STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366214	A. Building B. Wing	03/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canterbury Villa of Alliance	1785 Freshley Avenue Alliance, OH 44601

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22653 Based on medical record review, policy review, and interview, the facility failed to notify the physician when they were unable to obtain stat laboratory tests (Stat testing is a category of medical testing that prioritizes speed and efficiency in delivering results. It is reserved for situations where a healthcare provider requires test results as quickly as possible to make immediate clinical decisions.) in a timely manner for one (Resident #77) of three residents reviewed for dehydration. Findings include: Review of Resident #77's medical record revealed diagnoses including acute kidney failure, dementia, and malignant neoplasm of the bladder and prostate. A nursing note dated 02/01/25 at 11:15 A.M. revealed Resident #77's wife and son voiced concerns as they stated Resident #77 had not been eating or drinking well for the past few days. Per the family, Resident #77 had an emesis a few days earlier after a meal and had not been eating or drinking. Resident #77's son and wife stated Resident #77 had been sleeping more often and they were concerned. The physician was notified and gave an order for a basic metabolic panel on the following Monday, 02/03/25. (A basic metabolic panel (BMP) is a helpful and common test that measures several important aspects of your blood, like electrolytes and blood sugar. Healthcare providers often use it as a go-to blood test to assess your general physical health. It can also help diagnose, screen for and monitor certain health conditions.) A nursing note dated 02/01/25 at 1:00 P.M. indicated a Certified Nursing Assistant (CNA) notified the nurse Resident #77 had a small emesis while eating lunch. Abnormal lung sounds were noted in the right lower lung. Resident #77 was lethargic (decrease in consciousness) and the family stated Resident #77 had been coughing up yellow mucus. Resident #77's family stated they were concerned as they believed Resident #77 was declining. The family stated they were concerned with weight loss and decreased appetite. Resident #77 had been reporting to family he was not hungry and had not been eating or drinking well. The physician was notified and orders were received for a stat chest x-ray and stat Complete metabolic panel (CMP) and to discontinue the BMP ordered for 02/03/25. Notification was made for need for a stat chest x-ray. A nursing note dated 02/02/25 at 8:20 A.M. revealed Resident #77's attending physician was notified the stat CMP from 02/01/25 had not been drawn yet due to the lab not having a phlebotomist available. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nursing note dated 02/02/25 at 10:01 A.M. revealed the physician visited and spoke with Resident #77 and his family regarding his condition. New orders were received for a stat Complete Blood Count (CBC) with differential, stat abdominal x-ray and omeprazole (proton pump inhibitor used to decrease heartburn and acid production in the stomach) 20 milligrams every day. A subsequent note at 10:16 A.M. revealed notification was made for the need for stat abdominal series. A nursing note dated 02/02/25 at 2:30 P.M. indicated a phone call was made regarding the stat labs ordered from 02/01/25 and stat labs ordered 02/02/25. The laboratory representative stated the phlebotomist was unable to see requisitions on her tablet. The phlebotomist was having technical issues and left at 2 P.M. Importance of obtaining the stat labs was discussed stressing the need to have them drawn as soon as possible. The lab representative stated she would inform the phlebotomist who started at 2 P.M. The physician was notified. A physician progress note dated 02/02/25 at 4:01 P.M. indicated the abdominal film ordered earlier that day showed mild stool burden as well as bilateral ureteral stents with patency noted. Resident #77 presented with nausea and vomiting after a meal. Resident #77 had been having a poor appetite eating only a couple bites of breakfast and was less conversant. Resident #77 had blood work pending. Resident #77 was awake and alert during the visit. Lungs were clear to auscultation in all lung fields. Resident #77's abdomen was soft, non-tender and non-distended. Bowel sounds were present. A nursing note dated 02/02/25 at 5:15 P.M. indicated a call was received from the phlebotomist stating she was approximately an hour and a half away from the facility and was on her way. Review of laboratory results dated [DATE] revealed lab tests were collected on 02/02/25 at 6:50 P.M. Results included a blood urea nitrogren (BUN) of 82, creatinine of 2.84 and