| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 366380 | A. Building<br>B. Wing | 04/28/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Indianspring of Oakley | 4900 Babson Place<br>Cincinnati, OH 45227 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview with staff and emergency services provider (EMT), review of resident medical records, hospital records, emergency services (EMS) reports, and manufacturer guidelines, the facility failed to ensure Resident #109 was safely assisted with personal care to prevent a fall with injury and failed to thoroughly investigate the fall. This affected one (Resident #109) of five residents reviewed for accidents.<br><br>Findings include:<br><br>Resident #109 was admitted on [DATE] with a readmission date of 12/29/24 for diagnoses including acute and chronic respiratory failure with hypoxia, diabetes mellitus type 2 (DM2), cerebral infarction, hemiplegia and hemiparesis following cerebral infarction, peripheral vascular disease, and seizures.<br><br>Review of Resident #109's care plan initiated 03/17/24 for an activities of daily living (ADL) self-care deficit due to impaired mobility and balance revealed the resident required extensive assistance of two staff for bed mobility, toileting, and transfers.<br><br>Review of physician's orders revealed an order on 05/29/24 for an alternating pressure mattress.<br><br>Review of Fall Risk Scale Score dated 01/19/25 revealed a score of 12, indicating Resident #109 was at risk of falls.<br><br>Review of Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #109 had severe cognitive impairment and was dependent on staff for all care.<br><br>Review of Resident #109's progress note dated 04/10/25 at 8:48 A.M. revealed a fall occurred at 5:55 A.M.<br><br>(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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of EMS report dated 04/10/25 at 7:08 A.M. revealed Resident #109 fell at skilled nursing facility where (per staff) pt was being cleaned up and changed and when the aide went to pull the draw sheet from the pt's left side of the bed, this in turn flipped her over the mattress guards of the bed and then to the floor. Resident #109 has traumatic injuries to the mouth, nose, bridge of nose, and significant hematoma to forehead. Resident #109 was on blood thinners per staff, but aspirin only seen from brief review of paperwork. Resident #109 was baseline mentation and staff report no change in level of consciousness. Resident #109 was lifted back to bed by staff prior to EMS arrival. Aide who was involved did come to bedside and stated same situation as noted above. Resident #109 needed minor assistance for bleeding. Decision made to transport to local hospital due to resident condition, height of fall on head/face, and size of hematoma with associated blood thinner use.<br><br>Review of hospital records dated 04/10/25 at 7:27 A.M. revealed the ER noted per EMS Resident #109 was being cleaned when the patient fell out of bed, over bed guard. Resident #109 fell, hitting her head. Resident #109 had swelling and abrasion to forehead, bridge of nose, and bleeding from mouth.<br><br>Review of hospital records dated 04/10/25 at 7:40 A.M. revealed ER physician noted Resident #109 was being turned, or something similar and was rolled out of bed. Resident #109 landed on her face. Resident #109 presented with obvious trauma to the face, including some loose teeth.<br><br>Review of Resident #109's physician orders revealed an order dated 04/10/25 every day and night shift to cleanse hematoma with normal saline, pat dry, apply double antibiotic ointment, leave open to air.<br><br>Review of the Interdisciplinary Team (IDT) Follow Up Note for the incident date 04/10/25 at 5:55 A.M. revealed Resident #109 was at risk for falls related to a history of falls, atrial fibrillation, history of cerebrovascular accident, and seizures. Fall interventions put into place were fall mats to bedside, Resident #109 to be screened to assess bed mobility, and nonpowered mattress. The IDT note did not identify the root cause of the fall.<br><br>A request was made for the fall investigation related to Resident #109's fall and only a statement from CNA #280 was provided. There was no evidence of a thorough investigation being completed.<br><br>Observation on 04/21/25 at 12:20 P.M. of Resident #109 revealed the resident was lying on a flat mattress without bolsters or a perimeter mattress, with her feet floating on a cushion, fall mats were on the floor on each side of the bed. Resident #109 was not interviewable at the time of the observation.<br><br>Interview on 04/22/24 at 4:53 P.M. with EMT #650 revealed when they arrived at the facility, Resident #109 was already back in bed, and the mattress she was on had an attached rail on it or like a small speed bump. EMT #650 stated the EMS team had difficulty getting Resident #109 from the mattress to the gurney due to the mattress' side support rail. EMT #650 stated he was concerned an individual would have to exert a lot of effort to get Resident #109 over that bump by themselves. The staff member, possibly a nurse, onsite told him only one aide was performing personal care, and that one aide was attempting to remove the draw sheet out from under Resident #109, by herself, which caused Resident #109 to roll out of bed. EMT #650 stated Resident #109 was not able to move or brace herself against a fall and had significant visible injuries, including teeth that appeared damaged, a large contusion to her head, and the bridge of her nose. Resident #109 was transferred to a local hospital.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 04/23/25 at 3:10 P.M. with Certified Nursing Assistant (CNA) #280 stated she was providing incontinence care, and Resident #109 was a one person assist for personal care prior to the fall. CNA #280 stated she rolled Resident #109 away from her and she was trying to pull out the draw sheet, the mattress and the bolsters leaned away from her and Resident #109, which allowed Resident #109 to roll out of bed. CNA #280 checked on Resident #109 and she was responsive. CNA #280 called for help. Two nurses and CNA #280 were able to lift Resident #109 up and put her back in bed. CNA #280 stated she was suspended for her next scheduled shift and returned the next day for disciplinary education. CNA #280 stated she was told at the time of the re-education that Resident #109's alternating pressure bed could be made firmer during point of care and then turned back to the prescribed setting when the resident was not receiving care. CNA #280 stated she was not aware of that function of the mattress prior to the fall. CNA #280 stated if she had been aware of that function and trained fully on the use of the mattress prior to providing care to Resident #109, she felt the fall would not have occurred.<br><br>Interview on 04/24/25 at 2:30 P.M. with Director of Nursing (DON) revealed the facility's practice was to educate staff on providing care as instructed in the care plan, such as after a fall. While re-educating CNA #280 after the fall on 04/10/25, it was discovered CNA #280 was following the current plan of care. DON stated the root cause of the 04/10/25 fall was a decline in Resident #109's bed mobility, which was determined by therapy's reassessment of her mobility after the fall. DON stated the mattress was changed out in an abundance of care, as a low air loss mattress could contribute to accidents and falls. DON did not specifically recall speaking to CNA #280 about utilizing the autofirm setting on the low air loss mattress for care, however if CNA #280 stated that they discussed it during her re-education, then it probably happened.<br><br>Review of Fall and Accident Management, dated 06/2019, revealed the facility will work to 1. Identify hazard(s) and risk(s) to decrease the risk of injury; 2. evaluate and analyze hazard(s) and risk(s). Additionally, A score above 10 indicates an increased risk of falling.<br><br>Review of alternating pressure mattress manual revealed the mattress had an Autofirm mode which provided maximum air inflation to assist both resident and caregiver during resident care and transfer. Under general repositioning, it was note Autofirm mode may be helpful to achieve a firm surface for repositioning purposes.<br><br>This deficiency represents non-compliance investigated under Complaint Number OH00164933. |