STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365747	A. Building B. Wing	03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Astoria Place of Waterville	555 Anthony Wayne Trail Waterville, OH 43566

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 - 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** 35033 Based on review of the medical record, review of a self-reported incident, review of an incident report, review of hospital records, review of staff statements, staff interview, staff job description, and policy review, the facility failed to ensure staff assisted a resident with safe ambulation, report a resident fall, and ensure a resident was assessed for injuries prior to moving the resident after a fall, and ensure the resident's fall was thoroughly investigated. Additionally, the facility failed to implement fall prevention interventions. This resulted in Actual Harm on 02/12/25 when staff assisted Resident #47 to the bathroom without his walker, staff then picked the resident up off the floor after a fall, toileted the resident, and then walked the resident back to bed further increasing the risk for injury then never reported the fall to the nurse. The oncoming nursing shift later found the resident had bruising to the left lower lip and redness to the left side of the face and a displaced intertrochanteric fracture of the left femur, requiring surgical repair and hospitalization from [DATE] through 02/18/25. This affected one (#47) of three residents reviewed for falls. The facility census was 74. Findings include: Review of the medical record for Resident #47 revealed an admitted [DATE]. Diagnoses included hemiplegia and hemiparesis following cerebral infarction, type two diabetes mellitus, atrial fibrillation, difficulty walking, muscle weakness, osteoarthritis of unspecified hip, hypertension, anxiety disorder, bipolar disorder and vascular dementia. A diagnosis of displaced intertrochanteric fracture of the left femur was added on 02/18/25. Review of the annual Minimum Data Set (MDS) assessment completed 01/21/25 revealed the resident had severe cognitive impairment. The resident required substantial/maximal assistance for toileting, supervision/touching assistance for transfers and ambulation. Review of a fall risk assessment dated [DATE] revealed the resident was at high risk for falls. Review of a physical therapy discharge assessment dated [DATE] revealed the resident could ambulate 150 feet with front wheeled walker and supervision/stand by assist requiring ten percent verbal cues for proper use of walker. Discharge recommendations included the use of a front wheeled walker for ambulation. Review of the physician orders for 02/2025 revealed no orders for assistive mobility devices. (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 - Actual harm Residents Affected - Few	Review of the care plan initiated 01/18/24 and last revised on 01/22/25 revealed the resident was at risk for falls due to decline in functional mobility, diagnoses of anxiety, depression and vascular dementia, an elevated body mass index, restlessness, osteoarthritis of the hip, incontinent, use of psychotropic medications and weakness. Interventions included to be sure the resident's call light was within reach and encourage the resident to use it for assistance as needed. The resident needed prompt response to all requests for assistance. Physical/Occupational evaluation and treatment as indicated. The resident required the assistance one staff for transfers and assistance with toileting as needed. There was no documentation in the care plan for the resident to use a walker. Review of the staff schedule for 02/11/25 revealed Certified Nursing Assistant (CNA) #110 and CNA #112 were assigned to care for residents on the memory care unit including Resident #47 from 02/11/25 at 7:00 P. M. through 7:00 A.M. on 02/12/25. Review of a nurse progress note dated 02/12/25 at 7:50 A.M. revealed the nurse was notified by a nursing assistant that Resident #47 was not able to sit up or get up for breakfast on his own. The nursing assistant went to help the resident and when she touched his leg he yelled out in pain. The progress note stated that when the nurse was notified, the nurse further assessed Resident #47's skin and leg. Resident #47 had swelling to his left hip/leg, and his left leg was rotated outward. Resident #47 also had a swollen bottom lip on the left side, and red bump on his left cheek. The nurse notified nurse practitioner and received a STAT order for a left hip/pelvis X-ray and the rest of his leg if needed. The nurse progress note continued to say Resident #47 was complaining of pain and discomfort, was given