STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366300	A. Building B. Wing	02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canton Christian Home	2550 Cleveland Avenue NW Canton, OH 44709

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** 35765 Based on observation, record review, review of a facility investigation, review of a facility Self-Reported Incident, review of hospital records, interviews with staff, and review of facility policy, the facility failed to develop and implement a comprehensive and individualized fall prevention program to ensure Resident #45's safety and supervisory needs were addressed timely resulting in a fall with major injury. In addition, the facility failed to ensure appropriate interventions were implemented to prevent additional falls/injury. Actual harm occurred on 01/17/25 when Resident #45, who required a mechanical lift for transfers, was at high risk for falls, and had moderately impaired cognition, was hospitalized after sustaining right and left tibial fractures following an unwitnessed fall. Prior to the unwitnessed fall, a nursing assistant observed the resident yelling for help with her legs hanging out of bed and walked past her room without responding to the resident's calls for help. This affected one resident (#45) of three residents reviewed for falls. The facility census was 56. Findings included: Review of the medical record revealed Resident #45 was admitted to the facility on [DATE] with diagnoses including generalized anxiety disorder, major depressive disorder, vascular dementia, hypertension, transient ischemic attack, cerebral infarction, allergic rhinitis, left hemiplegia, diabetes, hypothyroidism, overactive bladder, peripheral vascular disease, Vitamin D deficiency, acute pain due to trauma, edema, obstructive and reflux uropathy, kidney disease, fracture of the right and left tibia, motion sickness, dermatophytosis, insomnia, anorexia, and adult failure to thrive. Review of the plan of care initiated on 08/30/22 revealed Resident #45 was at risk for falls related to left arm pain, hemiplegia, muscle weakness, decreased mobility, and incontinence. Interventions included to be sure the call light was within reach and encourage its use for assistance when needed, anticipate and meet needs as able, attempt to provide a safe environment, the resident liked to put the height of her bed up on her own so ensure education on this unsafe behavior, staff to ensure her bed locks were in place to help provide for her safety due to poor decision making (initiated 01/20/25), Dycem (rubber nonslip mat) to the recliner and check the placement, and place a red dot by the resident's name on the door name tag by the room. (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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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #45's physician's orders revealed the resident had orders for gripper socks every shift (initiated 08/26/22), Dycem to the recliner (initiated 01/03/23), and a fall mat to the left side of the bed (initiated 01/17/25). Review of the Fall Risk assessment dated [DATE] revealed Resident #45 was at a high risk for falls. The assessment indicated the resident was alert, she had no falls in three months, she was taking three to four medications that could increase the risk for falls, and the resident was chair bound and unable to perform gait/balance. The assessment stated the resident transferred with a mechanical (Hoyer) lift and two staff assistance, that she wanted to remain in bed all the time but would get up for showers at times and the fall prevention measures remained in place. Review of the quarterly Minimum Data Set assessment dated [DATE] revealed Resident #45 had moderately impaired cognition. The assessment revealed the resident required substantial (staff) assistance with rolling side to side and was dependent on staff for transfers. The assessment indicated the resident had not had any falls. Review of the progress note dated 01/17/25 at 3:34 A.M. revealed the nurse had entered the room for Resident #45 and she was lying on the floor on the right side with her feet towards the head of the bed. The resident's bed was up in the air when staff entered the room. Resident #45 denied any pain at the time of the assessment. She had range of motion without resistance to her upper and lower extremities. The resident denied hitting her head and no bumps or lumps were present. She was assisted off the floor with the Hoyer lift with three staff. Review of the progress note dated 01/17/25 at 1:12 P.M. revealed the Certified Nursing Assistant (CNA) was performing morning care and Resident #45 began yelling out in pain. She stated her left knee hurt. The nurse evaluated the resident and the resident's left knee was swollen. Resident #45 began to complain of pain and the Nurse Practitioner (NP) was called and ordered an x-ray and Tylenol every eight hours for three days. Review of the portable x-ray report dated 01/17/25 revealed Resident #45 had right and left tibial fractures. Review of the progress note dated 01/17/25 at 2:46 P.M. revealed x-ray results were obtained and the results were reported to the NP and Resident #45's family. There was a discussion pertaining to what treatment to seek, and a decision was made for the resident to be taken to the Ortho United Clinic; the family did not want the resident to be sent to the emergency room . The note indicated the resident's family would be updated once the facility staff knew anything. Review of the progress note dated 01/17/25 at 4:10 P.M. revealed staff called Resident #45's family to explain that they were unable to find non-emergent ambulance services to transport the resident to the outpatient orthopedics as previously discussed. They explained the resident would be transferred via emergency medical services (EMS) to the emergency room . Review of the progress note dated 01/17/25 at 4:31 P.M. revealed Resident #45's family was notified the resident was being transported to the hospital. