STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365306	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madison Health Care	7600 S Ridge Rd Madison, OH 44057

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 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013 Based on interview, record review, review of statement of expert evaluation and facility policy the facility failed to ensure Resident #103 resided in the least restrictive environment and was free from involuntary seclusion. This affected one resident (Resident #103) out of three residents reviewed for restrictive environment. The facility census was 102. Findings include: Review of Resident #103's closed medical record revealed an admitted [DATE] and diagnoses included generalized idiopathic epilepsy and epileptic syndromes, intractable with status epilepticus, schizoaffective disorder, bipolar type, and unspecified dementia, mild with other behavioral disturbance. Resident #103 was discharged from the facility on 03/14/24. Review of Resident #103's progress notes dated 10/10/22 included Social Worker Assistant (SWA) #323 called Resident #103's daughter who was also her POA (Power of Attorney) to set up an initial care conference. Resident #103's daughter informed SWA #323 that Resident #103 would be staying LTC (long term care). Relayed multiple psychosocial concerns with manipulation, staff splitting, physical and verbal assault towards caregivers, and medication noncompliance. Resident #103's daughter requested staff be mindful of Resident #103's history of calling 911 multiple times at a previous SNF (skilled nursing facility). Resident #103's daughter informed SWA #323 that Resident #103 had an arraignment on 10/11/22 for DV (domestic violence) against daughter while in the community. Initial care conference was set for 10/13/22 and Resident #103's family requested considering secured unit placement after the meeting and requested that Resident #103 not be made aware of the plan to be LTC until after the care conference. Review of Resident #103's Consent for Secured Unit dated 10/12/22 included Resident #103 signed the consent to be placed on the secured unit as ordered by the physician. The resident of this unit would be assessed quarterly to assess if a secured unit was still required. (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 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #103's care plan dated 10/13/22 and revised on 04/07/24 (after discharge) included Resident #103 was alert and could make or assist in making medically related decisions. Resident #103's family was making decisions for Resident #103 and directing care against Resident #103's expressed wishes. DPOA (Durable Power of Attorney) was modified and DPOA was no longer able to consent to secure placement (not retroactive). Resident #103 should be able to express and make decisions related to healthcare and care related issues with the assistance of family members per Resident #103's request. Daughter (former DPOA) and Resident #103's sister would not be given information in relation to Resident #103 as Resident #103 had declined this consent. Interventions included Resident #103's rights would be maintained by educating the family and resident of those rights; Social Services, Minimum Data Set (MDS) staff would facilitate meetings or exchange of information meetings with family members and Resident #103. Review of Resident #103's care plan dated 02/13/23 and revised on 04/07/24 included Resident #102 might exhibit behaviors related to schizoaffective disorder, anxiety, depression, metabolic encephalopathy. Resident #103 would remain safe, and not experience any complications related to behaviors. Interventions included in the event there was a disruptive behavior, redirect the resident and report the behavior; report any behaviors that could affect Resident #103's quality of life and, or could affect other residents. Review of Resident #103's care plan dated 04/11/23 and revised on 01/24/24 revealed Resident #103 was at risk for elopement due to cognitive impairments, continued to reside on the secured unit and remained appropriate. No exit seeking behaviors observed. Resident #103 would remain safe within the facility unless accompanied by staff or other authorized persons through the next review. Interventions included to discuss with resident, family risks of elopement, wandering; if resident was wandering in a potentially unsafe area or situation, redirect to a safer area. Review of Resident #103's Preadmission Screening and Resident Review (PASRR) evaluation dated 05/18/23 included Resident #103's care needs were appropriate to be serviced in any nursing facility setting. Currently care in a nursing facility is the least restrictive treatment setting, and Resident #103 could receive management and support for medical, self-care and safety needs. Resident #103 met PASRR inclusion criteria for serious mental illness with a diagnosis of conversion disorder with seizures or convulsions, dementia, mild with other behavioral disturbance, major depressive disorder, recurrent, severe with psychotic features, anxiety disorder and schizoaffective disorder, bipolar disorder. Review of Resident #103's progress notes dated 10/11/23 through 02/07/24 did not reveal evidence Resident #103 had behaviors including verbal aggression, yelling, screaming, wandering, pacing, or medication refusal to clinically justify the need for a secured