medication (scheduled Tylenol), vital signs were within normal limits and the resident will continue to be monitored. Review of a self-reported incident (SRI) report dated 02/12/25 at 10:00 A.M., a facility incident report and subsequent investigation revealed the resident had bruising to left lower lip, left cheek, and noted increased pain to left hip. Resident #47 was unable to give description. Full assessment head to toe completed. Left leg had increased pain and resident was unable to move left leg. Left leg also noted had shorten appearance to it. The nurse contacted the physician and received orders for a STAT x-ray. Physician and guardian notified. Review of the SRI summary of incident revealed the resident was found with an area of discoloration to the left lower lip and left cheek and leg pain. The nurse assessed the resident, and a stat x-ray was ordered showing a left femur fracture. Upon investigation it was reported that staff had assisted the resident to the bathroom in the early morning hours of 02/12/25 and his legs buckled and he went to the floor. The staff assisted the resident off the floor and onto the toilet and back to bed. The staff noticed the resident had difficulty walking and the resident was unable to tell staff what was wrong. The staff were educated on reporting any fall immediately upon discovery. Disciplinary action was taken as appropriate. Further review of the incident report and investigation revealed no documentation regarding what fall interventions were in place prior to the resident's fall including type of footwear worn and environmental conditions of the room. There were also no statements or interviews from the day shift nursing assistant receiving report from the night shift nursing assistant, there was no statement from the nursing assistant who discovered the injury, and no documentation if the resident was using his walker at the time of the fall. Review of a late entry nurses note dated 2/12/2025 at 10:09 A.M. revealed the resident had (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	bruising to left lower lip, left check, left side of head and noted increased pain to left hip. Resident unable to recall events. Full assessment head to toe completed. Left leg has increased pain and resident was unable to move left leg. Left leg also noted with shortened appearance. Nurse contacted physician and received order for STAT X-ray. Review of a nurses note dated 02/12/25 at 11:06 A.M. revealed the results of the x-ray included an acute-appearing fracture of the intertrochanteric left femur. There was a mild displacement of the distal fragment. There were no gross lytic or blastic lesions in the bones. There was no abnormal radiopaque foreign body. There was no dislocation. The joint spaces were unremarkable. Resident was sent out 911. Will continue to monitor. Responsible party was notified. The nurse practitioner and management notified. Review of a late entry nurses note for 2/13/25 at 9:20 A.M. revealed the Interdisciplinary Team (IDT) met to discuss resident related to fall dated 02/12/25. Resident was being assisted to the toilet when his knees buckled causing him to fall to the floor. An x-ray was completed related to leg pain and results showed a left femur fracture. Resident was sent to the emergency room for evaluation and treatment. Review of an undated and unsigned statement by Certified Nursing Assistant (CNA) #110 taken over the phone by the Director of Nursing (DON) revealed on the morning of the resident's accident, CNA #112 and CNA #110 walked the resident to the bathroom. CNA #110 stated the resident made it to the toilet, he went down saying he could not do it. The resident went to the ground, and we let him catch his breath. Afterward, we proceeded to lift him up and place him on the toilet. After the resident was done, we walked him back to bed. Review of an undated and unsigned statement by CNA #112 revealed on the night of the resident's incident, CNA #110 and CNA #112 walked the resident to the bathroom because he had a bowel movement. As they walked the resident to the toilet, the resident buckled to the floor. CNA #110 and CNA #112 helped the resident off the floor. Once the resident caught his breath they continued to take him to the toilet. CNA #110 and CNA #112 cleaned the resident up after using the toilet and walked the resident back to bed. CNA #112 noticed the resident was walking funny and asked him what happened, and the resident stated he did not know. Review of an undated unsigned statement for Registered Nurse (RN) #260 taken by Assistant Director of Nursing (ADON) #214 revealed no staff had reported a fall for Resident #47 on the 12-hour night