STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365802	A. Building B. Wing	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marjorie P Lee Retirement Community	3550 Shaw Avenue Cincinnati, OH 45208

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** 42492 Based on medical record review, review of the facility incident report, review of Root Cause Analysis report, hospital record review, resident, visitor, and staff interviews, review of personnel file, and policy review, the facility failed to ensure a resident was positioned safely during personal care. This resulted in Actual Harm to Resident #10 on 02/16/25 when Certified Nursing Assistant (CNA) #150 did not position Resident #10 correctly while providing personal care in bed and did not call for assistance prior to moving the bed when the resident was in a compromised position resulting in Resident #10 sustaining a left hip fracture, a small scalp laceration to the front top of her head, an abrasion to the right forearm, and a bruise with eye bleed to the left eye. This affected one (Resident #10) of three residents reviewed for falls. The facility census was 73. Findings include: Review of the medical record revealed Resident #10 was admitted to the facility on [DATE]. Diagnoses included fracture of unspecified part of the neck of the left femur, vascular dementia, injury of the head, hemiplegia affecting the left non-dominant side, and acute on chronic diastolic heart failure. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #10 had severely impaired cognition, had no behaviors, did not reject care, and did not wander. Resident #10 was dependent on staff for activities of daily living (ADL) care and required transfers with a mechanical lift. Review of the care plan dated 04/03/25 revealed Resident #10 was at risk for falls due to history of cerebral infarction with left-sided hemiplegia, need for assistance, and recent admission from a different facility. Resident #10 had a fall on 02/16/25. Interventions included two-person assistance with transfers and turning/repositioning in bed status post fall on 02/16/25. Resident #10 returned from the hospital on 02/20/25 with a fracture of unspecified part of neck of left femur, subsequent encounter for closed fracture with routine healing. Interventions included bolsters to bed (placed 02/24/25), provide toileting as needed, evaluate the need for positioning alarms, provide increased supervision according to needs, assess and treat orthostatic hypotension, and comprehensive medication review for polypharmacy and medications that increase fall risk. (continued on next page)

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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(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 dated 02/16/25 at 12:52 P.M. revealed CNA #150 reported at 10:10 A.M. that Resident #10 fell out of bed. Resident #10 was lying on the floor, diagonally in room, head towards window and feet towards the bathroom, and pillow under her head. CNA #150 stated he was in the process of turning her toward the wall to place the brief under her when she slipped between the bed and the wall. CNA #150 stated the bed was locked, he moved her left foot over her right when she began to slip, and he lowered her down the best he could. Resident #10 was noted with a small 1.0-centimeter (cm) abrasion to top of the head, bleeding a small amount of bright red blood, and an intact abrasion to right forearm. Four staff members assisted Resident #10 with a Hoyer lift after placing brief on her. Neuro checks were initiated. Resident #10 had a small blood vessel in the left eye (at 5 o'clock compared to pupil), was noted to be bleeding from a small scalp wound, and had a bruise noted to be coming out under and outer to left eyelid. The nurse notified the management staff and family. The on-call provider was called and gave orders to send out to emergency room (ER) for computed tomography (CT) scan due to Resident #10 was on the blood thinner, Eliquis. Resident#10 left the facility to go to the ER at 11:55 A.M. Review of hospital documentation revealed general examination on 02/16/25 at 3:15 P.M. showed mild swelling of the left thigh and hip with minimal shortening of the left lower extremity noted. X-ray imaging showed displaced fracture of the left femoral neck. Review of the facility's investigation dated 02/18/25 at 1:52 P.M. revealed Nurse Manager #132 concluded Resident #10 was dependent on staff for assistance with care and transfers. CNA #150 provided care to Resident #10 while she was in bed on a low air loss mattress. The bed was locked and was at waist level for CNA#150 to properly provide care. CNA #150 rolled Resident #10 over towards the wall when the resident's legs began to slide off the edge of the bed. CNA #150 attempted to pull the resident over by her legs but was unsuccessful. CNA #150 then unlocked the bed to move it away from the wall so he could get in to assist the resident, but that caused the resident to fall off the bed and onto the floor. Review of CNA #150's witness statement dated 02/18/25 revealed he rolled Resident #10 over in the bed towards the wall. Resident #10 had her right hand holding the rail and a pillow under her left hand. CNA #150 stated her leg was crossed over the other leg, and her leg was falling off the bed. At this time, the resident's face was against the handrail. CNA #150 stated he tried to pull the resident over with her legs but was unable to. CNA #150 did not want to pull on her upper body/shoulder due to a previous injury. CNA #150 stated when he couldn't get her pulled over by the legs, he then went to the foot of the bed, unlocked the bed, and moved it over to be able to assist her. When CNA #150 moved the bed, the resident's bottom half of her body started to fall onto the floor. CNA #150 stated he intervened by grabbing her upper body, protecting her head, and lowering her the rest of the way to the floor. CNA #150 stated he assisted the resident in lying on the floor and placed a pillow under her head. CNA #150 then went to get help. (continued on next page)

