STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365836	A. Building B. Wing	11/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village at St Edward Nrsg Care	3131 Smith Rd Fairlawn, OH 44333

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35771 Based on medical record review, staff interview, and review of the facility policy, the facility failed to timely notify resident representatives of significant changes in health status. This affected one (Resident #79) of three residents reviewed for falls. The facility census was 77 residents. Findings include: Review of the medical record for Resident #79 revealed an admitted [DATE] with diagnoses of vascular dementia with other behavioral disturbances, diabetes, expressive language disorder, adjustment disorder, rheumatoid arthritis and fracture of the first lumbar vertebrae with a discharge date of [DATE]. Review of the Minimum Data Set (MDS) assessment for Resident #79 dated 09/05/24 revealed the resident was severely cognitively impaired required staff assistance with activities of daily living (ADLs.). Review of the nurse progress note for Resident #79 dated 09/08/24 timed at 10:45 P.M. revealed the resident had a fall without injury and the resident's representative was notified. Review of the nurse progress note for Resident #79 dated 09/09/24 timed 1:35 P.M. revealed the resident had an unwitnessed fall in the hallway without injuries and the resident's representative was notified. Review of the communication with physician note for Resident #79 dated 09/09/24 timed 5:14 P.M. revealed the resident's representative was visiting and noticed the resident had complaints of pain to the left hand and the fifth digit appeared swollen and bruised. The nurse assessed the resident and notified the nurse practitioner who ordered an x-ray to the left hand. Review of the left-hand x-ray results for Resident #79 dated 09/09/24 timed 10:08 P.M. revealed the resident had an acute displaced fracture of the 5th digit (pinky finger) middle phalanx. Review of the nursing notes for Resident #79 dated 09/09/24 to 09/15/24 revealed the notes did not include notification to Resident #79's representative of the fracture. (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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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/04/24 at 12:30 P.M. with Resident #79's representative confirmed Resident #79's left finger did not look right on 09/09/24 so an x-ray was ordered. Resident #79's representative confirmed she was not notified until 09/16/24 that the resident had a fractured finger. Inteview on 11/04/24 at 12:45 P.M. with Director of Nursing (DON) confirmed the facility learned on 09/09/24 that Resident #79 had sustained a fracture to her finger. The DON confirmed the staff did not notify Resident #79's representative of the resident's fractured finger until 09/16/24. Review of the facility policy titled Notification of Condition of Change undated in the event of a clinical complication, the resident was informed of immediately and the physician thereafter. The resident's responsible party would be notified at the earliest convenience of the nurse, but within 24 hours of discovery.

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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 - Minimal harm or potential for 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** 35771 Based on medical record review, staff interview, resident representative interview, and review of the facility policy, the facility failed to implement interventions to prevent falls. This affected one (Resident #79) of three residents reviewed for falls. The facility census was 77 residents. Findings include: 1. Review of the medical record for Resident #79 revealed an admitted [DATE] with diagnoses of vascular dementia with other behavioral disturbances, diabetes, expressive language disorder, adjustment disorder, rheumatoid arthritis and fracture of the first lumbar vertebrae with a discharge date of [DATE]. Review of the Minimum Data Set (MDS) assessment for Resident #79 dated 09/05/24 revealed the resident was severely cognitively impaired, required staff assistance with bed mobility and transfers and used a walker and a wheelchair for mobility. Review of the nurse progress note for Resident #79 dated 09/08/24 timed at 10:45 P.M. revealed the resident had unwitnessed fall from her wheelchair by the nurses' station Review of the physician's orders for Resident #79 revealed an order dated 09/09/24 for the resident to have every 15-minute checks starting on 09/09/24 at 7:00 A.M for three days until 09/11/23 at 11:59 P.M. Review of the safety checks form for Resident #79 dated 09/09/24 revealed the resident's every 15-minute safety checks did not begin until 09/09/24 at 1:45 P.M. Review of the fall care plan for Resident #79 updated 09/09/24 revealed the resident was at risk for falls related to gait/balance problems, impaired cognition, impaired mobility, incontinence, pain, poor communication/comprehension, poor safety awareness, psychoactive drug use, history of falls, gout, and attempts to self-transfer. Interventions included staff should anticipate and meet the resident's needs. Interview on 11/04/24 at 12:45 P.M. with the Administrator and Director of Nursing (DON) confirmed Resident #79's every 15-minutes safety checks were supposed to begin on 09/09/24 at 7:00 A.M., but the staff did not start them until 09/09/24 at 1:45 P.M. 2. Review of the nurse progress note for Resident #79 dated 09/09/24 timed 1:35 P.M. revealed the resident had an unwitnessed fall in the hallway. Resident stated that she was trying to get into bed. Staff initiated neurological checks. Review of the neurological check records for Resident #79 revealed the resident's neurological checks were only completed until 09/10/24 at 2:20 A.M. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on at 2:10 P.M. and 3:05 P.M. with the Administrator and DON confirmed Resident #79 should have had a full 24-hours of neurological checks following the fall which occurred on 09/09/24 around lunchtime, and the facility failed to complete neurological checks for a full 24 hours following the fall. Review of the facility policy titled Neurological Assessment policy revealed neurological assessment would be initiated per facility protocol in events of falls with known head injury and/or unwitnessed falls. Neurological assessments would be done each shift for 24 hours, or longer as indicated, in the following instances: after a fall with actual or suspected head injury. 3. Review of the nurse progress note for Resident #79 dated 10/20/24 timed 12:10 P.M. revealed the resident had an unwitnessed fall without injury in her room while self-ambulating with her walker. Further review of the note revealed every 15-minute safety checks were initiated. Review of the nurse progress note for Resident #79 dated 10/20/24 timed at 6:27 P.M. revealed resident had an unwitnessed fall in her room and sustained a small bruise below the left knee. Review of the Interdisciplinary Team (IDT) review form for Resident #79 dated 10/21/24 revealed the resident had an unwitnessed fall in her room on 10/20/24. The IDT determined the resident should be referred to therapy for evaluation and should have every 15-minute safety checks for 24 hours. Review of electronic medical record and hard chart for Resident #79 revealed they did not include every 15-minute safety checks for 10/20/24 and 10/21/24. Interview on 11/04/24 at 12:30 P.M. with Resident #79's representative confirmed the staff said the resident was on every 15-minute safety checks following the fall on 10/20/24 around lunchtime but she felt the resident wouldn't have fallen again on 10/20/24 if the staff truly completed the 15-minute safety checks. Interview on 11/04/24 at 3:05 P.M. with the Administrator and DON confirmed the facility did not complete every 15-minute safety checks for Resident #79 on 10/20/24 or 10/21/24. Review of the facility policy titled Falls/Found on Floor Protocol undated revealed with each resident fall the facility would review and revise the resident's care plan if needed and the facility would implement new interventions to prevent further falls. This deficiency represents noncompliance investigated under Complaint Number OH00159164.