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	05/13/2024

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44808 Based on medical record review, review of the facility self-reported incidents (SRIs), staff interview, and review of facility policy, the facility failed implement their abuse policy regarding thoroughly investigating allegations of resident-to-resident abuse for Residents #50, #65, #128, and #129. This affected four residents (#50, #65, #128, and #129) of five reviewed for abuse. The facility census was 78. Findings include: 1. Review of the medical record for Resident #50 revealed an admitted [DATE] with diagnoses including dementia with behavioral disturbance, Alzheimer's disease, major depressive disorder, anxiety, delusional disorder, and schizoaffective disorder. Review of the annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #50 had severely impaired cognition and had experienced hallucinations and delusions within the seven days prior to the assessment. Review of Resident #50's progress note dated 12/10/22 at 1:57 P.M. indicated Resident #50 stood up and hit the resident next to her in the stomach and Resident #50 later came out of her room and hit the same resident again in the side of the stomach. Review of the medical record for Resident #129 revealed an admitted [DATE] with diagnoses including Alzheimer's disease, dementia with behavioral disturbance, major depressive disorder, and anxiety. Resident #129 discharged on [DATE]. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #129 had moderately impaired cognition and experienced delusions in the seven days prior to the assessment. Review of Resident #129's progress note dated 12/10/22 at 1:57 P.M. indicated Resident #129 was hit by another resident while sitting in her recliner in the common area. The progress note dated 12/10/22 at 6:09 P. M. indicated Resident #129 was hit in the stomach again by the same resident. The progress note dated 12/11/22 at 2:03 P.M. indicated Resident #129 was hit in the right side by another resident and about one hour later Resident #129 was hit again in the abdomen by the same resident. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility SRI dated 12/10/22 revealed a resident-to-resident altercation was reported to the Administrator on 12/10/22. The summary of the incident indicated Resident #50 walked over to Resident #129 and hit Resident #129. Neither Resident #50 nor Resident #129 could recall the incident after it happened. The SRI initial report form indicated facility staff witnessed Resident #50 hit Resident #129 in the stomach and rib with no bruising, pain, or swelling identified. The timeline included in the initial report of the SRI on 12/10/22 at 2:00 P.M. that Resident #50 hit Resident #129's right upper extremity and on 12/10/22 at 4:00 P.M. Resident #50 woke up and hit Resident #129 in the face. The witness statement, dated 12/10/22 at 2:00 P.M., by State tested Nurse Aide (STNA) #450 indicated Resident #50 hit Resident #129 on the right arm. The witness statement, dated 12/10/22 at 4:00 P.M., by STNA #261 indicated Resident #50 hit Resident #129 in the side of the face with a closed fist. No other witness statements were included in the SRI investigation. There was no documentation of interviewing or assessing like residents. On 05/07/24 at 9:55 A.M., interview with the Director of Nursing (DON) verified the details of the investigation did not add up and there were discrepancies between the progress notes and the witness statements. On 05/07/24 at 11:40 A.M., interview with the Administrator and DON stated Resident #129 was not hit in the face. The Administrator and DON verified the witness statement indicated Resident #129 was hit in the face and both the Administrator and DON stated that claim could not be verified because Resident #129 did not have any red marks on her face. The Administrator and DON continued insisting that Resident #129 was only hit in the stomach and never hit in the face, despite what the witness statement indicated. When asked about the discrepancies between the witness statements and the progress notes, the Administrator stated the progress notes were written by a nurse on a different unit because there was a medication technician on the secured memory care unit at the time of the incident. On 05/08/24 at 10:36 A.M., interview with the Administrator confirmed the facility did not implement their policy and complete a thorough investigation of the incident between Resident #50 and Resident #129. The Administrator stated she needed more training on conducting SRI investigations. Review of the facility policy, Abuse, Neglect, Exploitation & Misappropriation of Resident Property, dated November 21, 2016, revealed all incidents and allegations of Abuse, Neglect, Exploitation, Mistreatment of resident, or Misappropriation of Resident Property and all Injuries of Unknown Source must be reported immediately to the Administrator or designee and have evidence that all alleged violations are thoroughly investigated. 