STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365975	A. Building B. Wing	04/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Health Center	100 Pine Avenue St Clairsville, OH 43950

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 - 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** 33019 THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on observation, record review, review of equipment manufacturer guidelines, policy review and interview, the facility failed to ensure Resident #1 was provided adequate and proper assistance, following manufacturer's guidelines to reposition in a geriatric (geri) chair to prevent an accident with injury. This affected one resident (#1) of three residents reviewed for accidents. The facility identified seven additional residents (Resident #11, #13, #15, #17, #18, #20, and #21) who utilized reclining assistive devices for mobility. The facility census was 71. Findings include: Review of Resident #1's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including heart failure, diabetes mellitus, chronic kidney disease, and osteoarthritis. Review of the care plan with an initiation date of 07/14/22, revealed Resident #1 required (staff) assistance with activities of daily living (ADLs) related to diagnoses including generalized weakness and limited mobility with interventions including to turn and reposition as needed. An additional care plan dated 07/14/22, revealed the resident had an alteration in comfort related to impaired mobility, generalized weakness and osteoarthritis with interventions including to maintain proper body alignment and to reposition the resident for comfort. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident's Brief Interview for Mental Status (BIMS) score was 07, which indicated severe cognitive impairment. The resident required physical assistance with activities of daily living (ADLs). The assessment indicated the resident's mobility device was a wheelchair. The assessment further indicated the resident had functional impairment of range of motion of the upper and lower extremities. (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 - Minimal harm or potential for actual harm Residents Affected - Few	Review of a nursing progress note, authored by Licensed Practical Nurse (LPN) #76 dated 04/03/24 at 6:30 P.M. revealed the nurses were called to the dining room stat. Resident #1 was observed in the wheelchair with a deep laceration noted to the right, inner leg, extending from the knee to the ankle. A gross amount of blood and serous fluid was noted on the floor below the resident. 911 was notified and a second nurse applied pressure to the wound. The resident was transferred to the emergency room . The nursing progress note did not contain any information as to the cause of the leg injury. Review of the emergency department (ED) provider notes, dated 04/03/24, revealed Resident #1 presented to the ED for a right, lower leg laceration. Per Emergency Medical Service (EMS), the nursing facility staff were moving the resident while in a chair and she caught herself on the side of the chair. Essentially there was an eight-inch-long laceration with fatty tissue exposed, but bleeding was controlled when the resident arrived at the ED. The resident was unsure how she had suffered the injury. The resident stated she was in some pain. There was a 20-21 cm laceration, curved with fatty tissue exposed on the right, lower leg medial aspect, and was oozing blood. Resident #1 was given a Tdap vaccine and was administered Fentanyl 50 micrograms (mcg) for pain, Ancef antibiotic prophylactically, and lidocaine for the procedure for the closing of the laceration. An x-ray of the tibia-fibula was obtained to confirm there was no fracture. Resident #1 received 17 interrupted sutures with nine vertical mattress sutures to the laceration. There was some minimal oozing at the lower distal end of the wound. Resident #1 was ordered an antibiotic, Keflex for ten days and the sutures were to be removed in seven to ten days. Review of a nursing progress note dated 04/03/24 at 11:01 P.M. revealed Resident #1 returned from the hospital. The note revealed the resident required 28 sutures to the right, lower leg; a scant amount of bloody drainage was noted. The antibiotic Keflex 500 mg twice daily for ten days was ordered. Review of a General Investigation of Incident form, dated 04/03/24, completed by Director of Nursing (DON) #2, revealed the incident was due to State tested Nursing Assistant (STNA) #74 attempting to change Resident #1's position from reclining to sitting, while in the dining room for meal, when a latch lock gave out (on the chair). The chair went forward and Resident #1's leg fell to (the) side, catching on the chair. The investigation document was signed by the Administrator, DON #1 and DON #2. The incident form failed to contain any additional information related to how the facility determined the latch lock gave out on the chair or to determine that even if the latch lock gave out on the chair, that it would have resulted in the laceration/injury to the resident's leg. In addition, there was no evidence the facility investigated and/or concluded STNA #74 had ensured the resident was properly positioned in the chair prior to attempting to change the resident's position from reclining to sitting or that the STNA provided safe, adequate and necessary care to the resident to prevent the leg injury from occurring. Review of the Quarterly Interdisciplinary Team Plan of Care Review Summary dated 04/04/24 and signed by Social Services #800, the Administrator, DON#1 and DON #2 with two family members (by phone) revealed an incident occurred on 04/03/24. The note indicated the resident's chair had been provided by hospice. The review summary indicated a chair malfunction, causing the laceration, ER visit and sutures. The resident would be seen by wound care and sutures removed in seven to ten days. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the 3-Position Recliner Standard and Extra Wide Guidelines booklet ([NAME].B.4.23), provided to the surveyor by the DON as the procedure guidelines used by facility staff when operating the geri chair, revealed in order to place unit in the reclining position, the attendant should: ensure that the recliner lock bar is in stored position; stand at either side of the recliner; grasp armrest with one hand, and PVC push bar with the other; push down on push bar to recline the back to the first recline position; and to achieve second recline position: push on push bar again; and to raise upright: pull forward on push bar; and set recliner lock bar. Avoid placing hands or legs in creases near recliner mechanism. On 04/24/24 during the onsite investigation, the surveyor observed video camera footage with the Administrator, timed and dated 04/03/24 at 4:06:56 P.M. In the video, Resident #1 was seated in a geriatric chair, in a reclined position with her lower extremities covered with a white blanket, and being transported by STNA #74 into the dining room. The camera footage revealed upon entering the dining room, STNA #74 struck a dining room chair with the left side of the geri chair prior to reaching a dining table. STNA #74 positioned the geri chair with the footrest section under the table and then quickly proceeded to place the resident from a reclined position to an upright position while the STNA was standing behind the geri chair. STNA #74 was next observed stepping to the right side of the geriatric chair and looking down at the resident, and then immediately stepping back behind the geri chair and quickly lowering the resident back into a reclining position. Another staff member, STNA #70 was observed walking toward Resident #1 and then looking beneath the geri chair. STNA #70 and STNA #74 were observed looking at the floor beneath Resident #1. Nursing staff began arriving and provided care to Resident #1's right, lower extremity until emergency medical services (EMS) arrived and transported the resident to the ED. Interview on 04/24/24 at 2:06 P.M. with Ombudsman #400 revealed she was aware of the incident/injury that occurred involving Resident #1 on 04/03/24. Ombudsman #400 revealed she had reviewed the case involving Resident #1 and identified the chair used at the time of the incident had not been approved by facility therapy staff for the resident prior to use. Interview on 04/24/24 at 3:11 P.M. with Family Member #20 revealed she had received a call following an incident on 04/03/24. She stated the nurse who called was fumbling over her words, said there was a lot of blood and the resident was bad. The resident was transported to the emergency room and the hospital determined nothing was broken but that the resident had a bad gash. The resident required 28 stitches. Family Member #20 revealed she was told by the Administrator the cause of the incident was due to a wheelchair malfunction. Interview on 04/24/24 at 3:35 P.M., with the Administrator revealed STNA #74 was transporting Resident #1 to the dining room and in the process of moving the resident from the reclined position to an upright position, the back of the chair quickly went forward and the leg rest went down, resulting in Resident #1's leg moving off of the leg rest and getting caught between the leg rest and the frame of the chair. The Administrator was unable to provide any additional information as to the cause of the chair going quickly forward and/or evidence the STNA had ensured the proper positioning of the resident prior to attempting to move the chair to a seated position from a reclined position or that the STNA was providing adequate and necessary care at the time of the incident. (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 04/24/24 at 4:27 P.M. with STNA #70 revealed staff were moving people into the dining room and he heard a click and then saw Resident #1's geri chair slam forward. STNA #70 stated the geri chair was blue and white and they didn't use geri chairs in this facility. STNA #70 stated he saw blood coming from Resident #1's right leg and could see her leg was pinched between the side of the chair and the mechanism. Interview on 04/25/24 at 9:50 A.M. with Rehabilitation Director #3 revealed on 03/29/24 an STNA asked her to look at Resident #1's chair as there was a concern with it. Rehabilitation Director #3 stated she removed this chair from service and searched the facility for a temporary replacement; however, there was not another similar chair in the facility. Rehabilitation Director #3 stated she then contacted the resident's hospice provider to replace the resident's chair. A new chair was provided, however the resident was not assessed by therapy or facility staff for proper fit/positioning in the new chair prior to use. Rehabilitation Director #3 revealed she was unaware of the new chair being in use until after the incident that occurred on 04/03/24. Interview on 04/25/24 at 11:16 A.M. with STNA #74 revealed she was not assigned to care for Resident #1 on the day of the incident (04/03/24). STNA #74 stated she was working as a shower aide on 04/03/24 but was helping move residents to the dining room for dinner. STNA #74 stated she took Resident #1, who was sitting in her geri chair in the south hallway, near the nursing station, to the dining room for dinner. STNA #74 stated the resident's lower legs were covered with a blanket and stated she did not reposition the resident in the chair or check the resident's positioning prior to transporting her to the dining room or prior to putting the legs of the geri chair down so the resident would be sitting upright to eat. STNA #74 stated she pushed the resident to the dining room in the geri chair in a reclined position and when she got to the dining table, she was going to