

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366400	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER Beavercreek Health and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 3854 Park Overlook Drive Beavercreek, OH 45431	

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 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36303</p> <p>THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NONCOMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY.</p> <p>Based on review of medical records, staff interview, and policy review, the facility failed to ensure a licensed nurse communicated a resident incident, that was later determined to be a fall, to the oncoming licensed nurse to allow for ongoing monitoring and/or potentially prevent further incidents or falls. This affected one (#2) of three residents reviewed for falls. The census was 62.</p> <p>Findings include:</p> <p>Review of Resident #2's medical record revealed an admitted [DATE]. Diagnoses listed included anxiety disorder, right femur fracture, atrial fibrillation, hypertension, and repeated falls.</p> <p>Review of a quarterly Minimum data Set (MDS) assessment dated [DATE] revealed Resident #2 had moderately impaired cognition. Resident #2 had not had any reported falls.</p> <p>Review of progress notes dated 06/12/24 at 1:14 P. M revealed when nurse went into Resident #2's room to pass medications Resident #2 state, I fell sometime last night and my right leg has been hurting ever since. Resident #2 denied hitting head at this time. The nurse called the physician and obtained an order for X-ray (X-radiation) of right leg and ankle. Resident #2's family, Director of Nursing (DON) and Assistant Director of Nursing (ADON) were made aware.</p> <p>Review of progress notes dated 06/12/24 at 6:08 P.M. revealed X-ray technician was performing X-ray on Resident #2 on 06/12/24 at 2:40 P.M. The physician was in the room observing X-ray and noticed a possible fracture and ordered a right hip X-ray for clarification. Results were positive for right hip fracture. Resident #2 was sent to a local hospital on 06/12/24 at 3:45 P.M.</p> <p>Review of a progress note dated 06/12/24 at 11:55 P.M. revealed Resident #2 was observed on the floor by the state tested nursing assistant (STNA) at about 6:00 A.M. The nurse was notified and upon arriving at the scene Resident #2 was in sitting position between a chair and her bed. Resident #2 insisted multiple times that she intentionally sat on the floor because she forgot her walker and did not want to fall. Resident #2 was assisted off the floor by the nurse and STNA. Resident #2 denied any pain throughout the nurse's presence in the room.</p> <p>(continued on next page)</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>Review hospital documents dated 06/12/24 through 06/18/24 revealed Resident #2 required surgery to repair a right hip fracture.</p> <p>Interview with [NAME] President of Clinical Services (VPCS) #100 on 07/23/24 at 2:55 P.M. confirmed Registered Nurse (RN) #200 did not report finding Resident #2 on the floor of her room on the morning of 06/12/24 to the oncoming dayshift nurse. VPCS #100 confirmed RN #200 did not document finding Resident #2 on her floor until his next shift the night of 06/12/24. VPCS #100 stated that RN #200 did not consider finding Resident #2 on the floor a fall because she reported to him that she sat on the floor intentionally to avoid falling.</p> <p>Interview with RN #200 on 07/24/24 at 7:25 A.M. revealed he was informed by the STNA on duty on 06/12/24 that Resident #2 was on the floor. RN #200 asked Resident #2 how she ended up on the floor and she stated that she sat on the floor because she forgot her walker when going to the bathroom and did not want to fall. Resident #2 was assisted back in bed with the help of a STNA. Resident #2 denied any pain and showed no signs of pain when assessed. Resident #2 was independent with walking and sometimes forgot to use her walker. RN #200 did not remember telling the oncoming Licensed Practical Nurse (LPN) #150 about finding Resident #2 on her floor. RN #200 did not consider finding Resident #2 on the floor a fall because she could tell him that she sat on the floor intentionally. RN #200 did not document finding Resident #2 on the floor before he left the facility the morning of 06/12/24.</p> <p>Interview with LPN #150 07/24/24 at 8:25 A.M. revealed RN #200 did not report to her on 06/12/24 that Resident #2 was found on her floor. LPN #150 was not aware that Resident #2 was found on the floor by RN #200 on 06/12/24. When Resident #2 was first seen in the morning on 06/22/24 by LPN #150 she did not report pain. An STNA informed LPN #150 that Resident #2 was having pain. Resident #2 told LPN #150 that she had pain in her hip from a fall during the night. LPN #150 performed range of motion (ROM) and Resident #2 had pain with movement of her right leg. Resident #2's physician was called, and an X-ray was ordered. Resident #2's physician was during the X-ray and confirmed a right hip fracture. Resident #2 was sent to a local hospital for evaluation.</p> <p>Review of a facility policy titled Falls and Fall Risk, Managing revised March 2018 revealed the staff will monitor and document each resident's response to interventions intended to reduce falling or the risk of falling.</p> <p>As a result of the incident, the facility took the following actions to correct the deficient practice by 06/21/24:</p> <p>On 06/12/24 Resident #2 was fully evaluated by a licensed nurse and Medical Director. An X-tray was obtained, and Resident #2 was sent to a local hospital for further evaluation and treatment.</p> <p>On 06/13/24 current residents that were interviewable were interviewed to determine if they had any recent falls or if they had any concerns related to falls. No other residents were found to be affected.</p> <p>On 06/14/24 current residents unable to be interviewed had head-to-toe skin evaluations completed. No other residents were found to be affected.</p> <p>On 06/12/24 the Director of Nursing (DON)/ designee educated all nursing staff on facility policy Falls and Fall Risk, Managing.</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>On 06/15/24 the Administrator/designee audited three staff daily through 06/21/24 to ensure staff were able to demonstrate knowledge of managing falls. The results will be reviewed by the Quality Assurance (QA) committee for the need of continued monitoring. No continued monitoring was determined to be required.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00155290.</p>		