.M. of the third-floor dining room revealed staff and residents were present. The residents were finished eating and staff had placed breakfast trays in the tray cart and were cleaning off tables. Approximately 12 gnats were observed flying in the dining room. A three-shelf cart on wheels located on the side of the dining room had an empty tray on it. Further observation of the cart revealed a large amount of milk had spilled between the tray and the cart. Interview on 07/31/24 at 9:35 A.M. with State tested Nurse Assistant (STNA) #200 verified the gnats and empty tray with spilled milk between the tray and the cart.</p> <p>Observation on 07/31/24 at 9:47 A.M. of Resident #129's room located on the third floor revealed the resident was lying in bed. There were at least a dozen gnats crawling on a washcloth that was hanging on the headboard and another dozen lying in a box on the floor next to the resident's bed. Interview with the resident during the observation revealed the resident was not concerned the gnats in his room. Interview on 07/31/24 at 9:53 A.M. with Licensed Practical Nurse (LPN) #211 verified the gnats in Resident #129's room.</p> <p>Observations on 07/31/24 at 10:19 A.M. of the first-floor shower room revealed towels and blankets lying on the floor and a toothbrush on the floor of the shower stall. Interview on 07/31/24 at 10:19 A.M. with STNA #204 and STNA #206 verified the observations and each stated they were unaware of the condition of the shower room until this observation.</p> <p>(continued on next page)</p>

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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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observations on 07/31/24 at 4:32 P.M. of the third-floor shower room revealed the shower head and hose were hanging down because the clamp did not secure the shower head to the wall of the shower. The cover to the shower drain (a thin flat round piece of metal) was not properly secured. The screws were missing from the cover and the cover moved when touched. The shower stall had soap scum on the walls and floor. Interview during the observations with STNA #201 and the Housekeeping Manager verified the observations.</p> <p>Observations on 08/01/24 at 9:57 A.M. of the second-floor secured unit shower room revealed broken tile pieces, a blanket, and one shoe lying on the floor. Observation on 08/01/24 at 10:11 A.M. revealed STNA #219 walking a resident into the shower room. Interview with STNA #219 at this time revealed she had just showered another resident prior to walking the current resident into the shower room. STNA #219 verified the broken tile, blanket and shoe lying on the floor.</p> <p>Review of lists provided by the facility revealed Residents #1, #4, #5, #13, #17, #22, #23, #29, #31, #32, #35, #41, #46, #48, #52, #55, #56, #70, #71, #73, #75, #87, #88, #89, #93, #96, #97, #100, #102, #104, #112, #113, #114, #129, #132, #134, #135, #10, #14, #19, #26, #34, #37, #43, #44, #45, #47, #60, #61, #63, #67, #72, #77, #79, #80, #82, #85, #98, #107, #116, #119, #122, #123, #124, #128, #130, #131, #133, and #137 used the shower rooms and Residents #7, #9, #20, #24, #27, #28, #30, #33, #38, #51, #57, #59, #64, #65, #78, #92, #99, #101, #110, #118, and #126 ate their meals in the third floor secured dining room.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00156449 and OH00155557.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 35768</p> <p>Based on record review and interview the facility failed to develop a comprehensive care plan for Resident #133 related to the use of bed side rails which assisted Resident #133 with bed mobility and getting in and out of bed. This affected one (Resident #133) of six residents whose care plans were reviewed.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #133 revealed an admitted [DATE]. Diagnoses included unspecified abnormalities of gait and mobility, schizophrenia, and unsteadiness on feet.</p> <p>Review of the plan of care dated 07/28/22 revealed Resident #133 had an activities of daily living (ADL) self-care performance deficit related to schizophrenia, muscle weakness and use of psychoactive medications. The interventions listed did not include use of side rails or grab bars to the bed.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment, dated 06/06/24, revealed Resident #133 had intact cognition, was independent for rolling left to right while in bed and required touch assistance for sit to stand.</p> <p>Review of the nurse's progress note dated 06/26/24 timed at 6:44 P.M. revealed Resident #133 was found on the floor in her room yelling for help. Staff completed a full assessment of Resident #133 and no injuries were noted. Resident #133 stated I was reaching for my bars on the bed and could not find them, and that's how I fell . Resident #133 was assisted off the floor by three staff members.</p> <p>Review of the facility Side/Bed Rail Utilization assessment dated [DATE] revealed Resident #133 indicated the bilateral bedrails helped her roll to either side and the right rail helped her get in and out of bed.