STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365826	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Continuing Healthcare of Cuyahoga Falls	300 East Bath Road Cuyahoga Falls, OH 44223

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** Based on medical record review, staff interview, review of the facility investigation and facility policy review, the facility failed to thoroughly investigate the root cause of Resident #27's repeated falls on 03/16/25, 03/30/25, and 04/08/25, and failed to implement appropriate fall prevention interventions for Resident #27 to prevent further falls. Actual Harm occurred on 04/08/25 when Resident #27 fell attempting to transfer herself to the bathroom unsupervised resulting in a fall requiring hospitalization with a distal left tibia fracture. This affected one (Resident #27) of two residents reviewed for falls. The facility census is 50. Findings include: Review of the medical record for Resident #27 revealed an admission date of 12/26/22 and a readmission date of 04/11/25. Diagnoses included fracture of the shaft of the left tibia, hypertension, and type two diabetes mellitus. Review of the care plan dated 12/27/22 revealed Resident #27 has had falls and a potential for injury. Interventions included maintaining a clear pathway and monitoring for side effects of psychotropic medications. Updated interventions included encourage Resident #27 to wear briefs at all times (03/18/25), Resident #27 was to be in a tilt-in-space wheelchair and tilt when Resident #27 wants to rest (03/25/25). Review of the fall risk assessments dated 02/04/25 revealed Resident #27 was at risk for falls. Additional fall risk assessments completed on 03/17/25, 03/30/25, and 04/08/25 revealed Resident #27 was at high risk for falls. Review of the nursing progress note dated 03/16/25 revealed Resident #27 was observed on the floor alongside her bed. Resident #27 was alert and oriented to person only, and unable to describe the events that occurred. Resident #27 was assessed, and no injury was noted. The physician and Resident #27's family were notified. No new orders or fall prevention interventions were implemented at that time. Review of the fall investigation 03/16/25 did not include if the resident was incontinent at the time of the fall, if she was attempting to go to the bathroom at the time of the fall, when she was last toileted, what footwear she was wearing, or if the call light was activated. The Interdisciplinary Team (IDT) implemented an intervention on 03/18/25 to ensure Resident #27 wore briefs at all times as a result of the fall on 03/16/25. (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 nursing progress note dated 03/30/25 at 6:47 P.M. revealed Resident #27 was observed on the floor in her bathroom. Her wheelchair was in a locked position beside her in front of the sink. The nurse assessed injuries and Resident #27 reported no pain or discomfort at that time. The physician and Resident #27's family were notified. No new orders or fall prevention interventions were implemented at that time. Review of the fall investigation dated 03/30/25 did not include if the resident was incontinent at the time of the fall, if she was attempting to go to the bathroom at the time of the fall, if she was wearing a brief at the time of the fall, when she was last toileted, what footwear she was wearing, or if the call light was activated. The IDT implemented a new fall prevention intervention to apply non-slip strips to Resident #27's bathroom floor in front of the sink on 03/31/25 as a result of the fall on 03/30/25. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #27 had severe cognitive impairment. Resident #27 required extensive assistance with all activities of daily living. Resident #27 was frequently incontinent of urine and bowel. Review of the nursing progress note dated 04/08/25 at 3:02 P.M. revealed Resident #27's roommate informed the nurse that Resident #27 was on the floor in the bathroom. Resident #27 was assessed, and she reported pain in her left leg. The physician and Resident #27's family were notified. An order for an x-ray was obtained. Resident #27 was placed at the nurse's station in her chair as she kept attempting to transfer herself when left alone. Review of the nursing progress note dated 04/08/25 at 10:57 P.M. revealed Resident #27's x-ray of her left leg showed fractures. The nurse called 911, and Resident #27 was sent to the hospital. Resident #27's physician, family, and Director of Nursing (DON) were notified. Review of the fall investigation dated 04/08/25 revealed Resident #27 was attempting to transfer herself when she fell. She was complaining of left leg pain. The physician was notified and an order for a left hip x-ray was ordered. Resident #27 was placed at the nurse's station for extra monitoring. The fall investigation did not reveal if the call light was activated, what time Resident #27 was last toileted before her fall at 3:02 P. M., if she had a brief on as implemented on 03/18/25, if she was tilted back in the tilt-in-space wheelchair as implemented on 03/25/25, if the non-slip strips were on the bathroom floor as implemented on 03/31/25, or what type of footwear she was wearing. Review of the hospital paperwork dated 04/11/25 revealed Resident #27 was discharged from the hospital with a final diagnosis of left distal tibia shaft fracture. Review of the physician's order dated 04/11/25 revealed an order for 5-325 milligrams of Percocet (opioid pain medication) one to two tablets every four hours as needed for pain. Interview on 06/10/25 at 11:22 A.M. with the DON confirmed Resident #27 fell on [DATE] and suffered a fracture of her left tibia. The DON confirmed after every fall, the IDT meets to go over interventions. The DON reported she was not working at the facility at the time of the falls. