STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365163	A. Building B. Wing	04/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northcrest Rehab and Nursing Center	240 Northcrest Drive Napoleon, OH 43545

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** THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENCE OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY.Based on record review, staff interview, review of the fall investigation, review of staff statements, and review of the facility policy, the facility failed to follow the care plan and the information on the Kardex (mechanism that provides Certified Nursing Assistants the care needs of the residents) when providing care to a dependent resident. This resulted in Actual Harm on 02/10/26 when Resident #11 fell out of bed and sustained a laceration to the back of her head. This affected one (Resident #11) of three residents reviewed for falls. The facility census was 59.Findings include:Review of the medical record for Resident #11 revealed an admission date of 08/12/24. Diagnoses included traumatic subdural hemorrhage (bleeding in the brain) with loss of consciousness, chronic respiratory failure, paraplegia, contractures, heart failure, tracheostomy dependence for breathing, gastrostomy tube (for nutrition), and aphasia.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] for Resident #11 revealed she was severely cognitively impaired. Resident #11 was dependent for all care, incontinent of both bowel and bladder, and had special needs for tracheostomy care, suctioning, oxygen, and dependent on gastrostomy tube to meet all the required daily nutritional needs.Review of the care plan revised March 2026 for Resident #11 revealed she was care planned for activity of daily living (ADL) self-care deficit related to traumatic subdural hemorrhage form motor vehicle accident (MVA), paraplegia, cervical fracture, and contractures with intervention in place for two assists with bed mobility due to dependence. Resident #11 also had a care plan for increased risk for pressure ulcer development due to disease process and had an intervention in place for low air loss pressure reducing mattress with bolsters that required two staff assistance due to Resident #11's dependent care needs. Review of the Kardex for Resident #11 revealed the resident required two the assistance of two people for bed mobility due to her dependent status for care and the resident required the use of a low air loss mattress with bolsters and the assistance of two people for care. Review of the nursing progress note dated 02/10/26 at 12:40 A.M. authored by Licensed Practical Nurse (LPN) #500 for Resident #11 revealed the resident was found lying on the floor on her back between the side of the bed and the nightstand. Blood was on the floor near the head of the resident. Resident #11 was alert, eyes open, grinding teeth, and tracking (following) the writer with her eyes. Resident #11 was assessed; the physician was notified of the incident and was then sent to the local emergency room for evaluation and treatment.Review of the nursing progress notes dated 02/10/26 at 6:15 A.M. for Resident #11 revealed she returned from the local emergency room.Review of the local emergency room records dated 02/10/26 for Resident #11 revealed a computed tomography (CT) scan of the head, neck, brain, spine, and pelvis were completed and no acute findings were noted. All results were normal, no broken bones or bleeding on the brain were identified. Resident #11 revealed she had a fall from her bed. She sustained a laceration to the back of her head, that did not require staples or sutures and was sent back to the facility.Review of the nursing schedule for 02/09/26 revealed Certified Nursing Assistant (CNA) #400 and CNA #430 were both working the night shift from 6:00 P.M. to 6:00 A.M. on (continued on next page)

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.