43061 2 .Review of the medical record for Resident #65 was admitted on [DATE] with diagnoses including but not limited to unspecified dementia, severity, with other behavioral disturbance, cognitive communication deficit, unspecified mood (affective) disorder, post-traumatic stress disorder, chronic, alcohol use, unspecified with alcohol-induced persisting dementia, and alcohol abuse with withdrawal unspecified Review of Resident #65's quarterly MDS assessment, dated 02/06/24, revealed Resident #65 had impaired cognition with behaviors to include verbal and physical towards others. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #65's progress note dated 03/17/23 at 2:45 P.M. authored by the DON revealed STNA #247 witnessed Resident #65 hit Resident #128's hand twice as she reached to take his drink from his tray. The residents were separated immediately, and physician and guardian notified. Review of the medical record for Resident #128 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnosis included but not limited to unspecified dementia, severity, with other behavioral disturbance, cognitive communication deficit, unspecified mood (affective) disorder, Post-traumatic stress disorder, chronic, alcohol use, unspecified with alcohol-induced persisting dementia, and alcohol abuse with withdrawal unspecified Review of Resident #128's admission MDS 3.0 assessment, dated 03/16/23, revealed Resident #128 had severely impaired cognition. Review of Resident #128's progress note dated 03/17/23 at 2:41 P.M. authored by the DON revealed Resident #128 had her hand hit by another resident when she tried to take his drink off his tray. Residents were immediately separated. No injuries noted and the physician and daughter notified. Review of the facility's SRI, dated 03/17/23, indicated STNA #247 witnessed Resident #65 hit Resident #128's hand twice. The residents were immediately separated, and notifications were done. The SRI stated the incident occurred on 03/16/23 at 8:00 A.M. and administrator was notified of the incident on 03/17/23 at 8:00 A.M. but it did not say who notified her. The witness statement by STNA #247 was dated 03/17/23 but not timed. There was one statement for Resident #128 regarding a skin check was done by the Assistant Director of Nursing (ADON) #246 dated 03/17/23. Interview on 05/07/24 at 2:25 P.M. with the DON verified the facility did not complete skin checks on Resident #65 or all like residents residing on the dementia unit until it was time for the regularly scheduled weekly skin check. The DON verified the skin checks were not completed on the day they were made aware of the incident and they weren't completed specifically for their investigation of the incident. Interview on 05/08/24 at 7:54 A.M. with the DON revealed for incidents of abuse the expectation was to separate the residents immediately, do skin checks on both residents, and notify physician, family, the DON, and usually the Administrator. The DON reported skin assessments on all residents on the unit were done shortly after an incident. The DON reported the Administrator does the reporting. The DON verified skin checks were not done on Resident #65 or any other residents on the unit. Interview on 05/08/24 at 8:13 A.M. with the DON revealed she would have to check her notes about the incident. The DON did not remember since it happened a year ago. Interview on 05/08/24 at 8:44 A.M. with the Administrator revealed she believed she was notified of the incident on 03/17/24 by the DON. The Administrator confirmed the SRI had the incident occurred on 03/16/24 at 8:00 A.M. The Administrator reported skin checks should have been done on both the residents involved in the incident (Resident #65 and #128). The Administrator verified a skin check was not done on Resident #65. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 05/08/24 at 9:17 A.M. with the DON verified the Medication Technician (MT) #283 working the Dementia Unit where the incident occurred did not document as she should have for the incident between Resident #65 and Resident #128. The DON verified she was notified the day of the incident, 03/16/23, but did not recall what time she was notified that day. Interview on 05/08/24 at 9:39 A.M. with the DON revealed she gave the surveyor the wrong information. The DON retracted the previous statement and said since the incident was an isolated incident and the facility would not do skin assessments on everyone on the unit. Interview on 05/08/24 at 10:36 A.M. with the Administrator