shift from 02/11/24 into 02/12/25. Review of a skin assessment dated [DATE] revealed Resident #47 's left leg and hip were swollen and turned outward. The resident had a bruised and swollen lip and a red bump on the left cheek. Review of a hospital documentation dated 02/12/25 revealed the resident was admitted to the hospital on 02/12/25 at 11:53 A.M. The resident presented with a fall and hip pain from an unwitnessed fall at the nursing home. The outpatient x-ray showed fracture of the left intertrochanteric femur and mild displacement of distal fragment. The resident was unable to provide any history and believed it was 1978. The resident underwent imaging and found to have a severely comminuted intertrochanteric fracture through the proximal left femur with varus deformity of the proximal left femur. There was mild hemorrhage in the soft tissue surrounding the deformity. The resident denied pain. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the hospital imaging/diagnostics report dated 02/12/25 revealed a computed tomography (CT) of the left hip was completed. The resident had an acute severely comminuted intertrochanteric fracture through the proximal left femur with varus deformity of the proximal left femur. There was underlying diffuse osteopenia and mild hemorrhage in the soft tissues surrounding the proximal left femoral fracture deformity. The resident was also noted with mild underlying bilateral hip osteoarthrosis with underlying diffuse osteopenia. Review of the resident's care plan revised on 02/18/25 revealed the resident was at risk for falls and potential injury. Interventions included a low bed, maintain a clear pathway, mat on floor next to bed, non-slip material in chair, turn and reposition, Broda chair per therapy recommendation, call light in reach and encourage use, prompt response for requests for assistance. Review of the care plan for alteration in musculoskeletal status related to the fracture revealed an intervention for an abductor pillow while in bed. Review of corrective action counseling statements dated 02/19/25 for CNA #110 and CNA #112 revealed counseling completed for failure to follow instruction or to perform work according to procedure or policy. Review of a training in-service dated 02/19/25 revealed 74 staff received education on the fall policy. Observation on 03/20/25 at 9:39 A.M. of Resident #47 revealed the resident was in bed with his eyes closed. The bed was in the lowest position but was not a low bed. Resident #47's hip abductor was not in place and there was no floor mat next to the bed. Further observation revealed there was no nonslip material in place in the resident's wheelchair. Interviews on 03/20/25 at 9:39 A.M., CNA #272 verified the resident's hip abductor was not in place and was located in the resident's closet. CNA #272 verified there was no fall mat in place next to the resident's bed. CNA #272 was unaware the resident required a fall mat. CNA #272 verified the resident's bed was in the lowest position. Interview on 03/20/25 at 9:42 A.M., CNA #276 verified there was no nonslip material in place in the resident's wheelchair. CNA #276 revealed another resident must have moved it. Interview on 03/20/25 at 10:09 A.M., CNA #110 revealed on 02/12/25 before 6:00 A.M. CNA #112 assisted him with walking Resident #47 to the bathroom without his walker. CNA #110 revealed they got to the bathroom and the resident began to buckle. CNA #110 revealed CNA #112 and himself were on each side of the resident and lowered the resident to the ground on his buttocks with his legs in front of him in front of the toilet. CNA #110 revealed they got the resident back up and put him on the toilet. CNA #110 revealed the resident had not hit his head. CNA #110 stated four times the resident had not fallen; he was lowered to the ground. CNA #110 verified the incident was not reported to the nurse. During the interview CNA #110 revealed he told CNA #402 on the oncoming shift about lowering Resident #47 to the ground. CNA #110 revealed he was unaware that lowering a resident to the floor was considered a fall. CNA #110 stated he had been educated by the DON. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview on 03/20/25 at 10:56 A.M., CNA #276 revealed on 02/12/25 her shift started around 7:00 A.M. CNA #276 revealed around 7:30 A.M. Resident #47 requested assistance getting up. CNA #276 revealed as she went to assist the resident, the resident stated, my hip, my hip. CNA #276 revealed seeing a bruise on the resident's lip. CNA #276 revealed she requested the nurse to the room to assess the resident. CNA #276 revealed she wrote a statement. Interview by telephone on 03/20/25 at 11:04 A.M. and 2:49 P.M. was attempted unsuccessfully with CNA #402. Interview on 03/20/25 at 11:11 A.M., the DON revealed on 02/12/25 Resident #47 was found with unexplained injuries and a self-reported incident was reported. The DON revealed she was not in the building on 02/12/25. The DON revealed Resident #47 had a fracture to the left hip/femur. The DON revealed the resident was sent to the hospital where he received surgical repair and returned to the facility on [DATE]. The DON revealed during the investigation it was found that the resident had been assisted to the bathroom by CNA #110 and CNA #112. While in the bathroom the resident's legs buckled and he fell . The staff assisted him up and onto the toilet then walked him back to bed. The DON verified CNA #110 and CNA #112 never reported the fall and received written counseling action. The DON stated CNA #110 and CNA #112 stated the resident fell and never indicated he had been lowered to the floor. CNA #110 and CNA #112 stated if a resident was not injured then why would they report the incident to the nurse. The DON revealed staff were educated to report all falls even if lowered to the floor or change in plane. The DON revealed CNA #110 and CNA #112 stated the resident may have hit his head during the fall. The DON revealed not knowing what kind of footwear the resident was wearing at the time of the fall or if there were any contributing environmental factors. The DON revealed the resident was not care planned for gait belt use but maybe they should have used a gait belt. The DON revealed the incident occurred around 5:00 A.M. The DON verified there was missing information in the investigation, she claims she asked the questions and should have written down all the questions asked and their responses. Further interview with the DON revealed the nursing assistants stated the fall happened around 5:30 A.M. and the oncoming shift noticed around 7:30 A.M. The DON revealed the resident had an x-ray around 11:06 A.M. and was admitted to the hospital at 11:53 A.M. on 02/12/25. The DON verified she could not find a statement by CNA #276 and never interviewed CNA #402 who received report from CNA #110. Further interview on 03/21/25 at 1:18 P.M. the DON verified there was no documentation in the incident report or the investigation whether staff had the resident using his walker at the time of the fall. The DON revealed per therapy the resident should have been using his walker, and it was the safest way to walk Resident #47. The DON revealed the resident would need reminded to use his walker and often would refuse to use the walker. The DON verified there was no documentation in the medical record the resident had refused to use his walker at the time of the fall on 02/12/25. The DON further revealed the use of a walker was not required to be in the physician's orders or care plan. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview on 03/20/25 at 12:26 P.M., CNA #112 revealed on 02/12/25 around 5:00 A.M. to 5:30 A.M. Resident #47 was in bed and had a bowel movement. CNA #112 revealed CNA #110 and herself walked with the resident to the bathroom to clean him up. CNA #112 revealed they were not using a gait belt or the resident's walker because the resident could walk on his own. CNA #112 revealed they were walking behind the resident and the resident's legs buckled and CNA #110 and herself grabbed the resident's arms and lowered him to the floor on his bottom with his legs in front of him facing the toilet and his back to the door. CNA #112 revealed she had not noticed the resident hitting his head or face on anything. CNA #112 revealed waiting for the resident to catch his breath and then they got him up on the toilet, cleaned him up and walked him back to bed. CNA #112 revealed the resident was walking funny. CNA #112 revealed asking the resident what was wrong with his leg and the resident replied, I don't know. CNA #112 revealed not noticing any bruising or red marks on the resident's face. CNA #112 revealed the incident was not reported to the nurse because the resident had not voiced having pain. CNA #112 revealed the DON educated her for not reporting the incident. Interview follow-up on 03/20/25 at 12:51 P.M., the DON revealed she had just spoken with CNA #112 and CNA #112 told her the resident fell and had hit his head. The DON was not sure why CNA #112 and CNA #110 were inconsistent with their statements when reporting to the surveyor that the resident was lowered to the floor and had not hit his head as she had spoken with both of them earlier in the same day and they told her the resident fell , hit his head, and was not lowered to the floor. Observation and interview