BUN/creatinine ration of 28.9. Reference ranges for BUN were 7-26, creatinine were 0.74 to 1.35 milligrams per deciliter (mg/dL), and BUN/creatinine ratio were normal ratio of 10:1 to 10:1) A nursing note dated 02/03/25 at 2:06 A.M. revealed an order was received to send Resident #77 to the hospital. A nursing note dated 02/03/2025 at 8::22 A.M. revealed Resident #77 was admitted to the hospital with diagnoses of acute kidney injury and hydronephrosis (a condition that occurs when a kidney swells due to the inability to drain urine properly, typically caused by a blockage or obstruction in the urinary tract). On 03/11/25 at 10:39 A.M., Resident #77's attending physician was interviewed and stated he did not like to send residents to the hospital unless it was a known emergency. Unfortunately, in the nursing home setting sometimes vital signs were stable but the facility did not have the ability to do further testing. The facility was beholden to laboratory providers to draw labs and they were not always reliable. The physician (also the medical director) indicated he expected stat orders to be done the same day or at least be notified if they could not be obtained the same day. Unfortunately, he did not always receive notice when the labs were not completed. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/10/25 at 2:38 P.M., the Director of Nursing (DON) verified the stat CMP ordered on 02/01/25 was not obtained that day and the information was not provided to the physician until 02/02/25 at 8:20 A.M. over 19 hours later. The DON stated the facility had been having problems with the lab. The DON verified if there was difficulty obtaining a stat lab, the physician should be notified so he could decide if he wanted to send the resident to the hospital or change the course of treatment. Review of the lab policy, A Quick Reference for a One Time or Stat Order (undated) revealed a if there was a stat order, staff were to ensure STAT Order was selected. The requisition would automatically populate. The policy did not did not provide a time frame for obtaining stat laboratory tests. This deficiency is an incidental finding discovered during the complaint investigation.

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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** 22653 Based on observation, medical record review, review of hospice and hospital records, and interview, the facility failed to fully investigate concerns related to falls to ensure risk factors were addressed in the plan of care to prevent falls. The facility also failed to ensure physician orders were implemented for fall intervention. This affected two residents (#42 and #77) of three residents reviewed for falls. Actual Harm occurred on 02/07/25 when Resident #77, who was identified at risk for falls, cognitively impaired, required staff assistance with transfers and had concerns voiced to the facility from family and the hospice provider regarding the resident potentially falling, fell while ambulating unassisted resulting in a right femoral neck fracture. The resident reported complaints of pain following the fall and was transferred to the hospital. However, due to the resident's hospice status, the resident did not undergo surgical repair for the fracture. Findings include: 1.Review of Resident #77's medical record revealed diagnoses including generalized muscle weakness, need for assistance with personal care, intervertebral disc degeneration, dementia, abnormalities of gait and mobility, and anemia. An admission assessment dated [DATE] indicated Resident #77 was confused and anxious. The assessment indicated Resident #77 required assistance with transfers with a Hoyer lift and he was non-ambulatory. Safety interventions implemented included the use of a low bed. A plan of care initiated 12/31/24 revealed Resident #77 was at risk for falls related to impaired mobility/balance. The goal was to minimize potential risk factors related to falls. Interventions included keeping the bed in the lowest position, encouraging and reminding Resident #77 to ask for assistance, having commonly used articles within easy reach, using a low bed, and maintaining a clear pathway. Review of an Admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #77 was moderately cognitively impaired. Resident #77 had functional limitation in range of motion of one lower extremity. The MDS indicated Resident #77 required partial to moderate assistance for transfers between the bed and chair, toilet transfers and tub/shower transfers. Resident #77 walked ten feet with partial/moderate assistance. Resident #77 was not on hospice. A Physical Therapy (PT) discharge summary dated 01/31/25 indicated Resident #77 needed supervision or touching assistance to transfer to a standing position from sitting in a chair, wheelchair or on the side of the bed and was able to ambulate 30 feet with contact guard assist of one prior to discharge to the hospital. A nursing note dated 02/03/2025 at 2:06 A.M. revealed an order was received to send Resident #77 to the hospital. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of a hospital history and physical dated 02/03/25 revealed Resident #77 was sent to the emergency department because of abnormal labs showing renal failure and Resident #77 was feeling weak and not eating. Resident #77 was evaluated in the emergency department and a computed tomography scan of the abdominal pelvis showing hydronephrosis with ureteral stents and worsening of renal failure. Resident #77 was admitted for further evaluation and was also found to have a urinary tract infection (UTI). Resident #77 was a poor historian and had underlying dementia. Diagnoses included acute on chronic kidney injury, UTI, hydronephrosis, history of bladder cancer, dementia and chronic generalized weakness. Resident #77 returned to the facility on [DATE]. The admission assessment indicated Resident #77 was confused, had rhonchi (continuous low pitched, rattling lung sounds) bilaterally. Resident #77 required assistance with transfer. The assessment indicated Resident #77 was non-ambulatory, had half side rails, a bed in the lowest position and was on hospice care. Review of a hospice care plan dated 02/05/25 revealed a primary diagnosis of malignant neoplasm of the prostate with metastasis to bone. Safety measures included fall precautions. A fall risk assessment dated [DATE] revealed Resident #77 remained at risk for falls. Resident #77 had a history of falls within the past 90 days, was unable or unwilling to follow directions, was cognitively impaired, had behaviors, required assistance with elimination, did not ambulate, was unable to perform tests for balance, was unable to stand, had orthopedic risk factors and medications which contributed to the risk for falls. There was no evidence the plan of care was reviewed/revised after the resident's 02/05/25 readmission. A social service note dated 02/06/25 at 1:16 P.M. indicated a care conference was held and Resident #77 was being admitted to hospice services that day. Review of a hospice visit note dated 02/06/25 revealed safety and fall precautions were reviewed. Family reported that they noticed Resident #77 had been getting anxious and fidgeting a lot and trying to get up on his own, at times it was due to wanting to go home. Family expressed fear of Resident #77 falling in their absence. Family were at bedside most of the time but did go home at night time. Family talked with the hospice nurse on 02/05/25 about using an alarm but (facility) staff refused an alarm on 02/06/25 stating it was considered a restraint and against their policy since Resident #77 had not had any falls within the past 30 days. A nursing note dated 02/07/25 at 4:17 A.M. indicated Resident #77 was up walking with a walker without assistance and fell in the hallway outside of his room at 3:20 A.M. Resident #77 complained of right hip pain and was unable to move his right leg without pain. The right leg was noted to be shorter than the left and the right foot was rotated outward. At 3:30 A.M., Resident #77's wife and hospice were notified. At 3:40 A.M., hospice gave an order to send Resident #77 to the hospital for evaluation. At 3:45 A.M. emergency medical technicians were contacted for transport. Resident #77's wife and son were present at the facility and planned to meet Resident #77 in the emergency room (ER). At 4:07 A.M. Resident #77 was transported out of the facility. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A nursing note dated 02/07/25 at 8:30 A.M. revealed Resident #77 returned to the facility with a diagnosis of right femoral neck fracture. No surgery was planned due to hospice status. The family was asking questions regarding a bed alarm. The wife and son stated Resident #77 was attempting to get our of bed while in the ER. A new order was received for a bed alarm at that time. On 03/11/25 at 10:19 A.M., an interview with the Administrator revealed the facility had no policies specific to alarm use. The use was based on an individual basis. On 03/11/25 at 11:04 A.M. an interview with Hospice Nurse #100 revealed hospice had addressed the use of an alarm for Resident #77 but the facility refused, stating a resident had to have a fall within the past 30 days for an alarm to be used and because alarms were considered restraints. On 03/11/25 at 3:20 P.M., an interview with Certified Nursing Assistant (CNA) #110 revealed Resident #77's family was usually sitting with him during the day but when they left Resident #77 would attempt to get up independently. This behavior had occurred