STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365773	A. Building B. Wing	11/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Laurels of Kettering	694 Isaac Prugh Way Kettering, OH 45429

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** 34291 Based on medical record review, staff interview, resident interview, and policy review the facility failed to ensure a resident was provided with staff assistance at the bedside after toileting which resulted in a fall with injury. This resulted in actual harm when Resident #34 who required substantial/maximal assistance to transfer for toileting, did not have on gripper socks on her feet and was assisted off the bedside commode, became unsteady on her feet, was sat on the side of her bed, and the certified nursing assistant (CNA) left the resident alone and stepped out of the room to get additional staff assistance. The resident fell on to the floor face first when she was left on the side of the bed by herself resulting in a laceration that required the resident to get three stitches to her face. The affected one (Resident #34) of three residents reviewed for falls. The census was 83. Findings included: Review of the medical for Resident #34 revealed an admitted [DATE], diagnoses included heart failure, peripheral vascular disease, renal failure, diabetes, and septicemia. Review of fall risk assessment dated [DATE] revealed Resident #34 was not at risk for a fall. It revealed the resident had a fear of falling, muscle weakness, decreased lower extremity joint function, and a balance deficit, or gait deficit. The document further revealed the resident had urinary urgency. Review of the care plan dated 08/15/24 revealed the resident was at risk of falling with injury related to decreased mobility. Interventions were to encourage the resident to wear appropriate footwear, keep the resident's floors and environment free of clutter, keep the call light within reach and encourage the resident to use it. Review of Resident #34's quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident had functional limitations in range of motion for upper and lower extremities. Functional status was set-up or cleanup for eating, substantial/maximal assistance for toileting and transfers, and Resident #34 was dependent for bed mobility. A toilet transfer was not attempted due to medical condition or safety concerns. Resident #34 was coded as always incontinent of bowel and bladder. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(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	Review of the progress note on 10/17/24 at 5:05 P.M. revealed Resident #34 was sitting on the edge of the bed after being taken to the bedside commode by Certified Nursing Assistant (CNA) #84 (who is no longer employed at the facility) and the resident returned to the side of the bed after toileting at the bedside commode. The resident was having a hard time standing and sat on the side of the bed. The CNA left the room to get help, and the resident fell off the bed onto her face. Review of the investigation dated 10/17/24 for Resident #34 revealed the Licensed Practical Nurse (LPN) #142 was sitting at the nursing station charting and she heard a thump followed by moaning. Upon entering the room, the resident was lying in a prone position with a lean to the right side. The resident stated she was sitting on the edge of the bed unassisted and fell forward hitting her face on the floor. The resident hit her head with blood loss, and she was alert and oriented times four (person, place time, and situation). The resident had a visible laceration above her right eye with blood loss. The resident complained of head and facial pain. Vital signs were taken and were within normal limits. An emergency squad was called, and the resident was taken to the hospital. The resident had a gait imbalance and weakness. All the responsible parties were notified. Review of the post fall evaluation dated 10/18/24 revealed Resident #34 had a fall after returning to bed after toileting. The resident lost her balance during the fall and did not have any assistance. The resident was bare footed, no gait assistance devices were present, no call light was on and the resident was continent at the time of the fall. The new intervention was to not leave the resident sitting on the side of the bed unassisted. Review of the statement written by CNA #84 dated 10/17/24 revealed she assisted Resident #34 to the bedside commode and after the resident was done she was having a hard time standing and she sat her on the side of the bed. While the resident was sitting on the side of the bed the CNA stepped out of the room and asked for help and by the time the CNA turned around the resident had fallen. Review of the statement written by LPN #142 dated 10/17/24 revealed she was sitting at the nursing station and CNA #84 came out of the resident's room and asked for help with the resident. The LPN heard a sound of the resident hitting the floor. Upon entering the room, the resident was prone on the floor disrobed from the waist down. The resident complained of head and facial pain and there was a laceration above the right eye that was visible. Review of statement written by LPN #143 dated 10/17/24 revealed she was at the nursing station and the CNA #84 came out of the resident's room and asked if someone could help her with the resident. This nurse heard a loud thump and upon entering the resident's room she was lying prone on the floor with a lean to the right side. The resident complained about head and facial pain. There was a laceration above the right eye. Review of the hospital after visit summary document dated 10/17/24 revealed Resident #34 had a laceration to her right eye. Review of the record of discussion dated 10/17/24 with CNA #84 revealed she was educated on importance of not leaving resident sitting on the side of the bed especially when the resident was fatigued from care. The CNA was also educated on using the call light to ask for assistance prior to leaving the resident. The resident's safety will be maintained, and the resident will only be left in a safe position. The call light will be utilized to ask for assistance. The CNA didn't sign the document. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview with LPN #142 on 11/14/24 at 1:44 P.M. revealed she was at the nursing station when CNA #84 came out of Resident #34's room and asked for some help. LPN #142 stated she heard a thump in Resident #34's room. She stated when she got to the room the resident was lying on her side on the floor with a pool of blood on the floor. During an interview with LPN #143 on 11/14/24 at 1:41 P.M. revealed CNA #84 stuck her head out Resident #34's doorway and asked for help. She stated she heard the resident hit the ground. She said the resident was naked from the waist down, lying prone and slightly on her right side. During an interview with Resident #34 on 11/18/24 at 9:05 A.M. revealed she had to go to the bedside commode on 10/17/24 and CNA #84 got the commode and sat it next to the foot of the bed on the right side of the bed. She stated the aide told her to stand up after the resident urinated and defecated and the resident told the aide she wouldn't be able to stand very long, but the aide said she had to put the brief on her and the resident said no I am going to fall. The resident told the aide she wanted to sit on the side of the bed and the aide said no you are going to get feces on the clean linens and the resident told her if you wiped good enough that wouldn't be a problem. The resident believed she sat on the side of the bed and the aide left the room to get help and then she was on the floor without any garments on the lower half of her body. She said they sent her out to the hospital, and she had three stitches above her right eye brow. Review of the fall policy entitled Fall Management dated 09/22/23 revealed the facility will identify hazards and resident risk factors and implement interventions to minimize falls and risk of injury related to falls. Each resident is assisted in attaining/maintaining his or her highest practical level of function by providing the resident adequate supervision, assistive devices, and/or functional programs as appropriate to minimize the risk for falls. This deficiency represents non-compliance investigated under Complaint Number OH 00159180 and OH00159112.