STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366385	A. Building B. Wing	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canterbury of Twinsburg	9928 Vail Drive Twinsburg, OH 44087

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** THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on observation, staff and resident interviews, review of video footage, review of facility investigation, and facility policy review, the facility failed to ensure residents were safely transferred using a Hoyer lift. Actual Harm occurred on 05/08/25 at approximately 2:15 P.M. when Hospice Nurse Aide (HNA) #869 completed a Hoyer lift (a type of mechanical lift used to safely transfer individuals with limited mobility from one surface to another) transfer of Resident #21 without the assistance of a second person, resulting in Resident #21's arm becoming fractured. Resident #21 required an x-ray examination which revealed a displaced (a bone fracture where the broken bone fragments are no longer in normal alignment), separated (the bone is broken in two or more places creating a separate segment of bone between breaks), overriding (the broken ends of a bone overlap causing shortening) oblique (a type of bone fracture where the break occurs at an angle to the bone's long axis) fracture of the midshaft of the right humerus. Resident #21 was sent to the emergency room for evaluation and treatment. Resident #21 required surgical intervention on 05/14/25 for the fracture to her right arm. Resident #21 had an open reduction and internal fixation (ORIF) (a surgical procedure to repair a fracture which includes realigning of bone fragments and stabilizing with plates, screws or wires) of the right humerus with insertion of an intramedullary implant (a medical device used to stabilize fractures). This affected one Resident (#21) of three residents reviewed for transfers with a Hoyer lift. The facility identified 20 residents (#2, #3, #4, #5, #10, #11, #12, #13, #17, #21, #24, #28, #31, #32, #40, #41, #42, #43, #44, and #45) who required a Hoyer lift for transfers. The facility census was 45. Findings include: Review of the medical record for Resident #21 revealed an admission date of 03/13/25 and diagnoses including multiple myeloma in relapse, generalized muscle weakness, paraplegia, spinal stenosis of cervical region, severe protein calorie malnutrition, and anxiety disorder. Review of Resident #21's physician's orders revealed an order dated 03/14/25 for a Hoyer lift for all transfers. The order further specified that two staff members were needed to assist with the Hoyer lift. Resident #21 additionally had an order dated 03/17/25 noting that the resident was receiving hospice services for a diagnosis of multiple myeloma (a cancer of the plasma cells). (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 Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #21 had intact cognition. Resident #21 required total staff assistance for toileting hygiene, showering/bathing self, dressing, personal hygiene, bed mobility, and transfers. Review of the plan of care, revised 03/17/25, revealed Resident #21 required assistance with a majority of activities of daily living (ADLs) related to multiple myeloma. Interventions included using a Hoyer lift for all transfers with two staff member assistance, use one to two staff to assist with bed mobility and dressing, and bilateral upper grab bars to the bed to assist with bed mobility and repositioning. Review of the Hospice Nurse Aide (HNA) Plan of Care report dated 05/08/25 at 12:37 P.M. revealed Resident #21 was the client, and HNA #869 was the hospice staff assigned for care. The report indicated Resident #21 was paralyzed in her lower extremities from spinal cord compression and could be anxious at times. The report noted on 05/08/25, various personal care tasks were completed including a bath, oral hygiene, and transferring. The report included an entry by HNA #869 which noted she had to wait on staff to bring the Hoyer lift and shower chair, then a shower was given. The HNA indicated Resident #21 stated her right arm was broken. There was no additional information related to the incident or actions taken identified on HNA report. The bottom of the report in the section titled observations reported to the nurse listed there was nothing unusual to report. Review of a nursing progress note dated 05/08/25 at 2:29 P.M. revealed Resident #21 believed she broke her arm after a visit with the hospice aide during a Hoyer transfer into bed. The nurse was notified by the facility nurse aide. Resident #21 was assessed lying