on 03/20/25 at 12:58 P.M., the DON verified Resident #47 was not in a low bed. The DON revealed the resident's bed was in the lowest position. The DON revealed the care plan should have stated the bed should be in the lowest position instead of a low bed. The DON revealed a low bed would not be appropriate for Resident #47. Interview on 03/20/25 at 1:15 P.M., ADON #214 revealed initiating the investigation for Resident #47. ADON #214 revealed RN #260 was contacted and knew nothing about a fall from the previous shift. ADON #214 revealed going with RN #300 to assess Resident #47 for a second time around 8:00 A.M. to 8:30 A.M. on 02/12/25. ADON #214 revealed the resident was moaning in pain. The resident had rotation of the left leg with swelling and winced when touched. ADON #214 revealed the resident had bruising on the lip and a red mark on the left cheek. ADON #214 revealed RN #260 and RN #300 were not aware what happened to the resident. ADON #214 revealed attempts were made to contact CNA #110 and CNA #112, but no response was received. Interview on 03/20/25 at 1:08 P.M., Physician #100 revealed he had been notified Resident #47 had a fracture from a fall. Physician #100 revealed typically there would not be a fracture from being lowered to floor unless the resident had osteoporosis. Physician #100 revealed the resident had no bone density test results indicating osteoporosis. Interview on 03/20/25 at 3:29 P.M., RN #260 revealed working the memory care unit on the 12-hour shift from 02/11/25 through 02/12/25. RN #260 could not recall what time she last saw the resident during the shift. RN #260 revealed earlier in the shift the resident was walking around per his normal. RN #260 revealed the nursing assistants never reported the resident had fallen. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview on 03/20/25 at 3:34 P.M. RN #300 revealed on 02/12/25 CNA #276 was assisting residents with breakfast when Resident #47 asked for assistance to get out of bed. CNA #276 reported the resident stated ow when she tried to assist him. RN #300 revealed CNA #276 called her to the resident's room. RN #300 revealed Resident #47's left leg and hip were rotated outward, there was redness and bruising on the left side of the lip, and redness on the left side of his face. RN #300 revealed the nurse practitioner was notified with new orders received for an x-ray. RN #300 revealed Resident #47's scheduled medications including Tylenol were administered. RN #300 revealed the x-ray technician reported the resident most likely had a fracture. RN #300 revealed 911 was called while awaiting the final x-ray report. RN #300 revealed emergency medical services (EMS) were already in the building when the final x-ray results were received showing the fracture. Interview on 03/21/25 at 1:12 P.M., Physical Therapist (PT) #700 revealed Resident #47 had discharged from therapy with a recommendation for a front wheeled walker. PT #700 revealed staff had been instructed for the resident to use the walker and may require verbal cues to use the walker. PT #700 revealed the resident had dementia and would forget and often get up without his walker. PT #700 revealed the resident should have used the walker with staff. Review of the Certified Nursing Assistant job description revealed the nursing assistant would report all changes in the resident's condition to the nurse supervisor/charge nurse as soon as practical. Report all accidents and incidents observed on the shift they occur. Further review of the job description revealed to follow physician orders and follow directions of the physical therapist. Also, assist resident to walk with or without self-devices as instructed. Review care plans daily to determine if changes in the resident's daily care routine have been made on the care plan. Review of the facility policy Fall Policy, revised 01/03/25, revealed the facility would assure proper review of resident fall risk and implementation of interventions to attempt to prevent or reduce falls and injuries related to falls. Tracking would be done on an incident where a fall has occurred. A fall is when a resident is observed on the floor or when a resident was lowered to the floor with or without injury. Appropriate medical care would be provided as needed, including calling for emergency transport to the emergency room if indicated. Nursing notes would reflect the fall, assessment, care and monitoring provided and notifications. Care plans would be updated with new and discontinued interventions when reviewed and following a fall as appropriate. This deficiency represents non-compliance investigated under Master Complaint Number OH00163072 and OH00162984.