STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365424	A. Building B. Wing	04/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southbrook Healthcare Center	2299 S Yellow Springs Street Springfield, OH 45506

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. THE FOLLOWING SURVEY FINDINGS PERTAIN TO INCIDENCE OF PAST NONCOMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on record review, review of facility Self-Reported Incidents (SRIs), staff interview, and policy review, the facility failed to provide adequate supervision and monitoring for residents. This resulted in Actual Harm on 03/06/26 when Resident #12 rolled out of bed onto the floor during incontinence care, resulting in a fracture to his clavicle. This affected one (Resident #12) of three residents reviewed for accidents. The facility census was 89 residents. Findings include: Review of the medical record for Resident #12 revealed an admission date of 01/29/26 with diagnoses including end stage renal disease, cerebral infarction, and type two diabetes. Review of the Minimum Data Set (MDS) assessment for Resident #12 dated 03/13/26 revealed the resident had moderate cognitive impairment and was dependent on staff assistance for activities of daily living (ADL). Review of the care plan for Resident #12 dated 01/29/26 revealed the resident required the assistance of one staff with personal hygiene and toileting and the assistance of two for rolling left to right in bed. The resident was at risk of falls with interventions including staff to ensure the wheels to the bed were locked. Review of a nurse progress note for Resident #12 dated 03/06/26 revealed the aide called the nurse to Resident #12's room and the resident was sitting on his buttocks on the right side of the bed on the floor. The nurse assessed the resident with no complaints of pain or visible injuries. Review of a physician progress note for Resident #12 dated 03/07/26 revealed Resident #12 had complaints of left shoulder pain following the fall out of bed on 03/06/26. An X-ray revealed the resident had a distal left clavicle fracture. Review of an SRI for Resident #12 dated 03/09/26 revealed the facility initiated an investigation of possible neglect for Resident #12 based upon allegations from the resident's family member related to the fall on 03/06/26. The facility did not substantiate neglect or abuse but did determine Resident #12 fell out of bed while Certified Nursing Assistant (CNA) #24 was providing incontinent care to Resident #12 and the bed moved away causing the resident to roll out of bed. Resident #12 was a one-person assist for incontinence care but required a two-person assist for rolling side to side in bed. Review of the employee corrective action form for CNA #24 dated 03/09/26 revealed the aide received a written warning for a performance violation specifically for failing to use the Kardex to ensure the resident was properly cared for, failing to provide two-person assistance when it was called for, and was also educated on ensuring bed brakes were properly locked prior to providing resident care. During an interview on 04/17/26 at 3:18 P.M., the Administrator and the Director of Nursing (DON) stated on 03/06/26 CNA #24 was providing incontinent care by herself and she rolled Resident #12, causing him to fall out of bed sustaining a clavicle fracture. During their interview with CNA #24, the aide stated she thought she had locked the brakes on the bed, but the bed had moved as she was rolling the resident, causing him to fall with injury. Review of the facility policy titled Fall Prevention and Management undated revealed if a resident was determined to be at risk for falls the facility would implement a care plan with specific interventions to diminish the risk of falls with interventions to address environment factors, level of care needs, and risk factors resulting from mental or medical diagnoses. The deficiency was corrected on 04/03/26 when the facility implemented the following (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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(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	corrective actions:On 03/09/26, a new bed, a new mattress with bed bolsters and floor mats to both sides of the bed were provided to Resident #12.On 03/09/26 all residents' needs were reviewed to determine their level of assistance when providing care.Starting on 03/09/26, all staff were re-trained on the level of care and asking for assistance as required, correct use of bed brakes and the fall prevention policy. All staff were trained by 04/03/26.Starting on 03/10/26, staff were randomly observed providing resident care to ensure safety interventions were maintained.On 03/12/26, all residents were reviewed to ensure their bed brakes were operational and they had the proper mattress for care and transfers.Audits and observations to continue for six months and then randomly thereafter with results reported to the Quality Assurance Performance Improvement (QAPI) Committee. This deficiency represents noncompliance investigated under Complaint Number 2979798 and Incident Number 2806190.