| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **366416** | A. BUILDING _____ B. WING _____ | **06/18/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **VILLA VISTA ROYALE LLC** | **1800 SINCLAIR AVENUE STEUBENVILLE, OH 43953** |

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 0580<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record review, policy review and staff interview the facility failed to immediately notify Resident #20's family of an accident with injury requiring physician intervention. This affected one resident (#20) of three sampled residents.<br>Findings include: Review of Resident #20's medical record revealed an admitted d of 06/0[DATE]4 with [DIAGNOSES REDACTED]. Review of the 05/12/20 quarterly Minimum Data Set (MDS) 3.0 assessment revealed the resident was rarely or never understood with short and long term memory problems and had severely impaired daily decision making. Behavior present fluctuated related to inattentiveness and disorganized thinking. The assessment revealed the resident had no wandering behaviors. Adequate hearing and vision, clear speech but rarely/never understood or able to understand others. The assessment revealed the resident required extensive assistance from two staff for bed mobility and transfers. The resident was non-ambulatory and required extensive assistance from one staff for locomotion on and off unit. The resident had upper and lower extremity impairment on both sides and used a wheelchair and a Hoyer (mechanical) lift (with staff assistance) to get in and out of bed. Review of a progress note dated 06/15/20 at 7:50 A.M. revealed staff came to this nurse and reported they were not able to locate Resident #20 within the facility. All staff alerted to possible elopement. Immediate search of facility conducted and unable to locate resident. Outside search began and at 8:06 A.M. and the resident was located across from the front entrance of the facility over the embankment. Pressure was applied to lacerations noted to the resident's forehead and skin tears to the right hand and right upper arm. The resident was transferred by ambulance to the emergency room . Record review revealed there was no evidence Resident #20's family was notified of this incident. Interview on 06/16/20 at 10:05 A.M. with the Director of Nursing (DON) revealed she arrived to the facility on [DATE] at approximately 9:15 A.M. Upon learning the details of the incident (involving Resident #20) she asked what the family said and staff all looked at her. She stated she was informed that no one had called the resident's family. She learned the resident left by ambulance at approximately 8:30 A.M. Around 9:30 A.M. the DON called the daughter's cell phone and left a generic message on the phone. She then attempted to call the daughter's work number but indicated the number was not correct. She stated she called the resident's son and his phone just rang and rang. She then phoned the third contact, who was an ex daughter in law and left a message on her cell phone number. She then called the ex daughter in laws work number and she answered. The DON revealed in the mean time the hospital called and said they were having a hard time getting hold of the family. The DON verified the staff should of notified the family after they discovered the resident down the embankment. Review of the emergency room documentation revealed the resident's injuries included a complex seven centimeter laceration to right frontal scalp, nasal abrasion, multiple abrasions and skin tears to bilateral knees, right hand, shoulder and right arm. A CT scan of the head showed multiple scalp hematomas without lacerations as well as a small frontal foreign body. CT scan of the cervical spine revealed a non displaced [MEDICAL CONDITION] of C2 (cervical) with extension into lateral masses. Review of facility undated policy titled Notification of Changes revealed the facility would immediately inform the resident, consult with the resident's physician and the resident's legal representative or an interested family member when there was an accident involving the resident which resulted in injury and had the potential for requiring physician intervention and/or a decision to transfer or discharge the resident from the facility. Interview on 06/17/20 at 2:40 P.M. with the DON verified the facility did not contact Resident #20's family immediately or follow their notification policy. The DON included she had meant to go back and complete a late entry note related to the notification and had not. This deficiency substantiates Complaint Number OH 376. |

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

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.