

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365911	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/06/2024
NAME OF PROVIDER OR SUPPLIER  Winchester Terrace		STREET ADDRESS, CITY, STATE, ZIP CODE 70 Winchester Rd Mansfield, OH 44907	

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)
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47569</p> <p>Based on observation, medical record review, Self-Reported Incident (SRI) review, review of hospital records, facility investigation review, personnel file review, staff interview, and review of facility policy, the facility failed to ensure Resident #10 was transferred in a safe manner and as per the resident's assessed/planned needs to prevent an avoidable accident resulting in major injury.</p> <p>Actual harm occurred on 09/08/24 when Certified Nursing Assistant (CNA) #400 attempted to transfer Resident #10, who required the use of a mechanical lift for transfers, out of bed without an additional staff assisting and using the resident's walker. This improper transfer resulted in Resident #10 falling backwards onto the bed, striking her right elbow on the metal bed frame causing pain, a decrease in function of the resident's arm, swelling, redness, warmth and scattered bruising. An x-ray of the right elbow was completed on 09/09/24 and revealed a displaced fracture of the distal humerus (the long bone in the upper arm located between the shoulder joint and the elbow joint). The distal portion of the humerus joins with the bones of the lower arm at the elbow joint). The resident was subsequently transferred to the hospital for treatment and orthopedic consultation. This affected one resident (Resident #10) of two residents reviewed for falls. The facility census was 46.</p> <p>Findings Include:</p> <p>Review of the medical record for Resident #10 revealed admitted [DATE] with diagnoses including heart failure, type two diabetes mellitus, anxiety, depression, and difficulty with ambulation.</p> <p>Review of Resident #10's care plan initiated 02/21/23 revealed an alteration in self - mobility related to heart failure, difficulty in walking, and need for assistance with personal care with interventions to assist with bed mobility, transfers and ambulation.</p> <p>Review of Resident #10's Significant Change Minimum Data Set (MDS) Assessment, dated 08/29/24, revealed the resident had severely impaired cognition and required substantial/maximum (staff) assistance for mobility and bed/chair transfers.</p> <p>Review of hospital records, dated 09/01/24, revealed Resident #10 had been transferred to the emergency room due to a nosebleed which could not be controlled or stopped at the facility. Enroute to the hospital, Resident #10 had several episodes of bloody emesis. Resident #10 returned to the facility on [DATE] with diagnoses of acute upper gastrointestinal (GI) bleed and anemia.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the CNA's Information Binder, located at the nurses' station for CNA reference concerning the residents, revealed a list of residents requiring the use of the mechanical lift for transfers. The list was dated 09/01/24 and included Resident #10.</p> <p>Review of Resident #10's re-admission assessment, dated 09/06/24, revealed Resident #10 was dependent of staff assistance for personal care, bed mobility, and transfers.</p> <p>Review of the progress notes, dated 09/08/24, revealed no mention of any incidents involving Resident #10.</p> <p>Review of Resident #10's progress note, dated 09/09/24 at 8:57 A.M. and authored by Registered Nurse (RN) #213, revealed Resident #10 requested to go to the hospital due to complaints of pain in the right arm. Resident #10 was unable to squeeze RN #213's fingers during the assessment and Resident #10's right elbow appeared swollen. Resident #10 was administered Tylenol 325 milligrams (mg) two tablets for the pain. Resident #10 had not complained of right arm pain during the previous shift.</p> <p>Review of Resident #10's progress note, dated 09/09/24 at 12:05 P.M. and authored by RN #233, revealed Resident #10's right elbow was noted to be swollen and warm to touch with redness and scattered bruising to the area. The physician was notified, and an x-ray was ordered.</p> <p>Review of Resident #10's physician orders revealed an order dated 09/09/24 for an x-ray of the right elbow related to bruising and pain.</p> <p>Review of Resident #10's x-ray results of the right elbow, dated 09/09/24, revealed Resident #10 had a displaced fracture of the distal humerus.</p> <p>Review of Resident #10's progress notes, dated 09/09/24 at 1:57 P.M. and authored by RN #233, revealed an X-ray was completed with results reported as a displaced fracture of the distal humerus. The physician was notified with an order obtained for Resident #10 to be transferred to the hospital for orthopedic consultation. Resident #10's family member was notified of the same.