unit. Review of Resident #103's progress notes dated 10/18/23 included Resident #103 was seen in her room sleeping but aroused easily. Resident #103 was pleasant and denied concerns with mood, sleep, or appetite. Nursing staff stated she was compliant with treatment but continued med seeking behaviors and calling 911 to go to the hospital to get morphine. Staff denied any other acute concerns for Resident #103. (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #103's progress notes dated 11/07/23 at 4:21 P.M. included the nurse and Social Worker met with Resident #103. Resident #103 changed her mind and wanted to apply for Assisted Living (AL). If Resident #103 was found to be an inappropriate candidate for AL she wanted to be transferred to a different SNF. Review of Resident #103's progress notes dated 11/09/23 at 1:29 P.M. included Resident #103 no longer wished to have a transfer referral sent to a different SNF and asked the Social Worker to send information to another company to determine if she would be able to transfer to one of their buildings. Review of Resident #103's psychiatric progress notes dated 11/24/23 included Resident #103 presented calm and pleasant and appeared to be in good spirits. Resident #103 reported no concerns at this time. Resident #103 was open to all interventions, participated in the case management visit and was progressing as expected. The SNF staff reported no concerns at this time. Review of Resident #103's progress notes dated 12/06/23 at 9:11 A.M. revealed Resident #103 was deemed competent. Review of Resident #103's progress notes dated 12/09/23 at 6:09 P.M. revealed Resident #103 was repetitively asking staff how she could get out of the facility. Review of Resident #103's Quarterly Minimum Data Set assessment dated [DATE] revealed Resident #103 was cognitively intact. Resident #103 stated yes to had little interest or pleasure in doing things, felt down, depressed, hopeless, had trouble falling or staying asleep, felt tired having little energy and trouble concentrating. Resident #103 stated no to do you feel bad about yourself and do you think you would be better off dead or have thought of hurting yourself. Review of Resident #103's progress notes dated 01/05/24 at 10:45 A.M. revealed Resident #103 asked several staff for a ride to look at an apartment. A one-to-one with Resident #103 stated Resident #103 was her own person and needed to provide her own ride and a person to accompany her. Resident #103 stated she had no one and her daughter would not take her. Review of Resident #103's encounter notes dated 01/06/24 written by Resident #103's primary care physician who was also the facility Medical Director #508 included Resident #103 suffered from dementia and schizoaffective disorder and was unable to care for herself and required supportive care. Resident #103 was in no acute distress. Resident #103's mood was normal, mood was not anxious or depressed, and affect was not angry. Resident #103's behavior was not agitated, thought content was normal and judgement was normal. Review of Resident #103's psychiatric progress notes dated 01/10/24 included Resident #103 was seen in her room and was sitting on her bed. Resident #103 stated she had no issues with mood and denied AVH (auditory verbal hallucinations). Resident #103 reported her sleep was okay and she was looking into getting her own apartment but had financial limitations on getting there and back. No other concerns reported. Staff had no concerns for Resident #103 at this time. Further review of the notes did not reveal documentation Resident #103 resided on the secured memory care unit or a reason why it was necessary for her to be on the locked unit. (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #103's progress notes dated 01/11/24 at 2:35 P.M. revealed Resident #103 called family members and begged them to come and get her. Resident #103 was telling staff and family she was discharged . Review of Resident #103's Wander, Elopement assessment dated [DATE] (care plan dated 01/24/24 stated Resident #103 was at risk for elopement) included Resident #103 was cognitively impaired with poor decision-making skills and had a pertinent diagnosis of dementia. Resident #103 did not have a history of elopement and did not wander aimlessly, or non-goal directed. Resident #103 did not display exit seeking behaviors and resided on a secured unit. Resident #103 was not at risk for elopement at this time. Review of Resident #103's evaluation for Residents needing a secured unit dated 01/26/24 included the diagnosis for secured unit placement was unspecified dementia, mild with other behavioral disturbance and schizoaffective disorder, bipolar type. In the last 30 days Resident #103 had yelling, screaming, verbal aggression, was wandering, pacing, had medication non-compliance and made false accusations. Resident #103 needed a secured unit. Physician documentation supported placement on a secured unit. The evaluation did not contain the resident's response to the need for a secured unit placement. Review of Resident #103's medical record the 30 days leading up the 01/26/24 evaluation of secured unit revealed no evidence of yelling, screaming, verbal aggression, wandering, pacing, or medication non-compliance. The record did not reveal evidence the facility spoke with Resident #103 regarding her secured unit evaluation. Review of Resident #103's Statement of Expert Evaluation dated 02/07/24 