

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  366385	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/14/2024
NAME OF PROVIDER OR SUPPLIER  Canterbury of Twinsburg		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39969</p> <p>Based on record review and interview the facility failed to ensure Resident #27's call light was responded to in a reasonable amount of time. This affected one resident (#27) of three residents reviewed for call light response times. The facility census was 37.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #27 revealed an admitted [DATE] with diagnoses including difficulty walking, anxiety, obsessive compulsive disorder, and urinary incontinence.</p> <p>Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had intact cognition and required partial to moderate assistance from staff for toileting hygiene and substantial to maximum assistance for transfers. The assessment also indicated Resident #27 was frequently incontinent of bowel and bladder.</p> <p>Review of the alarm event report dated 11/07/24 through 11/14/24 revealed Resident #27's call light was pulled at 4:00 P.M. and cleared at 4:26 P.M. with the response time being 25 minutes and 35 seconds. On 11/09/24 Resident #27 pulled her call light at 6:30 P.M. and it was cleared at 7:28 P.M. with the response time being 58 minutes.</p> <p>Interview on 11/12/24 at 10:46 A.M. with Resident #27 revealed she often had to wait one to two hours for assistance after activating her call light.</p> <p>Interview on 11/14/24 at 1:11 P.M. with the Administrator verified the call light response times on the alarm event report for Resident #27 and stated when she reviewed the camera footage outside of Resident #27's room, no one entered Resident #27's room until the times the call lights were cleared on 11/07/24 and 11/09/24. The Administrator stated there were three aides working on those days and all were assisting other residents, and the nurse was passing medication.</p> <p>Review of the facility policy titled Answering the Call Light, undated, revealed the staff should answer the resident's call as soon as possible.</p>

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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47570</p> <p>Based on observation, interview and record review the facility failed to prevent a fall for Resident #8 who was completely dependent on staff for fall prevention. This affected one resident (Resident #8) of three residents reviewed for falls. The facility census was 37.</p> <p>Findings include:</p> <p>Record review revealed Resident #8 was admitted to the facility on [DATE] with diagnoses including persistent vegetative state, brain damage, lack of coordination, abnormal posture, and dementia. Review of physician order dated 12/05/19 revealed Resident #8's head of bed was to be up at a 30 degree angle. Review of physician orders dated 11/15/23 revealed Resident #8 had a camera in the room at the request of the Power of Attorney (POA). Review of a physician order dated 11/28/23 revealed Resident #8 was to be out of bed at 11 A.M. and back in bed at 5:00 P.M. Review of a physician order dated 08/05/24 revealed Resident #8 was a hospice resident due to anoxic brain damage.</p> <p>Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #8 was comatose. Resident #8 had impaired range of motion on both sides and was dependent for oral hygiene, bathing, dressing, personal hygiene, roll left to right in bed. She did not sit up in bed or lie back in bed or attempt to stand. Resident was dependent on staff to transfer out of bed. Did not attempt to walk ten feet. Resident had no falls since admission.</p> <p>Review of the Plan of Care dated 08/12/24 revealed Resident #8 was totally dependent on staff for all activities of daily (ADL). She was in a persistent vegetative state, did not make eye contact or communicate due to anoxic brain injury. Resident #8 was dependent for transfers and mobility. Interventions included bolsters to bed for boundaries, check and change every two hours for incontinence, custom wheelchair with custom cushion to chair when out of bed, resident was to wear regular socks when out of bed, resident was to be out of bed after 11 A.M. and back in bed before 5:00 P.M. per father's request; shower bed for all showers; transfer with Hoyer lift assist of two people; assist of one to two people for bed mobility; bed in lowest position at all times except when staff present during personal care; monitor for pattern of risk or tendency to fall; fall risk assessment quarterly and padded side rails up for boundaries.</p> <p>Review of Fall Risk Evaluation dated 08/07/24 at 2:58 P.M. revealed Resident #8 had no history of falls, was comatose, on anticonvulsant medication, antihistamine medication, anxiolytics, laxatives, and narcotics analgesics medication. Resident #8 was a fall risk due to medication use and change in medication from the past 30 days and ambulated with staff assistance and needed help with transfers.</p> <p>Review of a Nursing Note dated 08/08/24 at 1:34 A.M. revealed at approximately 12:15 A.M. a staff member walked past Resident #8's room and noticed Resident #8 was on the floor. Resident #8 was laying on her back on the floor of the left side of the bed. Vials were assessed. Two staff members helped Resident #8 back to bed by using the Hoyer lift. Skin assessment revealed a reddened area on the left side of the abdomen and left lower extremity. All parties were made aware, and Hospice was to evaluate the resident.