revealed the Administrator stated the investigations for these SRIs are crap. I get it. I need to do more training on SRI'S. Interview on 05/08/24 at 2:10 P.M. with STNA #261 revealed she witnessed the incident. STNA #261 reported Resident #128 reached for a drink from Resident #65's tray and Resident #65 hit Resident #128's hand two times and she immediately separated them and notified the nurse. STNA #261 was unable to remember who the nurse was. STNA #261 reported the nurse told her she would notify the further up what happened and told me to write my statement. STNA #261 reported she wrote a statement and gave the witness statement to the nurse. STNA #261 verified there was no witness statement from her in the SRI. Interview on 05/08/24 at 2:16 P.M. with the DON verified there was no witness statement in the SRI from STNA #261. The DON reported she had no explanation for what happened. Review of the facility policy, Abuse, Neglect, Exploitation & Misappropriation of Resident Property, dated November 21, 2016, revealed all incident and allegations of Abuse, Neglect, Exploitation, Mistreatment of resident, or Misappropriation of Resident Property and all Injuries of Unknown Source must be reported immediately to the Administrator or designee and have evidence that all alleged violations are thoroughly investigated.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44808 Based on medical record review, review of the facility self-reported incidents (SRIs), staff interview, and review of facility policy, the facility failed to thoroughly investigate allegations of resident-to-resident abuse for Residents #50, #65, #128, and #129. This affected four residents (#50, #65, #128, and #129) of five reviewed for abuse. The facility census was 78. Findings include: 1. Review of the medical record for Resident #50 revealed an admitted [DATE] with diagnoses including dementia with behavioral disturbance, Alzheimer's disease, major depressive disorder, anxiety, delusional disorder, and schizoaffective disorder. Review of the annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #50 had severely impaired cognition and had experienced hallucinations and delusions within the seven days prior to the assessment. Review of Resident #50's progress note dated 12/10/22 at 1:57 P.M. indicated Resident #50 stood up and hit the resident next to her in the stomach and Resident #50 later came out of her room and hit the same resident again in the side of the stomach. Review of the medical record for Resident #129 revealed an admitted [DATE] with diagnoses including Alzheimer's disease, dementia with behavioral disturbance, major depressive disorder, and anxiety. Resident #129 was discharged on [DATE]. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #129 had moderately impaired cognition and experienced delusions in the seven days prior to the assessment. Review of Resident #129's progress note dated 12/10/22 at 1:57 P.M. indicated Resident #129 was hit by another resident while sitting in her recliner in the common area. The progress note dated 12/10/22 at 6:09 P. M. indicated Resident #129 was hit in the stomach again by the same resident. The progress note dated 12/11/22 at 2:03 P.M. indicated Resident #129 was hit in the right side by another resident and about one hour later Resident #129 was hit again in the abdomen by the same resident. Review of the facility SRI dated 12/10/22 revealed a resident-to-resident altercation was reported to the Administrator on 12/10/22. The summary of the incident indicated Resident #50 walked over to Resident #129 and hit Resident #129. Neither Resident #50 nor Resident #129 could recall the incident after it happened. The SRI initial report form indicated facility staff witnessed Resident #50 hit Resident #129 in the stomach and rib with no bruising, pain, or swelling identified. The timeline included in the initial report of the SRI on 12/10/22 at 2:00 P.M. that Resident #50 hit Resident #129's right upper extremity and on 12/10/22 at 4:00 P.M. Resident #50 woke up and hit Resident #129 in the face. The witness statement, dated 12/10/22 at 2:00 P.M., by State tested Nurse Aide (STNA) #450 indicated Resident #50 hit Resident #129 on the right arm. The witness statement, dated 12/10/22 at 4:00 P.M., by STNA #261 indicated Resident #50 hit Resident #129 in the side of the face with a closed fist. No other witness statements were included in the SRI investigation. There was no documentation of interviewing or assessing like residents. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/07/24 at 9:55 A.M., an interview with the Director of Nursing (DON) verified the details of the investigation did not add up and there were discrepancies between the progress notes and the witness statements. On 05/07/24 at 11:40 A.M., an interview with the Administrator and DON stated Resident #129 was not hit in the face. The Administrator and DON verified the witness statement indicated Resident #129 was hit in the face and both the Administrator and DON stated that claim could not be verified because Resident #129 did not have any red marks on her face. The Administrator and DON continued insisting that Resident #129 was only hit in the stomach and never hit in the face, despite what the witness statement indicated. When asked about the discrepancies between the witness statements and the progress notes, the Administrator stated the progress notes were written by a nurse on a different unit because there was a medication technician on the secured memory care unit at the time of the incident. On 05/08/24 at 10:36 A.M., an interview with the Administrator confirmed the facility did not complete a thorough investigation of the incident between Resident #50 and Resident #129. The Administrator stated she needed more training on conducting SRI investigations. Review of the facility policy, Abuse, Neglect, Exploitation & Misappropriation of Resident Property, dated November 21, 2016, revealed all incidents and allegations of Abuse, Neglect, Exploitation, Mistreatment of resident, or Misappropriation of Resident Property and all Injuries of Unknown Source must be reported immediately to the Administrator or designee and have evidence that all alleged violations are thoroughly investigated. 43061 2. Review of the medical record for Resident #65 was admitted on [DATE] with diagnoses including but not limited to unspecified dementia, severity, with other behavioral disturbance, cognitive communication deficit, unspecified mood (affective) disorder, post-traumatic stress disorder, chronic, alcohol use, unspecified with alcohol-induced persisting dementia, and alcohol abuse with withdrawal unspecified Review of Resident #65's quarterly MDS assessment, dated 02/06/24, revealed Resident #65 had impaired cognition with behaviors to include verbal and physical towards others. Review of Resident #65's progress note dated 03/17/23 at 2:45 P.M. authored by the DON revealed STNA #247 witnessed Resident #65 hit Resident #128's hand twice as she reached to take his drink from his tray. The residents were separated immediately, and physician and guardian notified. Review of the medical record for Resident #128 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnosis included but not limited to unspecified dementia, severity, with other behavioral disturbance, cognitive communication deficit, unspecified mood (affective) disorder, post-traumatic stress disorder, chronic, alcohol use, unspecified with alcohol-induced persisting dementia, and alcohol abuse with withdrawal unspecified. Review of Resident #128's admission MDS 3.0 assessment, dated 03/16/23, revealed Resident #128 had severely impaired cognition. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #128's progress note dated 03/17/23 at 2:41 P.M. authored by the DON revealed Resident #128 had her hand hit by another resident when she tried to take his drink off his tray. Residents were immediately separated. No injuries noted and the physician and daughter were notified. Review of the facility's SRI, dated 03/17/23, indicated STNA #247 witnessed Resident #65 hit Resident #128's hand twice. The residents were immediately separated, and notifications were done. The SRI stated the incident occurred on 03/16/23 at 8:00 A.M. and administrator was notified of the incident on 03/17/23 at 8:00 A.M. but it did not say who notified her. The witness statement by STNA #247 was dated 03/17/23 but not timed. There was one statement for Resident #128 regarding a skin check was done by the Assistant Director of Nursing (ADON) #246 dated 03/17/23. Interview on 05/07/24 at 2:25 P.M. with the DON verified the facility did not complete skin checks on Resident #65 or all like residents residing on the dementia unit until it was time for the regularly scheduled weekly skin check. The DON verified the skin checks were not completed on the day they were made aware of the incident, and they weren't completed specifically for their investigation of the incident. Interview on 05/08/24 at 7:54 A.M. with the DON revealed for incidents of abuse the expectation was to separate the residents immediately, do skin checks on both residents, and notify physician, family, the DON, and usually the Administrator. The DON reported skin assessments on all residents on the unit were done shortly after an incident. The DON reported the Administrator does the reporting. The DON verified skin checks were not done on Resident #65 or any other residents on the unit. Interview on 05/08/24 at 8:13 A.M. with the DON revealed she would have