

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365654	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/09/2024
NAME OF PROVIDER OR SUPPLIER Austinwoods Rehab Health Care		STREET ADDRESS, CITY, STATE, ZIP CODE 4780 Kirk Rd Austintown, OH 44515	

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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37100</p> <p>Based on medical record review, hospital record review, facility policy review and interview, the facility failed to provide adequate two-person assistance with bed mobility for Resident #36 as assessed/planned resulting in an injury.</p> <p>Actual harm occurred on 10/05/24 when Resident #36 sustained a fractured hip when one staff member (State tested Nursing Assistant, (STNA) #110) was providing personal care for Resident #36. The resident had been assessed/planned to require two staff members for bed mobility prior to the incident. During care, the resident complained of extreme pain when the STNA lifted the left side of her body. On 10/07/24, the resident was transferred to the hospital for follow-up care. An x-ray obtained on 10/07/24 identified the fracture which the facility determined was caused by the single person bed mobility procedures with STNA #110 on 10/05/24.</p> <p>This affected one resident (#36) of three residents reviewed for accidents. The census was 90.</p> <p>Findings include:</p> <p>Record review revealed Resident #36 was admitted to the facility on [DATE] with diagnoses including multiple sclerosis, anxiety disorder, psychosis, major depressive disorder, quadriplegia, neuromuscular dysfunction of bladder, vitamin B deficiency, contracture, insomnia, glaucoma, and osteoporosis.</p> <p>Review of Resident #36's care card dated 09/20/24 revealed the resident required two-person assistance with bed mobility.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #36 was cognitively intact. The assessment indicated the resident was dependent on staff for bed mobility, rolling left and right in bed.</p> <p>Review of Resident #36's current care plan revealed the resident needed (staff) assistance with activities of daily living (ADL). One intervention within the care plan revealed she needed assistance with bed mobility. Another intervention within the care plan was for staff to follow the resident care card for assistance with her ADLs.</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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Review of Resident #36's hospital records dated 10/07/24 revealed Resident #36 mentioned to the hospital staff that when she was being transferred/moved in her bed on 10/05/24 when she felt a sharp pain to her left hip. An x-ray was completed on 10/07/24, and confirmed she had a impacted displaced subcapital left femoral neck fracture.</p> <p>Review of a facility Self-Reported Incident (SRI) dated 10/07/24, revealed Resident #36 was lying in bed on 10/05/24, and used her call light to request assistance with moving from one side to the other while in bed. State tested Nursing Aide (STNA) #110 arrived to the resident's room and attempted to assist Resident #36 with shifting her body from the left side to the right side. STNA #110 lifted Resident #36's left side of her body by herself, so she could remove the pillow and move it to the right side of the resident's body. During that time, Resident #36 expressed extreme pain when STNA #110 lifted the left side of her body. STNA #110 asked if she wanted the nurse to assess her, but Resident #36 declined. From 10/05/24 to 10/07/24, the resident received pain medication as ordered. An x-ray was not completed until 10/07/24. The results of the x-ray at the facility were inconclusive, so the resident was transferred to the hospital, where those x-rays confirmed she had a fractured hip, which was caused during the single person bed mobility procedures with STNA #110 on 10/05/24.</p> <p>Review of Licensed Practical Nurse (LPN) #107's interview statement dated 10/06/24 revealed Resident #36 told her about the incident the night before (on 10/05/24). She stated the aide turned her hard and quick, to the point that her left leg was not positioned correctly. LPN #107 confirmed she was still in pain. LPN #107 asked Resident #36 would like an x-ray in the morning. She also told the nurse she did not think she could attend her wound care appointment the next morning as it would be too painful to get on and off the gurney. She was given medication for pain at that time and stated she would let the daytime nurse know the next morning that they should get an x-ray.</p> <p>Review of LPN #105's interview statement dated 10/07/24 confirmed Resident #36 told her about the incident that happened on Saturday (10/05/24). She confirmed she had pain to her left side during the incident. LPN #105 documented she assessed her left and found no evidence of visible injury. But she contacted the nurse practitioner to report the incident and the pain; an x-ray was ordered for that day.</p> <p>Review of STNA #110's investigation statement dated 10/08/24 confirmed she was assisting Resident #36 with moving a pillow from underneath her left side and was going to move it to her right side as part of her turning schedule. She confirmed she was attempting to move the pillow from Resident #36 left side, and Resident #36 yelled in pain. She did not move her anymore. She ended her statement with, I was not told that 'Resident #36' required two people to assist her.</p> <p>Review of STNA #106's interview statement dated 10/10/24 revealed she worked the morning shift of Saturday, 10/06/24. She confirmed she was told by Resident #36 about the incident that happened the night before (10/05/24) and how her leg was hurting. She reported the incident and pain to the nurse that was working. She confirmed there was discomfort throughout her shift when they propped her up or moved her for care. There was nothing listed in the statement that the physician was notified about the incident or the resident's pain.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Interview with Resident #36 on 11/09/24 at 12:00 P.M. confirmed one staff person was assisting her when she had requested to be turned/propped to the other side in bed. She stated it's usually two staff that would come in and help, but she didn't know this aide and didn't know if she could do it by herself. She confirmed she felt severe pain in her left leg/hip area as soon as the staff person (STNA #110) lifted her left side to remove the pillow. Resident #36 confirmed she was in severe pain after the incident. She stated she did not see a doctor, a doctor was not offered to her, and she did not receive an x-ray regarding her hip pain until 10/07/24. She confirmed she would have liked an x-ray sooner had it been offered. She stated the pain didn't really stop, but she received her pain medication as she typically takes it.</p> <p>Interview with Licensed Practical Nurse (LPN) #105 and STNA #101 on 11/09/24 at 12:10 P.M. and 12:18 P. M. confirmed each time they go in to assist Resident #36 with transferring or moving in bed, they have two people to assist. They confirmed that one person would lift the sheet that was underneath Resident #36, and the other staff would grab/move the pillow.</p> <p>Interview with STNA #106 on 11/09/24 at 12:46 P.M. confirmed Resident #36 told her about the incident that happened with STNA #110 and how it caused her a lot of pain. She confirmed she told the on-shift nurse about the incident and the pain. She was not certain what all the nurse did, but the nurse did give the resident as needed pain medication. She stated Resident #36 had pain, but in her opinion, she was always in pain, so she didn't feel it was different than her typical pain. But she did confirm the pain seemed to be more frequent than her typical pain, which was why she reported it to the nurse. She does not know if the physician was notified during that shift; that would be the responsibility of the nurse.</p> <p>Interview with LPN #107 on 11/09/24 at 12:49 P.M. confirmed she was told about the incident that happened on 10/05/24 regarding Resident #36. She asked Resident #36 if she wanted to get an x-ray the next morning; Resident #36 confirmed she would like that. She also stated she offered to send Resident #36 to the hospital that night, but stated Resident #36 declined because getting on a gurney would hurt too much. LPN #107 stated she was not given any information from the morning shift nurse at shift change about an incident with Resident #36 or any extra pain. But LPN #107 stated she did not contact the nurse practitioner or physician that night because, the x-ray technicians would not come to a facility on a Sunday night.</p> <p>Review of facility Condition Change Reporting, Residents policy, dated July 2015, revealed communication with the physician, the resident, and/or the responsible party was maintained when there was a significant change in condition and/or treatment. The physician, resident, and/or responsible party were notified when the resident's physical, communicative, psychosocial, or functional status changes unexpectedly, the resident is injured, or if treatment was significantly altered.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00159103.</p>		