

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366111	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/10/2024
NAME OF PROVIDER OR SUPPLIER Falling Water Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 18840 Falling Water Strongsville, OH 44136	

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** 38523</p> <p>THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY.</p> <p>Based on observation, medical record review, resident and staff interview, review of medial imaging results, review of staff statements, and review of facility corrective action, the facility failed to provide adequate and sufficient assistance during personal care to prevent a fall with major injury for Resident #30.</p> <p>Actual harm occurred on 05/28/24 when Resident #30, who required staff assistance (care planned to require two-person assistance and/or substantial to maximal assistance with activities of daily living (ADLs)) sustained a fall out of bed resulting in a fractured left hip. At the time of the incident, one (1) staff member was providing care to the resident. This affected one (#30) of three residents reviewed for falls. The census was 99.</p> <p>Findings Include:</p> <p>Review of Resident #30's medical record revealed an admitted [DATE] with diagnoses including anemia, orthostatic hypotension, retention of urine, muscle weakness, chronic kidney disease, congestive heart failure, anxiety, and major depression.</p> <p>Review of a fall risk care plan dated 04/17/24 revealed Resident #30 was placed at risk for falls related to incontinence, weakness, anemia, end stage renal disease, diabetes mellitus, wounds, and immobility. Appropriate interventions were implemented to include use of non-skid footwear, maintain the resident's room free of accidents and hazards, ensure bed locks are engaged, place the call light in reach, and move the resident's room closer to the nurses' station.</p> <p>Review of an annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #30 was assessed with intact cognition with no range of motion impairments to the upper or lower extremities.</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 Resident #30's plan of care revised 05/16/24 revealed the resident had an ADL self-care deficit and the resident required assistance with ADLs related to incontinence, diabetes mellitus, weakness, and immobility. Interventions included the resident was totally dependent on staff for toilet hygiene, showers/bathing, and chair to bed transfers requiring two (2) or more helpers to do all of the work. An intervention included the resident required substantial/maximal assistance where helpers do more than half the effort to complete upper body dressing, personal hygiene, and rolling left and right. An intervention was also implemented which indicated the resident's assistance level with ADLs may vary based on the time of day, pain, mood, or fatigue and staff should document and adjust as indicated.</p> <p>Review of a late entry nursing progress note dated 05/28/24 at 7:45 P.M. revealed staff were alerted to Resident #30's room by a State tested Nursing Assistant (STNA) and Resident #30 yelling out for help. As the writer of the progress note entered the room, Resident #30 was observed rolling out of bed from behind a privacy curtain. The resident was mechanical (Hoyer) lifted from the floor using four (4) staff members to get the resident into bed. Resident #30 was noted with abrasions to his head, a skin tear to the top of the right hand, an abrasion to the front of the right shin, and bruising to the left arm. The resident was to be assisted by two staff for hygiene care, repositioning in bed, etc. The physician was notified, and x-ray imaging was ordered for the resident's hips and pelvis as the resident complained of pain while moving back to bed. The resident was able to move all 4 extremities.</p> <p>Review of a post-fall evaluation document dated 05/28/24 at 7:45 P.M. revealed Resident #30 sustained a fall in his room from bed which was in normal position. The resident was wearing non-skid socks and was not using any assistive devices. It was noted the last time the resident was toileted was on 05/28/24 at 7:45 P.M. and STNA #114 was the only witness to the fall. Vital signs were within normal limits, and the resident was complaining of pain in both hips and the left antecubital. The pain was described as achy and tender. Resident #30 was assessed with three (3) small abrasions on the top of his scalp, a skin tear on the back of the right hand, and an abrasion to the front of the right lower leg. Notification was made to the physician and resident's responsible party at 8:00 P.M. When the resident was asked what he was doing prior to the fall the resident responded that he was being changed and rolled off the side of the bed. The suspected root cause of the fall was the resident was holding onto a grab bar and started rolling off the edge of the bed. STNA #114 was not able to get to the other side of the bed fast enough to stop the resident from falling. It was also noted the resident was on an air mattress as a suspected root cause. Following the incident, staff identified the resident required two staff members to provide care at all times.