to check her notes about the incident. The DON did not remember since it happened a year ago. Interview on 05/08/24 at 8:44 A.M. with the Administrator revealed she believed she was notified of the incident on 03/17/24 by the DON. The Administrator confirmed the SRI had the incident occurred on 03/16/24 at 8:00 A.M. The Administrator reported skin checks should have been done on both the residents involved in the incident (Resident #65 and #128). The Administrator verified a skin check was not done on Resident #65. Interview on 05/08/24 at 9:17 A.M. with the DON verified the Medication Technician (MT) #283 working the Dementia Unit where the incident occurred did not document as she should have for the incident between Resident #65 and Resident #128. The DON verified she was notified the day of the incident, 03/16/23, but did not recall what time she was notified that day. Interview on 05/08/24 at 9:39 A.M. with the DON revealed she gave the surveyor the wrong information. The DON retracted the previous statement and said since the incident was an isolated incident, and the facility would not do skin assessments on everyone on the unit. Interview on 05/08/24 at 10:36 A.M. with the Administrator revealed the Administrator stated the investigations for these SRIs are crap. I get it. I need to do more training on SRI'S. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 05/08/24 at 2:10 P.M. with STNA #261 revealed she witnessed the incident. STNA #261 reported Resident #128 reached for a drink from Resident #65's tray and Resident #65 hit Resident #128's hand two times and she immediately separated them and notified the nurse. STNA #261 was unable to remember who the nurse was. STNA #261 reported the nurse told her she would notify the further up what happened and told me to write my statement. STNA #261 reported she wrote a statement and gave the witness statement to the nurse. STNA #261 verified there was no witness statement from her in the SRI. Interview on 05/08/24 at 2:16 P.M. with the DON verified there was no witness statement in the SRI from STNA #261. The DON reported she had no explanation for what happened. Review of the facility policy, Abuse, Neglect, Exploitation & Misappropriation of Resident Property, dated November 21, 2016, revealed all incident and allegations of Abuse, Neglect, Exploitation, Mistreatment of resident, or Misappropriation of Resident Property and all Injuries of Unknown Source must be reported immediately to the Administrator or designee and have evidence that all alleged violations are thoroughly investigated.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35765 Based on record review and interview the facility did not ensure the care plan included the use of a mechanical lift for transfers for Resident #227. This affected one resident (Resident #227) of 26 residents reviewed for care plans. The facility census was 78. Review of the medical record for Resident #227 revealed an admitted [DATE] with diagnoses including mechanical loosening of internal right knee prosthetic joint, infection, and inflammatory reaction due to internal right knee prosthesis, muscle weakness, depression, cardiomyopathy, hypercholesterolemia, atrial fibrillation, hypertension, osteoarthritis, and fibromyalgia. Resident #227 was transferred to the hospital from an out-patient appointment with her orthopedic surgeon on 04/04/24 and elected to not return to the facility. Review of the facility admission assessment dated [DATE] revealed Resident #227 was alert and oriented and able to make her needs known to staff. Resident #227 was weight bearing as tolerated to the lower extremities and would be transferred with assistance by staff. Resident #227 used a wheelchair for mobility. Review of the March 2024 and April 2024 physician orders for Resident #227 revealed an order dated 03/22/24 for occupational therapy five times weekly for four weeks for activities of daily living, therapeutic exercises, and therapeutic activities, and physical therapy five times weekly for 30 days for therapeutic exercises, therapeutic activities, manual therapy, neuro-muscular reeducation, gait training, and group therapy. There were no physician orders for a mechanical lift for transfers for Resident #227. Review of the facility document titled Physical Therapy PT Evaluation and Plan of Treatment, dated 03/22/24, revealed Resident #227 was referred to therapy following a right knee resection arthroplasty with debridement and antibiotic spacer placement. The treating therapist noted Resident #227 was displaying self-limiting behavior and fearfulness about being transferred so it was recommended on 03/27/24 for staff to use a mechanical lift so she could come to therapy to try to stand at the bars. On 03/28/24 the mechanical lift was