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview on 06/10/25 at 12:20 P.M. with Regional Nurse #610 revealed the facility did put a note in the investigation that non-slip strips were added to Resident #27's floor in front of the bathroom sink on 03/31/25 as a result of the fall on 03/30/25, but they did not update the care plan. Regional Nurse #610 confirmed that the facility did not thoroughly investigate the root cause of the falls that occurred on 03/16/25 and 03/30/25 and did not implement appropriate fall prevention interventions determined by a root cause analysis after each fall. She verified that making sure Resident #27, who was falling attempting to transfer herself to the bathroom, was wearing a brief at all times was not an appropriate intervention. Review of the facility policy titled Fall Management, revised July 2024, revealed the facility will develop an individualized fall prevention plan for each resident identified at risk. After a fall the interdisciplinary team will review fall incidents to determine contributing factors, implement appropriate interventions, and adjust the resident's care plan accordingly. This deficiency represents non-compliance investigated under Master Complaint Number OH00166603.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. Review of the medical record for Resident #9 revealed an admission date of 10/24/19. Diagnoses included weakness, gastro-esophageal reflux disease without esophagitis, vitamin D deficiency, and age-related osteoporosis without current pathological fracture. Review of the quarterly MDS assessment dated [DATE] revealed Resident #9 had intact cognition. Observation on 06/09/25 at 10:35 A.M. in the Resident #9's room revealed an opened store brand bottle of an antacid chewable, with more than 50% gone, sitting on the resident's bedside table. Interview at this time, Resident #9 stated she had a friend bring it in for her. Resident #9 stated they don't have it here and were too busy with other residents. Observation on 06/11/25 at 4:53 P.M. in Resident #9's room the bottle of store brand antacid was no longer on the bedside table. Interview at this time with Resident #9 revealed she still had them but had put the bottle in drawer of her nightstand next to her bed. Observed Resident #9 open the second drawer of the nightstand pull out the bottle of store brand antacids. Resident #9 stated she also keeps hemorrhoid cream in her bathroom and stated if the facility can order it for her, they can. Observed a store brand tube of hemorrhoid cream that was just about empty sitting on the bathroom sink. Review of the physician orders for June 2025 revealed Resident #9 had active orders for Tums oral tablet chewable (calcium carbonate (antacid). Give one unit by mouth every four hours as needed for heartburn/indigestion. There was also an order for Preparation H rectal ointment to insert one application rectally every six hours as needed for hemorrhoid. May give to the resident in a cup to apply. Observation on 06/11/25 at 5:03 P.M. with LPN #553 verified the observation of the store brand hemorrhoid cream and bottle of antacids in Resident #9's room. Interview at this time with LPN #553 stated she knows for sure the antacids should not be at bedside but wasn't sure about the hemorrhoid cream. Interview on 06/11/25 at approximately 5:10 P.M. with the Director of Nursing (DON) and Regional Nurse #605 revealed the resident needed a physician order to have both the hemorrhoid cream and antacid at bedside and verified Resident #9 did not have a physician order for those medications at bedside. Based on record review, observation, interview, and review of the facility policy, the facility failed to date a multi-use vial of medication for Resident #13 after opening. The facility also failed to ensure Resident #9 did not keep over the counter medications at her bedside. This affected two (Residents #13 and #9) out of how many 16 residents reviewed for medication storage and had the potential to affect all 50 residents residing in the facility. Findings include: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Review of the medical record for Resident #13 revealed an admission date of 02/24/21. Diagnoses included chronic obstructive pulmonary disease, type two diabetes mellitus, and asthma. Review of the physician's order dated 04/03/25 revealed to inject NovoLog 100 units/milliliters before dinner per sliding scale. Review of the quarterly Minimum Data Set (MDS) assessment 04/15/25 revealed Resident #13 had intact cognition. Resident #13 required set-up to moderate assistance for activities of daily living. Review of the care plan dated 04/22/25 revealed Resident #13 was at risk for infections related to daily insulin injections. Interventions included administering medications as ordered and monitoring and assessing injection site for pain and redness. Observation of the medication cart for the 400-hallway on 06/11/24 at 8:10 A.M. revealed a bottle of NovoLog for Resident #13 with no date opened marked on it. Interview during the observation with Licensed Practical Nurse (LPN) #553 confirmed the bottle was not dated when opened, and she was unable to verify when it was opened.