place the resident in a forward, upright position. STNA #74 stated, when I grabbed the latch, it wouldn't release, and then the chair slammed forward. STNA #74 stated she heard what sounded like a rush of water and she immediately knew something was wrong and she noticed some blood on the blanket and quickly moved the chair from the upright position back into the reclined position. STNA #74 confirmed she did not lift the blanket or observe Resident #1's legs or lower extremities after observing blood on the blanket. STNA #74 stated after positioning the resident back into the reclined position, she saw the resident's right lower, leg hanging over the side of the leg rest with blood dripping from it. The STNA stated she had been educated in the past regarding geri chair use, but stated she was unable to recall when. Interview on 04/25/24 at 12:14 P.M., with the Administrator and DON revealed there was no evidence Resident #1 had been assessed for proper fit/positioning at the time the geriatric chair was provided for use. When asked if STNA #74 had used the geri chair on 04/03/24 according to the manufacturer's guidelines, neither the Administrator of DON provided an answer. Review of STNA #74's employee file revealed a hire date of 02/08/16. An STNA orientation checklist for Transferring Residents dated 06/17 was included in the employee's file. However, there was no additional training related to specific types of wheeled chairs (including geri chairs) and/or resident safety/positioning. The facility was unable to provide any additional documented evidence of employee training for STNA #74 related to resident safety/positioning. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/26/24 at 6:13 P.M. the Administrator emailed information to the surveyor not contained in the original investigative information and after the survey had been completed. The emailed information included: The Resident Handling/Transfers Policy and Procedure dated 10/18/01, revised on 07/2006 (that had previously been requested by the surveyor during the survey) and the following statements: An undated typed statement from the Administrator that indicated the durable medical equipment (DME) provider confirmed that the geri chair used during the incident with Resident #1 on 04/03/24 was cleaned and tested with no mechanical issues. A typed statement dated 04/04/24 and signed by Social Services #800 revealed she observed and participated in trialing of geri chair. She being of similar weight to Resident #1, sat in the chair while staff member (unidentified) operated chair with no malfunctioning of chair. A typed statement dated 04/04/24 signed by DON #1 revealed trial geri chair with other staff member (not identified) while having staff member of similar weight as resident. Chair did not malfunction and worked properly during trial. A typed statement dated 04/04/24 and signed by the Administrator revealed geri chair was operating and functioning correctly when reviewed by myself on 04/04/24. I also trialed the chair with a staff member (unidentified) in the chair with a similar height and weight of Resident #1. Chair functioned as it should and did not malfunction. A typed statement signed by Administrative LPN #805 and dated 04/04/24 revealed this nurse observed staff members (unidentified) operating geri chair with similar height and weight of Resident #1. Chair appeared to function as it should with no abnormal findings. Review of the facility's policy titled, Resident Handling/Transfers, with a revision date of July 2006, revealed it was the policy of the facility to ensure residents were handled and transferred safely to prevent or minimize risks for injury and provide and promote a safe, secure and comfortable experience for the resident while keeping the employees safe in accordance with current standards and guidelines. The resident's mobility needs would be reviewed quarterly and as needed based on observations or recommendations. The staff inspect the equipment prior to use and would alert maintenance or other designee if the equipment was not functioning properly. The deficient practice was corrected on 04/08/24 when the facility implemented the following corrective actions: On 04/03/24, all wheelchairs/specialty chairs were audited by the Director of Nursing for safety and functioning with no concerns noted. On 04/03/24, resident audits were initiated on 04/03/24 by the DON or designee weekly, for four weeks to assess and ensure residents were in the proper wheelchair and the wheelchair was functioning properly. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/05/24, a Quality Assurance meeting was held with all department managers and the medical director to discuss the incident on 04/03/24 and to develop an action plan to prevent future occurrences. The QA committee decided going forward, the facility would provide wheelchairs from their DME provider only to ensure safety and oversight. However, if DME was used from a Hospice provider, Rehabilitation Director #3 would inspect the DME prior to use. Hospice would notify the Administrator of the anticipated delivery date if DME was ordered through Hospice. On 04/08/24 an in-person staff meeting was held with education of the following topics: wheelchair/specialty chair safety and maintenance, wheelchair education, Hospice wheelchairs/specialty chairs, Kardex interventions, skin interventions and having DME inspected before use. For staff unable to attend, the education was provided by phone. Eighty-one staff members were educated. Results of all audits would be reviewed at all monthly Quality Assurance and Performance Improvement meetings held monthly and any concerns will be addressed. No transfer or equipment injuries have occurred since 04/08/24 and the time of the onsite complaint investigation. This deficiency represents non-compliance investigated under Complaint Number OH00152972.