in bed with notable swelling and discoloration to her right arm. Resident #21 complained of pain and was unable to move her right arm. The nurse practitioner (NP) was notified and ordered a status immediate (STAT) x-ray. The nurse administered pain medication and immobilized Resident #21's right arm. Review of the physician's order dated 05/08/25 revealed an order for an x-ray of Resident #21's right humerus. Review of the Radiology Results Report dated 05/08/25 at 3:09 P.M. revealed Resident #21 had a displaced, separated, and overriding oblique fracture of the midshaft of her right humerus. Review of a nursing progress note dated 05/08/25 at 3:51 P.M. revealed the resident's x-ray resulted in the identification of a displaced, separated and overriding oblique fracture of the midshaft of the right humerus. The NP was notified of the results and gave an order to send Resident #21 to the emergency room for evaluation and treatment. Resident #21 was transported via non-emergent transport service. Review of the physician's order dated 05/08/25 revealed an order to send Resident #21 to the emergency room for treatment and evaluation of a right humerus fracture. Review of the hospital After Visit Summary dated 05/08/25 revealed Resident #21 was seen in a local emergency department for an arm injury and diagnosed with closed displaced oblique fracture of the shaft of the right humerus. A splint was applied, and pain medication was administered. Review of a nursing progress note dated 05/09/25 at 12:54 A.M. revealed Resident #21 returned to the facility. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the Physicians Medical Visit assessment dated [DATE] revealed Resident #21 was seen following an incident with a Hoyer lift and a hospice caregiver. Resident #21 insisted her arm was broken and an x-ray was completed revealing a right humerus fracture. Resident #21 was sent back from the emergency room with surgery scheduled for the following week. Review of an incident note dated 05/09/25 at 3:18 P.M. revealed Resident #21 was being transferred via Hoyer lift on 05/08/25 by a hospice aide and got scared during the transfer. Resident #21 stated she grabbed onto the grab bar on the bed during the transfer and felt like her arm was broken. Resident #21 stated she immediately notified the hospice aide and was told to stop being dramatic. The hospice aide did not request nor did she wait for a second person to assist during the Hoyer transfer. It was noted that Resident #21's daughter had a camera in the resident's room and was able to view video footage. Review of an order note dated 05/11/25 at 12:13 P.M. revealed the NP gave a new order to start 30 milligrams (mg) of Morphine Sulfate (an opioid analgesic used to treat moderate to severe pain) controlled-release every eight hours, 15 mg Oxycodone (an opioid used to treat moderate to severe pain) every three hours, and 650 mg Tylenol three times per day for severe pain. Review of the physician's order dated 05/12/25 revealed an order for Resident #21 to direct admit to the hospital for surgical intervention of a right upper extremity fracture. Review of the Transfer Form assessment dated [DATE] revealed Resident #21 had a planned transfer to the hospital for a scheduled surgical procedure. Review of a nursing progress note dated 05/12/25 at 11:10 A.M. revealed Resident #21 was transferred to the hospital. Resident #21 was given as needed (PRN) Oxycodone prior to the transfer. Review of an incident note dated 05/16/25 at 12:43 P.M. revealed the facility Administrator received camera footage from Resident #21's daughter related to Resident #21's right arm fracture. The Administrator initiated a self-reported incident (SRI) after reviewing the video footage. The Administrator met with Resident #21's daughter who confirmed Resident #21's surgery went well. Review of the SRI Form Initial Report dated 05/16/25 revealed the facility had reported allegations of physical abuse and neglect for Resident #21 to the State Agency. On 05/08/25, the facility was notified that Resident #21 complained of pain and the inability to move right arm. It was found that Resident #21 had a fracture of her right arm sustained during a Hoyer lift transfer by a hospice aide. On 05/14/25, Resident #21 had surgical repair of her right arm fracture. On 05/16/25, camera footage was received from Resident #21's daughter and was reviewed with suspicion of abuse and/or neglect. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the SRI Form Follow-up Investigation Report dated 05/22/25 revealed Resident #21 stated she was returned to her room after receiving a shower and the hospice aide was in the room stated she needed to leave. Resident #21 reported feeling rushed by the hospice aide. Resident #21 reported the hospice aide transferred her via Hoyer lift without getting assistance from another caregiver. Resident #21 stated she got scared during the transfer and put her arm out to hold onto the grab bar. Resident #21 stated she told the hospice aide she broke her arm, and the hospice aide told her to stop being dramatic. Resident #21 stated she felt pain and discomfort. It was confirmed the hospice aide did not request assistance for a Hoyer transfer and had been trained that the Hoyer lift required two people for use. The facility unsubstantiated physical abuse and neglect. It was noted that the hospice company also filed an SRI related to the situation. Review of the hospital Patient Discharge Instructions dated 05/23/25 revealed Resident #21 admitted to the hospital on [DATE]. Resident #21 had an open reduction and internal fixation (ORIF) of the right humerus with insertion of an intramedullary implant (a medical device used to stabilize fractures). Review of a nursing progress note dated 05/23/25 at 4:43 P.M. revealed Resident #21 returned from the hospital. Resident #21 had sutures present on her right shoulder and down her arm. Review of a physician's order dated 05/23/25 revealed an order to monitor the 34 staples on Resident #21's right arm for signs and symptoms of infection. An observation on 06/05/25 at 10:40 A.M. revealed Resident #21 was sitting up in bed with her right arm propped on a pillow. There was a healing surgical area to Resident #21's right arm. There were no bruising or visible signs of infection noted. An interview on 06/05/25 at 10:40 A.M. with Resident #21 confirmed there had been an incident with a Hoyer lift resulting in a broken arm. Resident #21 stated she had received a shower from a hospice aide and needed to be transferred back to bed. Resident #21 stated she was fearful of the Hoyer lift. Resident #21 stated she asked HNA #869 if two people were required for the Hoyer transfer and HNA #869 told her she did not have time to wait for another staff member. Resident #21 stated during the transfer she had grabbed onto the grab bar and when HNA #869 pushed her in the lift she heard a loud pow. Resident #21 stated her arm went completely limp and she knew it was broken. Resident #21 stated she informed HNA #869 her arm was broken and HNA #869 told her to stop being so dramatic. Resident #21 stated she continued to state her arm was broken, however HNA #869 did not report to anyone what had happened and made no attempts to comfort her. Resident #21 described the event as traumatic and depressing. Resident #21 stated she had to have surgery on her right arm. An interview on 06/05/25 at 11:28 A.M. with the daughter of Resident #21 revealed on 05/08/25 at 2:42 P.M. she had received a call from her mother. Resident #21's daughter reported her mother was hysterical and she could not understand her. She indicated at the same time, the facility called to report there had been an incident involving her mother, and they would be obtaining an x-ray for suspicion of a broken arm. The nurse reported there was an incident involving a Hoyer lift operated by a hospice staff member. Resident #21's daughter stated she had a camera in Resident #21's room and she had reviewed the footage. The daughter reported HNA #869 had completed a Hoyer lift transfer alone and HNA #869 did not attempt to obtain assistance or call for help. The daughter stated the video had audio and visual of when Resident #21's arm was broken mid-transfer. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	An interview on 06/05/25 at 1:08 P.M. with Hospice Director of Quality #868 and the Administrator confirmed HNA #869 had transferred Resident #21 using a Hoyer lift by herself rather than with two staff as required. Hospice Director of Quality #868 and the Administrator confirmed at no time did HNA #869 seek assistance from the facility for the Hoyer lift transfer of Resident #21 back into bed. Hospice Director of Quality #868 and the Administrator confirmed upon review of the camera footage there was a very obvious break with disfigurement at Resident #21's shoulder. An interview on 06/05/25 at 1:58 P.M. with Licensed Practical Nurse (LPN) #806 revealed she was the assigned nurse to Resident #21 on 05/08/25. LPN #806 stated Certified Nursing Assistant (CNA) #816 had alerted her that Resident #21 thought her arm was broken. LPN #806 stated during her assessment, Resident #21 was in pain and