

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  366419	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/13/2024
NAME OF PROVIDER OR SUPPLIER  Legacy Twinsburg		STREET ADDRESS, CITY, STATE, ZIP CODE 8551 Darrow Road 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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42011</p> <p>Based on review of a video recording, staff interview, record review, and review of the facility policy, the facility failed to treat a resident with respect and dignity. This affected one (Resident #72) of three residents reviewed for dignity and respect. The facility census was 69.</p> <p>Findings include:</p> <p>Record review for Resident #72 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included dementia, diaphragmatic hernia, and muscle weakness.</p> <p>Review of the Medicare five-day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #72 was severely cognitively impaired. Resident #72 had clear speech, was able to understand others and was able to make self-understood. Resident #72 had impairment on both sides of lower extremities, was dependent on staff for toileting, bed mobility, moving from a sitting to standing position, and transfers.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the video footage provided by the family, dated 10/11/24 at 9:30 A.M., revealed the family had a video camera in Resident #72's room. The video footage showed State tested Nursing Assistant (STNA) #243 entered Resident #72's room and did not say anything upon entering. Resident #72 was lying in bed with her eyes closed, STNA #243 did not say anything to Resident #72, and pulled Resident #72's blanket down. Then STNA #243 stated to Resident #72 it was time to get up. Resident #72 stated No. After STNA #243 repeated the request for Resident #72 to get up, STNA #243 left the room and immediately returned to the room (time stamp was one second). STNA #243 did not talk to Resident #72, raised Resident #72's bed, removed the blanket covering Resident #72 and began removing her gown. Then STNA #243 stated Hey, you got to get up. The response from Resident #72 was not clear in the video. STNA #243 then removed Resident #72's brief and threw it on the floor. STNA #243 did not provide peri care after removing the old brief or prior to placing a new brief on her. STNA #243 did not talk to Resident #72 and proceed to dress Resident #72 while in bed, pulling at Resident #72's shoulder, arms and legs multiple times to reposition her while dressing her. Resident #72 made moaning sounds during the procedure. After placing Resident #72's pants on, STNA #243 placed Resident #72 on her side to pull the back of her pants up. Resident #72 grabbed the side rail with her right arm. STNA #243 then pulled at Resident #72 right arm and right leg until she released the rail placing her back on her back side. After placing Resident #72's shirt on, STNA #243 lowered the bed, positioned Resident #72's legs over the side of the bed. Resident #72 was viewed stating something to STNA #243 that was not audible. STNA #243 grabbed Resident #72's hands, Resident #72 pulled her hands back towards her chest, away from STNA #243. STNA #243 then grabbed Resident #72's shoulders and quickly pulled her to an upright position. (Resident #72 appeared to be flaccid and not actively participating with the positioning or transfer). Resident #72 was lowered to the floor after an attempt to transfer her to a bedside chair was unsuccessful.</p> <p>Interview on 11/07/24 at 8:37 A.M. with Unit Manager #206 stated Resident #72's family was insistent that she get out of bed every day. Resident #72 was becoming weaker due to the progression of her disease process. The family was aware but continued to insist she be made to get out of bed anyway. Unit Manager #206 confirmed Resident #72 had the right to refuse and those rights should have been respected.</p> <p>Interview on 11/07/24 at 12:25 P.M. with STNA #243 confirmed on 10/11/24 at 9:30 A.M. she went into Resident #72's room to get her up. Resident #72 refused; she did not want to get out of bed. STNA #243 revealed she left the room to tell the nurse and was told by an administrative staff member (couldn't remember who) that she needed to get Resident #72 up anyway. When she went back in the room, Resident #72 continued to refuse and be resistant to getting up but she got her up anyway but then had to lower her to the floor. STNA #243 confirmed she did not clean resident or provide peri care prior to placing a new brief on and getting her dressed. STNA #243 confirmed she transferred Resident #72 out of her bed against her will.</p> <p>Interview on 11/12/24 at 10:42 A.M. with the Administrator and Regional Clinical Service Manager #304 confirmed Resident #72 had the right to refuse to get out of bed and staff were expected to honor residents rights. The Administrator and Regional Clinical Services Manager #304 confirmed the staff should be talking and explaining the care they were going to provide.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility policy titled, Ohio Resident Rights and Facility Responsibilities dated as reviewed 10/24/23 revealed it is the facilities policy to abide by all residents rights, and to communicate these rights to residents and their designated representatives in a language that they can understand. The resident has the right to be free from physical, verbal, mental and emotional abuse and to be treated at all times with courtesy, respect, and full recognition of dignity and individuality. The resident rights included the right to have all reasonable requests and inquiries responded to promptly. The right to participate in decisions that affect the residents life. The right for self-determination including the right to choose activities and schedules including waking times and the right to refuse treatment.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00159090.