

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366025	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/08/2024
NAME OF PROVIDER OR SUPPLIER MT Healthy Christian Home		STREET ADDRESS, CITY, STATE, ZIP CODE 8097 Hamilton Avenue Cincinnati, OH 45231	

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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37447</p> <p>Based on record review, observation, staff interview, and review of the facility policy, the facility failed to provide adequate supervision to prevent falls with injury. This resulted in Actual Harm to dependent Resident #20 when a staff member who was providing incontinence care to the resident without additional staff assistance turned away from the resident to discard cleaning materials and the resident fell from the bed. Resident #20 sustained the following injuries from the fall from the bed: a scalp laceration which required repair with sutures, a sternal fracture, a fracture of the left clavicle, a fracture of the second rib on the left side, a closed fracture of the spinous process of the thoracic vertebra and the transverse process of the lumbar vertebra. This affected one (Resident #20) of three residents reviewed for falls. The facility census was 66.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #20 revealed an admitted [DATE] with diagnoses including type two diabetes, hypertensive chronic kidney disease, dysphagia, cerebrovascular disease, vascular dementia, psychotic disorder with delusions, osteoporosis, anemia, atherosclerotic heart disease, gastro-esophageal reflux disease, osteoarthritis, glaucoma, hypertension and cardiomyopathy.</p> <p>Review of the Minimum Data Set (MDS) assessment for Resident #20 dated 02/07/24 revealed the resident was moderately cognitively impaired and was dependent on staff assistance for all activities of daily living (ADLs) including toileting and bed mobility for which she required the assistance of two staff.</p> <p>Review of the care plan for Resident #20 dated 02/08/24 revealed the resident was at risk for falls and/or fall related injury related to wheelchair use, history of fall related injury, impaired vision, incontinence, medication use, required use of a mechanical lift with transfers and had diagnoses of polyarthritis, dementia, severe depression, and psychosis. The resident was dependent on staff and Hoyer lift for transfers. Interventions included the following: Dycem to wheelchair under Roho cushion, use Hoyer lift for all transfers, monitor, anticipate and intervene for fall risk factors, place call light within reach, encourage call light use and answer promptly, provide environmental adaptations as appropriate, and assist with and monitor positioning.</p> <p>Review of the care plan for Resident #20 dated 02/08/24 revealed the resident had an ADL self-care deficit and required total assistance of one to two staff with incontinence needs. The care plan was updated on 03/20/24 to indicate the resident required two staff for incontinence care.</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 fall risk assessment for Resident #20 dated 03/10/24 revealed the resident was at moderate risk for falls and took medications and had diagnoses which contributed to her fall risk. The residents' risk factors also included wheelchair use and disorientation.</p> <p>Review of the progress note for Resident #20 dated 03/20/24 timed at 6:58 P.M. revealed the aide notified the nurse that the resident was on the floor on her left side next to the bed with a moderate amount of blood noted on the floor. The nurse called 911 to transport the resident to the hospital.</p> <p>Review of the fall investigative summary for Resident #20 dated 03/20/24 revealed during peri-care the resident changed the position of her body causing her to roll from the bed. State tested Nurse Aide (STNA) #98 attempted to intervene but was unable stop the resident from falling out of bed. Staff assessed Resident #20 for injury and called 911. Staff applied pressure to the resident's head laceration while awaiting transfer to the hospital. Resident #20 returned with a head laceration and multiple fractures. New interventions for Resident #20 were staff to ensure the resident was a two-person assist for peri care, and her low air loss mattress was replaced with a standard pressure reduction mattress.</p> <p>Review of the progress note for Resident #20 dated 03/21/24 timed at 1:52 P.M. revealed the interdisciplinary team (IDT) met to discuss the resident's fall. The IDT determined the root cause of the fall was the change to the resident's weight distribution on the low air loss mattress when the resident changed positions during peri-care. The new interventions were replacing the mattress and ensuring two people assisted the resident with peri-care.</p> <p>Review of the hospital notes for Resident #20 dated 03/21/24 revealed the resident fell from the bed and sustained a scalp laceration repaired with sutures, a sternal fracture, a fracture of the left clavicle, a fracture of the second rib on the left side, a closed fracture of the spinous process of the thoracic vertebra and of the transverse process of the lumbar vertebra.</p> <p>Review of the progress note for Resident #20 dated 03/21/24 timed at 4:06 P.M. revealed the resident returned to the facility with a laceration with sutures to the left side of her forehead, edema to the left side of her face, bruising to her right arm and a sling on her left arm for clavicle fracture support.</p> <p>Observation on 04/04/24 at 11:35 A.M. of Resident #20 revealed the resident was lying on a standard mattress and had bruising to the entire left side of her face from her forehead and extending to her neck. The bruising was brown and green in color and appeared to be fading. There was evidence of a laceration to the resident's head which appeared as a dark circle to the left side of the resident's forehead. Resident #20 was wearing a sling on her left arm and was unable to be interviewed due to cognitive impairment.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 04/04/24 at 2:10 P.M. with STNA #98 confirmed she was doing a routine check and change for Resident #20 on 03/20/24. STNA #98 was holding onto the resident with one hand and giving peri care with the other hand. STNA #98 confirmed she turned slightly to dispose of the wipe while still keeping one hand on Resident #20 and felt Resident #20 start to slip. STNA #98 confirmed she tried to intervene and keep Resident #20 from falling out of bed, but she was unable to prevent the fall. STNA #98 confirmed after Resident #20 slipped to the floor she noted blood coming from the resident's head, so she called for the nurse who assessed the resident and sent her to the hospital via 911. STNA #98 further confirmed Resident #20 was supposed to be a two person assist for checks and changes, but they were short of help that day and the care was provided at the shift change, so she completed the task on her own. STNA #98 further confirmed she felt the resident's weight shift on the low air loss mattress contributed to the fall and the facility got the resident a standard mattress after the fall.</p> <p>Interviews on 04/04/24 at 4:40 P.M. with STNA #38 and at 4:50 P.M. with STNA #67 confirmed if a resident had been determined to be dependent for toileting and incontinence care, two staff should provide assistance, and the care should never be completed with just one aide.</p> <p>Interview on 04/04/24 at 5:00 P.M. with the Administrator and the Director of Nursing (DON) confirmed Resident #20 had a fall from the bed on 03/20/24 which occurred when STNA #98 was providing incontinence care to the resident by herself without the assistance of an additional STNA. The Administrator and the DON confirmed Resident #20 sustained the following injuries as a direct result of the fall from the bed on 03/20/24: a scalp laceration which required repair with sutures, a sternal fracture, a fracture of the left clavicle, a fracture of the second rib on the left side, a closed fracture of the spinous process of the thoracic vertebra and the transverse process of the lumbar vertebra. Further interview confirmed the facility's IDT met on 03/21/24 and made the decision to replace Resident #20's low air loss mattress with a standard mattress and to update the resident's care plan to indicate Resident #20 required the assistance of two staff with incontinence care. Interview confirmed prior to Resident #20's fall on 03/20/24 the resident's care plan indicated the resident required the assistance of one to two staff with incontinence care and left it up to the judgment of the STNAs performing the care to determine if one or two staff should be used.</p> <p>Review of the policy titled Falls (undated) revealed the nurse and the physician would identify residents with a history of falls and risk factors for falling. The nurse would complete a fall risk assessment for each resident, and the staff, and the physician would identify pertinent interventions to prevent falls.</p> <p>This deficiency represents noncompliance investigated under Complaint Number OH00152423.</p>		