</p> <p>Review of the facility Functional Abilities and Goals assessment dated [DATE] revealed Resident #133 required moderate assist for rolling left to right while in bed and chair/bed-to-chair transfer from bed to wheelchair.</p> <p>Interview on 08/01/24 at 9:31 A.M., the Regional Support Administrator (RSA) #212 revealed the facility had an outside company come in and survey the facility. After the survey they were directed to remove all the bed side rails and grab bars. RSA #212 stated the bars and side rails were removed July 2024.</p> <p>Interview on 07/31/24 at 1:29 P.M. with Licensed Practical Nurse (LPN) #215 revealed staff had removed the half side rails from Resident #133's bed the day before or on the same day she fell from bed. LPN #215 stated she was upset the side rails had been removed because Resident #133 used the side rails to get in and out of bed. LPN #215 verified Resident #133's care plan did not include information regarding use of side rails.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 08/01/24 at 11:53 A.M. with Resident #133 revealed she had a fall because she did not have the side rails on her bed. Resident #133 stated before the side rails were removed she used to be able to get out of bed without staff, now she was dependent on staff for assistance to get in out of bed.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 35768</p> <p>Based on record review and interview the facility failed to ensure timely assessment of residents and review of the risks and benefits of bed rails with the residents after removing all bed rails that were currently in place and being used by the residents. This affected six (Resident #7, #12, #16, #85, #131, and Resident #133) of 19 residents whose side rails and grab bars were removed. Based on observation, record review and interview the facility also failed to provide timely incontinence care to prevent incontinence dermatitis. This affected one (Resident #66) of three reviewed for incontinence care.</p> <p>Findings include:</p> <p>1. Interview on 07/31/24 at 9:32 A.M. with Licensed Practical Nurse (LPN) #202 revealed management removed all the bed rails from resident beds leaving residents dependent on staff for mobility and transfers. LPN #202 stated it made it more difficult on staff because the residents were leaning and grabbing on the staff for help.</p> <p>Interview on 07/31/24 at 10:00 A.M. with LPN #211 revealed all the bed rails were removed from resident beds because the state agency told them their use was illegal.</p> <p>Interview on 08/01/24 at 9:31 A.M. with Regional Support Administrator (RSA) #212 revealed the facility had an outside company come in and survey the facility. They were directed to remove all the bed rails. RSA #212 stated all residents would be reassessed by the therapy department for bed mobility and use of bed rails. RSA #212 stated the bed rails were removed in July 2024.</p> <p>Interview on 08/01/24 at 10:12 A.M. with Therapy Director (TD) #213 revealed she was directed by RSA #212 to start assessing the residents for bed mobility on 07/31/24. TD #213 verified the residents were without bed rails for over a month.</p> <p>Interview on 08/01/24 at 10:43 A.M. with Maintenance Director #214 revealed he was told to take the grab bars and side rails off all beds around 06/20/24.</p> <p>2. Review of the medical record for Resident #7 revealed an admitted [DATE]. Diagnoses included unspecified dementia, mild, with anxiety, schizoaffective disorder, unsteadiness on feet, other abnormalities of gait and mobility, and unspecified intellectual disabilities.</p> <p>Review of the plan of care dated 04/14/23 revealed Resident #7 had a activities of daily living (ADL) self-care performance deficit related to schizoaffective disorder, intellectual disabilities, muscle weakness, and anxiety. Interventions included the use of bilateral grab bars to assist with mobility.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment, dated 07/13/24, revealed Resident #7 had intact cognition and was independent with rolling, sitting to standing, and lying to sitting while in bed.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the facility Functional Abilities and Goals assessment dated [DATE] revealed Resident #7 required moderate assistance to roll left to right while lying in bed, and to move from lying on back to sitting on the side of the bed.</p> <p>Review of the facility Side/Bed Rail Utilization assessment dated [DATE] revealed Resident #7 was observed with bed mobility supine (lying on back) to/from sitting to/from standing at edge of bed safely. Resident #7 stated that she previously had grab bars on her bed that she used because it made her mobility easier.</p> <p>Interview on 07/31/24 at 10:14 A.M. with Resident #7 revealed she did not like it when staff removed the grab bars from her bed. Resident #7 said she felt safe when the grab bars were present and the bars helped her get in and out of bed independently; without the grab bars she was dependent on staff to assist her out of bed.