</p> <p>Further review of the medical record revealed an order dated 09/09/24 to transfer the resident to the hospital for an orthopedic consultation.</p> <p>Review of Resident #10's hospital discharge paperwork, dated 09/06/24, revealed a diagnosis of a comminuted fracture of the right distal humerus. Discharge orders included the use of a splint and follow up with the orthopedic physician. Further review revealed an order for pain medication Norco 5-325 milligrams (mg) take one tablet by mouth every four hours as needed for pain.</p> <p>Review of Resident #10's progress notes, dated 09/09/24 at 7:42 P.M., revealed Resident #10 returned to the facility with a splint to the right elbow, due to family declining orthopedic surgery.</p> <p>(continued on next page)</p>		

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F 0689  Level of Harm - Actual harm  Residents Affected - Few	<p>Review of a facility Self-Reported Incident (SRI), tracking number 251667, dated 09/09/24, revealed the facility reported an incident of physical abuse involving Resident #10. The SRI included bruising was noted to the resident's right arm and the resident stated her arm hurt. CNA #400's statement dated 09/10/24 at 9:30 A.M. revealed on 09/08/24 at 8:00 P.M. CNA #400 attempted to assist and transfer Resident #10 to use the restroom by using Resident #10's walker. Resident #10 fell back onto the bed, striking her right elbow on the metal bed frame. CNA #400 assisted Resident #10 back into bed and completed incontinence care via a check and change. CNA #400 stated check and changes were completed for the remainder of 09/08/24's night shift for Resident #10. When CNA #400 was asked if Resident #10 had a fall, CNA #400 stated Resident #10 never hit the floor. Further review of the SRI revealed the CNA did not report the incident to the nurse working because the CNA did not think the resident hitting her elbow on the bedframe resulted in an injury.</p> <p>Review of the facility's investigation, initiated on 09/09/24, included CNA #310's statement dated 09/10/24 revealing assistance was given to CNA #400 with incontinence care for Resident #10 at approximately 8:00 P.M. and again between 1:00 A.M. and 2:00 A.M. Resident #10 was in bed during these times and CNA #400 had stated Resident #10 had been attempting to get out of bed and into the recliner. CNA #310 had updated CNA #400 with Resident #10's new transfer status with the use of a mechanical lift (hoyer).</p> <p>Review of Registered Nurse (RN) #213's statement dated 09/09/24 at 6:00 P.M. revealed RN #213 had been alerted at approximately 7:00 A.M. on 09/09/24 by staff (unidentified) concerning Resident #10's right arm hurting and Resident #10's request to go to the hospital. RN #213 was approached again by staff with Resident #10 reportedly saying he dropped her, and her arm hurt. RN #213 entered Resident #10's room and observed her right arm was elevated on a pillow. When RN #213 asked Resident #10 what had happened, Resident #10 stated he dropped me, picked me up and my arm hurts. RN #213 asked Resident #10 which arm hurt and Resident #10 used her left hand and pointed to her right arm.</p> <p>Review of Resident #10's Medication Administration Record (MAR) dated 09/09/24 to 09/30/24 revealed the pain medication Norco 5-325 mg was administered on 09/11/24 two times, on 09/12/24 three times, and on 09/13/24 one time for pain levels ranging from four to 10 with 10 being considered the worst pain the resident had experienced. The pain medication was documented as being effective in controlling Resident #10's pain.</p> <p>Review of Resident #10's orthopedic follow-up appointment dated 10/24/24 revealed Resident #10 continued to have swelling to the right elbow with a severely displaced humerus fracture continuing. Resident #10's Power of Attorney (POA) had opted to not have surgical intervention due to co-morbidities of Resident #10 and was considering hospice services for the same.</p> <p>Review of CNA #400's personnel file revealed CNA #400 was hired on 08/19/24, completed orientation and received the employee handbook on 08/19/24. CNA #400's employment was terminated on 09/13/24 for company policy violation.</p> <p>An interview on 10/31/24 at 1:10 P.M. was attempted with Resident #10 but the resident was unable to be interviewed due to impaired cognition.</p> <p>(continued on next page)</p>		