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the fall investigation was conducted on 11/13/24 at 1:59 P.M. with Corporate Infection Control Registered Nurse (CICRN) #503 and revealed an incident report was done on 08/08/24 at 1:34 A.M. The incident report indicated at approximately 12:15 A.M. on 08/08/24 a staff member walked past Resident #8's room and noticed the resident on the floor. Upon entering the room, the nurse observed the resident lying on her back on the floor on the left side of the bed. Vials were assessed, skin assessment was done, and a reddened area was noted on the left side of the abdomen and left lower extremity. Resident #8 was put on every 15-minute checks.</p> <p>Review of fall investigation witness statement from the Director of Nursing (DON) revealed Resident #8 was found on the floor by the left side of the bed. Redness was observed to the abdomen and left lower extremity, no other apparent injuries. The facility implemented fall mats placed on both sides of the bed and the bed would have bolsters .</p> <p>Review of the witness statement provided by RN Unit Manager #504 revealed the staff was unable to determine Resident #8's orientation due to vegetative state. Resident #8 had little body movement and extremities were ridged.</p> <p>Review of the witness statement report dated 08/08/24 written by Certified Nurse Assistant (CNA) #328 revealed he did rounds that night. Resident #8's body was ridged, and level of conscience was stupor.</p> <p>Review of a Hospice note dated 08/08/24 written by Hospice Nurse #508 revealed a post-fall visit was made for Resident #8. Hospice received a concerning message regarding Resident #8's fall out of bed since she was immobile other than involuntary movements of her head intermittently. Hospice team immediately ordered bolsters for the bed. After review of the POA's video from the surveillance camera in Resident #8's room revealed the resident shifted little by little over several hours until she tumbled out of bed. No injuries were noted. Hospice did initiate scheduled morphine due to possible discomfort from the fall.</p> <p>Interview on 11/13/24 at 2:56 P.M. with Resident #8's POA #505 and father revealed he had camera footage of the night Resident #8 fell out of bed. The POA stated Resident #8 was sitting up in the bed at a high angle and slipped out of the bed. A nurse walked in the room and did not reposition the resident therefore Resident #8 continued to slip down the bed on the left side until she fell out of the bed. POA #505 stated he denied X-rays to be done because he did not want Resident #8 to miss her hospital appointment the next day at 9:00 A.M. for her feeding tube.</p> <p>Interview on 11/13/24 at 3:05 P.M. with Licensed Practical Nurse (LPN) #312 revealed she walked past Resident #8's room after receiving report and noticed Resident #8 was not in her bed. LPN #312 stated Resident #8's bed was at a high angle to prevent her from aspiration, but was unable to say if the resident was in the bed at a high angle.</p> <p>Interview on 11/13/24 at 3:44 P.M. with CNA #324 revealed Resident #8 had her bed at a 30-to-45-degree angle. CNA #324 stated she helped place Resident #8 in bed around 5:30 P.M. on 08/07/24.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 11/13/24 at 3:50 P.M. of facility owned video footage of the 100 hall the night on 08/07/24 with Regional Administrator/Corporate MDS RN ( RA/CMDSRN) #506 revealed a staff member entered Resident #8's room at 11:54 P.M. and was viewed to have left Resident #8's room at 11:54 P.M. RA/CMDS RN #506 confirmed a staff member entered Resident #8's room at 11:54 P.M. and remained in the room for less than one minute.</p> <p>Interview on 11/14/24 at 7:23 A.M. with CNA #328 revealed a nurse found Resident #8 on the floor. CNA #328 stated he saw Resident #8 at 9:30 P.M. that night. CNA #328 stated Resident #8 was sitting up at about a 40-degree angle. CNA #328 stated he was not sure which CNA was caring for Resident #8 the night she fell out of bed so he assisted getting Resident #8 back into bed with additional staff.</p> <p>Interview on 11/14/24 at 9:16 A.M. with CNA #507 revealed Resident #8 fell because gravity brought her down to the floor, the head of the bed was too high, and she tipped over. CNA #507 was not Resident #8's assigned CNA that night. CNA #507 stated at no time did she touch Resident #8 prior to the fall.</p> <p>Observation on 11/14/24 at 12:05 P.M. of date and time stamped photos provided by Resident #8's POA from the room video surveillance revealed Resident #8 became uncentered in the bed starting around 6:15 P.M. on 08/07/24. Resident #8 was observed leaning to the left at 6:30 P.M. and at 7:00 P.M. resident was observed to lean against the left bed rail. At 11:41 P.M. it was observed resident's head was leaning against the left bed rail. At 11:50 P.M. observation of Resident's head slid off the left bed rail. Resident #8 fell out of her bed at 12:09 A.M. on 08/08/24. Resident #8 was on the floor for three minutes before staff entered the room to observe resident on the floor. Further review of the photos revealed on 08/07/24 at 11:53 P.M. Resident #8 was not centered in her bed and was visibly leaning to the left side of the bed. No staff was observed in the room to reposition the resident.