</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>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> 42011</p> <p>Based on review of a video recording, staff interviews, record review, and review of the facility policy, the facility failed to safely transfer a resident per the care plan, failed to timely assess the resident status post fall, and document the fall in the medical record. This affected one (Resident #72) of three residents reviewed for falls. The facility census was 69.</p> <p>Findings include:</p> <p>Record review for Resident #72 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included dementia, calculous of the gallbladder, diaphragmatic hernia, and muscle weakness.</p> <p>Review of the Medicare five-day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #72 was severely cognitively impaired. Resident #72 had impairment on both sides of lower extremities and was dependent on staff for bed mobility, moving from a sitting to standing position, and transferring.</p> <p>Review of the care plan dated 08/05/24 revealed Resident #72 was a fall risk characterized by impaired balance and impaired mobility. Interventions included to assist with transfers, locomotion, and mobility. Resident #72 was safe to transfer with two assists per nursing judgement if Resident #72 assisted with weight bearing. In periods of non-weight bearing, Resident #72 was to be transferred via mechanical lift.</p> <p>Review of the video footage provided by the family, dated 10/11/24 at 9:30 A.M. revealed there was a camera in Resident #72's room. The footage provided revealed State tested Nursing Assistant (STNA) #243 entered Resident #72's room. Resident #72 was lying in bed with her eyes closed. STNA #243 dressed Resident #72 while Resident #72 was lying in bed. STNA #243 then positioned Resident #72 to the edge of the bed. Resident #72 appeared to be flaccid and not actively participating with the positioning or transfer. Resident #72 had white socks on and no shoes. STNA #243 placed her right hand/forearm under Resident #72's right armpit, then positioned herself behind Resident #72 and placed her left hand under Resident #72's left armpit while attempting to lift Resident #72 up from the bed. Resident #72 continued to be flaccid, her legs were positioned forward, (not downward as in a standing position). STNA #243 was positioned behind Resident #72 and lifted Resident #72 from the bed. Resident #72's feet slid forward as STNA #243 was lifting her from behind. Resident #72's feet bumped into the bedside table and positioned the right foot under the bottom leg of the table. STNA #243 unsuccessfully attempted to lift Resident #72's back to the edge of the bed, the bedside table moved with her due to the right foot being still located under the lower bar of the table. STNA #243 then lowered Resident #72 to the floor. Two additional staff members (identified by Administrator as Licensed Practical Nurse (LPN) #209 and STNA #243) entered the room. The three staff members picked Resident #72 up off the floor by her shoulders and arms. Resident #72 was heard stating owe loudly. The staff members placed Resident #72 in a chair located near the bed. LPN #209 and STNA #243 then turned and left the room. LPN #209 was observed to leave the room and did not complete an assessment on Resident #72 for a potential injury prior to leaving the room.</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>Resident #72's medical record, including the progress notes and assessments, revealed no documentation of Resident #72 being lowered to the floor or Resident #72 being assessed for injuries by a licensed nurse after being lowered to the floor.</p> <p>Interview on 11/07/24 at 12:25 P.M. with STNA #243 stated she was attempting to get Resident #72 out of bed and Resident #72 refused to get out of bed. STNA #243 stated she was told to get Resident #72 up anyway by administrative staff. STNA #243 stated she had prior training on transferring residents but she was not given a verbal report on how to transfer Resident #72. There was nothing available in writing on how to transfer the resident, so she attempted to transfer her by herself. STNA #243 confirmed she lowered Resident #72 to the floor then two staff members came in and assisted her with picking Resident #72 up off the floor and placing her in a chair.</p> <p>Interviews on 11/07/24 between 1:50 P.M. and 2:10 P.M. with STNA #297 and #305 confirmed they do not have any written information including in the electronic medical record to determine how to transfer residents. STNA #297 and #305 stated they usually just ask someone.</p> <p>Interview on 11/12/24 at 10:42 A.M. with the Administrator and Regional Clinical Service Manager #304 confirmed the Administrator previously viewed the video of Resident #72 dated 10/11/24 at 9:30 A.M. The Administrator stated there was confusion by STNA #243 on how to transfer Resident #72. The Administrator confirmed the transfer for Resident #72 should have involved two staff members to assist with the transfer. Regional Clinical Service Manager #304 stated if any resident was lowered to the floor, it was considered a fall, and the resident should be assessed at that time and confirmed the assessment should be documented.</p> <p>Review of the facility policy titled, Falls - Clinical Protocol dated 11/30/23 revealed the staff will evaluate and document falls that occur while the individual is in the facility, for example when and where they happen, any observations of the events, etc. An additional form provided with the policy untitled included the procedure for falls. The procedure for after a fall included: Resident assessment, includes head - to- toe, vital signs, pain assessment, and active and passive range of motion assessment and document in the progress notes. Initiate every shift follow up documentation for 72 hours.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00159090.</p>		