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F 0689  Level of Harm - Actual harm  Residents Affected - Few	<p>An interview on 10/31/24 at 2:20 P.M. with the Director of Nursing (DON) confirmed Resident #10 sustained a fractured right distal humerus when CNA #400 attempted to transfer Resident #10 not using the required mechanical lift and assistance from other staff. CNA #400 attempted to stand the resident, using her walker to transfer the resident from the bed to the chair. The resident fell backward, onto the bed and struck her elbow on the frame of her bed resulting in a humeral fracture. The DON shared CNA #400 was suspended pending an investigation and ultimately terminated on 09/13/24 for violating company policy.</p> <p>A review of the facility's policy titled, Ambulation/Transfer Policy revealed to prevent and/or reduce injury to staff and residents. It was the intent of the facility to provide safe transfers and ambulation for our clients and prevent injury to clients and staff during this process.</p> <p>This deficiency is an incidental finding discovered during the complaint investigation.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47569</b></p> <p>Based on observation, record review, interview and facility policy review the facility failed to maintain infection control measures during incontinence care for a resident. This deficient practice affected one resident (Resident #13) of three residents reviewed for incontinence care. The facility census was 46.</p> <p>Findings Include:</p> <p>An observation on 10/20/24 at 11:00 A.M. revealed Certified Nursing Assistant (CNA) #322 and CNA #209 completing incontinence care for Resident #13. CNA #322 had a basin with warm water sitting on the bedside table with a bottle of personal hygiene soap. CNA #322 placed the used washcloth on the bedside table. CNA used one washcloth to wash Resident #13's front peri-area and groin area, once washing was complete CNA #322 placed the used washcloth on the bedside table without a barrier. CNA #322 then took another wet washcloth and rinsed Resident #13's front peri-area and groin area, once completed CNA #322 placed the used washcloth on the bedside table. CNA #322 took a towel and dried the area, placing the towel on the bed sheet at the foot of Resident #13's bed. Resident #13 was rolled onto the left side; CNA #322 then took the two wash cloths which were used to clean the front peri-area and groin area for Resident #13 and washed and rinsed Resident #13's buttocks and was dried with the same towel. Once CNA #322 completed the incontinence care of Resident #13, the used washcloths and towel were placed on the bed sheet at the foot of the bed. CNA #322 removed the left-hand glove to retrieve a trash bag and grabbed the used washcloths and towel with the bare left hand and placed them into the trash bag. CNA #322 then donned a glove on their left hand without washing or sanitizing hands and applied preventative cream to Resident #13's buttocks. CNA #322 then removed the water basin from the bedside table and then returned the bedside table to the end of the bed. Water was observed on the bedside table. CNA #322 wiped up the water with several tissues but did not disinfect the bedside table.</p> <p>A review of the medical record for Resident #13 revealed an admitted [DATE] with diagnoses including stroke, high blood pressure, Bell's Palsy, and right sided weakness. Resident #13 had moderately impaired cognition, was always incontinent of bladder and bowel, and was receiving hospice services. Resident #13 was dependent on staff for personal care and hygiene to be completed.</p> <p>A review of Resident #13's physician orders revealed an order dated 09/24/24 for the application of house barrier cream to peri-area and bilateral buttocks twice daily and as needed (PRN) may keep at bedside, CNA may apply.</p> <p>An interview on 10/30/24 at 11:15 A.M. with CNA #322 confirmed there were only two washcloths used to complete incontinence care for Resident #13, their bare hand removed soiled linens from the bedside table and the foot of the bed, and their hands were not washed or sanitized prior to donning a new glove, and the bedside table was not disinfected after soiled linens placed on the surface without a barrier.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview on 10/30/24 at 12:15 P.M. with the Director of Nursing (DON) revealed the expectations of the facility staff is to use multiple washcloths while completing incontinence care, the use of gloves, washing hands, and disinfecting the equipment used during the procedure. The DON stated CNA #13 should have followed infection control procedures while completing incontinence care for Resident #13.</p> <p>A review of the facility's policy titled, Handwashing revealed, Handwashing should be performed before and after care is given. Gloving does not replace the need for handwashing.</p> <p>This deficiency is an incidental finding discovered during the complaint investigation.</p>		