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	the 100 and 200 halls.Review of the facility's fall investigation dated 02/10/26 revealed Resident #11 was dependent for all care. She sustained a fall from bed as the result of a staff member performing ADL care independently when the needs of Resident #11 were two staff assistance for resident safety for all bed mobility due to her vegetative state and use of the low air loss mattress.Review of the written statement dated 02/10/26 authored by CNA #400 revealed she was in Resident #11's room providing evening care and performing incontinence care. She propped Resident #11 on her side and walked away from the bedside to get washcloths from the bathroom. CNA #400 heard a crash and saw Resident #11 lying on the floor with blood coming from the back of her head. CNA #400 stated she was the only CNA in the room and the other CNA, CNA #430, was assisting another resident when the incident occurred. Review of the written statement dated 02/10/26 authored by CNA #430 revealed she was in Resident #11's room along with CNA #400 and Resident #11 was in her bed. CNA #430 then left the room to check on other residents on the 100 hall and when she returned to Resident #11's room, the resident was lying on the floor, and the bed was in a high position at approximately waist high. CNA #400 asked CNA #430 to lower the bed and assist with getting Resident #11 back into bed. CNA #430 refused and immediately went to get the nurse. Review of the incident and accident report dated 02/10/26 at 12:40 A.M. for Resident #11 revealed predisposing environmental factors, predisposing physiological factors, and predisposing situation factors were all marked as other. The explanation of other was documented as the resident had an air mattress and CNA #400 was assisting the resident by herself. The Interdisciplinary Team (IDT) met on 02/10/26, reviewed the incident and a Self-Imposed Plan of Correction (SIPOC) (the facility's internal root cause analysis with plan of correction) was initiated along with education. During an interview on 03/31/26 at 12:00 P.M., the Director of Nursing (DON) stated that for night shift there are two aides per unit and the expectation of the aides is to work together on the unit to help each other with the residents that are two assists with care. Each CNA is assigned a specific hallway for documentation purposes. During an interview on 03/31/26 at 12:20 P.M., the Administrator stated the facility's interdisciplinary team (IDT) meets twice daily on weekdays at 9:00 A.M. and 3:00 P.M. to review any clinical concerns, this includes fall that have occurred. The Administrator stated the meetings are documented on the Clinical Checklist form that collects the weeks minutes from the meetings.Review of the Clinical Checklist for the week of 02/09/26 through 02/15/26 revealed Resident #11's incident of fall was reviewed per protocol.Attempted phone interviews on 03/31/26 with CNA #430 and LPN #500 were unsuccessful. CNA #400 was not interviewed as she was no longer employed at the facility.Review of the facility policy titled Falls and Fall Risk, Managing, revised December 2007, revealed based on previous and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling.The deficient practice was corrected on 02/11/26 when the facility implemented the following corrective actions: On 02/10/26 a head to toe assessment was completed by LPN #500 and Resident #11 was assisted off the floor and returned to bed by LPN #500 and CNAs #400 and #430. Another head to toe assessment was completed by the DON/designee on 02/10/26 and included thorough skin, wound, pain, and neurological assessments along with a check of Resident #11's range of motion (ROM). On 02/10/26 physician was notified by the DON/designee, and an order was obtained to send Resident #11 to the local emergency room for evaluation and treatment. On 02/10/26 the DON/designee notified the family of the incident and the plan to transfer Resident #11 to the emergency room for evaluation. On 02/10/26 fall risk assessment was completed for Resident #11 by the DON/designee. On 02/10/26 all residents with an order for a low air loss mattress was checked to ensure appropriate for use and replace with a regular pressure reduction mattress as appropriate by DON/designee.On 02/10/26 all residents with a low air loss mattress were audited to ensure the care plan and Kardex adequately reflected two person assistance being required for bed mobility by DON/designee.On 02/10/26 the facility identified that all residents that utilize a low air loss mattress are at risk.On 02/10/26 all nurses were educated on ensuring residents are appropriate to use LAL (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	mattress by DON/designee.On 02/10/26 all nursing staff were educated on the use of two assistance for bed mobility for anyone who utilizes a LAL mattress by DON/designee.On 02/10/26 CNA #400 was administered a Teachable Moment related to the care provided to Resident #11 by utilizing only one staff member for bed mobility for the resident when two staff assistance was required by the nurse on duty. On 02/10/26 CNA #400 was administered progressive discipline following the fall investigation by way of phone by the Administrator and DON, however, CNA #400 refused to sign the discipline form.Ongoing audits began on 02/11/26 to audit two residents with low air loss mattresses three times per week for four weeks and then randomly thereafter by DON/designee.Ongoing audits began on 02/11/26 to audit two residents with low air loss mattresses and all newly ordered air mattresses to ensure the care plan and Kardex accurately reflect two person assistance for bed mobility three times a week for four weeks and randomly thereafter by DON/designee. Ongoing audits began on 02/11/26 to audit two residents with low air loss mattresses three times per week for four weeks to ensure bed mobility is completed with the assistance of two staff members.Results of the audits were presented to the Quality Assurance Performance Indicators (QAPI) on 03/31/26 to review the plan of correction; no changes or issues were noted.This deficiency represents non-compliance investigated under Master Complaint Number 2748389 and Complaint Number 2746217.