included Resident #103 was alert and oriented times three (time, place, person). Resident #103 was able to articulate her situation verbally and showed a good understanding of care needs and financial concepts. Resident #103 had mild memory impairment with a history of poor judgement and mild impairment in concentration and comprehension. Due to physical impairments Resident #103 would need assistance in caring for self but was mentally able to make and understand her own decisions. Review of Resident #103's progress notes dated 02/07/24 at 1:15 P.M. included Resident #103 had a statement of expert evaluation completed today and the recommendation was Resident #103 was capable of handling her own finances as well as caring for herself. Resident #103 was notified of the findings. Resident #103 desired to stay in her current room and transfer off the dementia unit when a bed became available. Resident #103 was aware there was no bed available at this time and was willing to wait for a bed. Resident #103 aware she was able to make her own decisions regarding her care and services and those decisions would be honored to the best of the facility ability within the confines of the services the facility offered and the capacity to give such service. T Review of Resident #103's medical record after being determine competent to care for herself and finances on 02/07/24 revealed the facility did not re-evaluate Resident #103's need for secured unit. (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #103's progress notes dated 03/13/24 at 12:40 P.M. included SWA #323 received a phone call from Resident #103 stating she was attempting to sign off the secured unit and go downstairs in order to purchase pop. Resident #103 stated she informed the nursing staff she had permission from SWA #323 to do so. SWA #323 spoke with Resident #103 and informed Resident #103 that she did have a conversation with Resident #103 to give her permission to leave the memory care unit, and off unit privileges were not something that typically occurred with residents who resided on the memory care unit. SWA #323 offered to purchase Resident #323 a pop, but she declined stating she did not have money. Resident #103 was told she could attend activities with staff members should she desire to do so before her transfer tomorrow. Review of Resident #103's progress notes dated 03/14/24 at 12:45 P.M. included Resident #103 was discharged to another facility via the facility bus. Interview on 12/16/24 at 10:48 A.M. with Resident #103 revealed she was on a locked unit but I tested competent. Resident #103 stated she did not agree to stay on the locked unit, was upset about being on the unit, and kept telling the staff to test me and finally she obtained an attorney. Resident #103 stated she resided on the locked unit about a year and a half and was moved to another nursing facility in March 2024 and did not reside on a locked unit in the new facility. Interview on 12/16/24 at 1:18 P.M. with Ombudsman #509 revealed he met with Resident #103 and they had discussions about her family overstepping their boundaries. Ombudsman #509 stated Resident #103 did not feel she belonged on the locked memory care unit, and he was not sure why she was in the secured unit. Ombudsman #509 stated Resident #509 got a lawyer, did not want her daughter to continue being the POA, and wanted new POA papers completed. Ombudsman #509 indicated Resident #509 moved to a new facility in March 2024. Interview on 12/17/24 at 10:33 A.M. with Certified Nursing Assistant (CNA) #316 revealed Resident #103 was pretty independent and needed minimal help with things like emptying her catheter bag and getting ice chips. CNA #316 stated Resident #103 was alert and oriented and had moments of confusion. CNA #316 indicated Resident #103 never told her she did not belong on the secured unit but other staff members told her Resident #103 said she did not belong on the secured unit. CNA #316 stated Resident #103 did not pace, wander, yell, kick, was not verbally aggressive and barely came out of her room. Interview on 12/17/24 at 10:45 A.M. with SWA #323 revealed Resident #103 resided at the facility for quite a while and she was originally admitted to the skilled and long-term care unit. Resident #103 was moved to the secured memory care unit after a meeting with her DPOA, due to memory impairment and disruptive behaviors. When she was first admitted to the facility Resident #103 was facing legal charges for abuse of her daughter in the home and had verbal aggression towards staff. SWA #323 revealed Resident #103 had an agreement with the judge and did not have to go to jail because she was residing in a skilled nursing facility. SWA #323 stated Resident #103 could not sign herself out of the facility because she had a DPOA. SWA #323 stated Resident #103 did not like her daughter making decisions on her behalf, and had an expert evaluation completed on 02/07/24. SWA #323 stated as far as she knew this was the first expert evaluation completed. SWA #323 indicated Resident #103 often called 911, would mimic seizures when she did not want to have therapy. SWA #323 stated Resident #103 told her all the time she did not think she should be on the secured memory care unit. In review of Resident #103's clinical justification for the secured unit, SWA #323 could not provide further evidence to support Resident #103's placement on the secured unit from 10/01/23 through 