throughout Resident #77's stay. When asked about fall interventions for Resident #77, CNA stated Resident #77 had a low bed. On 03/11/25 at 3:27 P.M., an interview with Registered Nurse (RN) #120 revealed Resident #77 had been found up walking independently at times on day shift. Night shift had also reported Resident #77 tried to get up independent at night. Resident #77 had a low bed. Family was present a lot during the day. RN #120 stated she knew family had requested an alarm, at least a couple days. Hospice had also talked about using an alarm when admitting Resident #77 to their services and had spoken to the Assistant Director of Nursing (ADON)/Licensed Practical Nurse (LPN) #130 and was told the facility was not going to initiate alarm use. On 03/11/25 at 3:34 P.M. an interview with LPN #130 revealed Resident #77 spent a lot of time in his room. The facility usually did not use alarms without a history of falls because alarms could upset residents. LPN #130 verified the alarm use might be upsetting to one resident but not another and could be a restraint for one resident but not another. It would require an individual evaluation for each resident. Any evaluation for alarm use for Resident #77 was requested but none was provided. LPN #130 stated the Director of Nursing (DON) was present during the discussion regarding alarm use. On 03/11/25 at 3:40 P.M. an interview with the DON revealed she was not aware of hospice addressing alarm use but they could have written an order although staff had told them an alarm could not be applied. The DON stated she was aware of the family's request for alarm use. The DON stated she was part of a discussion when family requested alarm use (could not provide a date). The DON stated she reviewed progress notes and there was no documentation of Resident #77 attempting to self-transfer or ambulate independently. Based on that lack of information she determined an alarm would be an unnecessary intervention. The DON verified she did not interview any staff or do any further investigation regarding the risk involved with Resident #77 making attempts to get up and walk independently. Without any evidence of the attempts to self transfer, no need was identified to re-evaluate the plan of care for new interventions. Despite the family concern, no new interventions related to fall prevention was implemented and Resident #77 experienced a self-transfer fall on 02/07/25 and received a right femoral neck fracture that was not surgically repaired due to the resident's hospice status. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the facility's fall management policy, dated 10/17/16, revealed each resident would be assessed throughout the course of treatment for different parameters such as cognition, safety awareness, fall history, mobility, medications, or predisposing health conditions that could contribute to fall risk. An interdisciplinary plan of care would be developed, implemented, reviewed and updated as necessary to reflect each resident's current safety needs and fall reduction interventions. 2. Review of Resident #42's medical record revealed diagnoses including generalized muscle weakness, hallucinations, history of falling, chronic pain, hypertension, difficulty walking, unsteadiness on feet, abnormalities of gait and mobility, and dementia. A care plan initiated 12/13/24 indicated Resident #42 was at risk for falls related to impaired mobility, muscle weakness, abnormalities of gait/mobility, difficulty walking, history of stroke and history of falling. Interventions included keeping the bed in the lowest position, encouraging and reminding Resident #42 to ask for assistance, keeping commonly used articles within easy reach and maintaining a clear pathway. A fall risk assessment dated [DATE] indicated Resident #42 was at risk for falls. Risk factors included a history of one to two falls in the last 90 days, a fall in the last 30 days, cognitive impairment, behaviors, need for assistance with ambulation, ambulating with problems and with or without assistive devices. The assessment revealed Resident #42's balance was unsteady and he was only able to stabilize with staff assistance. Other risk factors included age, cardiovascular issues, neuromuscular or functional issues and medication use. On 01/07/25 an order was written for a pressure sensor alarm to the chair with instructions to check placement and function every shift. The plan of care was updated to reflect the alarm use. On 03/10/25 at 4:43 P.M., Resident #42 was observed sitting in the wheelchair in the secure unit dining area without the alarm box in place. LPN #140 verified the alarm was not on as ordered. This deficiency represents non-compliance investigated under Master Complaint Number OH00162793 and Complaint Number OH00162716.