

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385206	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER Mennonite Home		STREET ADDRESS, CITY, STATE, ZIP CODE 5353 Columbus Street SE Albany, OR 97321	

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 - 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** 26991</p> <p>Based on interview and record review it was determined the facility failed to timely evaluate and analyze repeated falls to ensure fall interventions were effective for 1 of 3 sampled residents (#4) and failed to ensure fall interventions were followed for 1 of 3 sampled residents (#1) reviewed for accidents. As a result, Resident 1 fell and sustained a fracture. Findings include:</p> <p>1. Resident 1 was admitted to the facility in 2018, with a diagnosis of Parkinson's disease.</p> <p>A 11/2/23 Significant Change MDS revealed Resident 1 had dementia and did not ask staff for ADL assistance. Resident 1 was assessed to be at risk for falls and interventions included a motion sensor (device placed near the resident and alerts staff when the resident moves) was to be used when she/he sat in a recliner. The assessment indicated Resident 1 liked to sit in a recliner near the dining room.</p> <p>An Investigation revealed Resident 1 fell on [DATE] at 6:19 PM. The investigation indicated Resident 1 had a history of falls and staff were to place a motion sensor near her/him to detect movement. The motion sensor was not in place at the time of the fall. Staff 5 (CNA) was interviewed and reported she did not place the sensor after Resident 1 was transferred to the recliner. Staff 4 (LPN Resident Care Manager) reviewed the facility video footage which revealed the following:</p> <p>-6:12 PM staff visualized the Resident 1 in her/his recliner.</p> <p>-6:15 PM Resident 1 was eating dinner.</p> <p>-6:18 PM Resident 1 stood up from her/his chair and held onto a table with one hand as she/he attempted to walk.</p> <p>-6:19 PM Resident 1 fell on to her/his right side.</p> <p>A 3/13/24 Hospital After Visit Summary revealed Resident 1 was transferred to the hospital for right arm pain. The resident was diagnosed to have a right arm fracture and a sling (device made from material to keep the arm stable and provide support to allow a fracture to heal) was placed.</p> <p>On 7/23/24 and 7/24/24 attempts to interview Staff 5 were unsuccessful.</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 - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 7/23/24 at 12:50 PM, Staff 4 (LPN Resident Care Manager) stated she completed a comprehensive investigation for Resident 1's 3/13/24 fall because the resident sustained an arm fracture. She was able to interview all staff and view video footage to determine the sensor was not placed at the time of the fall. A former resident notified staff of the fall, staff assessed the resident, and she/he was transported to the local hospital for evaluation and treatment.</p> <p>2. Resident 3 was admitted to the facility in 2024, with a diagnosis of dementia and weakness.</p> <p>A 4/16/24 Significant Change MDS revealed Resident 3 was at risk for falls due to severe cognitive impairment and poor safety awareness.</p> <p>Incident Investigation Summaries revealed:</p> <ul style="list-style-type: none"> -Resident 3 was found on the floor on 4/18/24. The investigation was not completed until 5/17/24. -Resident 3 was found on the floor on 5/4/24. The investigation was not completed until 7/2/24. -Resident 3 was found on the floor on 5/12/24. The investigation was not completed until 7/2/24. <p>On 7/23/24 at 1:56 PM, Staff 4 (LPN Resident Care Manager) stated she was behind on completing fall investigations.</p> <p>On 7/23/24 at 2:33 PM, Staff 2 (DNS) and Staff 1 (Administrator) acknowledged the investigations should be completed timely to ensure the care plan was followed, an analysis of the fall was completed to ensure current care plans were appropriate, and neglect of care or abuse did not occur.</p>		