

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366129	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2025
NAME OF PROVIDER OR SUPPLIER Gillette Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 3310 Elm Rd Warren, OH 44483	

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. (continued on next page)

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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and review of facility policy, the facility failed to conduct complete and thorough post-fall investigations to mitigate risk of falls . This affected one resident (Resident #94) of four residents reviewed for falls. The facility census was 93. Findings include: Record review for Resident #94 revealed an admission date of 05/23/25 with diagnoses including unspecified dementia, anxiety, difficulty walking, malnutrition and right femur fracture. Pertinent physician orders included non-skid pad to wheelchair, body pillow to open side of bed, non-skid pad to wheelchair cushion, floor mat to open side of bed, non-skid socks on at all times, brake sentry to wheelchair, and physical therapy evaluate and treat. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #94 had moderate cognitive impairment, had a fall with fracture prior to admission and had a fall since admission. Resident #94 was incontinent bladder. Review of Resident #94's plan of care, date initiated 05/28/25, revealed Resident #94 was at risk for falls related to history of falls, impaired cognition, and safety awareness with history of dementia, decreased abilities to transfer and ambulate, decreased balance, lower extremity strength and endurance. The interventions included to anticipate and meet needs, non-skid pad on top of and underneath wheelchair cushion (06/03/25); be sure call light is within reach, body pillow to open side of bed per order (06/03/25); ensure that resident is wearing appropriate footwear when ambulating or mobilizing in wheelchair (06/03/25); follow facility fall protocol , resident needs activities that minimize the potential for fall providing diversion and distraction (06/03/25); one person staff assistance with wheeled walker for transfers (06/04/25), and floor mat to open side of bed (06/17/25); and assist to toilet as needed and per schedule for incontinence; assure that break century is present and functioning properly (06/24/25). Further review of the care plan, date initiated 06/04/25, for Resident #94 revealed she was incontinent of bladder related to impaired functional mobility and incontinence. The interventions included check and change every two hours for incontinence and assist, remind and encourage resident to toilet as per scheduled toileting program. Further review of Resident #94's medical record revealed Resident #94 had falls in the facility on 05/26/25, 06/12/25, 06/16/25, 06/20/25, 06/24/25 and 07/04/25 and concerns were identified regarding complete and thorough post-fall investigations with the following incidents: Review of a progress note dated 06/12/25 revealed staff observed Resident #94 sitting in her wheelchair talking to another resident. Resident #94 was leaning over towards the other residents and slid from the seat of the wheelchair onto the floor landing on her right side with her arm under her head. Vital signs were obtained, and a body assessment revealed no injuries. The resident was placed back in the wheelchair with dycem (non-skid mat) placed under the chair cushion. The physician and family were notified. Review of the facility fall investigation dated 06/12/25 revealed the fall occurred at 10:42 A.M. Resident #94 was found lying on the floor on her right side with right arm underneath her head. There were no obvious injuries noted. A non-skid pad was placed to the top of the wheelchair underneath the buttocks of the residence. The incident occurred in the dining room. Review of the six witness statements within the investigation revealed staff indicated they were unaware of the incident unless notified by other staff to assist in response. There was no documentation within the investigation to indicate when the last time the resident was seen by staff, or last checked or changed for incontinence care. The investigation summary indicated the conclusion was that Resident #94 was leaning to talk to someone and slid out of her wheelchair sustaining no injuries. Review of a progress note dated 06/16/25 revealed the nurse was told by the nurse aide that Resident #94 was on the floor. The nurse found Resident #94 naked, lying on her back in front of her dresser. Resident #94 stated she was not sure what happened. The nurse and aide assisted the resident back to bed. Vital signs were obtained and were within normal limits. A skin assessment revealed a one centimeter skin tear to the right elbow which was treated. Resident #94 denied hitting her head and there were no wounds. An interventions of a floor mat to the left side of the bed was initiated. The residents daughter and the physician were notified. Review of the facility fall investigation dated 06/16/25 revealed the fall occurred at 8:15 P.M. and Resident #94 was found lying on her back naked with her legs out in front of her. A skin tear to the right elbow was noted. The resident had removed all of her clothing, her non-skin socks and her brief. Resident #94 was incontinent of urine. Review of the witness statements by staff within the investigation revealed there was no documentation to indicate when the resident was last seen by staff or when the resident was last toileted or checked and changed for incontinence care prior to the fall. The investigation summary indicated Resident #94 was found on the floor naked after attempting to self transfer</p>		