STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366341	A. Building B. Wing	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wayne County Care Center	876 S Geyers Chapel Road Wooster, OH 44691

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** 47569 Based on a Self-Reported Incident (SRI) review, record review, review of hospital records, facility investigation review, personnel file review, staff interviews, and facility policy review the facility failed to provide adequate staff assistance during resident care resulting in a fall with major injury. Actual harm occurred on 07/24/24 at 4:20 A.M. when State tested Nursing Assistant (STNA) #300 was providing incontinence care to Resident #6, who required two staff assistance with bed mobility, repositioned the resident onto her right side and Resident #6 kicked her left leg out and began sliding out of the bed and landed on her right side. The resident sustained bruising to her right hand, left eye, left shin, left index finger, right upper chest and right forearm, a skin tear to left hand third digit and pain to right leg and hip. An x-ray of the right hip and leg was completed on 07/25/24 at 9:21 A.M. and revealed a fracture to the right femoral neck. The resident was subsequently transferred to the hospital and had surgical repair of the right hip. This affected one resident (Resident #6) out of two residents reviewed for falls. The facility census was 40. Findings Include: A review of the medical record for Resident #6 revealed an admitted [DATE] with diagnoses including Alzheimer's dementia, stroke, high blood pressure, anxiety, contractures, and osteoporosis. A review of Resident #6's skin impairment risk care plan dated 07/05/22 and revised on 07/25/24 revealed a low air loss mattress to the bed for pressure reduction related to impaired mobility. A review of Resident #6's Activities of Daily Living (ADL) care plan revision date 04/13/24 revealed Resident #6 required total assist with all ADL and mobility tasks with one to two assists with incontinence care and toileting and two persons assist with bed mobility. Further review of Resident #6's care plan revealed fall care plan revised 08/11/22 revealed interventions including keep call light in easy reach, keep frequently used items in easy reach, observe Resident #6 has nonslip footwear in place, and observe Resident #6's glasses are kept in a safe place, assist with placement prior to transfers. A review of Resident #6 fall risk assessment dated [DATE] revealed Resident #6 was at high risk for falls related to muscle weakness, contractures and dementia. (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 the current physician orders revealed acetaminophen 650 milligrams orally every four hours as needed for pain- not to exceed 3,000 mg daily and Morphine Sulfate (concentrate) oral solution 10 mg per 0. 5 milliliters (ml)- give 10 mg by mouth every two hours as needed for dyspnea (shortness of breath) both dated 05/24/24. A review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #6 had severely impaired cognition with a Brief Interview of Mental Status (BIMS) score of two out of a possible 15. Resident #6 was always incontinent of both urine and bowel requiring staff assistance with incontinence care. Resident #6 was non-ambulatory using a wheelchair for mobility and was dependent on staff for completion of all cares including transfers and bed mobility. A review of Resident #6's Kardex (information reference for State tested Nursing Assistants regarding resident specific needs to be able to provide the appropriate care) dated 07/24/24 revealed Resident #6 required one-to-two-person assistance with toileting and incontinence care and two persons assist with bed mobility. A review of Resident #6's progress notes revealed: On 07/24/24 at 7:06 A.M., authored by Licensed Practical Nurse (LPN) #224, revealed at 4:30 A.M. STNA #300 reported Resident #6 had rolled out of bed onto right side while providing care. Upon entering room Resident #6 was observed positioned on her back on the floor beside the bed with a pillow under her head. LPN #224 assessed Resident #6 with vital signs including blood pressure - 152/92 millimeters of mercury (mmHg) (normal blood pressure is 120/80 mmHg), pulse - 94 (beats per minute) (normal range 60-90), respirations (per minute) (normal range 12-20 breaths per minute) - 20, temperature - 97.6 (degrees Fahrenheit) and blood oxygen (saturation) level 93% (normal greater than 92%). On further exam there was a skin tear noted to (the resident's) left hand third digit and discoloration observed to (the) left index digit prior to transfer