</p> <p>On 11/14/24 at 12:38 P.M. an interview with RA/CMDS RN #506 and CIC RN #503 verified the date and time stamped photos provided by the POA showed when staff checked on the resident at 11:54 P.M. on 08/07/24 the resident was not repositioned to prevent her from falling out of bed, and verified a person in a vegetative state should not have sustained a fall out of bed.</p> <p>Review of facility policy titled Falls and Fall Risk, Managing, undated, revealed the staff would identify interventions related to the resident's specific risks and try to prevent the resident from falling.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013</b></p> <p>Based on observation, interview, record review and review of the facility policy the facility failed to ensure appropriate infection control practices were implemented when Resident #10 was provided incontinence care. This affected one resident (Resident #10) of 37 residents observed for infection control. The facility identified 11 residents (Resident's #10, #12, #13, #14, #15, #17, #18, #25, #26, #30 and #40) as incontinent and residing on the nursing unit of Resident #10. The facility census was 37.</p> <p>Findings include:</p> <p>Review of Resident #10's medical record revealed an admitted [DATE] and diagnoses included unilateral primary osteoarthritis right hip, muscle weakness, and chronic kidney disease.</p> <p>Review of Resident #10's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #10 was cognitively intact. Resident #10 required substantial to maximal assistance with toileting hygiene and bathing. Resident #10 was always incontinent of urine and frequently incontinent of bowel.</p> <p>Review of Resident #10's care plan revised 11/13/24 included Resident #10 required maximal assistance with majority of ADL's due to osteoarthritis in the right hip. Resident #10 was incontinent of bladder and continent of bowel and was able to make need to toilet known to staff the majority of time. Resident #10 would present with no further decline in bowel and bladder continence through the next review date. Interventions included to check every two hours and change as needed for incontinence; Enhanced Barrier Precautions for CRE (carbapenem-resistant enterobacteriaceae) in urine, use gown and gloves for all hands on care (dressing, bathing, showering, transfers, providing hygiene, toileting assistance, changing linens, device care use, wound care requiring a dressing).</p> <p>Observation on 11/13/24 at 4:03 P.M. of Certified Nursing Assistant (CNA) #370 revealed CNA #370 was preparing to enter Resident #10's room to provide incontinence care. CNA #370 gathered supplies for Resident #10's incontinence care, entered Resident #10's room, donned an isolation gown and gloves and proceeded to provide incontinence care. CNA #370 started Resident #10's incontinence care, removed her soiled brief, used wash cloths to clean the perineal area, realized she had not prepared plastic bags for the soiled wash cloths and the soiled disposable incontinence brief so she stopped the incontinence care while she prepared the plastic bags and placed the soiled items in the bags. CNA #370 continued with Resident #10's incontinence care without changing her gloves. Resident #10 was incontinent of urine and bowel and had a small to moderate amount of formed stool during the observation. When CNA #370 was finished providing incontinence care she did not change or remove her soiled disposable gloves and adjusted Resident #10's gown, her sheets and bed linens, using the bed control raised the head of Resident #10's bed to a forty five degree angle, using the TV control turned the television volume up, and touching the light switch by Resident #10's bed, turned the light in the room off. CNA #370 picked up the plastic bags with the soiled items, opened the door to Resident #10's room with the same soiled gloves and left the room.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 11/13/24 at 4:08 P.M. of CNA #370 confirmed she did not change her soiled gloves after providing Resident #10's incontinence care for urine and bowel, and confirmed she touched Resident #10's sheets, bed linens, light switch, and bed and television remotes with her contaminated gloves. CNA #370 stated she should have changed her gloves after providing Resident #10's incontinence care.</p> <p>Review of the facility policy titled Policy for Incontinent/Perineal Care undated included incontinence care was important because moisture and soiling of skin contributes to skin breakdown. The perineal area also was the primary portal of entry for bacteria into the urinary tract, potentially causing infection. Therefore it was important that this area be kept as clean as possible. If gloves become grossly contaminated with feces etcetera, gloves should be changed before continuing. Return resident to clean, comfortable position. Clean resident's unit, provide clean linen as needed, and return items to the appropriate place.</p>