03/14/24. (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/17/24 at 11:23 A.M. with CNA #324 revealed Resident #103 was pretty much independent, was pleasant most of the time, and slightly confused at times. CNA #324 stated Resident #103 told her she did not like residing on the locked memory care unit, and wanted to be with a group of people she could talk to. CNA #324 indicated Resident #103 wanted to be transferred to a different facility. Interview on 12/17/24 at 12:03 P.M. with the Administrator revealed Resident #103 called 911 often, was accusatory and would cause staff splitting. The Administrator stated Resident #103 would fake seizures at times, but did not know why. Resident #103 had issues with her daughter who was her DPOA, and had the DPOA revoked. The Administrator stated Resident #103 was appropriate for the secured memory care unit, she had a dementia diagnosis, exhibited behaviors, and was disruptive when she did not live in the secured memory unit and that was why she was not moved. The Administrator confirmed there was no documentation in the medical record to explain the clinical justification of the secured unit placement, including progress notes dated 10/11/23 through 03/14/24 that Resident #103 exhibited disruptive behaviors, yelled, was verbally aggressive, wandered or paced. Interview on 12/17/24 at 2:44 P.M. with the Administrator, Licensed Practical Nurse/Minimum Data Set Nurse (LPN/MDS) #223, and Medical Director (MD) #508 revealed LPN/MDS #223 stated Resident #103 had increased behaviors and due to her diagnoses the facility and interdisciplinary team felt it was appropriate for her to be placed on the secured memory care unit. The Administrator stated she was not working at the facility when Resident #103 was placed on the secured unit but Resident #103 caused staff splitting and had manipulative behaviors. The Administrator stated Resident #103 did not exhibit dangerous behavior, it was mostly cognitive and disruptive to other residents. LPN/MDS #223 stated she could not remember if Resident #103 posed a risk to herself or other residents. MD #508 stated there had to be documentation which backed up why Resident #103 was placed on the secured unit and to check the psychiatry progress notes to see if there was documentation that supported Resident #103 being placed on the secured unit. MD #508 stated when he saw her she appeared to be okay, did not have aggression, did not like it at the facility and wanted to go home. In review of Resident #103's clinical justification for the secured unit, MD #508 stated nothing strikes my mind why Resident #103 needed to be placed on the secured memory unit and he would have documented it if it had. Interview on 12/17/24 at 3:00 P.M. with the Administrator confirmed she had provided all the information she could find that showed justification for Resident #103's placement on the secured unit. The Administrator confirmed Resident #103's assessment for the secured unit dated 01/26/24 stated she had behaviors of yelling, screaming, verbal aggression, wandering, pacing, medication non-compliance and her progress notes did not reveal evidence these behaviors occurred. The Administrator confirmed Resident #103's elopement assessment dated [DATE] stated she was not at risk for elopement but was care planned for being at risk. Review of an email sent 12/18/24 at 12:00 P.M. by the Administrator revealed on 12/06/23 at 9:11 A.M. Resident #103's progress notes stated Resident #103 was deemed competent because she had a BIMS assessment on 9/22/23 getting a score of 13 signifying she was cognitively intact. (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Secure Unit Guidelines revised 10/2017 included to reside on the secure unit a resident should meet at least one of the following criteria: have a diagnosis of dementia or other health condition that would benefit from being in a smaller unit that allowed for increased staff interventions and supervision because of the physical layout, a resident who was identified to be unsafe outside the facility without supervision who had a history of elopement or was assessed to be at risk for exit seeking, wandering behaviors that increased the likelihood of a successful elopement, a resident who chooses to be on the unit because of personal preference, a resident who chose to be on the unit to be with or near a spouse, relative or friend. The resident would be assessed to determine if the met any of the criteria to reside on the secured unit. If the resident, responsible party agreed to the placement the physician was also notified for approval. A care plan with appropriate interventions to provide for the resident's safety, including the placement on the secured unit would be completed. This deficiency represents non-compliance investigated under Complaint Number OH00160639.