</p> <p>Interview on 07/31/24 at 4:09 P.M. with Certified Occupational Therapy Assistant (COTA) #210 revealed residents could benefit from the use of siderails/grab bars that did not restrain or restrict the residents. COTA #210 stated Resident #7 utilized the grab bars to get in and out of bed independently.</p> <p>3. Review of the medical record for Resident #12 revealed an admitted [DATE]. Diagnoses included altered mental status, unspecified, obesity, difficulty in walking, muscle weakness and a history of falls.</p> <p>Review of the plan of care dated 04/12/23 revealed Resident #12 had a risk for falls due to history of falls, muscle weakness, difficulty walking, and psychotropic medication use. Interventions included the use of bilateral grab bars to enhance bed mobility dated 04/17/24.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment, dated 07/10/24, revealed Resident #12 had intact cognition and was independent with activities of daily living.</p> <p>Review of the facility Side/Bed Rail Utilization assessment dated [DATE] revealed Resident #12 utilized bed rails to roll, reposition, and perform bed mobility tasks. Resident #12 stated she was unable to use a trapeze because it hurt her back and was very difficult. Resident #12 stated she was able to utilize bed rails with increased independence.</p> <p>Review of the facility Functional Abilities and Goals assessment dated [DATE] revealed Resident #12 was independent with activities of daily living.</p> <p>Interview on 08/05/24 at 9:38 A.M. with Resident #12 revealed staff took the grab bars away and she now had to rely on staff to get out of bed. Resident #12 stated she spent more time in bed now due to not having the bars.</p> <p>3. Review of the medical record for Resident #16 revealed an admitted [DATE]. Diagnoses included vascular dementia, other abnormalities of gait and mobility, unsteadiness on feet, unspecified lack of coordination and a history of falls.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the plan of care dated 04/12/23 revealed Resident #16 had a risk for falls related to deconditioning and psychoactive drug use. Interventions included the use of bilateral half siderails to assist with mobility dated 12/01/23 and 04/10/24.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment, dated 07/07/24, revealed Resident #16 had intact cognition and was independent with activities of daily living.</p> <p>Review of the facility Functional Abilities and Goals assessment dated [DATE] revealed Resident #16 was independent with activities of daily living.</p> <p>Review of the facility Side/Bed Rail Utilization assessment dated [DATE] revealed Resident #16 utilized bilateral bed rails to safely roll, reposition, and perform bed mobility tasks. Resident #16 reported she was spending more time in bed due to increased difficulty performing bed mobility without rails.</p> <p>Interview on 08/05/24 at 9:32 A.M. with Resident #16 revealed staff took her bed bars away and she needed them to pull herself up and get out of bed. Resident #16 stated she now spent more time in her bed due to not having the bars for assistance.</p> <p>4. Review of the medical record for Resident #85 revealed an admitted [DATE]. Diagnoses included difficulty in walking, bi-polar disorder, unspecified abnormalities of gait and mobility, and obesity.</p> <p>Review of the plan of care dated 04/12/23 revealed Resident #85 had an activities of daily living (ADL) self-care performance deficit related to impaired balance, weakness, rhabdomyolysis, and bi-lateral lower extremity lymphedema. Interventions included the use of bilateral half siderails to assist with mobility dated 04/13/23.</p> <p>Review of the facility Functional Abilities and Goals assessment dated [DATE] revealed Resident #85 required moderate assistance for toilet hygiene, rolling left to right in bed and toilet transfers.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment, dated 06/05/24, revealed Resident #85 had intact cognition and required moderate assist for rolling left to right in bed.</p> <p>Review of the facility Side/Bed Rail Utilization assessment dated [DATE] revealed Resident #85 used bed rails for rolling and repositioning and bed mobility.</p> <p>Interview on 07/31/24 at 11:16 A.M. with Resident #85 revealed he could roll and reposition himself in bed with the siderails, now that the siderails had been removed he was dependent on staff for assistance.</p> <p>5. Review of the medical record for Resident #131 revealed an admitted [DATE]. Diagnoses included unspecified abnormalities of gait and mobility, vascular dementia, and muscle weakness.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the plan of care dated 07/26/24 revealed Resident #66 had potential for pressure ulcer development related to limited movement and medical status. Interventions included to provide weekly skin checks and to follow policies/procedures for prevention/treatment of skin breakdown.</p> <p>Review of the admission Minimum Data Set (MDS) assessment, dated 07/28/24, revealed Resident #66 had impaired cognition and was dependent for all activities of daily living. There was no documentation of skin alterations.</p> <p>Review of the facility weekly skin assessments revealed documentation dated 06/06/24, 06/10/24, 06/27/24, 07/09/24 and 08/03/24 which indicated Resident #66 had no skin alterations.