STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365785	A. BUILDING _____ B. WING _____	**09/30/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WILLOWOOD CARE CENTER OF BRUNSWICK	**1186 HADCOCK RD BRUNSWICK, OH 44212**

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 -** Minimal harm or potential for 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** Based on observation, record review, incident report review, policy review and interview, the facility failed to implement fall interventions, as determined necessary by the care plan, for Residents #1 and #5. This affected two (Residents #1 and #5) of three residents reviewed for falls. The census was 70. Findings include: 1. Record review of Resident #1 indicated an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the health status note dated 07/15/20, timed 12:21 A.M. indicated the nurse was called to Resident #1's room by nurse aide who reported an unwitnessed fall. When the nurse arrived, the resident was sitting on the floor with legs stretched out in front of her and wheelchair behind her. Review of the health status note dated 07/15/20 timed 7:31 A.M. indicated interdisciplinary review of Resident #1's fall from 07/14/20. The resident stated she was looking for something in the second drawer of bedside table and she leaned forward without locking the chair and chair slipped out behind her. She landed on buttocks and fell backwards hitting her head. Review of the health status note dated 07/15/20 timed 2:58 P.M. indicated Resident #1 complained of pain to left hip. An x-ray was ordered with findings of acute fracture of lateral and medial aspects of pubic ramus. Review of the incident report checklist dated 07/15/20 indicated a new intervention implemented after the fall was an anti-roll back chair. Review of the fall care plan, updated on 07/15/20 indicated Resident #1 was at risk for falls as evidenced by a history of falls, received daily medications which increased risk of falls, impaired balance, required assistive device when ambulating, was able and did use the call light and waited for staff assistance. Interventions implemented included: anti-rollback wheelchair and keep the call light within reach at all times. Review of the fall risk data collection tool dated 08/18/20 indicated Resident #1 had intermittent confusion, had problems with balance while standing and walking and the most recent fall was on 07/14/20 which resulted in a major injury. Resident #1 was assessed as being at high risk for falls. Review of the Minimum Data Set (MDS) 3.0 annual assessment dated [DATE] indicated Resident #1 was cognitively intact and utilized a wheelchair for mobility. Observation on 09/21/20 at 3:30 P.M. revealed Resident #1 was sitting in a wheelchair, in her room with a mechanical lift pad underneath her. There were not anti-roll back devices applied to the resident's wheelchair. Observation on 09/22/20 at 1:33 P.M. revealed Resident #1 was sitting in a wheelchair, in her room with a mechanical lift pad underneath her, both legs were propped up on the wheelchair leg rests. There were not anti-roll back devices applied to the resident's chair and the call light cord and button was wrapped around the call light mount on the wall approximately four feet away from the resident. Interview, during the observation, regarding the call light revealed Resident #1 stated, I'm not able to reach that. Interview on 09/22/20 at 1:34 P.M. with State tested Nurse Aide (STNA) #10 revealed herself and Licensed Practical Nurse (LPN) #1 had used a mechanical lift to transfer Resident #1 from the bed to the wheelchair after lunch. STNA #10 verified Resident #1's call light cord and button were wrapped around the call light wall mount and out of reach for the resident. Observation on 09/22/20 at 2:10 P.M. with the Director of Nursing (DON) and LPN #11 revealed Resident #1 continued to sit in a wheelchair in her room and there were not anti-roll back devices applied to the wheelchair. Resident #1's roommate, Resident #5, was sitting in a wheelchair in the room that had anti-roll back devices applied to the wheelchair. Interview, during the observation, with the DON and LPN #11 verified Resident #1 did not have antiroll back devices applied to the wheelchair that she was sitting in and Resident #1 and Resident #5 had inadvertently had their wheelchairs switched. Review of the undated fall management policy indicated to initiate a fall prevention care plan when appropriate with strategies to minimize risk and potential for injuries. 2. Record review of Resident #5 indicated an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the fall care plan updated on 08/14/20 indicated Resident #5 was at risk for falls as evidenced by requiring assistance with transfers, history of falls and impaired balance. Interventions implemented included: Dycem (a nonslip material) to wheelchair. Review of the MDS 3.0 annual assessment dated [DATE] indicated Resident #5 was moderately cognitively impaired and utilized a walker and wheelchair for mobility. Review of the fall risk data collection tool dated 08/25/20 indicated Resident #5 was disoriented at all times and had poor vision. Resident #5 was assessed as being at high risk for falls. Observation on 09/22/20 at 12:00 P.M. revealed Resident #5 was sitting in a wheelchair in a common area, sleeping, wearing glasses and sneakers. There was a cushion positioned underneath the resident and above the wheelchair seat. Resident #5 refused to be assisted to stand when STNA #10 asked. Interview, during the observation, with STNA #10 verified Resident #5 did not have Dycem on her wheelchair cushion or underneath the cushion as STNA #10 could not find the Dycem prior to assisting Resident #5 to the wheelchair earlier in the day. STNA #10 stated the Dycem material was on top of Resident #5's dresser. Observation on 09/22/20 at 12:05 P.M. revealed a blue roll of Dycem material was lying on top of Resident #5's dresser. Interview on 09/22/20 at 2:10 P.M. with the DON and LPN #11 verified Resident #5 should had Dycem applied to her wheelchair as indicated by the care planned interventions. This deficiency substantiates Complaint Number OH 353.

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.