offered to the resident, and the Physical Therapist educated the resident on positioning with the mechanical lift for her right leg. The resident was alert and oriented to person, place, and time and able to understand and be understood and was independent with instructions. The resident got up into sitting position upright in a wheelchair with use of the mechanical lift. Review of the admission Minimum Data Set (MDS) 3.0 assessment, dated 03/28/24, revealed Resident #227 required partial or moderate assistance for sit-to-stand transfers and chair/bed-to-chair transfers. Resident #227 required total dependence on staff for toilet transfers and shower transfers. Review of the point of care documentation for March 2024 and April 2024 revealed Resident #227 was transferred either by two staff assist or by using a mechanical lift. The mechanical lift was used on 03/29/24, 03/30/24, 03/31/24, 04/02/24, and 04/04/24. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the care plan, date initiated 03/22/24, revealed Resident #227 required assistance with activities of daily living (ADLs) due to impaired mobility, right knee replacement revision with loosening of the prosthetic and joint infection, muscle weakness, abnormalities of gait and mobility, and fluctuations in ADL abilities at different times of the day. Interventions included transfer with physical assistance and gait belt as tolerated. There was nothing in the care plan to indicate therapy had recommended the use of a mechanical lift for transfers due to self-limiting behaviors and fearfulness during therapy nor were there any interventions listed regarding using a mechanical lift. Interview on 05/08/24 at 8:26 A.M. with STNA #265 verified Resident #227 was being transferred using a mechanical lift. Interview on 05/08/24 at 4:17 P.M. with Registered Nurse (RN) #280 stated Resident #227 admitted to the facility with orders for weight bearing as tolerated, and RN #280 said she believed Resident #227 was transferred with a mechanical lift since admission. Interview on 05/08/24 at 4:37 P.M. with MDS Nurse #208 and the Director of Nursing (DON) verified Resident #227 was transferred using mechanical lifts on 03/29/24, 03/30/24, 03/31/24, 04/02/24, and 04/04/24. The DON stated she did not know why staff were using a mechanical lift when Resident #227 did not have orders or a care plan for a mechanical lift. MDS Nurse #208 confirmed it should have been written as an order and added to the care plan.

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	366214	A. Building B. Wing	05/13/2024

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.

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F 0689 Level of Harm - Minimal harm or potential for 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** 35765 Based on review of the medical record , review of the facility investigation and interview with staff the facility failed to provide the appropriate level of staff assistance and supervision during resident care for Resident #127 resulting in Resident #127 hitting his head on the wall. This affected one resident (Resident #127) of seven residents reviewed for accidents. The facility census was 78. Findings included: Review of the medical record revealed Resident #127 was admitted to the facility on [DATE]. Diagnoses included multiple sclerosis, cerebral infarction, vascular dementia, dysphonia, anxiety disorder, dysphagia, aphasia, peripheral vascular disease, cognitive communication deficit, adult failure to thrive, major depressive disorder, and insomnia. Review of the quarterly Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #127 had moderately impaired cognition and required extensive assistance of two staff members for bed mobility. Review of the care plan, date initiated 07/26/22, revealed Resident #127 may be at risk of developing complications associated with decreased activity of daily living self performance related to demetia and multiple sclerosis (MS) with gait and balance impairments. Interventions included assistance with bed mobility and did not specify how many staff were needed to assist him with bed mobility. The care plan also identified him as at risk for falls due to impaired balance, dementia, impaired cognition, personal history of falls, and neurological impairment. Review of the progress note dated 05/02/23 at 9:25 P.M. revealed Resident #127 was lying in bed and he complained of the right side of his head hurting, He told the nursing assistant an old lady had hit his head off the wall when she was turning him. The nursing assistant immediately notified the nurse and she assessed the resident. The resident stated again the old lady hit his head on the wall when she was doing his care that morning. The resident did not have any swelling or