STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365904	A. Building B. Wing	04/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saint Joseph Care Center	2308 Reno Drive NE Louisville, OH 44641

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 Note: The nursing home is disputing this citation.	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** 44810 Based on closed record review, review of a facility fall investigation, interviews and review of the facility policies, the facility failed to ensure adequate, individualized and effective fall risk interventions were in place to prevent a fall with injury for Resident #60, a resident at risk for falls. This affected one resident (#60) of three residents reviewed for falls. The facility census was 51. Actual Harm occurred on 03/10/25 when Resident #60 sustained an unwitnessed fall out of bed resulting in a fractured left arm, a laceration to the right side of her forehead, and a bruise to her right cheek. Prior to the incident, the resident had been having behaviors which staff identified as terminal agitation. The facility failed to ensure adequate, individualized and effective fall risk interventions were in place prior to the fall with injury to meet the resident's total care and safety needs. Findings include: Review of the closed medical record for Resident #60 revealed an admitted [DATE] and a discharge date of [DATE]. Resident #60 had diagnoses including atrial fibrillation, anxiety disorder, morbid obesity, and acute kidney failure. Review of a fall risk assessment dated [DATE] (completed on admission), revealed Resident #60 was assessed to be at high risk for falls. However, no additional fall risk assessments were completed until 03/11/25, following a fall with injury that occurred on 03/10/25. (At the time of the assessment on 03/11/25, Resident #60 was assessed to be at high risk for falls). Review of the initial care plan dated 11/25/20 revealed Resident #60 was at risk for falls. Interventions (also dated 11/25/20) included completing fall risk assessments and providing ongoing review for the resident's safety needs. NO new updates or fall related focus areas were identified after this time. Review of the physician's orders revealed Resident #60 was admitted to hospice services on 01/28/25. (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 Note: The nursing home is disputing this citation.	Review of the medication administration record revealed Resident #60 had an order for Morphine sulfate (opioid pain medication) one milliliter every four hours for pain. She also had an order for Ativan (antianxiety medication) one tablet by mouth every four hours for anxiety and restlessness. Review of the significant change Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #60 had intact cognition. The assessment revealed Resident #60 required moderate to extensive (staff) assistance for all activities of daily living. Resident #60 was always incontinent of urine and occasionally incontinent of bowel. Resident #60 was identified as a fall risk due to taking anti-anxiety medications daily during the seven-day assessment reference period. Review of a nursing progress note dated 03/10/25 at 5:47 A.M. revealed Resident #60's daughter put the call light on and was stating her mother was trying to take her clothes off and get out of bed. Resident #60 was asking about her grandmother. The note revealed the nurse educated Resident #60's daughter about terminal agitation, and the nurse was going to administer a dose of Ativan, but Resident #60 calmed down. Record review revealed no new safety or fall risk interventions were implemented or considered at this time. Review of a nursing progress note dated 03/10/25 at 9:41 P.M. revealed Resident #60's daughter walked into the resident's room and ran out screaming stating her mother was on the floor. The nurse entered the room, Resident #60's bed was in a high position, and she (the resident) was lying on the ground on her stomach with her head, shoulders, and arms under the bed. A small amount of blood was visualized on the floor next to Resident #60. Vital signs were assessed, and Resident #60 was reporting pain in her left arm and head. The hospice agency was notified, and an x-ray of the left shoulder was ordered. Emergency responders assisted to help Resident #60 back into bed. At the time of the incident, the resident's family made the decision not to send the resident to the emergency room . Review of the left shoulder x-ray dated 03/11/25 for Resident #60 revealed an acute displaced fracture of the left humorous metaphysis. Review of a facility unwitnessed fall investigation dated 03/10/25 revealed Resident #60's family (daughter) walked into her room and ran out stating her mother was on the floor. Resident #60 was found on the floor lying on her stomach with head shoulders and arms under the bed. Resident #60's bed was in a high position. A small amount of blood was on the floor next to the resident. Initial assessment of Resident #60 revealed she was oriented to person, situation, and place. Her predisposing factors included she had periods of confusion, was incontinent, a recent change in cognition, weakness, gait imbalance, and impaired memory. Review of a witness statement from Certified Nursing Assistant (CNA) #499, (no longer employed at the facility), revealed she changed Resident #60 a little after 8:00 P.M. (on 03/10/25) that day. Resident #60 was still urinating, so she informed her she would return. CNA #499 then went back to change her again, and she put the bed in the lowest position and put the resident's bed remote in the drawer of her bedside table. CNA #499 then went to care for other residents until she heard the nurse calling for her. (However, Resident #60's sister was in the room on 03/10/25 from 7:00 P.M. to 8:40 P.M. and stated no staff came into the room while she was visiting). Resident #60 was lying on the floor and due to her position, it was difficult to assess her. Resident #60's family was very upset with CNA #499, so the nurse had her stay in the hallway with her. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of a statement from Nurse Manager #505 revealed she arrived on the unit on 03/10/25 at 9:57 P.M. Two nurses were in Resident #60's room attempting to assess her. The nurses informed her that the emergency medical services team was in route. Nurse Manager #505 then notified the hospice agency and the Director of Nursing (DON). Blood was coming from Resident #60 on the right side of her forehead and after the area was cleaned, a small laceration was discovered that eventually stopped bleeding. Resident #60's right cheek had some bruising as well, and she was complaining of left shoulder pain. Resident #60's family agreed to not send the resident out but an order for a left shoulder x-ray was obtained and neurological checks were instituted. Interview on 04/17/25 at 9:40 A.M. with the Administrator revealed the facility had investigated Resident #60's fall. She reported prior to the fall, the aide had left Resident #60's bed in the lowest position (she was unsure of the time this occurred) and put the bed remote (used to raise and lower the bed) in the bedside drawer, which was a hospice recommendation. The Administrator revealed Resident #60 unfortunately experienced end of life psychosis and raised her bed because she preferred it that way and fell out. She reported the resident's daughter did find Resident #60 on the ground. The Administrator also revealed Resident #60 had some behaviors of removing all of her clothing and trying to walk. Resident #60 was not left alone after she was found on the ground and a staff member, and the daughter were present with her the whole time she was on the ground. Interview on 04/17/25 at 10:25 A.M. with the Director of Nursing (DON) confirmed there was only ever a fall risk assessment for Resident #60 on admission in the year 2020, and the facility never re-assessed the resident until 03/11/25 after she fell . She confirmed the family did not want to send the resident to the hospital, but she did receive an x-ray in the facility of her left shoulder, which showed a left humerus fracture (as a result of the fall). During the interview, the DON also confirmed Resident #60's fall prevention care interventions had not been updated since the resident's admission on 11/25/20 as noted above even though the resident was at risk for falls and demonstrated behaviors that increased her fall risk and safety needs prior to the fall with fracture that occurred on 03/10/25. A telephone interview on 04/17/25 at 11:18 A.M. with Resident #60's daughter revealed the resident's sister was the person who found the resident lying on the floor all bloody on 03/10/25. She reported her sister immediately called her, and she was at the facility within five minutes. Resident #60's daughter reported her mother had behaviors of trying to get out of bed and remove her clothing for a couple of nights prior to the incident, and at that time, hospice staff made a recommendation to keep the resident's bed in the lowest position. When she arrived at the facility, she reported that her mother was lying on her belly on the right side of the bed. There was blood all over the floor and the wall. She reported that the bedside table where the bed remote was placed in an open drawer was also on the right side of the bed next to Resident #60's head. Resident #60 had suffered a laceration to her head, and her daughter reported the next day her right eye was swollen shut. Resident #60's daughter also confirmed Resident #60 suffered a right shoulder and arm fracture due to the fall, but the family chose not to send the resident to the emergency room because her mother was terminal and not doing well. Resident #60's daughter reported they (the whole family) already knew the resident was nearing the end of her life but voiced concerns the resident had to suffer so much (as a result of the fall/fracture) before she passed away. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A telephone interview on 04/17/25 at 3:65 P.M. with Resident #60's sister revealed she was at the facility on 03/10/25 from approximately 7:00 P.M. until 8:40 P.M. when she left. She reported during this visit, Resident #60 was in and out of consciousness, but was sleeping when she left. Resident #60's sister reported that no staff member came into the room during her visit on this date/time. She also reported the resident's bed was also raised in a high position when she was visiting which she stated surprised her because the (hospice) staff had left handwritten notes next to the resident's bed stating to leave the bed in the lowest position. Resident #60's sister reported she did not question staff about her bed being in the highest position because she was so distraught watching her sister go in and out of consciousness. Resident #60's sister reported she could not confirm where the bed remote was because she did not pay attention to that. Resident #60's sister reported after she left at 8:40 P.M., she did return to the facility at which time Resident #60 was lying on the ground on her stomach on the right side of the bed complaining about her left shoulder and had a cut and bruises to the right side of her face. A telephone interview on 04/21/25 at 8:45 A.M. with Licensed Practical Nurse (LPN) #506 revealed she was the nurse on duty on 03/10/25, the night Resident #60 fell . She reported she was two doors down passing medications to other residents when she saw Resident #60's family enter the resident's room. The resident's family then came out screaming the resident was on the floor. She reported Resident #60 was lying on her stomach half under the bed and half outside the bed. LPN #506 reported that when she went to assess Resident #60, the resident screamed, I fell and don't touch me, my arm is broken. LPN #506 confirmed the bed remote was on the floor next to Resident #60 at that time. LPN #506 reported she did not know how the bed ended up in the highest position but stated Resident #60 preferred it that way, but since Resident #60 was at the end of life and not always with it, staff decided to keep the bed in the lowest position. Review of the visitor sign-in logs from 03/10/25 revealed that Resident #60's sister signed in at 7:00 P.M. and signed out at 8:40 P.M. Review of the facility policy Falls and Fall Risk, Managing, revised March 2018, revealed based on previous evaluations and current data, the staff would identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. Resident conditions that might contribute to the risk of falls include delirium and other cognitive impairment and medication side effects of medication. The staff with the input of the attending physician, would implement a resident-centered fall prevention plan to reduce the specific risk factors of falls for each resident at risk or with a history of falls. This deficiency represents noncompliance investigated under Master Complaint Number OH00164791 and Complaint Number OH00164470.