STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366427	A. Building B. Wing	03/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Liberty Nursing Center of Colerain Inc	8440 Livingston Road Cincinnati, OH 45247

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** 40472 Based on medical record review, staff and physician interviews, review of facility policies, review of facility investigation, and review of the hospital records, the facility failed to provide Resident #100 with necessary and appropriate assistance with bed mobility during incontinence care resulting in the resident falling out of bed. This resulted in Actual Harm when Nurse Aide (NA) #45 was providing incontinence care to Resident #100 without the appropriate level of assistance, the resident rolled out of the bed, was sent to the hospital, and subsequently sustained a fracture to right tibia and fibula which required surgical interventions. This affected one (#100) of the three residents reviewed falls. The facility census was 70. Findings included: Review of the closed medical record for the Resident #100, revealed an original admitted [DATE] and was discharged on [DATE]. Diagnoses included, but not limited to cerebral infarction (Stroke), cerebral vascular accident (CVA), rheumatoid arthritis, contracture left hand, delusional disorders, Dementia without behavioral disturbances, convulsions, hypertension (HTN), hemiplegia on left side and seizure disorder. The diagnoses was silent for Osteopenia and or degenerative joint disease (DJD). Review of the quarterly and most recently completed Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #100 had severely impaired cognition, had no behaviors, did not reject care, did not wander, was dependent for transfers, toileting and bathing and required two plus person extensive physical assistance for bed mobility, eating, personal hygiene and resident was always incontinent of bowel and bladder. Review of plan of care last updated 01/07/22 indicated resident was incontinent of bowel and bladder, required total care with activities of daily living (ADLS) and rarely participated in her care and resident had limited physical mobility related to refusing to get out of bed. Plan of care revealed resident was resistive to care related to dementia, was at risk for falls due to CVA, poor body control, dementia, and dependent on staff for mobility and transfers. Interventions last updated for bed mobility dated 11/15/19 indicated resident was an extensive assist of one to two persons to turn and reposition, keep bed in lowest position when providing care, and anticipate resident's needs. Review of the most recent Morse Fall Scale for Resident #100 dated 04/06/21 revealed resident was at moderate risk for falling. An updated Morse Fall Scale was completed on 02/18/22 at 7:33 A.M. which indicated resident was at high risk for falling. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of physician orders for Resident #100 dated 05/12/21 revealed resident was ordered to be transferred by Hoyer lift for all transfers and air mattress to bed to reduce pressure and to reduce risk for pressure related wounds. Orders dated 02/18/22 revealed resident was ordered to be sent to hospital for evaluation and treatment. Review of orders were silent for any orders related to incontinence/personal care for resident. Review of Temporary (Nurse's Aide) NA job description for NA #45 dated 11/16/21 revealed aides would perform certain services for the facility's residents for which they had been trained and found to be competent in performing and the aide was to perform and direct patient care job functions. Descriptions included check resident routinely to ensure their personal care needs were being met and seek additional help when needed and follow established safety precautions in the performance of all duties. Review of most recent weight for Resident #100 dated 02/11/22 revealed resident weighed 191 pounds. Review of Licensed Practical Nurse (LPN) #34 witness statement dated 02/18/22 at 5:30 A.M. indicated she was notified by NA #45 that resident had slid out of bed during care. Notes indicated LPN #34 discovered resident on the side of the bed closest to residents left side, between bed and window, resident was on her knees facing the head of bed and resident was leaning towards the bed holding on the grab bar. Notes indicate resident was complaint of pain in knees. Notes indicated resident was assisted to the floor and resident was noted with high anxiety about touched or moved and voicing fear of falling. Notes indicated resident had no deformities, vital signs normal and no change in mental status and resident and NA stated resident did not hit her head. Notes indicated resident continued to complain of right knee and hip pain. Notes indicated resident was administered Tylenol (pain), physician was notified, and LPN was educated on NAs to use two persons assist with all care of residents. Notes indicated frequent checks were completed and bruising appeared just below right knee and resident continued to be afraid of being touch and fear of falling during attempted assessments. Notes indicated NAs reported resident continued to yell and tell them not to touch her. Notes indicated resident son was notified, day shift nurse was given report and was awaiting response from physician. Review of incident/accident log date 02/18/22 at 5:35 A.M. indicated Resident #100 had a fall during staff assist. Review of pain Tool document for Resident #100 dated 02/18/22 at 7:34 A.M. revealed resident complained of pain in right lower leg and bruising was noted, and leg, right hip, and left hip with no noted deformities. Notes indicated resident was very difficult to assess due to behaviors and pain was worse with range of motion. Review revealed no previous pain tool assessments for resident. Review of the nurse progress notes for Resident #100 dated 02/18/22 at 8:04 A.M. by LPN #34 revealed the physician and resident's son were notified and was awaiting response from physician. Progress notes at 11:54 A.M. by LPN #32 indicated resident complained of right knee pain upon movement, physician was in the facility, assessed resident's knee and ordered resident to be sent hospital via 911. Notes indicated the hospital and family was called. Progress notes were silent for any documentation by LPN #34 which detailed the incident or resident assessment. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of physician notes for Resident #100 dated 02/18/22 indicated resident was weak, had decreased range of motion and physician discussed findings with staff. Notes dated 02/18/22 indicated Physician # 50 arrived in facility, assessed Resident #100 for fall for which she indicated she was not notified of fall. Notes indicated right knee had deformities, bruising and resident had decreased range of motion in and pain and tenderness in right knee and resident was ordered to be transferred to hospital. Review of hospital notes for Resident #100 dated 02/18/22 indicated resident was evaluated in the emergency room for fall and resident stated everything hurt. Computerized tomography (CT) of right femur indicated resident had impacted nondisplaced right proximal tibia fracture centered at the metaphysis and nondisplaced fibular neck fracture. X-ray of the right knee indicated mildly displaced impacted right proximal tibial fracture centered at the metaphysis and fibular neck fracture. Hospital notes indicated there was a subtle cortical step off at the right femoral neck intertrochanteric region. Hospital notes indicated a surgical consult was completed and resident was admitted , preoperative orders were placed for surgical interventions were scheduled the following day to repair fractures. Review of the facility investigation dated 02/18/22 indicated Director of Nursing (DON) collected witness statements from NA #45, LPN #34 and DON made statements regarding the fall/incident. Review of STNA #45's witness statement dated 02/18/22 and untimed indicated she was changing resident when NA asked resident to roll over and NA grabbed the lift sheet, pulled it towards her and the resident slid off bed feet first while holding on to rail. Review handwritten note by DON dated 02/18/22 and untimed indicated she spoke with LPN #34 and facility needed a witness statement of incident. Notes also indicated DON instructed LPN #34 to make sure the DON was notified any falls and LPN was required to complete a progress note for any incidents. Same handwritten note indicated DON spoke to NA #45 about the incident with resident. Notes indicated NA explained the incident which matched her witness statement. Notes indicated NA #45 was educated on using two persons assist for resident and with residents who were more complex and bigger residents. Review of handwritten note from DON dated 02/21/22 and untimed indicated resident had osteopenia, degenerative joint disease, on multiple medications which cause weakness to bones and bone loss. Notes indicated the way the resident fell , how she leaned, given her weight, flaccid left side and being on left side, the type of break as well as being on low air loss mattress (regular size), her investigation led to being an accident and not out of any malice or intent. Interview with LPN #32 on 02/28/22 at 12:29 P.M. indicated she was assisting nursing staff on 02/18/22 when she heard something happened to Resident #100 during a staff assist. LPN #32 resident was complaining of pain and when physician arrived to do rounds, LPN #32 asked Physician #50 to see resident. LPN #32 stated resident was assessed and immediately sent to the hospital for leg pain and injuries. LPN #32 initially stated she did not know about the incident, but then stated she learned the incident happened during the night on 02/17/22 when a NA rolled the resident in bed while providing care and resident slid into floor and resident was hanging on to assist bar. LPN #32 stated resident was on an air mattress, and they are very slick, and resident slid out of bed during care. LPN #32 stated she did not know much about the details and surveyor would have to talk to DON and she could relay more details of the incident. LPN #32 stated resident was sent to hospital and never returned (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview with DON on 02/28/22 at 12:50 P.M. indicated she investigated the 02/18/22 incident by interviewing staff and indicated she collected witness statements from the nurse on duty and the NA who was providing care at time of incident. DON stated she discovered NA #45 was in Resident #100's room providing incontinence care by herself at approximately 5:00 A.M. when NA #45 rolled resident to the left side (weak side), so resident could use her right arm (strong side) to hold on to the assist rails. DON stated resident's legs slid off the bed and landed on floor while resident hung on to the assist rail with her right arm. DON stated when Agency LPN #34 entered resident's