</p> <p>Review of a written statement dated 05/28/24 given by STNA #114 revealed at approximately 7:45 P.M. he was doing a bed change on Resident #30. STNA #114 documented he rolled the resident over to face the door and the resident was grabbing the side rail holding himself over. As STNA #114 was putting the corners of the sheet on the bed, Resident #30 started to roll off the bed. STNA #114 reached to grab for the resident and yelled for help. STNA #114 documented Resident #30 slipped from his grip and rolled off the bed just as staff members entered the room.</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>Review of a typed statement dated 05/29/24 at 2:25 P.M. given by Licensed Practical Nurse (LPN) #132 revealed she just had finished shift report and was at the nurses' station charting when she heard a yell for help and a thud. LPN #132 observed Resident #30 laying on the floor between the two beds in his bedroom and his nurse aide was on the opposite side of the bed moving toward the resident. LPN #132 stated the resident was alert and oriented and indicated he rolled out of bed when the nurse aide was providing care and was not sure how it happened as it happened so quickly. LPN #132 documented the resident was assessed and was able to move his hands and arms with no issues. The resident indicated he had discomfort in both hips and he was able to move his right left more than his left leg. There was no obvious external rotation or significant length differences when comparing the resident's legs.</p> <p>Review of a nursing progress note dated 05/29/24 at 5:22 P.M. revealed Resident #30 complained of severe left arm pain in the morning and an order for x-ray imaging of the left arm from shoulder to fingertips was ordered. The resident was medicated with narcotic pain medications; however, the medication was not effective. Results of the resident's x-rays revealed a possible fracture of the left hip and the resident was sent out to the hospital. Review of a subsequent nursing progress note on 05/29/24 at 11:40 P.M. revealed Resident #30 was being admitted to the hospital due to a left hip fracture from a fall.</p> <p>Review of x-ray imagine results dated 05/29/24 revealed Resident #30 was found with irregularity of the left intratrochanteric region and may represent a nondisplaced fracture. The femoral heads showed no concerns, and the surrounding soft tissue was normal. X-rays of the left hand to shoulder revealed no acute fractures and the surrounding tissue was normal.</p> <p>Interview with the Administrator on 06/04/24 at 3:30 P.M. verified Resident #30 rolled out of bed approximately at 7:45 P.M. on 05/28/24. At the time of the incident, Resident #30 was holding the upper assist rail and his legs started going off the bariatric low air loss mattress with bolsters mattress. The Administrator revealed prior to the incident, the resident could hold the rail once assisted to roll onto his side, but stated the resident did not have the upper arm strength to roll himself over. The Administrator stated STNA #114 was providing incontinence care for the resident at the time of the incident. The Administrator indicated the facility notified the family, an x-ray was ordered, and the x-ray showed a possible fracture of the resident's left hip.</p> <p>Observation of Resident #30 on 06/06/24 at 7:57 A.M. revealed the resident was laying in bed with no obvious concerns noted. An interview was attempted with the resident; however, no information was able to be provided regarding the fall on 05/28/24 from the resident.</p> <p>Interview on 06/06/24 at 3:53 P.M. with STNA #114 via telephone revealed (on 05/28/24) he had to do a full bed change on Resident #30. While providing care, STNA #114 indicated he turned the resident to wipe his back side, and the resident was fine. STNA #114 stated Resident #30 was holding on to the upper side rail while he went to fit the corner of the sheet on the corner of the bed. STNA #114 stated, out of the corner of his eye, he could see Resident #30 started to slip. STNA #114 stated he got a little hold of Resident #30, but the resident slipped from his grasp. STNA #114 stated he called for help and Resident #30 fell off the bed as 2 staff members were coming in.</p> <p>As a results of the incident, the facility implemented the following corrective actions to correct the deficient practice on 06/03/24:</p> <p>(continued on next page)</p>		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	<p>On 05/29/24, Resident #30 was sent out to the hospital for evaluation and treatment of a suspected left hip fracture. The resident was readmitted to the facility on [DATE].</p> <p>On 05/31/24, an audit was completed on all residents with air mattress to ensure there were not issues with the mattresses and application of the mattresses was appropriate. There were no concerns noted.</p> <p>On 05/31/24, all resident care plans were reviewed and updated to ensure proper interventions were in place for assistance with care with no concerns noted.</p> <p>On 05/31/24, all staff members were educated that all residents utilizing an air mattress required a 2-persons assistance with care and to check the resident's Kardex for updates to the resident's tasks.</p> <p>On 06/03/24, audits were initiated to ensure 2-person assistance with utilized for residents with low air loss mattress. The audits were of three residents weekly for three weeks to ensure compliance. Review of the audits completed for the weeks of 06/03/24 and 06/10/24 revealed no concerns were identified.</p> <p>This deficiency represents noncompliance investigated under Complaint Number OH00154514.</p>		