</p> <p>Review of shower sheets for Resident #66 dated 07/24/24 through 08/03/24 revealed no documentation indicating the resident had alterations in skin.</p> <p>Review of incontinence care tracking documentation from 07/22/24 through 08/07/24 revealed staff provided incontinence care twice on 07/22/24, once on 07/23/24, twice on 07/24/24, and 07/25/24, once on 07/26/24, once on 07/28/24, twice on 07/30/24, once on 07/31/24, once on 08/02/24, twice on 08/04/24, once on 08/05/24, and twice on 08/06/24 and 08/07/24.</p> <p>Review of the July/August 2024 treatment administration records (TAR) for Resident #66 revealed an order for nystatin external powder, apply to groin and under both breast topically every day for redness dated April 2024 through 07/21/24. Further review of the TAR revealed a order for nystatin external cream 100,000 unit/gram, apply to effected areas topically every 12 hours as needed for irritation. There was no documentation on the TAR indicating staff had applied the nystatin cream since 07/21/24.</p> <p>Review of the plan of care dated 08/07/24 revealed Resident #66 had actual impairment to skin related to redness to perineum and sacrum. Interventions included to encourage medication and treatment regimen. The plan of care also indicated Resident #66 had bowel incontinence related to Wernicke's encephalopathy and disease process. Interventions included to check resident on routine rounds and assist with toileting as needed and provide peri-care after each incontinent episode.</p> <p>Observation on 08/06/24 at 9:00 A.M. revealed State tested Nurse Assistant (STNA) #217, STNA #218 and Unit Manager #221 providing incontinence care for Resident #66. Upon removal of Resident #66's incontinence brief a red rash covering the resident's entire peri area including the buttocks was observed. When asked about the rash, the STNAs stated Oh, she has had that rash forever. Continued observations revealed after the STNAs cleaned the entire peri-area and were getting ready to secure the brief in place the Unit Manager stated, are you going to put cream on her? The STNAs retrieved a tub of thera calazinc body shield from a basket in the resident's room and applied the barrier shield.</p> <p>Interview on 08/07/24 at 8:22 A.M. with the Director of Nursing (DON) revealed she was not aware of Resident #66's rash but she would check into it. The DON verified the documentation in the incontinence care tracking indicating staff only provided incontinence care one or two times daily from 07/22/24 through 08/07/24. The DON said Resident #66 was also receiving care from hospice services and that the hospice staff came in and completed incontinence care during their visits.</p> <p>Review of hospice documentation revealed hospice services did not visit daily and when they did visit, they stayed an average of 45 minutes to 1.5 hours.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Aristocrat Berea Healthcare and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 255 Front Street Berea, OH 44017	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 08/07/24 at 8:52 A.M. with the Wound Nurse verified the information on the TAR and stated she was not made aware of the rash until 08/06/24. The Wound Nurse stated she would put Resident #66 on the list to be assessed by the wound physician.</p> <p>Interview on 08/07/24 at 11:30 A.M. with Nurse Practitioner (NP) #220 revealed she was not aware of Resident #66's rash because hospice rarely communicated with her. NP #220 stated she assessed Resident #66 last week but did not observe the rash because no one informed her of the rash. NP #220 stated she would assess Resident #66 and her share findings.</p> <p>During a follow up interview with NP #220 on 08/07/24 at 11:53 A.M., NP#220 stated Resident #66's rash was dermatitis due to poor incontinence care.</p> <p>Review of the NP note dated 08/07/24 revealed Resident #66 had incontinent dermatitis to peri-area.</p> <p>Review of incontinent dermatitis on www.healthline.com revealed incontinent dermatitis was caused by ineffective or poor condition management which included prolonged exposure to urine and feces and inadequate cleaning of the exposed area.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00155631, OH00156449, and OH00155557.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 35768</p> <p>Based on record review and interview the facility failed to ensure residents were redirected from safety hazards affecting Resident #135 and failed to ensure bed rails were not removed prior to assessing the resident's ability to exit the bed safely without the rails affecting Resident #133. This affected two of six residents reviewed for falls.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #133 revealed an admitted [DATE]. Diagnoses included unspecified abnormalities of gait and mobility, schizophrenia, and unsteadiness on feet.</p> <p>Review of the plan of care dated 07/28/22 revealed Resident #133 had an activities of daily living self-care performance deficit related to schizophrenia, muscle weakness and use of psychoactive medications.