her arm was visibly swollen. Resident #21 reported the injury occurred during a Hoyer transfer into bed. LPN #806 confirmed she had not been notified by HNA #869 that there had been an injury to Resident #21's arm. LPN #806 indicated HNA #869 had not requested assistance for the Hoyer transfer back to bed nor had she utilized the call light to attempt to call for other staff to assist. LPN #806 stated she had gotten into contact via phone with HNA #869. LPN #806 indicated she was able to confirm with HNA #869 that she had operated the Hoyer alone. HNA #869 indicated she did not have time to wait around and HNA #869 stated I don't know how dramatic she (Resident #21) is. LPN #806 stated she was very upset that HNA #869 was calling Resident #21 dramatic for being in pain. LPN #806 stated there were plenty of staff available at the facility to assist hospice caregivers with Hoyer lift transfers or other care. An interview on 06/05/25 at 2:57 P.M. with CNA #816 revealed she was the assigned nurse aide for Resident #21 on 05/08/25. CNA #816 indicated she had assisted HNA #869 with Hoyer lift transfer into a shower chair. CNA #816 indicated she set up supplies for HNA #869 and changed the bed sheets for Resident #21. CNA #816 indicated she told HNA #869 to use the call light when she was ready to get Resident #21 back into bed. CNA #816 indicated another resident's call light was activated so she answered the light. CNA #816 indicated she saw the call light on for Resident #21 and figured they were done with the shower. CNA #816 indicated when she entered the room, she found Resident #21 back in bed and she was alone in the room. Resident #21 stated her arm was broken and she was in pain. CNA #816 indicated she reported it to the nurse immediately. CNA #816 confirmed HNA #869 did not request assistance after the shower to Hoyer transfer Resident #21 back to bed. CNA #816 confirmed Hoyer lift transfers required two staff assistance. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	An interview on 06/06/25 at 1:43 P.M. with HNA #869 confirmed she had been to the facility to care for Resident #21 on 05/08/25. HNA #869 confirmed the hospice policy was to transfer a patient via Hoyer lift with two people. HNA #869 indicated this was the first time she had cared for Resident #21. HNA #869 stated Resident #21 requested a shower, so she rang the call light for the facility nurse aide. HNA #869 stated several times she had to wait on facility staff. HNA #869 stated Resident #21 was able to assist with bathing her upper body and able to hold herself forward in the shower chair to wash her back. HNA #869 stated she brought Resident #21 back to her room after the shower. HNA #869 stated I cannot sit and wait more time for someone to come help her get Resident #21 back into bed. HNA #869 stated Resident #21 was small, and she felt she could certainly do it herself. HNA #869 stated during the Hoyer transfer Resident #21 had put her hand on the grab bar then stated her hand was broken. HNA #869 stated I didn't want her to get too excited or overly dramatize. HNA #869 stated Resident #21 was able to move her fingers, so she did not think anything was broken. HNA #869 stated she finished care on Resident #21 and left the facility. HNA #869 stated she normally worked as a home health aide and did not operate a Hoyer lift on a day-to-day basis. HNA #869 confirmed she did not call for assistance from another staff member for a Hoyer transfer. HNA #869 indicated she had already had to wait on the facility staff and indicated if they knew Resident #21 needed a Hoyer transfer then they should have just come back to the room. Review of the camera footage from the camera in Resident #21's room dated 05/08/25 (provided to the surveyor on 06/06/25) revealed: a. Review of the one minute and 30 second video dated 05/08/25 at 1:56 P.M. revealed CNA #816 and HNA #869 were in Resident #21's room. Resident #21 was in bed with HNA #869 standing on the right side at the foot of the bed and CNA #816 was standing on the left side of bed. The nurse aides were talking with Resident #21 while getting her ready to get into shower chair. Resident #21 began assisting with the removal of her clothing for the shower. Resident #21 was noted to be able to remove her own shirt with the use of both hands and arms. Resident #21 was able to help turn onto her right side using both arms while removing her pants. Resident #21 was not complaining of any pain at this time. b. Review of the 18 second video dated 05/08/25 at 2:12 P.M. revealed HNA #869 wheeling the shower chair back into Resident #21's