room, resident's feet were in the floor holding her up and resident was hanging on to bed with right arm complaining of pain in legs. DON stated resident was placed back in bed by staff, and the physician and family was called. DON stated the facility physician made rounds later that morning, assessed resident and sent resident to hospital where she was diagnosed with right fibula neck fracture, displaced tibia, and fracture at metaphysis tibia fibular, admitted to hospital and had surgery for injuries. DON concluded resident was care planned for one to two persons assist, was on a low air loss mattress (LLAM) bed which made surface slick and contributed to resident sliding off the bed on and the incident was an accident and not any type of malice or intent. DON stated resident had history of osteopenia from the hospital records which could lead to bones being fractured easier and resident received numerous medications that could have decreased bone mass causing an easier fracture. DON stated she immediately added a two person assist for all care, educated staff on using two persons assist for Resident #100, ordered a bariatric bed, and added interventions to check on resident more often. DON stated resident never returned to the facility. DON verified there were no documented assessments or progress notes from the incident. DON also verified NA #45 provided incontinence by herself, resident had a fall, was transferred to the hospital, and ended up requiring surgical interventions secondary to the fall. Interview with LPN #34 on 02/28/22 at 2:47 P.M. indicated she was called to resident's rooms on 02/28/22 around 5:30 A.M. and found resident on the side of bed of bed closest to the window, on her knees and right arm was hanging on to the assist bar. LPN #34 stated resident was twisted facing bed and knees were toward the head of the bed. LPN #34 stated they lowered resident to floor, put a flat sheet under her and four staff members lifted her back into bed. LPN #34 stated resident was very anxious and panicky over incident. LPN #34 stated when staff were laying resident down to floor resident kept stating I am falling and more anxious. LPN #34 stated she did a pain assessment once resident was back in bed on resident and resident freaked out when she attempted to touch legs or hip. LPN #34 stated she attempted to do a range of motion assessment and resident freaked out again complaining of pain. LPN #34 stated NA #45 completed incontinence care by herself at time of incident and LPN #34 stated she was not very familiar with resident due to being agency but had been told resident was a very difficult to provide care for and should have been a two person assist. LPN #34 stated she reported the fall to the oncoming shift nurse, sent a message to the physician via the MatchMD (electronic reporting system) and called the family around 8:00 A.M. LPN #34 stated when she was getting ready to leave, the physician had not called back yet, so she created a note so others would know the physician had been contacted. LPN #34 additionally stated resident had some bruising on her knee, but her assessment did not lead to resident needing to be sent to the hospital at the time of incident and was going to leave the decision to the physician from her message on the MatchMD. LPN #34 verified she forgot to put in a progress note or an assessment of the fall and stated she did not notify administration. (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	Interview with NA #45 on 02/28/22 at 4:04 P.M. indicated she provided incontinence care for Resident #100 on 02/18/22 around 5:30 A.M. when she rolled resident towards the window (left weak side) when residents legs slid off the bed and resident slid into the floor. NA #45 indicated resident was on her knee and was holding on to the assist bar with her strong arm (right). NA #45 stated she immediately left to get the nurse. NA #45 stated resident's legs were twisted under her and somewhat holding her up along with resident holding onto assist bar and resident was complaining of pain and yelling help me. NA #45 stated LPN #34 had to twist resident while she rested on her legs as they tried to get resident on the floor to be able get resident back in bed. NA #45 stated she had to get two additional staff members to assist getting resident back in bed. NA #45 stated they laid resident flat in floor, put a sheet under her and lifted her into the bed. NA #45 stated the nurse checked her vitals, gave her pain medications. NA #45 stated the DON questioned her a few hours later and asked her to complete a statement. NA #45 stated she did not know how many staff were ordered to provide care or how many staff were care planned to provide incontinence care, but STNA stated she often provided care by herself due to low staffing, but resident should have had two staff members due to resident's weight and resident often resisted and pushed away. NA #45 stated she was the only NA on the hallway. Phone interview with MDS/Registered Nurse (RN) #21 on 03/01/22 at 10:40 AM indicated she was tasked with doing MDS assessments and updating residents care plans. RN #21 stated Resident #100 was able to hold the assist rail some days and others she was too weak to assist with care. RN #21 stated she updated the care plan after the incident on 02/18/22 to indicate resident was a two person for all care. During review of the care plan at same time, revealed RN #22 last updated the care plan on 01/07/22 which indicated resident was a