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment, dated 06/06/24, revealed Resident #133 had intact cognition. Resident #133 was independent for rolling left to right while in bed.</p> <p>Review of the facility Side/Bed Rail Utilization assessment dated [DATE] revealed Resident #133 utilized the bilateral bed rails to help her roll to either side and the right bed rail to get in and out of bed.</p> <p>Review of the facility Functional Abilities and Goals assessment dated [DATE] revealed Resident #133 required moderate assist for rolling left to right while in bed and chair/bed-to-chair transfer from bed to wheelchair.</p> <p>Review of the incident log for the past three months revealed Resident #133 had a fall on 06/26/24.</p> <p>Review of the nurse's progress note dated 06/26/24 timed at 6:44 P.M. revealed Resident #133 was found on the floor in her room yelling for help. Staff completed a full assessment and no injuries were reported. Resident #133 stated I was reaching for my bars on the bed and could not find them, and that's how I fell . Resident #133 was assisted off the floor by three staff members.</p> <p>Interview on 07/31/24 at 9:32 A.M. with Licensed Practical Nurse (LPN) #202 revealed management removed all the grab bars and side rails leaving residents dependent on staff for mobility and transfers.</p> <p>Interview on 07/31/24 at 1:29 P.M. with LPN #215 revealed she could not remember if management removed the side rails the day before or on the same day Resident #66 had her fall. LPN #215 was upset because Resident #133 used the rails to get in and out of bed and Resident #133 had no falls prior to this incident.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 08/01/24 at 11:53 A.M. with Resident #133 revealed she had a fall because she did not have the rails on her bed. Resident #133 stated she used to be able to get out of bed without staff using the side rails. Resident #133 stated she was now dependent on staff for assistance.</p> <p>38091</p> <p>2. Resident #135 was admitted to the facility on [DATE] with diagnoses that included dementia, restlessness and agitation and generalized anxiety disorder. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #135 was severely cognitively impaired and required supervision for completing his activities of daily living.</p> <p>Review of the care plan dated 02/12/24 revealed Resident #135 was at risk for falls related to psychoactive drug use.</p> <p>Review of the falls risk assessments from 06/23/24, 05/09/24, and 02/09/24 revealed Resident #135 was at moderate risk for falls.</p> <p>Observation on 08/01/24 at 10:18 A.M. revealed Resident #135 was sprinting laps up and down the hallway. While he was sprinting down the hallway the floor was noted to be wet and Maintenance Technician (MT) # 400 was pushing a large floor scrubbing machine down the hallway.</p> <p>While Resident #135 was running down the hallway he passed State tested Nursing Assistant (STNA) #475 who was engaging in documentation of activities in the hallway on a rolling cart, Licensed Practical Nurse (LPN) #485 documenting inside the nurse's station and Activities Workers (AW) #450 conversing in the hallway, multiple times. After completing approximately two laps up and down the hallway AW #450 began running alongside Resident #135. After running for approximately 15 feet Resident #135 fell to his knees on the floor.</p> <p>Interview with AW #450 on 08/01/24 at 10:24 A.M. verified the events of the observed fall. AW #450 further stated that Resident #135 believed he was part of the Olympics and ran sprints down the hallway all the time.</p> <p>Review of the facility fall policy dated 04/01/21 revealed It is the policy of this facility to assure proper review of resident fall risk and implementation of interventions to attempt to prevent or reduce falls/accidents and injuries related to falls.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00155557 and OH00155631.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>38091</p> <p>Based on observation, staff interview and policy review the facility failed to ensure ice machines were maintained in a clean and sanitary condition. This had the potential to affect all residents. The facility census was 140.</p> <p>Findings include:</p> <p>Observation of the facility's ice machine on 08/01/24 at 7:45 A.M. with Dietary Manager (DM) #924 revealed the main ice machine was not working and had been out of service since 06/24/24. DM #924 explained that the facility was awaiting parts to replace the unit and the facility was temporarily using the ice machine on the second floor to meet its needs.</p> <p>Observation of the second floor ice machine on 08/01/24 at 9:11 A.M. with DM #924 revealed the top portion of the ice machine had a large area of slimly brown and green mold. The machine also had a noticeable musty smell when opened. DM #924 verified the condition of the ice machine at the time of observation.</p> <p>Review of the policy clean schedules dated 10/01/21 revealed culinary manager or designee monitors sanitation of department and assigns correction as needed.</p>		