STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366286	A. Building B. Wing	07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Continuing Healthcare at Cedar Hill	1136 Adair Avenue Zanesville, OH 43701

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** 33019 THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on medical record review, policy review, facility investigation review and staff interview, the facility failed to prevent a resident fall with major injury. Actual Harm occurred on 06/24/24 when Resident #14, who was identified as a fall risk, was hit by a dietary cart (used to transport resident meal trays) that was being steered by Dietary [NAME] #20, causing the resident to fall and sustain a right hip fracture. The resident was emergently transported to the hospital and admitted for surgical intervention to repair the right hip fracture. This affected one resident (#14) of three residents reviewed for falls. The facility census was 70. Findings include: Record review revealed Resident #14 was admitted to the facility on [DATE] with diagnoses that included femur fracture, metabolic encephalopathy, dementia, Alzheimer's disease, and anxiety disorder. Review of the Care Plan, dated 10/13/23, revealed Resident #14 was at risk for falls related to gait/balance problems, unsteady gait, history of falls, and the use of psychotropic medications and the resident used a walker. Review of the Minimum Data Set (MDS) assessment, dated 03/08/24, revealed Resident #14 was moderately cognitively impaired and had a diagnosis of Alzheimer's disease. The assessment indicated the resident was independent with most activities of daily living (ADLs) and his mobility device was a walker. Review of a Fall Risk Assessment, dated 06/10/24, revealed the resident was at risk for falls. (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the nursing progress note, dated 06/24/24 at 11:45 A.M., revealed Resident #14 was found lying on the floor, on his back, in the lobby. Resident #14's walker was across the lobby. Resident #14 stated he was trying to get a puzzle out of the bookshelf. A skin tear to right elbow and left hand were noted. Resident #14 complained of right leg pain. The assistant director of nursing called emergency medical services (EMS); EMS arrived at approximately 11:55 A.M. Resident #14's granddaughter was notified, and a voice mail was left for Resident #14's son. Resident #14's son called back at 12:40 P.M. and was notified. Resident #14's physician was notified at 12:15 P.M. The progress note revealed an immediate intervention was to place a bright colored sign on Resident #14's walker to remind the resident to use his walker when ambulating. Resident #14 was alert and oriented and educated to always use his walker. Review of the Incident and Accident Investigation, dated 06/24/24, (authored by Licensed Practical Nurse (LPN) #34) revealed Resident #14 sustained a fall on 06/24/24 at 11:48 A.M. when he was hit with a dietary cart by staff who could not see the resident while pushing the cart, resulting in a fall. The resident sustained a fractured right hip and multiple skin tears. The investigation further revealed the incident occurred in the hallway and the immediate actions taken following the fall was the assessment of range of motion and vital signs. The resident was unable to straighten his right, lower extremity and rotation was noted. The resident was sent to the emergency room for evaluation and treatment. A bright colored sign was placed on the walker to remind the resident to use the walker. Review of the Emergency Department (ED) Provider Note, dated 06/24/24 at 12:52 P.M., revealed Resident #14 presented with a chief complaint of a fall and stated a staff member at the nursing home accidentally struck him with a dinner cart and he fell , landing on his right hip. The resident sustained skin tears to his left hand and right arm. Review of the right hip revealed deformity, tenderness, and decreased range of motion. Minor skin tears to the left, third and fourth digits and right elbow, forearm, and hand were noted. Review of a Hospital History and Physical (H and P) report, dated 06/24/24 at 2:01 P.M., revealed Resident #14 had diagnoses including Alzheimer's disease, who presented to the emergency roiagnom on [DATE] with right hip pain following a mechanical fall. The resident stated that he was at his nursing home facility, and someone was walking by with a cart that hit him and he lost his balance and fell on his right side. The resident was found to have a right hip fracture and was admitted for an orthopedic evaluation. The pre-operative evaluation determined the resident had a moderate risk for surgery, but the final decision to take the resident to the operating room was left to the surgical and anesthesia teams. Review of a progress note, dated 06/25/24 at 9:54 A.M., revealed the interdisciplinary team met to discuss Resident #14's fall on 6/24/24. All proper notifications were made. Immediate intervention was put in place and education was provided to all staff about using two staff to move the tall dietary cart. The interdisciplinary team agreed with interventions and plan. Review of a nurse practitioner progress note, dated 07/01/24, revealed Resident #14 was seen for a hospital follow-up. The resident was hospitalized from 06/24/24 through 06/28/24 due to a right hip fracture. His hospital course included surgical repair of a closed fracture of the right hip on 06/25/24, intravenous (IV) iron therapy, and aggressive bowel regimen for constipation. The resident's pain was controlled with narcotic pain medication. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview on 07/16/24 at 9:15 A.M. with the Administrator verified Resident #14 had a fall on 06/24/24. The Administrator revealed the resident was walking in the main lobby without his walker when Dietary [NAME] #20, who was pushing the large dietary cart, accidentally bumped into the resident with the dietary cart. The Administrator stated the facility investigation revealed the staff member only looked around one side of the dietary cart and not both sides of the cart prior to pushing the dietary cart. The Administrator stated the staff member never saw Resident #14 and when the dietary cart bumped the resident, it caused him to lose his balance and fall. The Administrator confirmed the fall caused the resident to fracture his hip/femur which required a surgical repair. The Administrator stated the facility now requires two staff to move the large dietary cart to ensure residents are not bumped by the cart. Interview on 07/30/24 at 8:39 A.M. with Dietary [NAME] #20 revealed on 06/24/24 she was transporting the food cart through the corridor between the dining room and therapy area when she made a sharp turn. Resident #10 was located by the wall on the right side of the cart and Resident #14 was standing near the puzzles on the left side of the cart. Dietary [NAME] #20 stated that she was trying to avoid bumping into Resident #10 and did not see Resident #14 at the time. Dietary [NAME] #20 stated that she felt something, stopped pushing the cart, and then heard Resident #14 yelling. Dietary [NAME] #20 stated she looked around the cart and observed Resident #14 lying on the ground, grabbing the metal cart, and he must have hit something sharp which resulted in bleeding from one of his hands. Dietary [NAME] #20 stated a nurse came and assessed the resident immediately after the incident. Dietary [NAME] #20 confirmed she could not see over the tall, metal cart while pushing it from behind. The Dietary [NAME] verified she only looked around the right side of the cart but not the left side of the cart before she hit Resident #14. On 07/30/24 at 9:50 A.M., an interview with Regional Administrator #120 revealed she was unaware of any facility policy regarding safe transportation of dietary carts prior to the incident involving Resident #14. Review of facility policy and procedures revealed the facility did not have any type of policy in place related to moving the dietary carts prior to Resident #14's fall, nor did the facility have specific education for staff regarding the movement of dietary carts prior to Resident #14's fall. The deficient practice was corrected on 06/24/24 when the facility implemented the following corrective actions: On 06/24/24 the facility initiated a Facility Self-Imposed Action Plan which included the following: On 06/24/24, Resident #14 was immediately assessed by LPN #34 on 06/28/24 at 11:45 A.M. and sent to the emergency department for evaluation. The resident was admitted and his right hip was surgically repaired. On 06/24/24, one-on-one education was provided by the Administrator to Dietary [NAME] #20 that moving forward, all tall meal carts need to be taken to/from the unit/kitchen by two staff members to ensure the hallway is clear for the cart. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 06/24/24, 46 nursing, dietary, and housekeeping staff were educated by the Administrator via in-person or over the phone, that all tall meal carts will be transported to/from kitchen by two staff members (one in front and one in back). On 06/24/24, an initial audit was completed by the DON during the supper meal, to ensure the tall meal carts were being transported to/from the kitchen/unit with two staff members. On 06/24/24, the DON initiated an audit by observation to ensure tall meal carts are being transported to/from the unit/kitchen by two staff members. Audits will be completed twice weekly for four weeks then as determined by the DON or designee. The audits began on 06/28/24. All audits will be reviewed by Quality Assessment and Performance Improvement (QAPI) during meetings held monthly and any concerns will be addressed. Two new dietary carts, shorter in design and permit visibility over the cart during transport, were approved by corporate and ordered. The new carts will replace the current tall dietary carts. No further injuries have resulted from the dietary carts since 06/24/24. This deficiency represents non-compliance investigated under Complaint Number OH00155268.