STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365297	A. Building B. Wing	12/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shelby Skilled Nursing and Rehabilitation	705 Fulton Street Sidney, OH 45365

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. (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

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 - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on medical record review, staff interviews, review of the facility fall investigation report, and policy review, the facility failed to ensure a neurological evaluation were timely initiated after a resident fall with reported head injury. This affected one (#02) out of the three residents reviewed for falls. The facility census was 44. Findings include: Review of the medical record for Resident #02 revealed an admission date of 09/04/25 with medical diagnoses of acute respiratory failure, anemia, Alzheimer's disease, heart failure, and hypertension. Review of the medical record for Resident #02 revealed an admission Minimum Data Set (MDS) dated [DATE] which indicated Resident #02 had severe cognitive impairment and required substantial/maximum staff assistance with toilet hygiene, supervision with transfers and bed mobility, and set-up assistance with eating. Review of the medical record for Resident #02 revealed a nurse's note, dated 10/16/25 at 9:43 A.M. which stated the nurse was alerted by a State Tested Nursing Assistant (STNA) that she had lowered Resident #02 to the floor after Resident #02 tried to sit down and missed the recliner. The note indicated Resident #02 did not have any injuries. Review of a nurse's note, dated 10/16/25 at 2:00 P.M., stated clarified with facility Nurse Practitioner to initiate neurological (neuro) checks as STNA reported though Resident #02 was lowered to the floor, resident's left temple bumped the bedside table. Review of the facility fall investigation report for Resident #02's fall on 10/16/25 at 9:43 A.M., revealed a written statement by STNA #123 which stated she lowered Resident #02 to the floor and Resident #02 swiped her head on bedside table. STNA #123 stated she informed Licensed Practical Nurse (LPN) #110 and LPN #135 that Resident #02 had fallen and swiped her head on the bedside table. Review of the statement by LPN #110 stated she was informed by STNA #123 that she had lowered Resident #02 to the floor on 10/16/25 and Resident #02 did not hit her head. Review of the statement by LPN #135 stated she was called to Resident #02's room by STNA #123 who stated she lowered Resident #02 to the floor. The statement by LPN #135 stated STNA #123 informed her that when she lowered Resident #02 to the floor she may have brushed her head against the tray table because Resident #02 was rubbing the back of her head. Review of the fall investigation revealed no documentation to support the facility staff-initiated neuro checks until 10/16/25 at 2:00 P.M. Interview on 11/25/25 at 8:03 A.M. with LPN #110 confirmed she was the nurse who took care of Resident #02 on 10/16/25 when she fell at 9:43 A.M. LPN #100 confirmed Resident #02 was cognitively impaired and confused. LPN #110 stated she was notified by STNA #123 that she had lowered Resident #02 to the floor and that Resident #02 didn't hit her head but could have brushed it on the bedside table. LPN #110 stated she asked Resident #02 if she hit her head and Resident #02 denied hitting her head on anything. LPN #110 confirmed she did not initiate neuro checks after Resident #02's fall on 10/16/25 at 9:43 A.M. Interview on 11/25/25 at 10:16 A.M. with Unit Manager #145 stated she was notified on 10/16/25 at 2:00 P.M. by the nursing staff that Resident #02 had been lowered to the floor and may have hit her head. Unit Manager #145 confirmed the staff had not initiated neuro checks. Unit Manager #145 stated an order was received to start neuro checks at that time. Unit Manager #145 confirmed the facility nurses should initiate neurological checks for any resident falls that are unwitnessed or if the resident hits their head. Review of the facility policy titled, Neurological Assessment, stated the purpose of the procedure was to provide guidelines for a neurological assessment: 1) upon physician order; 2) when following an unwitnessed fall; 3) subsequent to a fall with a suspected head injury; or 4) when indicated by resident condition. The deficient practice was corrected on 10/20/25, when the facility implemented the following corrective actions: On 10/16/25, Unit Manager #145 assessed Resident #02 and was found to be absent from any adverse effects related to fall. On 10/16/25, Unit Manager #145 notified Resident #02's responsible party of the concern. On 10/16/25, Unit Manager #145 notified the facility Nurse Practitioner of delay in the initiation of proper neurological checks following the fall on 10/16/25 and gave directions to initiate neurological checks at the beginning interval, per protocol, at the time of notification. On 10/16/25, Administrator suspended LPN #110 upon identification of delay in initiating appropriate neurological check post fall for Resident #02 on 10/16/25. On 10/17/25, LPN #110's employment was terminated. On 10/17/25, Director of Nursing (DON) completed medical record audit of current facility residents who had fallen in the past 60 days to ensure neurological checks were initiated promptly as per protocol and documentation was complete and accurate. There were no variances as a result of the audit