room backwards. HNA #869 could be heard saying You ain't fitting to sit here because I am about to put you in this bed baby. Resident #21 asked You can do this on your own? HNA #869 indicated I am going to have to because I don't have all day to sit here. At no time was the call light visibly activated. c. Review of the 16 second video dated 05/08/25 at 2:13 P.M. revealed HNA #869 could be seen in the corner of the video attaching the Hoyer straps to the Hoyer lift. Resident #21 was instructing HNA #869 on which straps to use for the Hoyer sling. d. Review of the 16 second video dated 05/08/25 at 2:14 P.M. revealed HNA #869 continuing to try to attach Resident #21's Hoyer sling straps to the Hoyer lift. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	e. Review of the one minute and 43 second video dated 05/08/25 at 2:15 P.M. revealed Resident #21 was no longer seen in the shower chair. From out of frame, the shower chair was pushed further into the room by the foot of Resident #21's bed then Resident #21 comes into frame suspended in the Hoyer lift. HNA #869 was the only caregiver present in Resident #21's room. HNA #869 was seen pushing Resident #21 towards the right side of the bed in the Hoyer lift. Resident #21 was seen swinging back and forth in the Hoyer sling uncontrolled. Resident #21 tells HNA #869 to watch out for the cords on the floor. HNA #869 indicated Oh they have got the bed down low, [expletive], and she walks to the left side of the bed after moving the shower chair out of the way. At this time, HNA #869 had no hands on the Hoyer lift or Resident #21. Resident #21 was still suspended in the air and seen swinging back and forth in the Hoyer lift. Resident #21 could be seen with both hands holding onto the Hoyer sling. HNA #869 began raising the bed height and came back around to push Resident #21 over the right side of the bed. HNA #869 pushed the Hoyer lift over a bump and Resident #21 stated You are running into a cord. HNA #869 positioned Resident #21 with her bottom over the bed and Resident #21's legs remained hanging over the side of the bed. HNA #869 walked back around to the left side of the bed. Resident #21 had her left hand holding the Hoyer sling and her right hand reached out and grabbed the grab bar attached to the bed. Resident #21 was facing the base of Hoyer lift and HNA #869 grabbed ahold of the sling to turn Resident #21 over the bed. Resident #21 had visible bolsters on each side of the bed and her legs remained hanging over the side of the bed. HNA #869 pulled on the Hoyer sling and tried to turn Resident #21 unsuccessfully, then used a hand to grab Resident #21's legs. HNA #869 pulled one leg at a time over the bed. When HNA #869 pulled Resident #21's right leg over the bed, a loud popping noise could be heard and Resident #21 called out. Resident #21's right arm immediately went limp, and Resident #21 loudly says Ow I just broke my arm, I just broke my arm. HNA #869 walked back around to the right side of the bed. Resident #21 could be heard making a grunting and moaning sound, and her face was seen with a painful grimace. HNA #869 did not respond to Resident #21 in any way at this time. HNA #869 began pushing the Hoyer lift further over the bed with Resident #21 swinging in the sling and her right arm limp at her side. HNA #869 said Oh, your dressing is coming off and Resident #21 said Get me in the bed. HNA #869 said You are on the bed, honey; Just relax while lowering Resident #21 to the bed. Resident #21 said I think it is broken, I don't know then stated, No, I didn't, I can move my hand, as she wiggled the fingers on her right hand. HNA #869 said Yeah, stop being so dramatic. It's alright. You are fine. Relax. Chill out. HNA #869 began to unhook the straps from the Hoyer lift at the end of the video. f. Review of the 46 second video dated 05/08/25 at 2:17 P.M. revealed Resident #21's right arm remained limp at her side and Resident #21 could be heard grunting and moaning. HNA #869 was still removing the Hoyer straps from the Hoyer lift then removed the Hoyer lift from over the bed. Resident #21 could be seen grimacing. g. Review of the 17 second video dated 05/08/25 at 2:18 P.M. revealed Resident #21 lying on her back with her right arm remaining limp at her side. Resident #21 was looking up at the ceiling and making grunting and moaning noises. HNA #869 approached the right side of the bed and grabbed Resident #21's right arm by the wrist and lifted her arm. Resident #21 said No, don't move it. HNA #869 said No, you got to move it to get it out of the way. You are going to have to roll over so we can get this wet pad from under you. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	h. Review of the 51 second video dated 05/08/25 at 2:18 P.M. revealed HNA #869 said Just try to relax, okay? Don't be so dramatic that makes it worse. HNA #869 uncovered Resident #21's lower half of her body. Resident #21 was wiggling and writhing in the bed and continued to grimace and make groaning and moaning noises. HNA #869 was standing on the right side of bed then said, Come this way and reaches over Resident #21 for her left leg and arm. HNA #869 said You think you broke your arm come this way then pulled Resident #21 towards her right side. Resident #21 was unable to provide much assistance in rolling. HNA #869 tucked the Hoyer pad under Resident #21 then said, Okay now we have to go the other way. Resident #21 attempted to help turn onto her left side and reached with her left hand towards the grab bar. Resident #21's right arm was completely limp hanging by her side. Visible to the camera there was obvious deformity to the arm under Resident #21's right shoulder. Resident #21 was grimacing and yelled out Ow, ow. Resident #21 can be seen trying to lift her right arm, but it slipped further down, and the deformity can be seen further. Resident #21 appeared to be crying. HNA #869 continued to try to get the Hoyer sling out from under Resident #21. HNA #869 walked away from Resident #21 who remained rolled onto her left side and said, Relax a minute let me get you a diaper. Resident #21 laid back down and was still grimacing, and as she rolled back unassisted it appeared her right arm was partially under her. i. Review of the 17 second video dated 05/08/25 at 2:19 P.M. revealed Resident #21 was seen lying on her back grimacing and moving her left arm around. HNA #869 exited the bathroom with a brief. j. Review of the 30 second video dated 05/08/25 at 2:19 P.M. revealed HNA #869 had returned to the right side of the bed with a brief. Resident #21 was lying on her back. HNA #869 said Okay go that way again, then HNA #869 pushed Resident #21 over onto her left side by her right hip and right shoulder. The deformity on Resident #21's right arm could be seen again from the camera angle. Resident #21 was grimacing. HNA #869 tucked the brief under Resident #21 then turned her onto her right side by grabbing her left knee and hip. k. Review of the 41 second video dated 05/08/25 at 2:19 P.M. revealed Resident #21 was seen on her back with the brief under her. Resident #21 appeared to be opening and closing her mouth without saying anything. HNA #869 attempted to secure the brief and realized it was backwards. HNA #869 said Oh [expletive], it is [expletive] backwards. No wonder. Alright, roll back over to me. HNA #869, again, rolled Resident #21 onto her right side and said That is ridiculous as she forcefully grabbed Resident #21 by the back of her left hip pulling her over onto her right side. Resident #21's buttock wound could be seen with HNA #869's gloved fingertips pressing onto it as she pulled the brief out. Resident #21 could be heard saying Ow. HNA #869 said Hold on. Hold on. Sorry, then rolled her back to the left side. Resident #21's right arm was completely hanging behind her and Resident #21 was grimacing and crying. HNA #869 then said Alright, move that arm up there and grabs her by the right hand. Resident #21's head drops back to the bed. l. Review of the 28 second video dated 05/08/25 at 2:20 P.M. revealed HNA #869 again rolled Resident #21 back onto her right side. Resident #21 continued to grimace and make grunting and moaning noises. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366385	A. Building B. Wing	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canterbury of Twinsburg	9928 Vail Drive Twinsburg, OH 44087

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	m. Review of the one minute and 40 second video dated 05/08/25 at 2:21 P.M. revealed HNA #869 removed the wound dressing from under Resident #21's bottom. Resident #21 continued to grimace and was observed to rub her left hand over her face in clear distress. Resident #21's right arm remained limp by her side. HNA #869 said they do this twice a week for you? I can't believe it. That's too much for you. It's too much. Once a week. The way you are carrying on. No way you should be doing this twice a week. It's too much. Hmm, it's too much. HNA #869 got the brief secured and re-attached Resident #21's catheter bag to the bed, then grabbed a gown. HNA #869 sprayed Resident #21 with an unidentified spray from bedside table then applied lotion to her legs. HNA #869 began