total care with ADLS and rarely participated in her care. Additional review of care plan during the interview, revealed interventions updated 11/5/19, revealed resident was listed as extensive assist of one to two person to turn and reposition. RN #21 stated she was behind on updating care plans and must have forgotten. RN #21 verified resident was very weak and rarely participated in care. Phone interview with facility Physician #50 on 03/01/22 at 3:00 P.M. indicated she was making her regular rounds in the facility and was asked by the Unit Manger/LPN #32 to see Resident #100 due to knee pain. Physician #50 indicated she was never contacted by staff at time of fall and was unaware of any injuries until she arrived in the facility. Physician #50 stated she assessed resident and immediately sent her out due to deformity, bruising and increased pain. Physician #50 stated she was told a NA was changing her in bed and rolled her too far and resident ended up in the floor. Physician #50 stated she also assessed Resident #100 in the hospital and was determined she had fractures in lower right leg because of the fall and required surgery the following day to repair the fractures. Review the personnel record for the unlicensed NA #45 revealed NA #45 was hired on 11/15/21 under the waiver from CMS for nurse's aide being licensed. Notes indicated NA #45 completed online temporary nurse aide training on 05/11/20. NA #45 completed all required hiring requirements. Review of Temporary Nurse Aide Skills competency checklist revealed NA #45 was observed and checked off for positioning, moving a resident and restorative care on 11/16/21 by Unlicensed NA #43. Review of facility policy titled Acute Condition Changes - Clinical Protocol dated 03/01/2018 revealed the direct care staff would be training in recognizing subtle but significant changes in residents. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of 07/01/17 facility policy titled Accidents and Incidents -Investigating and Reporting revealed all accidents or incidents involving residents occurring on the premises shall be investigated and reported to the Administrator. This deficiency substantiates Complaint Number OH00130378.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40472 Based on medical record review, staff interview, review of the witness statements and policy review the facility failed to ensure resident medical records were complete and accurately documented a resident fall out of the bed. This affected one resident (#100) of the three residents reviewed for falls. Total census was 73. Findings included: Review of the closed medical record for the Resident #100 revealed an original admitted [DATE] and discharged on [DATE]. Diagnoses included cerebral infarction (Stroke), cerebral vascular accident (CVA), rheumatoid arthritis, contracture left hand, delusional disorders, dementia without behavioral disturbances, convulsions, hypertension (HTN), hemiplegia on the left side and seizure disorder. There was no diagnoses for Osteopenia and or degenerative joint disease (DJD). Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #100 had severely impaired cognition, had no behaviors, had not rejected care, had not wandered, was dependent for transfers, toilet use and bathing and required two plus person extensive physical assistance for bed mobility, eating, personal hygiene and Resident #100 was always incontinent of bowel and bladder. Section-K (swallowing disorders) revealed resident had a feeding tube and received nutrition through enteral device. Section-B (hearing) resident had moderately difficult hearing and had hearing aids and did not have corrective lenses. Review of the physician orders for Resident #100 dated 02/18/22 revealed the resident was ordered to be sent to hospital for evaluation and treatment. Review of the Licensed Practical Nurse (LPN) #34 witness statement dated 02/18/22 at 5:30 A.M. indicated she was notified by the State tested Nursing Assistant (STNA) #45 Resident #100 had slid out of the bed during care. LPN #34 discovered Resident #100 on the side of the bed closest to residents left side, between the bed and the window, the resident was on her knees facing the head of bed and was leaning towards the bed holding onto the grab bar. Resident #100 had complaints of knee pain. Resident #100 was assisted to the floor and was noted with high anxiety when touched or moved and voiced fear of falling. The resident had no deformities, vital signs were normal and no change in mental status and STNA #45 stated the resident had not hit her head. Resident #100 continued to complaint of right knee and hip pain, was administered Tylenol (pain) and the physician was notified. LPN #34 educated the STNAs to use two person assistance with all care of residents. Frequent checks were completed and bruising appeared just below the right knee and Resident #100 continued to be afraid when touched and had a fear of falling during attempted assessments. Resident #100 continued to yell and tell them not to touch her. Witness statement notes indicated Resident #100's son was notified, the day shift nurse was given report and was awaiting a response from the physician. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the nurse progress notes for Resident #100 dated 02/18/22 at 8:04 A.M. written by LPN #34 revealed the physician and the resident's son were notified and was awaiting a response from the physician. Progress notes at 11:54 A.M. written by LPN #32 indicated Resident #100 complained of right knee pain upon movement, the physician was in the facility, assessed the resident's knee and ordered the resident to be sent the hospital via nine-one-one (911). The progress notes had no documentation written by LPN #34 which detailed the fall, the incident, or the resident's assessment. Review of the STNA #45's witness statement dated 02/18/22 and untimed indicated she was changing Resident #100 and asked the resident to roll over and the STNA #45 grabbed the lift sheet, pulled it towards her and the resident slid off the bed feet first while holding on to the grab rail. Review of a handwritten note by the Director of Nursing (DON) dated 02/18/22 and untimed indicated she spoke with LPN #34 and the facility needed a witness statement of the incident. The DON instructed LPN #34 to ensure the DON was notified of any falls and the LPN was required to complete a nurse's progress note for any falls/incidents. Interview on 02/28/22 at 12:29 P.M., LPN #32 revealed she was assisting the nursing staff on 02/18/22 when she heard something happened to Resident #100 during a staff assist. LPN #32 stated the resident complained of pain and when the physician arrived to do rounds, LPN #32 asked the Physician #50 to see the resident. LPN #32 stated Resident #100 was assessed and immediately sent to the hospital for leg pain and injuries. LPN #32 stated she had no details due to no progress note was written by LPN #34. LPN #32 verified there was no documented incident related to fall. Interview on 02/28/22 at 12:50 P.M., the DON revealed she investigated the 02/18/22 incident by interviewing staff and indicated she collected witness statements from the nurse on duty and the STNA who provided care at the time of the incident. The DON stated she discovered STNA #45 was in Resident #100's room providing incontinence care by herself at approximately 5:00 A.M. when the STNA #45 rolled resident to the left side (weak side), so the resident could use her right arm (strong side) to hold on to the assist rails. The DON stated Resident #100's legs slid off the bed and landed on floor while the resident hung on to the assist rail with her right arm. The DON stated when Agency LPN #34 entered the resident's room, the resident's feet were on the floor holding her up and the resident was hanging on to the bed with right arm complaining of pain in legs. The DON stated Resident #100 was placed back in bed by staff, and the physician and family was called. The DON verified there were no documented assessments by LPN #34 or progress notes from the fall/incident and the DON indicated she educated LPN #34 on accuracy of medical records. (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/28/22 at 2:47 P.M., LPN #34 revealed she was called to Resident #100's room on 02/18/22 around 5:30 A.M. and found the resident on the side of the bed closest to the window, on her knees and her right arm was hanging on to the assist bar. LPN #34 stated Resident #100 was twisted facing the bed and her knees were toward the head of the bed. LPN #34 stated they lowered the resident to the floor, put a flat sheet under her and four staff members lifted her back into the bed. LPN #34 stated Resident #100 was anxious and panicky over the incident. LPN #34 stated when staff laid the resident down to the floor the resident kept stating I am falling and became more anxious. LPN #34 stated she completed a pain assessment once the resident was back in bed and the resident freaked out when she attempted to touch her legs or hip. LPN #34 stated she attempted to do a range of motion assessment and Resident #100 freaked out again complaining of pain. LPN #34 stated STNA #45 completed incontinence care by herself at the time of the incident and LPN #34 stated she was not very familiar with Resident #100 due to being agency but had been told the resident was difficult to provide care for and should have been a two person assist. LPN #34 stated she verbally reported the fall to the oncoming shift nurse, sent a message to the physician via the MatchMD (electronic reporting system) and called the family around 8:00 A.M. LPN #34 stated when she was getting ready to leave, the physician had not called back, so she created a small note so others would know the physician had been contacted. Additionally, LPN #34 stated Resident #100 had some bruising on her knee, but her assessment did not lead to the resident needing sent to the hospital at the time of incident and was going to leave the decision to the physician from her message on the MatchMD. LPN #34 verified she forgot to put in a progress note or an assessment of the fall and stated she had not notified the administration. Review of the facility policy titled Charting and Documentation dated 07/01/17 revealed all services rendered to the resident progress toward the care plan goals, or any changes in resident's medication, physical, functional psychosocial condition, shall be documented in the residents medical record. Policy indicated any changes in the resident's condition and/or events, incidents or accident involving the resident, shall be documented in the resident medical record: Review of the facility policy titled Accidents and Incidents -Investigating and Reporting dated 07/01/17 revealed all accidents or incidents involving residents occurring on the premises shall be investigated and reported to the Administrator. This is an incidental finding discovered during the investigation of Complaint Number OH00130378.