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	07/28/2022

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** 25908 Based on medical record review, review of the hospital record, staff interview, review of the education, and review of the fall investigation, the facility failed to provide safe bed mobility during incontinence care. This resulted in Actual Harm when Resident #79 sustained a subdural hematoma requiring an emergency room visit, when State tested Nursing Assistant (STNA) #122 rolled Resident #79 away from her and the resident fell out of the raised bed onto the floor. This affected one resident (#79) of three residents reviewed for falls. The facility census was 80. Findings include: Review of the medical record revealed Resident #79 was admitted to the facility on [DATE]. Diagnoses included hypertension, depression, dementia, and anxiety. Resident #79 discharged from the facility on 07/11/22. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #79 had impaired cognition. The resident required extensive care of one staff for bed mobility, dressing, and toilet use and was dependent for transfers. The assessment indicated the resident was always incontinent of bowel and bladder. Review of the plan of care dated 07/05/22 revealed Resident #79 had a self-care deficit and was at risk for falls due to weakness and impaired mobility. Interventions included to assist with daily hygiene, grooming, dressing, oral care and eating as needed, assist to reposition, have commonly used articles within easy reach, keep the bed in a low position, lay down after meals and keep the resident in common areas when up. Review of a progress note dated 05/14/22 at 1:49 A.M. revealed Resident #79 was being changed and fell out of bed after STNA #122 turned the resident over away from her and Resident #79 fell to the floor from a high position. The resident was transferred to the hospital due to complaints of a headache, a large hematoma, and swelling of her face. Review of the local hospital emergency room notes dated 05/14/22 revealed Resident #79 had a subdural hematoma in the right frontal area. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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	Review of the facility fall investigation dated 05/14/22 revealed the Director of Nursing (DON) was notified of Resident #79's fall. After a full investigation and root cause analysis it was determined during routine care STNA #122 turned the resident away from her to provide incontinence care and the resident moved her shoulders forward and rolled out of bed. Immediately following the head-to-toe assessment Resident #79 was sent to the emergency room for an evaluation. Interview with the DON on 07/27/22 at 1:00 P.M., revealed STNA #122 was from an agency. The DON noted STNA #122 should not have turned Resident #79 away from her. Residents should always be turned toward the person giving care. The DON also noted the bed was raised to the high position. Review of the education titled Bed Mobility During Care, revealed always, turn the resident towards you. Make sure there is plenty of room to roll the resident without being on the edge. This deficiency substantiates Complaint Number OH00134175.