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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 document titled ERS Critical Incidences Root Cause Analysis 2025 dated 02/26/15 revealed in summary: CNA #150 informed the nurse at approximately 10:10 A.M. that Resident #10 had fallen out of bed. Resident #10 was noted to be laying on the floor, diagonally in room, head towards window and feet towards bathroom, with pillows under her head supporting her. CNA #150 stated he was in the process of turning her toward the wall to place the brief under her when she slipped between the bed and the wall. CNA #150 stated the bed was locked, he moved her left foot over her right when she began to slip, and he lowered her down the best he could. The nurse notified management and family. The on-call provider was called and gave orders to send out to ER for CT scan due to Resident #10 being on a blood thinner, Eliquis. Resident#10 left the facility to go to the ER at 11:55 A.M. The hospital performed a whole-body scan and discovered a fracture on the left-hip. An additional review of Timeline and Causal Factor Chart revealed CNA #150 was performing morning care with Resident #10 in bed. CNA #150 turned resident onto her right side towards the wall. The bed was locked. Resident #10's legs began to fall off the bed. CNA #150 unlocked the bed to get to the resident. While moving the bed, the resident's lower torso fell off the bed, due to gravity. CNA #150 then lowered her upper torso onto floor and notified the nurse that resident was on the floor. It was noted that CNA #150 did not position the resident correctly prior to turning, and CNA #150 did not call for assistance in a compromising situation but attempted to address on his own. The root cause of the fall was assessed to be human error: the CNA did not position Resident #10 correctly while providing personal care in bed, did not follow procedure, and did not call for assistance prior to moving the bed when the resident was in a compromised position. Review of the personnel file revealed CNA #150 was hired on 08/23/22 and was terminated on 03/24/25. Review of the Corrective Counseling notice dated 03/24/25 revealed CNA#150 was terminated on 03/24/25 related to meal documentation discrepancies and for putting the health and wellbeing of Resident #10 in jeopardy on 02/16/25 after failing to provide proper positioning in bed while providing care and failing to call for assistance resulting in a fall with injury to the resident. During an interview on 04/04/25 at 10:42 A.M., the Director of Nursing (DON) stated Resident #10 was sent to the hospital after a fall on 02/16/25 to be evaluated for a bleeding scalp laceration because she was on blood thinners. The hospital informed the facility Resident #10 had a hip fracture. The facility completed an incident report and root cause analysis which indicated the fall was caused by human error. CNA #150 had not positioned Resident #10 appropriately prior to turning her in bed and failed to call for assistance before unlocking the bed. When Resident #10 started to slide out, CNA #150 attempted to get between the bed and the wall to assist with lowering her to the floor. As Resident #10 went down, Resident #10 scraped her head on the arm rail and had a small abrasion that was bleeding. After the fall incident with Resident #10 on 02/16/25, the DON stated no other residents were assessed for fall interventions; no other audits were completed except the facility audited to ensure the bolsters were in place on Resident #10's bed when Resident #10 returned from the hospital; All nursing staff were educated about proper positioning of the resident in bed during care with return demonstration. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During concurrent interviews on 04/04/25 at 2:10 P.M., Resident #10 stated she was ok and indicated she was still having pain related to the fall. A family friend at bedside stated that since the fall, Resident #10 has increased pain, had become less communicative, and had increased memory lapses. The visitor stated prior to the fall; the family was looking forward to bringing the resident home but were no longer sure due to increased care needs related to the fall. Review of the policy titled Fall Prevention and Management Protocol dated 02/23/21 revealed residents were assessed for risk factor for falling and the interdisciplinary team developed a plan for services to reduce the resident's risk for falls. This deficiency represents noncompliance investigated under Complaint Number OH00162748.