to rub lotion on Resident #21's limp right arm and Resident #21 gasped out as the HNA reached her upper arm. HNA #869 stopped momentarily and appeared to be looking at Resident #21's right arm then said, Does it hurt that bad? Resident #21 said Yeah. HNA #869 then picked up Resident #21's right arm by the elbow. Resident #21 reached down and touched her right arm saying, It is broken right here. As HNA #869 lifted Resident #21's right arm, the arm appeared unstable in the mid to upper arm region. n. Review of the 27 second video dated 05/08/25 at 2:22 P.M. revealed Resident #21 was heard saying I am already sensitive because of my multiple myeloma. HNA #869 said Yeah well you are supposed to keep your hands inside [the Hoyer lift]. Resident #21 said I know, I know. HNA #869 said and you just did the opposite then starts putting a gown on Resident #21. Resident #21 was still grunting and moaning. HNA #869 lifted Resident #21's right arm by the wrist saying, I am going to raise it up a little bit and Resident #21 gasps in a painful manner. o. Review of the 26 second video dated 05/08/25 at 2:23 P.M. revealed Resident #21 grunting and moaning and she had a pained facial expression. HNA #869 covered Resident #21 with a gown. p. Review of the 14 second video dated 05/08/25 at 2:23 P.M. revealed Resident #21 continued grunting and moaning and had a pained facial expression. HNA #869 was placing a catheter leg strap on her right leg. q. Review of the 22 second video dated 05/08/25 at 2:23 P.M. revealed HNA #869 placed a pillow behind Resident #21's head. r. Review of the 25 second video dated 05/08/25 at 2:24 P.M. revealed HNA #869 said Okay when I came in here your pillow was on this side indicating to her left side. I am going to put it on that side while indicating to her right side. HNA #869 grabbed a body pillow and while standing on Resident #21's left side, HNA #869 grabbed the bed pad and pulled Resident #21 over from the right to the left. HNA #869 said You just relax, honey. Resident #21 could be heard yelling loudly Ow. HNA #869 said Just relax and tucked the body pillow under Resident #21 who could be heard crying. HNA #869 said Hold on. Hold on. s. Review of the 51 second video dated 05/08/25 at 2:24 P.M. revealed Resident #21 could be heard crying and HNA #869 said You got to try to relax and know we know what we are doing. You know what I mean? I mean some of us know what we are doing, I don't know if everybody knows, but I know I know what I am doing, and I wouldn't do it if I didn't know. You know? HNA #869 tucked a pillow under Resident #21's feet and Resident #21 continued to grimace. HNA #869 asked You okay? and Resident #21 asked for another pillow under her head. HNA #869 tucked another pillow under her head. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	t. Review of the one minute and 40 second video dated 05/08/25 at 2:26 P.M. revealed HNA #869 raised the head of the bed. Resident #21's right arm remained limp and was laying on her right hip area. HNA #869 adjusted the tray table and covered Resident #21 with a blanket. Resident #21 reached out with her left hand to grab her folded glasses and was only able to open them with one hand. HNA #869 lowered the bed. u. Review of the 28 second video dated 05/08/25 at 2:27 P.M. revealed HNA #869 walked out of the video frame. v. Review of the 18 second video dated 05/08/25 at 2:29 P.M. revealed Resident #21 asked for her call light and pointed at it with her left hand. Resident #21's right arm was covered by the blanket. HNA #869 put the call light in Resident #21's left hand. It was observed to be a pad style call light. Resident #21 said I need pain pills. HNA #869 said Yeah, I'm sure you do at this point. Alright. Resident #21 immediately turned the call light on, and a small red light could be seen on the wall by call light cord. HNA #869 turned to leave and walked out of frame. Resident #21 reached for her cell phone. At no time during the video review was it evident that HNA #869 requested additional assistance with getting Resident #21 back into bed via the Hoyer lift. There was no activation of the call light until Resident #21 activated the call light at 2:29 P.M. There was no evidence HNA #869 addressed Resident #21's clear signs of pain or that she addressed the residents' concerns that her arm was broken. Review of the facility policy titled, Lifting Machine, Using a Portable, dated December 2013, revealed two nursing assistants were required to perform this procedure. Any problems or complaints made by the resident related to the procedure should be docume[TRUNCATED]