discoloration. He did not want any Tylenol for pain. The physician, responsible party, and the Director of Nursing (DON) were notified. There was no new order at this time. Review of the progress notes dated 05/03/23 at 5:57 A.M. revealed Resident #127 continued to complain of right forehead pain which was now more localized to the eyebrow area, no discoloration or edema noted. Review of the facility investigation revealed a witness statement from Resident #127 dated 05/03/23. The witness statement revealed the older aide who was working yesterday morning smacked Resident #127's head against the wall when getting him ready. When he was asked if he thought it was on purpose or accident, he stated he did not know. Review of the signed witness statement from State tested Nursing Assistant (STNA) #201 dated 05/22/23 revealed she was taking care of Resident #127 and while giving care she rolled him on his side and accidentally hit his head on the wall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the pain assessment dated [DATE] at 9:28 P.M. revealed Resident #127 was having mild pain to his right forehead due to hitting his head into the wall. On 05/07/24 at 9:54 A.M. an interview with the DON revealed she had dated the witness statement from STNA #201 for 05/22/23 in error and it was supposed to be dated 05/03/23. On 05/07/24 at 2:37 P.M. an interview with STNA # 201 confirmed she was providing care and bed mobility to Resident #127 by herself. She stated when she rolled him over towards the wall, he yelled ouch and stated she had hit his head on the wall. She stated his bed was up against the wall. She stated she apologized to him and Resident #127 stated he was okay. She stated she reported it as soon as it happened. She stated she did not know if it left a mark on his head.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35765 Based on observation, review of the medical record and interview with staff the facility failed to ensure Resident # 17, #26, #62 and #132 had drinking water available in their rooms. This affected four residents (Resident # 17, #26, #62 and #132) of five residents observed during medication administration. The facility census was 78. Finding included: 1. Review of the medical record revealed Resident #132 was admitted to the facility on [DATE]. Diagnoses included chronic kidney disease, dementia, anemia, diabetes, anxiety, major depressive disorder, diarrhea, hypothyroidism, and diverticulosis. Review of the admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #132 had moderately impaired cognition. Review of the physician orders revealed Resident#132 had an order for a low concentrated sweets diet with regular texture and thin liquids dated 04/25/24 and an order for Levaquin (antibiotic) 500 milligrams once daily for seven days for a positive urinalysis dated 05/06/24. Observation of medication administration on 05/05/24 at 7:30 A.M. revealed Resident #132 did not have any fresh water or cup in her room. An interview at this time with Licensed Practical Nurse (LPN) #200 verified Resident #132 did not have a glass or fresh water in her room. Review of the physician's note dated 05/06/24 at 1:33 P.M. revealed Resident #132 was out to the emergency room for a complaint if intense acute onset abdominal/pelvic pain. The resident was discharged back to this facility with a diagnosis of a urinary tract infection and was placed on Levaquin antibiotic therapy. The Resident denied any current abdominal pain. Levaquin was prescribed with a daily probiotic. 2. Review of the medical record revealed Resident #26 was admitted to the facility on [DATE]. Diagnoses included urinary tract infection, congestive heart failure, dysphagia, neoplasm of liver, gallbladder and bile ducts, peripheral vascular disease, hypertension, atherosclerotic heart disease, depression, diabetes, anxiety disorder, atrial fibrillation, and acute kidney failure. Review of the MDS 3.0 assessment dated [DATE] revealed Resident #26 had severely impaired cognition. Review of the physician orders revealed Resident #26 had a diet order for low concentrated sweet, no added salt diet with regular texture and thin liquids dated 03/12/24. Observation on medication administration on 05/05/24 at 7:10 A.M. revealed Resident #26 did not have a cup with water in his room. An interview at this time with Registered Nurse #236 revealed he should have fresh water in his room and she verified there was not any in his room for him to drink. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	On 05/05/24 at 10:43 A.M. an interview with Resident #26 revealed most of the time he had fresh waster but sometimes they did not pass it out. 3. Review of the medical record revealed Resident #62 was admitted to the facility on [DATE]. Diagnoses included dementia, diabetes, Poly-osteoarthritis, gout, anxiety disorder, peripheral vascular disease, Alzheimer's disease, and left tibia and fibula fracture. Review of the physician orders revealed Resident #62 had a diet order for low concentrated sweet with regular texture and thin consistency liquids dated 02/28/23. Review of the annual MDS 3.0 assessment dated [DATE] revealed Resident #62 had severely impaired cognition. Observation of medication administration on 05/05/24 at 7:37 A.M. revealed Resident #62 did not have any fresh water in his room. An interview at this time with LPN #200 verified Resident #62 did not have any fresh water or cup in his room. 4. Review of the medical record revealed Resident #17 was admitted to the facility on [DATE]. Diagnoses included pubic fracture, clavicle and nasal bones, weakness, eyeball and orbital contusions, diabetes, anxiety disorders and osteoarthritis. Review of the physician orders revealed Resident #17 had a diet order for low concentrated sweets with regular texture and thin liquids dated 04/05/24. Review of the admission MDS 3.0 assessment dated [DATE] revealed Resident #17 had moderately impaired cognition. Observation of medication administration on 05/05/24 at 7:30 A.M. revealed Resident #17 did not have any fresh water or cup in his room. An interview at this time LPN #200 verified Resident #17 did not have a glass or fresh water in his room.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35765 Based on observation, review of the medical record and interview with the staff the facility failed to ensure the aerosol mask for Resident # 44 and the oxygen tubing and nasal cannula for Resident #39 were stored in a protective barrier when not in use. This affected two residents (Resident #39 and #44) of four residents reviewed for oxygen therapy. The facility identified 17 residents (Resident #1, #4, #11, #12, #13, #16, #24, #37, #39, #42, #45, #48, #51, #54, #65, #71, and #230) who required use of oxygen and eight residents (#1, #37, #44, #52, #61, #71, #73, and #230) who required aerosol treatments. The facility census was 78. Findings included: 1. Review of the medical record revealed Resident #44 was admitted to the facility on [DATE]. Diagnoses included chronic obstructive pulmonary disease, dementia. diabetes, congestive heart failure, Alzheimer's disease, chronic kidney disease, hypertension, peripheral vascular disease, anxiety disorder anemia, bilateral breast removal, presence of an intraocular disease, depression, gastric ulcer, and obstructive sleep apnea. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #44 had moderately impaired cognition and required oxygen therapy. Review of the physician orders revealed Resident #44 had an order for ipratropium-albuterol solution 0.5-2.5 milligrams inhalation every four hours while awake for chronic obstructive pulmonary disease dated 05/04/24. Observation on 05/05/24 at 10:13 A.M. revealed Resident #44 was up in the recliner with her oxygen on. Her aerosol mask was lying directly inside the top drawer of her bedside table without being placed in a protective barrier. An interview at this time with Licensed Practical Nurse (LPN) #200 verified the aerosol mask should be placed in a protective barrier bag when not in use, however, there was not one in her room. On 05/07/24 at 2:23 P.M. an interview with the Director of Nursing (DON) verified aerosol masks and oxygen tubing should be stored in a protective barrier when not in use. 2. Review of the medical record revealed Resident #39 was admitted to the facility on [DATE]. Diagnoses included chronic obstructive pulmonary disease, end stage renal disease, atrial fibrillation, weakness, pleural effusion, atherosclerotic heart disease, myocardial infarction, acute respiratory failure, congestive heart failure, hypothyroidism, hypertension, major depressive disorder, peripheral vascular disease, cardiac pacemaker, sick sinus syndrome, transient ischemic attack, and adjustment disorder with depressed mood. Review of the physician orders revealed Resident #39 had an order for oxygen at two liters as needed per nasal cannula to maintain saturation above 90 percent dated 04/08/24. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #39 had intact cognition and required oxygen therapy. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Observation on 05/05/24 at 10:10 A.M. revealed the oxygen nasal cannula and tubing was lying across the top of the oxygen concentrator and not in a protective barrier. An interview at this time with LPN #200 verified the oxygen tubing and nasal cannula should be stored in a protective barrier when not in use. On 05/07/24 at 2:23 P.M. an interview with the DON verified aerosol masks and oxygen tubing should be stored in a protective barrier when not in use.