STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366263	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grace Brethren Village	1010 Taywood Road Englewood, OH 45322

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 - Actual harm Residents Affected - Few	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** 44069 Based on record review, interviews, and policy review, the facility failed to prevent a resident from falling out of bed. This resulted in Actual Harm when Resident #11 fell out of bed and was transferred to the hospital where she was found to have a thoracic (section of the spine between the neck and end of ribs) compression fracture. This affected one (Resident #11) out of three residents reviewed for falls. The facility census was 38. Findings include: Review of the medical record for Resident #11 revealed an admitted [DATE]. Diagnoses included type two diabetes mellitus without complications, generalized anxiety disorder, hypertensive heart disease without heart failure, depression, moderate protein-calorie malnutrition, age-related osteoporosis without current pathological fracture, acute respiratory failure with hypoxia, intervertebral disc disorders with radiculopathy lumbar region, muscle weakness, and unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Review of the plan of care, initiated on 09/09/22, revealed Resident #11 was at risk for falls related to balance problems, muscle weakness, lack of coordination, dementia, and diabetes mellitus. Interventions included anticipating and meeting the resident's needs, ensuring call light is within reach, encouraging the resident to use the call light for assistance, and physical therapy evaluation and treatment as ordered or as needed. Review of the plan of care, revised on 12/12/24 revealed Resident #11 had activities of daily living self-care performance deficit related to activity intolerance, impaired balance, lack of coordination, history of right femur fracture, diabetes mellitus, and need for varying levels of assistance. Interventions included extensive assistance by one staff for turning and repositioning in bed at least every two hours and as necessary. Review of the annual Minimum Data Set (MDS) assessment, dated 01/13/25, revealed Resident #11 had moderately impaired cognition. Resident #11 required setup assistance for eating, partial/moderate assistance for oral hygiene, and was dependent for toileting, bathing, dressing, personal hygiene, and bed mobility. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the incident report, dated 02/16/25, revealed Resident #11 was found face down on the floor between her bed and recliner and could not provide a description of what happened. Resident #11 was transported to the hospital via ambulance. No injuries were noted, but staff were unable to fully assess the resident due to her position on the floor. Review of the hospital history and physical dated 02/16/25 revealed Resident #11 was seen in the emergency room following the fall. The assessment indicated imagining studies determined Resident #11 had a non-displaced oblique fracture (a fracture where the bone breaks at an angle but the broken pieces remain in their original position) through the left T1 transverse process (wing-like sides of the first vertebra of the thoracic spine often caused by trauma or muscle contraction). Resident #11 was given a thoracic-lumbar-sacral orthosis (TLSO) brace. Review of the progress note dated 03/02/25 revealed a nurse was alerted by the aide that Resident #11 was throwing things around the room. Upon entry to Resident #11's room, she was hanging off the bed and was repositioned back in bed by the nurse and the aide. During an interview on 03/13/25 at 11:50 A.M., Certified Nurse Aide (CNA) #92 stated Resident #11 required significant assistance with positioning. CNA #92 stated Resident #11 often slid to the left side of the bed so she would place a pillow on Resident #11's left side to help with her leaning. During an interview on 03/13/25 at 2:29 P.M., the Interim Director of Nursing (DON) stated Resident #11 was found between her bed and recliner on her left side with a pillow and blanket under her hip. The Interim DON reported she was unaware of Resident #11's leaning to the left side of the bed and verified there had been no interventions in place to prevent Resident #11 from falling out of bed. The Interim DON stated she would have explored the use of bolsters or another intervention if she had been made aware. The Interim DON also advised she was unaware that Resident #11 had been found hanging out of the bed after the fall on 02/16/25 that resulted in a fracture. Review of the policy titled Falls and Fall Risk, Managing, revised March 2018, revealed based on current data, staff would identify interventions related to the resident's specific risks to try to prevent the resident from falling and to try to minimize complications from falling. This deficiency represents non-compliance investigated under Complaint Number OH00163256. This is an example of continued non-compliance from the survey dated 01/30/25.