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013 Based on observation, interview, record review and review of the facility policy, the facility failed to implement care planned interventions to ensure Resident #66's open area to the crease of the left buttock and posterior thigh was identified and treated timely. This affected one resident (Resident #66) out of three residents reviewed for wounds. The facility census was 102. Findings include: Review of Resident #66's medical record revealed an admitted [DATE] and diagnoses included type two diabetes mellitus, depression, bipolar disorder, schizoaffective disorder and acquired absence of left upper limb below the elbow. Review of Resident #66's Annual Minimum Data Set assessment dated [DATE] revealed Resident #66 was cognitively intact. Resident #66 was dependent for toileting hygiene, bathing, personal hygiene and lower body dressing. Resident #66 was frequently incontinent of urine and bowel. Review of Resident #66's care plan dated 10/23/23 and revised on 11/13/24 included Resident #66 had the potential for alteration in skin integrity. Resident #66 refused showers and bed baths at times. Resident #66 would not develop skin breakdown through the comprehensive review. Interventions included to provide assistance with hygiene, including peri-care as needed. Resident #66 required assistance with ADL's (activity of daily living) related to cognitive impairment and immobility. Resident #66 would be well groomed and free of odors at all times and would participate as able in ADL self-care. Interventions included to inspect skin condition daily during personal care and report any impaired areas to the charge nurse. Review of Resident #66's medical record progress notes dated 11/17/24 through 12/16/24 did not reveal evidence Resident #66 had an open area in the crease of his left posterior thigh and buttock. Interview on 12/16/24 at 12:55 P.M. with Certified Nursing Assistant's (CNA)'s #308 and #507 revealed Resident #66 was provided incontinence care before lunch and would let them know when he needed it. CNA's #308 and #507 stated Resident #66 did not have open areas on his buttocks or surrounding areas. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 12/16/24 at 3:00 P.M. with Resident #66 revealed Licensed Practical Nurse (LPN) #329 and CNA #308 used a mechanical lift to transfer him to his bed for incontinence care. When Resident #66 was rolled onto his side and his incontinence brief was removed a border foam dressing dated 12/16/24 was noted on his left lower buttock area, and the dressing was not adhered to Resident #66's skin on three sides. LPN #329 stated the foam dressing was a pad and protect and there were no open areas, but she would remove it because it was coming loose and replace it. LPN #329 removed the dressing and an open area under the dressing could be seen, but the wound bed could not be easily visualized because it was covered with white cream. LPN #329 and CNA #308 confirmed the wound was covered with barrier cream and the wound was there when the previous incontinence care was completed. The open area was approximately one and a half inches by a half inch. LPN #329 and CNA #308 confirmed there was an open area in the crease of Resident #66's left buttock and thigh and the surrounding tissue was dark red and purple colored. Resident #66 stated he had not been getting treated right and his guardian told him he did not have a sore on his buttock area. Review of Resident #66's medical record revealed no evidence the wound covered in barrier cream was assessed with orders to treat prior to the observation on 12/16/24 at 3:00 P.M. Review of Resident #66's progress notes dated 12/16/24 at 7:04 P.M. revealed Resident #66 was seen at the bedside by his insurance company CNP (Certified Nurse Practitioner). The area to his left posterior thigh was washed with soap and water to remove the barrier cream. Resident #66's posterior thigh was observed with healed healthy scar tissue from a previous wound. A new linear superficial abrasion was noted distal to the scar tissue from the foam dressing and it measured length 2.0 cm, width 0.25 cm, and depth was 0.1 cm. No drainage or odor was observed. New order to cleanse with normal saline, pat dry, and apply zinc barrier cream and leave open to air BID (twice a day) and prn (as needed). Discontinue the foam dressing and follow up with CNP on 12/23/24. Resident #66's guardian was notified. Review of CNP #510's encounter notes dated 12/16/24 included Resident #66 was seen while laying in his bed. LPN #329 and the Director of Nursing were at the bedside. Assessment of left posterior thigh included noted area of healthy pink scar tissue being treated with foam dressing for pad and protection due to previous wound. Washed left posterior thigh with soap and water to remove barrier cream. Noted healthy pink scar tissue from previous wound. New linear superficial abrasion noted distal to the scar tissue, and likely etiology was from foam border dressing. The area measured length 2.0 cm, width 0.25 cm, and depth 0. 1 cm. No drainage or odor observed. Abrasion mildly TTP, no signs or symptoms of infection. Placed new order to cleanse with normal saline, pat dry, apply zinc barrier cream, leave open to air, twice a day and as needed. Discontinue foam dressing and follow up with the Wound CNP on 12/23/24. Review of the facility policy titled Wound Care revised 11/2018 included it was the policy of the facility to provide therapeutic treatment to heal wounds. Treatments implemented by a nurse required a physician's order. Wounds would be evaluated when they were noted and weekly until resolved. Wound would be monitored for location, size, undermining, tunneling, exudates, necrotic tissue and presence or absence of granulation tissue and epithelialization. Notify the physician upon discovery of new skin areas and when delay in healing was noted. Obtain physician orders for treatment to begin at the time of discovery. This deficiency represents non-compliance investigated under Complaint Number OH00159773.

