STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365394	A. Building B. Wing	06/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Continuing Healthcare at Adams Lane	1856 Adams Lane Zanesville, OH 43701

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** 43063 THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on record review and interview, the facility failed to maintain fall safety interventions for Resident #64 to prevent a fall with injury. Actual Harm occurred on 04/20/21 when Registered Nurse (RN) #213 left the resident's room after providing care and failed to put the resident's bed in the lowest position, place a mat to the floor and a wedge cushion to the left side of the resident's bed resulting in the resident falling out of bed and sustaining a facial laceration requiring stitches, a nose fracture and a closed head injury. This affected one resident (#64) of three residents reviewed for falls. Findings include: Review of Resident #64's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including dementia, ataxia (the loss of control of body movements), hypertension and osteoarthritis. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment, dated 03/19/21 revealed Resident #64 had severely impaired cognition, required extensive assistance of two staff for bed mobility and was totally dependent on staff for transfers. Review of the fall risk assessment, dated 03/22/21 revealed Resident #64 had a very high potential for falls. A plan of care, dated 03/22/21 revealed Resident #64 was at risk for falls related to dementia, impaired balance, poor safety awareness, being unaware of limitations and a history of falls with fracture. Interventions included a low bed, placing a mat on the floor next to the bed and a wedge cushion to the left side of the bed. Review of a nursing progress note, dated 04/20/21 at 4:58 P.M. revealed Resident #64 had a fall. The resident was observed to have confusion, swelling to her nose, a puncture wound to her forehead and was stating pain to her head. Resident #64's primary care physician provided an order to send the resident to the emergency room . At 11:30 P.M., the resident returned from the hospital with stitches to a facial laceration, a diagnosis of a nose fracture and a closed head injury. (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

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(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	Record review revealed Resident #64 sustained a fall on 04/20/21. Review of the facility fall investigation revealed on 04/20/21 at 4:58 P.M., Resident #64 was observed on the floor. The resident had previously been in bed. The resident did not know why she was on the floor. The fall investigation revealed fall interventions were not in place at the time of the fall. On 05/26/21 at 10:06 A.M. interview with the Director of Nursing (DON) revealed Resident #64 had been seen by the wound nurse, Registered Nurse (RN) #213, immediately prior to the fall on 04/20/21. The DON revealed RN #213 had left the resident's room without ensuring fall interventions were in place and when she returned to the room, the resident was observed on the floor. On 05/26/21 at 10:10 A.M. interview with the Administrator verified the fall interventions care planned for Resident #64 were not in place at the time the resident fell from bed and sustained injuries. Review of the facility policy titled Fall Prevention, dated February 2021 revealed appropriate interventions would be initiated to prevent falls. The deficient practice was corrected on 04/22/21 when the facility implemented the following corrective actions: Resident #64 was sent to the emergency room for evaluation and treatment on 04/20/21. On 04/20/21 the RN #213 was immediately educated by the Assistant Director of Nursing of the importance of having resident fall interventions in place. On 04/20/21 a new intervention was initiated by the Assistant Director of Nursing to pad the side of the air conditioner in Resident #64's room. On 04/20/21 the Assistant Director of Nursing initiated education to staff regarding reading the kardex prior to caring for residents and having fall interventions in place as appropriate. On 04/20/21 at 11:30 P.M., Resident #64 returned from the emergency room . All fall safety interventions were in place and determined to be appropriate at that time. On 04/21/21 the Director of Nursing and nursing management team initiated and completed whole house audits to ensure residents' fall interventions were in place and reflected on care plan and kardex as appropriate. On 04/21/21 the Director of Nursing and nursing management team initiated and completed whole house audits on residents' fall risk assessments and ensured these were current. From 04/20/21 through 04/21/21 the Director of Nursing and nurse management team completed education with direct care staff regarding having residents' fall interventions in place as appropriate. On 04/21/21 the Director of Nursing initiated audits to ensure fall interventions were in place. These audits would be completed three times per week for two weeks, then weekly times four weeks and then as determined as necessary. (continued on next page)

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(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	On 04/22/21 RN #213 was given a notice of corrective action regarding Resident #64's fall due to interventions not being put in place prior to her leaving the room. Education was provided at that time by the Assistant Director of Nursing. This deficiency substantiates Complaint Number OH00122305.