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the progress note dated 01/18/25 at 2:15 A.M. revealed Resident #45 was admitted to the hospital with acute pain in the knees, hyperglycemia, a pancreatic lesion, closed fracture of the tibia, and a urinary tract infection. Review of the hospital history and physical dated 01/18/25 revealed Resident #45 presented to the emergency room from the nursing facility with knee pain after an unwitnessed fall. She was typically non-ambulatory and used a Hoyer lift. The resident stated everything hurt. An x-ray revealed Resident #45 had proximal bilateral tibial fractures. The hospital recommended the resident be non-weightbearing, to utilize bilateral knee braces and an orthopedic consult. Review of an undated hand-written signed witness statement from CNA #102 revealed another aide [CNA #104] walked past the room of Resident #45 and heard her call out. That aide [CNA #104] let CNA #102 and Licensed Practical Nurse (LPN) #103 know. They walked to the resident's room within minutes of the other aide telling them, and Resident #45 was on the floor on her right side and the bed was in a high position. After the nurse assessed the resident, they placed Resident #45 into bed with the Hoyer lift with no complaints from the resident. Resident #45 stated she was trying to sit up to lean on her table and as she attempted to do that, the table slid and so did she. She stated she had to vomit. Resident #45 expressed no pain during care or turning. Review of a hand-written signed witness statement from CNA #104 dated 01/17/25 revealed on 01/17/25 at 3:00 A.M. she was walking back from break and she saw and heard Resident #45. She saw that the resident was laying down with her feet hanging off the side. She stated it did not look like the resident was trying to get out of bed, so she went to her aide [CNA #102] who was just a few feet away and alerted her to Resident #45's behavior. Review of a hand-written signed witness statement for LPN #103 revealed an aide came to let Resident #45's aide know that her legs were hanging out of the side of the bed. The nurse and the aide entered the room and Resident #45 was on the ground with the bed up in the air. The nurse assessed the resident and notified the Director of Nursing (DON). The resident had no noticeable injuries, and she did not complain of pain. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of a facility Self-Reported Incident report dated 01/17/25 revealed an aide [CNA #104] was returning to the floor from a break at approximately 3:00 A.M., when she approached Resident #45's room. She stated she saw the resident with her leg sticking out of the covers and reported hearing the resident state, Help me get me out of here. The CNA stated she told the CNA assigned to the resident (CNA #102) Your girl is yelling for you. She stated she proceeded down the hall and returned to her assignment. CNA #102 stated she completed her task she was working on and went to Resident #45's room. LPN #103 and CNA #102 entered the room and found Resident #45 on the floor on her side with her head at the foot of the bed. LPN #103 completed an assessment, vital signs and range of motion. Three staff used a Hoyer lift to return Resident #45 to bed. The Executive Director interviewed staff involved with the incident. CNA #104 stated, The bed was a normal height for [Resident #45], she plays with that controller all the time. The Executive Director verified how high, and CNA #104 stated About regular height of a normal bed. The Executive Director clarified that it was not in the lowest position, CNA #104 said, Correct like where you could stand up from the bed normally. CNA #104 reiterated that the resident was always putting the bed up and down in height, as well as adjusting the head of the bed. The Executive Director again asked for clarification and CNA #104 stated Just below hip height. CNA #104 stated the height of the bed seemed normal to her as the resident kept bed higher than most others. The Executive Director interviewed CNA #102 who stated CNA #104 told her the resident was asking for help. She stated before she finished what she was doing, the resident was on the floor. CNA #102 retrieved a nurse to inform her of Resident #45 on the floor. CNA #102 stated she asked the resident what she was trying to do, the resident responded Nothing, just turn in the bed. Resident #45 stated she put her hand on the overbed table and leaned on the table, then she was on the floor. CNA #102 stated the overbed table was near her legs and lower torso and that the residents' head was pointed to the right, which was at the foot of the bed, looking out to the hallway. CNA #102 stated the nurse asked resident about pain and resident stated she had no pain, but she did wince at a bit and the resident stated she wanted to be in bed. Three staff returned her to bed. CNA #102 stated when the resident was returned to bed, the aide changed the resident thinking the reason she attempted to get up was because her brief was soiled, but the aide stated the diaper was even hardly wet, I expected that maybe it would be soaking and that is why she tried to get up. She stated she rolled the resident through her hips to change her, and she never complained of pain and the staff cleaned her up. CNA #102 did state that she took the bed controls away from the resident, because she would put the bed height up and that the bed was fully extended in height. As part of the facility investigation, the Executive Director interviewed CNA #200 who stated that an LPN informed her that Resident #45 was on the floor. The aide confirmed the resident's location on floor, on her right side with her head to the foot of bed and facing the door. CNA #200 stated the nurse completed vital signs and range of motion on the residents' legs. She stated the resident did have some pain, but also stated she was ok. CNA #200 stated The bed was kind of high, but she plays with the remote. She raises the whole thing up and the head all the way up. When the Executive Director asked for clarification on how high, she stated All the way up to about my hips. As part of the investigation, the Executive Director interviewed LPN #103 who stated when she and CNA #102 entered the room, they found Resident #45 on her right side, with her head facing the door on the floor. She stated she assessed the resident, and she really did not complain of pain. Resident #45 was placed back in bed via three staff and a mechanical lift. LPN #103 stated she notified the physician, left a message for the resident's family and called and notified the DON. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The facility SRI included on day shift the same day, the day shift aide [CNA #202] was providing care to Resident #45 and the resident reported pain in her left knee. Upon visualizing the knee, CNA #202 observed swelling and bruising and reported it to the day shift nurse, who assessed and phoned the nurse practitioner and received orders for an x-ray. X-rays were obtained and confirmed bilateral tibia fractures. The family was notified and preferred the resident was not sent to the emergency room if possible and to utilize Ortho United STAT Care. The facility was unsuccessful in obtaining non-emergent cot transport. The squad was called, and Resident #45 was transferred to the emergency room for treatment. She was admitted on [DATE] at 2:30 A.M. inpatient and returned to the facility's care on 01/21/25. As a result of the incident, staff were educated on the high/low lock out on beds. Review of the facility's summary of the fall investigation dated 01/22/25 revealed on 01/17/25 at approximately 5:56 A.M. the DON was notified by LPN #103 that Resident #45 had an unwitnessed fall out of her bed while attempting to get up. Resident #45 had reported to the staff she had been sitting on the edge of her bed and was leaning on a bedside tray table and when she attempted to stand, the tray table she was leaning on moved and she fell . Per the nurse, Resident #45 was assessed, and no injury was noted. She had full range of motion to all her extremities, and she did not verbalize any pain with assessment. The nurse and two nursing assistants used a Hoyer lift to assist Resident #45 back into bed. The facility investigation revealed on 01/17/25 at approximately 11:26 A.M. the DON was called to the bedside of Resident #45 by a staff nurse because Resident #45 was complaining of pain in her left leg at the knee. Resident #45 was resting in bed with an emesis basin by her head when the DON entered the room. Resident #45 responded to voice and was able to verbalize to the DON that her leg hurt. When Resident #45 was asked what leg hurt, she pointed to her right leg. The DON proceeded to assess both of her legs. Her bilateral legs were warm to touch with slight bruising and mild swelling was noted to both legs, just below the knee. Her pedal pulses were strong to the tops of both feet. Resident #45 was able to move both legs and feet. She was able to wiggle her toes on both feet and all toes had good capillary refill. Resident #45 was able to press down her with toes and pull back with her toes on the nurse's hands. There were no signs or symptoms of pain noted when the resident moved her lower extremities independently. When the nurse put pressure on either leg near the knee, Resident #45 cried out, and when the staff rolled her to provide care, she cried out. Resident #45 was able to verbalize she fell early that morning because she was trying to get out of bed. She was not able to say what time the fall happened or why she was trying to get out of bed. At approximately 11:57 A.M. the Nurse Practitioner was updated and had given orders for an X-ray on both legs and Tylenol for pain. The x-rays were completed and the results indicated bilateral fractures to the tibias. Resident #45 was sent to the hospital. Observation with the Director of Nursing on 02/14/25 at 10:15 A.M. revealed Resident #45 was up in the tilt-in-space wheelchair, on a lift pad, her call light was within reach, she had braces to both her lower extremities with an abductor pillow between her legs, and her feet were bare. At the time of the observation, interview with the Director of Nursing (DON) verified Resident #45 should have had shoes on her feet or gripper socks per the physician orders. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 02/14/25 at 1:45 P.M. an interview with the DON revealed it would be her expectation for the staff member to go into the room and assist a resident if they were yelling for help and had their legs out of the bed. She stated the staff were educated to not walk past the room if a resident was yelling for help. She stated CNA #104 was interviewed as to why she walked past the room and did not go into the room of Resident #45 and CNA #104 stated she wished she would have now, but her aide was standing right outside her room when she told her, and she thought she would go right in to check on her. On 02/14/25 at 1:50 P.M. an interview with the Executive Director indicated she expected the staff to go into the room when a resident was yelling out and had their legs out of the bed. During the interview the Executive Director stated when CNA #104 was walking past the room she just told CNA #102 that Resident #45 needed her. Review of the facility policy titled, Falls Prevention, dated 01/24/23 revealed the facility would ensure a fall interdisciplinary prevention and management program would be maintained to reduce the incident of falls and the risk of injury to the residents and promote resident independence. The policy indicated that CNA's would follow the interventions as outlined in the care plan and they would assist and report any resident who appeared unsteady. It also stated the fall prevention interventions would be reviewed and the care plan would be modified in collaboration with the interdisciplinary team. This deficiency represents non-compliance investigated under Complaint Number OH00161945.