back into bed. Resident #6 was awake, and no pain or distress indications were observed by LPN #224. The physician and Director of Nursing was notified of the fall. On 07/24/24 at 7:30 A.M., authored by LPN #222, revealed STNAs (unidentified) reported Resident #6 required assistance in her room, upon entry LPN #222 observed Resident #6 was sitting in the wheelchair slouched forward and drooling. Resident #6 was difficult to arouse with a blood pressure reading at 89/50 (mmHg) and pulse at 90 (bpm), respirations were uneven and unlabored (no respiratory rate or additional assessment of the resident's respiratory status was documented). After approximately 90 seconds, Resident #6 returned to baseline level of alertness and orientation. Resident #6 was returned to bed by staff and the use of a mechanical lift. Resident #6's blood pressure reading was 120/58 (mmHg) and pulse was 89 (bpm). Resident #6 refused the breakfast meal and denied having pain. On 07/24/24 at 10:27 A.M., authored by Registered Nurse (RN) #320, revealed Resident #6's daughter was notified of the fall and a new order for diuretic medication Lasix related to increased edema to lower legs noted on 07/23/24. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 07/24/24 at 9:31 P.M., authored by RN #257, revealed an STNA (unidentified) alerted RN supervisor (RN #257), and staff LPN regarding Resident #6 was grimacing and yelling with movement of her right leg during evening care. Resident #6's right lower leg below the knee was observed discolored and swollen and presented as displaced (there was no further clarification indicated in the medical record) and RN #257 was not available for interview). The physician, Director of Nursing and wound nurse were notified. On 07/24/24 at 11:29 P.M., authored by RN #257, revealed a new order for a right femur two views X-ray, right tibia/fibula two view X-ray related to acute pain due to trauma/fall. The right leg presents displaced and Resident #6 grimacing and yelling out during care. On 07/25/24 at 12:58 P.M., authored by RN #315, revealed Resident #6's daughter was updated on (the resident's) current condition, pain management, pending X-ray results and ongoing fall investigation. On 07/25/24 at 2:27 P.M., authored by RN #315, revealed the physician and the Director of Nursing were notified of the X-ray results. Per the physician recommendation to call the family to see if they want the resident evaluated for an orthopedic consult for surgical intervention, Resident #6's daughter was notified and will speak with the rest of the family. On 07/25/24 at 3:15 P.M., authored by RN #257, revealed Resident #6's daughter notified the facility and requested Resident #6 be sent to the hospital for evaluation by an orthopedic physician. RN #257 updated the physician, and an order was received for Resident #6 to be transferred to the hospital. Transportation was requested and will be at the facility at 4:15 P.M. Resident #6's family was notified and will meet Resident #6 at the hospital. On 07/25/24 at 8:30 P.M., authored by LPN #312, revealed the hospital notified the facility Resident #6 was being admitted to the hospital for surgical repair of her right hip fracture. A review of Resident #6's Medication Administration Record (MAR) dated 07/01 /24 to 07/26/24 revealed the following entries for pain management: On 07/24/24 at 5:13 A.M. acetaminophen 650 milligrams (mg) orally (po) was administered for a pain level at three out of 10) on a scale of 0-10 with 0 being no pain and 10 indicating the worst pain). On 07/24/24 9:42 P.M. Morphine 10 mg/0.5 milliliter (ml) was administered by mouth for pain level at eight out of 10. On 07/25/24 at 8:10 A.M. Morphine 10 mg po was administered for pain level at six out of 10. On 07/25/24 at 12:11 P.M. Morphine 10 mg po for a pain level of three out of 10. On 07/25/24 at 4:00 P.M. Morphine 10 mg for a pain level at three out of 10. A review of Resident #6's X-ray results with service date 07/25/24 at 9:12 A.M. and report date 07/25/24 at 1:24 P.M. revealed the conclusion was a right femoral neck/intertrochanteric fracture and right periprosthetic supracondylar fracture with evidence of mild healing. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of Resident #6's hospital documents dated 07/25/24 to 07/29/24 revealed Resident #6 received an open reduction and internal fixation (ORIF) surgery related to the right femoral neck fracture on 07/28/24 and was discharged back to the facility on [DATE]. Further review of the facility's fall investigation for Resident #6 dated 07/24/24 and 07/25/24 revealed a statement dated 07/24/24 at 6:30 A.M. authored by STNA #300 indicating Resident #6 was administered incontinence care and bed mobility by STNA #300 without assistance from other staff members. Resident #6 had been moving her legs during care and STNA #300 requested Resident #6 to stop moving her legs, but Resident #6 continued to move her legs. STNA #300 had repositioned Resident #6 onto her right side to continue incontinence care. STNA #300 stated Resident #6 moved her left leg over the edge of the bed and then continued to slide off the edge of the bed onto the floor. STNA #300 immediately moved onto the bed and lowered Resident #6's upper body onto the floor. STNA #300 ensured Resident #6 was safe and went to notify the floor nurse of the incident. A statement dated 07/26/24 authored by LPN #224 revealed LPN #224 had been Resident #6's nurse during the incident on 07/24/24 at 4:30 A.M. when LPN #224 was performing medication administration when STNA #300 advised her Resident #6 was on the floor beside the bed, lying on her right side. Resident was repositioned onto her back for LPN #224 to complete a head-to-toe assessment. LPN #224 assessed for range of motion to bilateral lower extremities, there was no range of motion observed due to contractures. There was no displacement and/or shortening of either leg prior to transferring Resident #6 back into bed by use of a mechanical lift. Review of Self-Reported Incident Tracking Number 250054 dated 07/25/24 revealed an allegation of physical abuse and neglect when Resident #6 fell out of bed on 07/24/24. An assessment was completed, and the resident showed no signs of pain or discomfort. Today (07/25/24), the resident showed signs of pain and discomfort. Through investigation, the Administrator identified Resident #6 required two-person assistance with bed mobility. The resident was limited with any mobility, required the use of a Hoyer (mechanical) lift from her chair to the bed. The resident is unable to stand or walk and has limited cognitive ability but recognizes familiar faces with a smile. Further review revealed STNA #300 provided a statement and explained what happened on 07/24/24. The STNA explained to the Administrator and others that she was providing incontinence care and rolled Resident #6 to herself on the left side (of the resident). She then rolled the resident over to her right side, when the resident's left leg jerked and she (the resident) started sliding out of bed. STNA #6 grabbed her on the right and crawled on the bed to get a better hold of Resident #6. STNA #300 could not hold the resident so she helped the resident to the floor. STNA #300 did move her head, putting a pillow under it and went to the hallway for help. The LPN then did evaluate the resident checking range of motion and vitals. The LPN then told the STNAs to get the Hoyer. They Hoyered her (the resident) back to bed. The facility unsubstantiated the allegation citing evidence was inconclusive, but abuse, neglect or misappropriation is suspected. In conclusion, statements did support STNA #300 was not following the resident's care Kardex. A review of STNA #300 employee file revealed a hire date of 02/08/21 and a resignation date of 08/01/24. STNA #300 had been suspended on 07/24/24 pending completion of the fall investigation for Resident #6. STNA #300 was scheduled for a pre-disciplinary conference on 08/01/24 at 1:00 P.M. STNA #300 had submitted a resignation letter dated 08/01/24 with resignation effective immediately and did not attend the scheduled conference. Attempts to reach LPN #224 and RN #320 were made during the survey however, unsuccessful. No return calls from either nurse were provided. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	An interview on 09/09/24 at 9:50 A.M. with the Administrator confirmed Resident #6's fall was caused when inappropriate assistance by STNA #300 during incontinence care on 07/24/24 at 4:20 A.M. The Administrator stated a facility investigation was initiated immediately with STNA #300 being suspended pending completion of the investigation. The facility had scheduled a pre-disciplinary conference with STNA #300 on 08/01/24 however, the STNA submitted her immediate resignation on 08/01/24 without reason provided. Observation on 09/09/24 at 1:15 P.M. revealed Resident #6 was sitting in a Broda wheelchair in the unit lounge watching television. Resident #6 was not observed in bed to watch bed mobility assist by staff. Review of the facility's policy titled, Falls and fall Risk, managing dated 03/18 revealed, Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes 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 OH00156843 and OH00156546.