STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365398	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Best Care Health and Rehabilitation	2159 Dogwood Ridge Road Wheelersburg, OH 45694

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 INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY.Based on closed record review, staff interviews, policy review, and review of hospital documentation, the facility failed to ensure a resident received adequate assistance during a transfer to prevent an avoidable fall. This resulted in Actual Harm to Resident #95 when on 12/21/25 she fell on to the floor in the bathroom while being assisted with toileting by one staff member. Resident #95 sustained a fracture of the right femoral head and the left distal femur. This affected one (Resident #95) of three residents reviewed for falls. The facility census was 90.Findings include:Record review for Resident #95 revealed an admission date of 05/02/25. Diagnoses included congestive heart failure, polyneuropathy, difficult ambulation, muscle weakness, and chronic obstructive pulmonary disease. Review of the Lift, Transfer, Reposition Assessment, dated 05/16/25, revealed Resident #95 was at risk for falls and required two-persons substantial/maximal assist for transfers with the use of a gait belt.Review of the care plan, dated 06/18/25, revealed Resident #95 had intact cognition, and she was at risk for falls due to weakness and poor balance. The interventions included encouraging proper footwear when out of bed. Review of the care plan, dated 10/09/25, revealed Resident #95 required a functional maintenance program for transfers to restore their ability to assist with transfers between surfaces. Interventions included utilizing a gait bait belt with moderate-maximum assistance.Review of the Minimum Data Set (MDS) assessment, dated 12/01/25, revealed Resident #95 was cognitively intact. Resident #95 required substantial/maximal physical assistance for all transfers. Resident #95 was not steady and was unable to stabilize without staff assistance for moving from a seated to standing position, walking, and surface to surface transfer. Review of the progress note, dated 12/21/25 at 1:05 P.M. by Licensed Practical Nurse (LPN) #600, revealed Certified Nursing Assistant (CNA) #920 walked up to the nursing station for LPN #600 to come to Resident #95's room. Upon entry, LPN #600 observed Resident #95 sitting on the bathroom floor, complaining of left knee pain with multiple abrasions. Resident #95 was assisted to bed by the nurse and CNA #920. At 1:30 P.M. a STAT (without delay) order for imaging was obtained for both lower extremities including both hips. Fifteen-minute checks and neurological checks were initiated, with all being completed.Review of the Imaging Report dated 12/21/25 revealed a study time of 5:28 P.M. The facility was notified of the results at 7:34 P.M. The results of this imaging showed severe right hip degenerative changes with deformity in the right femoral neck. The left femur showed an acute distal femoral metadiaphysis fracture (the anatomical region of a long bone that encompasses the junction between the widened end and the shaft) with generalized osteopenia. The progress note dated 12/21/25 at 7:28 P.M. revealed notification to the physician of preliminary imaging reports and an order was obtained to send Resident #95 to the emergency room via emergency medical system (EMS) transport.The progress note dated 12/22/25 at 1:01 A.M. revealed Resident #95 was being admitted to the hospital with active diagnoses (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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NAME OF PROVIDER OR SUPPLIER Best Care Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 2159 Dogwood Ridge Road Wheelersburg, OH 45694	

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F 0689 Level of Harm - Actual harm Residents Affected - Few	of a right hip fracture along with a fracture to the left femur.The progress note dated 12/22/25 at 6:38 A.M. revealed the receiving hospital was transferring Resident #95 to another hospital due to compartment syndrome (severe, often acute, condition where high pressure builds with muscle compartment, restricting blood flow and causing oxygen deprivation) related to the left femur fracture. Review of the Fall Assessment Quality Assurance Performance Improvement (QAPI) report revealed Resident #95 had a fall on 12/21/25 at approximately 1:05 P.M. in the bathroom and sustained a major injury and was sent to the emergency room. The investigation stated the care plan interventions/strategies were in place. Resident #95 fell during transfer to the toilet, and the possible root cause was knee giving out. The QAPI action plan was to utilize the sit-to-stand lift to transfer Resident #95. The investigation did not address that Resident #95 required two persons to transfer and during this incident, only one person transferred Resident #95. The investigation did not address that CNA #920 did not utilize a gait belt which was part of the resident's plan of care. The report did not include any staff names involved with the QAPI action plan.The witness statement (undated) by CNA #920 revealed on12/21/25 at 1:05 P.M., CNA #920 was taking Resident #95 to the restroom and the resident stated that her knee was hurting her. Resident #95 was holding on to the bar in the bathroom. CNA #920 moved the wheelchair and was behind Resident #95 when Resident #95 began falling to her side. Resident #95 fell backwards toward the other bathroom door. Nurse was notified.Review of Resident #95's hospital records from Hospital #1, dated 12/22/25, revealed Resident #95's imaging showed a left distal femur fracture and a right hip fracture. This resident also arrived at the hospital being hypotensive (low blood pressure) with no external signs of bleeding or hemorrhage. The discharge plan was a closed left femoral fracture, fracture of right hip, anemia, and acute hypotension. Resident #95's condition at discharge was serious. Resident #95 was transferred to a Level One Trauma Center at Hospital #500 due to suspicions of internal bleeding of the left thigh. The family elected hospice services on 12/31/25.Review of Hospital #500's records revealed Resident #95 was treated for hemorrhagic shock and acute on chronic shock. The physician stated the left femur fracture was pathological due to a combination of osteopenia and trauma and that alone would not have resulted in fracture.Review of the death certificate and coroner's report dated 01/09/26 revealed Resident #95's cause of death to be medical decline following a left distal femur fracture with surgical therapy as a consequence of a ground level fall.During an interview on 02/13/26 at 2:34 P.M., LPN #600 stated Resident #95 fell on [DATE] while CNA #920 was assisting her to the toilet by herself. LPN #600 stated CNA #920 came to get him at the nursing station and said Resident #95 had fallen. LPN #600 stated Resident #95 required a two-person assist and this transfer was completed by only CNA #920. During an interview on 02/17/26 at 12:31 P.M., the Director of Nursing (DON), Assistant Director of Nursing (ADON) #330, [NAME] President of Clinical Operations #900, and Regional Resource Nurse #910 verified CNA #920 improperly transferred Resident #95 alone without the use of a gait belt for a safe transfer. They verified Resident #95 sustained a right hip fracture and a left femur fracture because of the transfer, with CNA #920 being terminated on 12/29/25 for inadequate work performancesReview of the policy titled Falls/Accidents/Incidents, dated 07/17/23, revealed the intent of this requirement is to ensure the facility provides an environment that is free from accident hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents. An avoidable accident means the accident occurred the facility failed including implement interventions, including adequate supervision and assistive devices, consistent with a resident's needs, goals, care plan and current professional standards of practice to eliminate the risk, if possible, and, if not, reduce the resident of an accident.The deficient practice was corrected on 02/06/26 when (continued on next page)

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