

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366123	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/10/2024
NAME OF PROVIDER OR SUPPLIER Accord Care Community Orrville LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1980 Lynn Drive Orrville, OH 44667	

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 - Minimal harm or potential for 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** 45441</p> <p>Based on record review, fall investigation review, interview and policy review, the facility failed to have documented evidence fall prevention interventions were implemented and failed to ensure care plans were updated timely to prevent repeat falls for Resident #56. This affected one resident (#56) of three residents reviewed for falls. The facility census was 55.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #56 revealed and admitted [DATE] and a discharge date of [DATE]. Diagnoses included dementia, diabetes, adult failure to thrive, anxiety, cognitive communication deficit, insomnia, and lack of coordination.</p> <p>Review of the quarterly MDS assessment dated [DATE] revealed Resident #56 was severely cognitively impaired. He required supervision or touch assistance for eating, and partial to moderate assistance from oral hygiene, toileting, showering, dressing, and hygiene.</p> <p>Review of the care plan dated 10/23/23 revealed Resident #56 was at risk for falls due to dementia, medications, and impaired safety awareness. Interventions included elbow protectors to be worn as tolerated, encouraging the resident to use the bathroom upon rising, before and after meals and at bedtime, and providing periods of rest.</p> <p>Review of the physician's orders for November 2024 revealed an order to remind and demonstrate the use of the call light two times a day for Resident #56, which began on 11/20/24.</p> <p>Review of the fall risk assessment dated [DATE] revealed Resident #56 was at a high risk for falls.</p> <p>Review of the fall investigation dated 11/23/24 at 3:00 P.M. revealed Resident #56 was found on the floor and lying on his back in between the beds in his room. Resident #56 did have a bowel movement, and it appeared Resident #56 was rushing to get to the bathroom and fell on his way. No injuries were noted. An intervention was added to assist Resident #56 to the toilet after lunch in between lunch and dinner. The investigation did not include documented evidence of Resident #56's witness statements regarding the event, when Resident #56 was last toileted, and if Resident #56 was wearing elbow protectors and non-skid socks. There was also no documented evidence that the resident's care plan was updated to include assisting the resident to the toilet after lunch and between lunch and dinner.</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 - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the fall investigation dated 11/25/24 at 1:58 A.M. revealed Resident #56 was observed lying on his back on the floor in his room by the door. He was noted to have visible bruising starting on the right side of his head, right upper arm, right forearm, right elbow and right knee. Resident #56 was incontinent at the time of the fall. He was not able to answer questions appropriately, pupils were pinpoint and non-reactive to light. Vital signs included a BP 142/108, pulse 56, respirations 10, oxygen saturation 73%, and temperature 96.9 degrees F. Resident #56 was last noted to be resting quietly in bed approximately 30 minutes prior to the incident. He was wearing gripper socks on his feet. Resident #56 received oxygen at four liters per minute and his oxygen saturation increased to 97%. A skin and range of motion assessment was unable to occur due to Resident #56 being immobilized for safety until the paramedics arrived. The physician was notified and ordered Resident #56 be sent to the emergency department (ED), Resident #56's responsible party was also notified. There was no documented evidence of whether or not Resident #56 was wearing elbow protectors and when the resident was last toileted.</p> <p>Review of the ED discharge instructions dated 11/25/24 at 2:18 A.M. revealed Resident #56 was treated for a fall, an abrasion to the right arm and a closed head injury. Instructions were to follow up with his primary care physician within two to four days.</p> <p>Interview on 12/09/24 at 2:38 P.M. with Licensed Practical Nurse (LPN) #205 confirmed the facility did not obtain witness statements for the fall investigations for Resident #56.</p> <p>Review of Resident #56's care plan dated 12/09/24 revealed a new intervention which included assistance with toileting between lunch and dinner was added after surveyor intervention.</p> <p>Interview on 12/10/24 at 8:51 A.M. with the Director of Nursing (DON) confirmed the fall investigation for Resident #56 did not include documented evidence that all interventions were in place or when the resident was last toileted prior to the fall. The DON also verified a new intervention which included assistance with toileting between lunch and dinner was not timely added to the resident's care plan after the fall that occurred on 11/23/24.</p> <p>Review of the facility policy titled Falls and Fall Risk, Managing, dated March 2018, revealed the facility would monitor and document a residents' response to interventions intended to reduce falls or risks of falls and reevaluate conditions and interventions as needed.</p> <p>This deficiency represents noncompliance investigated under Master Complaint Number OH00160153.</p>		