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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** 42013 Based on observation, interview, record review and review of the facility policy the facility failed to ensure Resident #10 had effective fall interventions in place to prevent frequent falls. This affected one resident (Resident #10) out of three residents reviewed for falls. The facility census was 102. Findings include: Review of Resident #10's medical record revealed an admitted [DATE] and diagnoses included moderate intellectual disabilities, major depressive disorder, generalized idiopathic epilepsy and epileptic syndromes, not intractable without status epilepticus, and unsteadiness on feet. Review of Resident #10's care plan dated 08/20/21 and revised 08/19/24 included Resident #10 had potential risk for falls and injury related to seizures, unsteadiness and use of psychoactive and seizure medications. Resident #10 was provided a helmet but was non compliant with use despite encouragement. Resident #10 continued to attempt self-ambulation and transferring despite constant reminders from the staff to call for assistance. Resident #10 was noncompliant with calling for assistance with ambulation and tripped on the fall mat. Resident #10 became angry when staff attempted to assist with ambulation. Resident #10 continued noncompliance with safety precautions and using call light to request staff assistance with transfers. Resident #10 refused safety interventions. Resident #10 did not safely utilize recommended safety precautions consistently. Resident #10 had increased falls occurring with seizure activity and was sent to the emergency room . Resident #10 would be free from injury every day until next review. Interventions included to encourage and remind Resident #10 to utilize non-skid footwear (socks with grippers or shoes) while out of bed; keep call bell attached to light fixture string to have easy accessibility for increased use. Review of Resident #10's Annual Minimum Data Set assessment dated [DATE] revealed Resident #10 had moderate cognitive impairment. Resident #10 required supervision or touching assistance for toileting, upper and lower body dressing, putting on and taking off footwear. Resident #10 required partial to moderate assistance for bathing, personal hygiene, chair, bed-to-chair transfer, sit to stand and toilet transfer. Review of Resident #10's Fall Risk Evaluation dated 11/05/24 revealed Resident #10 was a high fall risk. Review of the facility incident log dated 12/01/23 through 12/16/24 revealed Resident #10 had witnessed falls on 12/19/23, 01/12/24, 01/27/24, 01/31/24, 05/02/24, 05/08/24, 05/09/24, 06/19/24, 06/27/24, and 07/20/24. Review of the facility incident log dated 12/01/23 through 12/16/24 revealed Resident #10 had unwitnessed falls on 12/21/23, 12/31/23, 02/14/2, 03/08/24, 04/27/24, 04/30/24, 05/18/24, 05/31/24, 06/03/24, 07/04/24, 07/07/24, 08/01/24, and 11/05/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365306	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madison Health Care	7600 S Ridge Rd Madison, OH 44057

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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	Review of Resident #10's progress notes dated 12/01/23 through 12/16/24 revealed Resident #10 experienced multiple falls which resulted in injuries with fractures. After each fall an intervention was initiated. Observation on 12/16/24 at 12:37 P.M. of Resident #10 revealed he was sitting in a wheelchair and propelling the wheelchair in the hall. Resident #10 had a boot on his right foot, and his left foot had a sock on it. Resident #10 was not wearing a shoe or non-skid gripper socks on his left foot. Certified Nursing Assistant (CNA) #501 confirmed Resident #10 did not have a shoe or a non-skid sock on his left foot and took him in his room to assist him to put a shoe on his left foot. Interview on 12/16/24 at 12:44 P.M. of CNA #501 revealed she assisted Resident #10 to put a shoe on because the staff worked as a team, but she was not assigned to care for him. CNA #501 did not know why Resident #10 did not have a non-skid sock or a shoe on his left foot. Observation on 12/17/24 at 8:15 A.M. of Resident #10 revealed he was sitting in a wheelchair in front of the meal cart and putting his breakfast tray on the cart. Resident #10 was wearing a boot on his right foot and a sock on his left foot. Resident #10 did not have a non-skid gripper sock or a shoe on his left foot. Observation on 12/17/24 at 12:38 P.M. of Resident #10 revealed he was sitting in the common area eating lunch. Resident #10 had a boot on his right foot and a sock on his left foot. Resident #10 did not have a non-skid gripper sock or a shoe on his left foot. Interview on 12/17/24 at 12:40 P.M. of Registered Nurse (RN) #310 revealed Resident #10 fell a lot and was noncompliant with the interventions implemented to help prevent falls. RN #310 stated Resident #10 was in a room by the nurses station so staff could keep an eye on him and there were a lot of fall interventions in place. RN #310 confirmed Resident #10 did not have a non-skid gripper sock or a shoe on his left foot. RN #310 stated Resident #10 liked his independence. Observation of Resident #10's room with RN #310 revealed the call light was not tied to the light cord which was one of the fall interventions. RN #310 confirmed the call light was not tied to the light cord. RN #310 indicated staff was constantly reminding Resident #10 to use his call light, but for him it was a dignity and independence thing and the reminders did not work. RN #310 stated Resident #10 changed his clothes three to four times a day and a lot of times he would take his shoe off and not put it back on. Observation on 12/17/24 at 12:47 P.M. of CNA #422 assisting Resident #10 into bed. CNA #422 took time to make sure Resident #10 was comfortable and had his needs met. Interview on 12/17/24 at 12:52 P.M. of CNA #422 revealed Resident #10 had resided in the facility for a long time and he was stubborn. CNA #422 stated she made sure everything was in reach and tried to constantly keep an eye on him because he did not activate his call light. CNA #422 stated she did not know why Resident #10 did not have a shoe or a non-skid gripper sock on his left foot, but she did not give him a shower or help him get dressed. CNA #422 indicated the shower aide gave the shower and helped him get dressed. CNA #422 stated Resident #10 would often kick his shoe off but would leave the non-skid gripper sock on. CNA #422 stated she felt like the facility could give Resident #10 the care he needed to keep from falling. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/17/24 at 1:06 P.M. of CNA #505 revealed Resident #10 was a major fall risk and required assistance with his care. CNA #505 stated she assisted Resident #10 with a shower today and helped him get dressed. CNA #505 stated Resident #10 could assist with putting his shirt and pants on, could put his shoe on, but had a hard time putting socks on and needed quite a bit of help with socks. CNA #505 stated she put Resident #10's shoe in front of him and he was able to put it on by himself. CNA #505 stated she helped Resident #10 put socks on but they were not non-skid gripper socks. Interview on 12/17/24 at 3:38 P.M. of the Director of Nursing (DON) revealed Resident #10 had a lot of falls and multiple falls with fractures. The DON stated Resident #10's room was moved close to the nurses station and his interventions were reviewed. The DON indicated Resident #10 was very impulsive, but she felt the staff did a good job and he could safely be cared for at the facility. The DON stated Resident #10's falls were reviewed at the corporate level and it was hard to come up with different interventions. Review of the policy titled Fall Prevention Program revised 06/01/24 included each resident would be assessed for fall risk and would receive care and services in accordance with their individual level of risk to minimize the likelihood of falls. Fall interventions included to encourage residents to wear shoes or slippers with non-slip soles when ambulating. This deficiency represents non-compliance investigated under Complaint Number OH00159658.