

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366459	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/06/2024
NAME OF PROVIDER OR SUPPLIER Brunswick Pointe Transitional Care		STREET ADDRESS, CITY, STATE, ZIP CODE 4355 Laurel Road Brunswick, OH 44212	
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** 37095 THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NONCOMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on medical record review, resident interview, staff interview, review of hospital records, review of the facility investigation and review of facility policy, the facility failed to ensure residents were safely secured during transportation in the facility van. This resulted in Actual Harm on 07/15/24 when Resident #56's wheelchair was not safely secured in the facility van and tipped during transportation. Resident #56's weight rested on the left seatbelt shoulder strap, resulting in a fracture to her left upper arm. This affected one resident (#56) of three residents reviewed for transportation safety. The facility census was 89. Findings include: Review of Resident #56's medical record revealed an admitted [DATE]. Diagnoses included diabetes, end stage renal disease and unspecified dementia. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #56 was moderately cognitively impaired. Review of Resident #56's progress notes revealed on 07/15/24, upon return from dialysis, the resident reported increased left shoulder pain and X-rays were ordered. Review of a progress note dated 07/16/24 revealed the X-ray identified a fracture to the left upper arm with diffuse osteopenia. The physician ordered an orthopedic consult and sling to the arm. Resident #56 stated the fracture occurred during transport back to the facility from dialysis. On 07/18/24, Resident #56 complained of increased pain, had increased confusion, and attempted to self-transfer. Resident #56 was sent to the hospital for further evaluation. Review of hospital documents revealed Resident #56 was admitted on [DATE] for a left humerus fracture. An orthopedic consult on 07/18/24 revealed there was no bruising, swelling, or other injury around the fracture site and recommended the arm to be non-weight bearing with a sling on at all times. Further review revealed a head computed tomography (CT scan) was completed with no abnormalities noted. Resident #56 was treated for a urinary tract infection (UTI) and discharged back to the facility on [DATE]. (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 366459	Facility ID: 366459 If continuation sheet Page 1 of 4

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview on 08/01/24 at 9:10 A.M. with the Administrator confirmed on 07/15/24 there was an incident on the facility van in which Resident #56 tipped in her wheelchair during transportation. The Administrator stated one of the wheelchair straps was loose and Resident #56's wheelchair leaned to the side when the driver turned into the facility parking lot. The Administrator stated the seatbelt shoulder strap prevented Resident #56 from completely tipping over. The Administrator denied Resident #56 hit the side of the van or the floor, but verified the resident suffered a left humerus low impact fracture as a result of the incident. Interview on 08/01/24 at 9:15 A.M. with Resident #56 revealed she was riding the facility van, returning from dialysis, and was not properly secured. Resident #56 stated this caused her to fall sideways and hit her left arm on the wall, causing a fracture. Resident #56 stated there was no shoulder strap over her arm and she was unsure if there were any security straps on her wheelchair. Following the event, Resident #56 stated she had pain in her arm and was sent to the hospital, where she learned she had a fracture. Concurrent observation confirmed Resident #56's left arm was in a sling. Interview on 08/05/24 at 11:12 A.M. with the Director of Nursing (DON) and Regional Registered Nurse (RRN) #501 revealed the facility investigated the incident involving Resident #56 and were not able to determine if the resident impacted anything when her wheelchair tilted in the van. The facility investigation identified one of the wheelchair anchor straps was loose, allowing the right wheel of the wheelchair to raise off the ground during a sharp turn. The facility believed the fracture resulted from the pressure of leaning against the seatbelt shoulder strap when the wheelchair tilted. Interview on 08/01/24 at 12:44 P.M. with Transport Aide (TA) #201 revealed, while turning into the facility parking lot on 07/15/24, Resident #56 cried out that she was tilting. TA #201 stopped the van and found Resident #56's wheelchair was tilting and the right wheel was approximately one inch off the ground. TA #201 stated Resident #56 had a seatbelt on and the shoulder strap was over the resident's left arm/shoulder. TA #201 stated she repositioned Resident #56 and denied the resident hit the wall or the floor of the van during the incident. TA #201 did not know how the wheelchair was able to tilt and speculated she did not strap the wheelchair anchors tightly enough. Interview on 08/05/24 at 8:56 A.M. with Nurse Practitioner (NP) #801 revealed on 07/15/24, the facility reported Resident #56 bumped her arm and an X-ray was ordered. NP #801 assessed Resident #56 the following day and identified no sign of injury on her head or arm. NP #801 stated the fracture did not require hospitalization and an orthopedic consult was ordered. One or two days later, Resident #56 presented as confused and she was sent to the hospital for further evaluation to rule out a head injury. Resident #56 returned to the facility the following day. A head CT was completed at the hospital and there was no evidence of a head injury. NP #801 stated Resident #56 was diagnosed with a UTI, which was likely the cause of the confusion. (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the facility investigation, initiated on 07/15/24, revealed an X-ray dated 07/15/24 identified Resident #56 had a minimally impacted fracture of the left upper arm with diffuse osteopenia. The investigation documentation noted Resident #56's wheelchair tilted when the van was turning into the facility. The seatbelt held her in place and the resident did not make contact with the side of the van. Resident #56 complained of increased shoulder discomfort and NP #801 was notified. A range-of-motion assessment revealed the resident was guarded with her left shoulder. Resident #56's son said she told him she hit her head, and the facility performed neurological checks with no negative findings. Notes completed by NP #801 revealed a X-ray identified the resident had an arm fracture, which was assessed by the physician to be nonemergent. The medical team ordered her arm to be non-weight bearing in a sling and an orthopedic consult. No wounds or bruises were noted on assessment. On 07/18/24, NP #801 noted there were conflicting stories about the course of events and it was possible the resident hit their head. NP #801 sent the resident to the emergency room for evaluation, and a follow-up note revealed Resident #56 was returned to the facility the next day with no evidence of head injury. Review of the facility policy titled Bus/Van Transportation Policy, revised June 2019, revealed residents transported in wheelchairs must have lap belts applied and be secured using at least four lockdown straps allowing no more than a quarter inch of chair wheel movement. As a result of the incident, the facility took the following actions to correct the deficient practice by 07/19/24: On 07/15/24, Resident #62 was assessed for injuries, an X-ray was ordered, and neurological checks initiated. On 07/15/24, the Administrator or designee re-educated TA #201 on the facility bus and van transportation policy. On 07/15/24, the Administrator audited all residents who received transportation in the facility van in the two weeks prior to the event on 07/15/24. No similar concerns were identified. On 07/16/24, Maintenance Director (MD) #401 provided a competency test to TA #201, which included demonstration of proper securement of wheelchairs in the van. On 07/16/24, MD #401 examined the facility van and identified no mechanical problems with the wheelchair securement devices. Beginning on 07/17/24, and completed on 07/19/24, RRN #501 and Regional Maintenance Director (RMD) #402 re-educated and competency tested all staff who drive the facility van on proper safety measures. On 07/17/24, RMD #402 examined the van and verified there were no mechanical problems with the wheelchair securement devices. Beginning on 07/17/24, the DON audited one transportation service, one time daily for five days. This continued for two weeks with no negative outcomes or additional concerns identified. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 07/18/24, Resident #62 presented with confusion and was sent to the hospital for further evaluation for a head injury. CT scans showed no evidence of a head injury. Resident #62 was seen by orthopedics, with no additional treatment recommendations made related to the left upper humerus fracture. Resident #62 was diagnosed with a UTI and returned to the facility on [DATE]. On 07/19/24, an Ad Hoc Quality Assurance and Performance Improvement (QAPI) Committee meeting was held to review the event, review corrective action, and review facility policies related to transportation. The committee meeting was attended by the Administrator, Medical Director and the DON. The Administrator will be responsible for on-going compliance and any areas of concern will be presented, and addressed, by the QAPI committee. This deficiency represents noncompliance investigated under Complaint Number OH00156271.		