STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365904	A. BUILDING _____ B. WING _____	08/20/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SAINT JOSEPH CARE CENTER	2308 RENO DRIVE NE LOUISVILLE, OH 44641

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** Based on observation, interview, record review, and facility policy review the facility failed to ensure ordered interventions were in place and functional to prevent falls for Resident #44. Actual Harm resulted when Resident #44 sustained a [MEDICAL CONDITION] after an unsupervised transfer and fall on 07/29/20. This affected one of four residents reviewed for falls (Residents #44, #45, #47 and #49). The facility census was 42. Findings include: Review of the medical record revealed Resident #44 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the most recent significant change Minimum Data Set 3.0 (MDS) assessment, dated 07/22/20, revealed Resident #44 was cognitively impaired and required extensive assistance of one or two staff for most activities of daily living including transfers and toileting. The assessment indicated the resident had not had a fall since the last assessment. Review of the care plan for falls initiated 01/25/17 and updated through 10/25/20 revealed she was at risk for falls due to increased confusion, decreased mobility and poor safety awareness. She also would intentionally place herself on the floor at times. Interventions included redirection, floor mats beside the bed, a low, extra wide bed to allow for more movement, gripper socks and assistance or encouragement to use the bathroom. A non-sound pressure alarm that triggered the resident's call light was ordered on [DATE]. Review of nursing notes dated 06/13/20 at 4:45 A.M. revealed Resident #44 was found on the floor. The pressure alarm was sounding through the call light and the resident was not injured. An intervention was put in place to assist the resident to the bathroom if she awakens through the night. Resident #44 had a hospital stay from 06/26/20 through 06/28/20 and on return to the facility, she was placed in a different room due to the need to quarantine for COVID 19. She later developed symptoms of COVID 19 and was kept in the quarantine unit until the testing was negative and symptoms resolved. She was transferred to a room out of the quarantine unit on 07/28/20. Review of a nursing note dated 07/29/20 at 2:34 A.M. revealed the resident was found on the floor in front of a recliner and stated she had walked from the bathroom and fell . The note indicated the resident complained of pain to her hips and elbow. An order was obtained for x-rays of both hips, the pelvis and left elbow. Review of the x-ray results obtained on 07/29/20 (no time indicated) revealed Resident #44 had an acute, impacted, right, subcapital femoral neck fracture ([MEDICAL CONDITION]). A nursing note dated 07/29/20 at 7:15 A.M. revealed the nurse practitioner was notified of the x-ray results and the resident was sent to the hospital for evaluation. Review of the fall investigation for the incident on 07/29/20 revealed a statement by State tested Nursing Assistant (STNA) #100, dated 07/29/20. STNA #100 stated she had been in and out of the resident's room several times for the resident unplugging the bed alarm setting off the call light. The statement indicated the resident was checked and changed (incontinence care) at 1:30 A.M. and at 2:15 A.M. a door slam was heard. The STNA statement indicated the resident slammed the bathroom door while falling. Review of the nursing notes dated 08/18/20 at 11:40 A.M. revealed the resident returned to the facility with bruising to the right elbow and staples noted to the right outer thigh after surgery to repair her [MEDICAL CONDITION]. An interview by phone with STNA #100 on 08/19/20 at 1:36 P.M. revealed she had been told the resident was more confused than usual on 07/28/20 due to the room change. She stated the resident had been playing with the bed alarm several times through the night and had set off the alarm by disconnecting it from the wall. She stated she had reset the alarm several times but it did not alarm when the resident got up before the fall. She stated she was alerted to the fall by hearing the bathroom door slam. She verified she had not talked to the nurse about the resident's behavior that night of disconnecting the alarm. An interview with Licensed Practical Nurse (LPN) #200, on 08/19/20 at 1:45 P.M. revealed she was the nurse working the night the resident was found on the floor with the fracture. She stated she was not aware of the resident's increased confusion and behaviors related to disconnecting the bed alarm. She stated if she would have known about the behavior of disconnecting the alarm, she would have explored other interventions to alert staff to unsupervised transfers, such as moving the alarm out of her reach or to the other side of her bed, as she (the resident) always laid on one side. She verified the resident stated she had gotten up, gone to the bathroom and fell as she made her way back to bed. Further review revealed the fall investigation also included statements from STNA #101 and #102, whose statements were written on 07/29/20. Both indicated they were in a dining room near the resident's room and heard a door slam, which alerted them the resident had fallen. An interview with Registered Nurse (RN) #300 on 08/19/20 at 2:00 P.M. confirmed Resident #44 had increased confusion due to a room change and according to the fall investigation and interviews, had been found by the nursing staff to have set off the alarm to her bed by manipulating the cords earlier that evening prior to the fall. RN #300 stated the resident was able to disconnect the cords, which resulted in the alarm not going off when she got up, walked to the bathroom unassisted, and fell on her return to bed, subsequently fracturing her hip. RN #300 confirmed there had been no other interventions put in place to more closely monitor Resident #44 on that night, even though staff were aware she was restless and had been manipulating the alarm. Observation of a non-sound bed alarm with RN #300 on 08/19/20 at 2:10 P.M. in an empty room revealed the alarm consisted of a pad which would be placed under the resident's top sheet with a cord coming from the pad to a box. Another cord connected the box to the call light. RN #300 verified the cord to the pad would have come out under the sheet and could have been placed so the resident could not see the cord or have access to the cord or the box to prevent her from disabling the alarm. RN #300 also verified if the resident had been anxious and focused on the alarm, staff should have ensured other measures were put in place to prevent unassisted transfers. She further verified the fall resulted in a [MEDICAL CONDITION] that required surgery. Resident #44 was observed in her room and bed on 08/19/20 at 2:30 P.M. She appeared comfortable but was confused and not interviewable. A cord for the non-sound alarm was noted coming from under the resident and attached to the call light. Review of the facility fall policy, revised March 2018, revealed staff should monitor the residents response to interventions to reduce the incidence of falls and reconsider the interventions if necessary.

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.