STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365572	A. Building B. Wing	05/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eastland Rehabilitation and Nursing Center	2425 Kimberly Parkway East Columbus, OH 43232

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, review of hospital records, staff interviews, and review of facility policies, the facility failed to ensure accuracy of the medical record related to residents neurological assessments. This affected two Residents (#54 and #78) of three reviewed for falls. The facility census was 76. Findings include: 1. Review of the medical record revealed Resident #78 was admitted to the facility on [DATE] and had diagnoses that included encephalopathy, chronic obstructive pulmonary disorder (COPD), and psychotic disturbance. Review of Resident #78's Minimum Data Set (MDS) 3.0 assessment completed 03/01/26 indicated the resident had severe cognitive impairment. Further review of the medical record for Resident #78 revealed the resident suffered an unwitnessed fall that was discovered about 2:00 A.M. on 4/12/26 in which the resident suffered swelling and bruising to the left upper and lower eyelids in addition to a laceration (near) the left eye. As a result of the fall, Resident #78 was placed on neurological checks per facility protocol; checks every 15 minutes for one hour, every hour for 4 hours, then every 4 hours for 19 hours. Review of the Neurological Assessment Flow Sheet for Resident #78 revealed the facility checks were conducted on 04/12/26 at 2:00 A.M., 2:15 A.M., 2:30 A.M., 2:45 A.M., 3:00 A.M., 4:00 A.M., 5:00 A.M., 6:00 A.M., 7:00 A.M. and 11:00 A.M. Review of the 11:00 A.M. neurological assessment documentation noted the resident had a blood pressure of 122/78, a temperature of 97.8 degrees Fahrenheit, a pulse of 72 beats per minute and respirations of 18 breaths per minute. The assessment also noted the resident was alert, had an appropriate pain response, was able to move all extremities, and the residents pupils were equal and reactive to light. Review of the hospital record for Resident #78 stated the resident was admitted to the hospital at 9:54 A.M. on 04/12/26 for a fall (traumatic event). During the hospital stay, Resident #78 was diagnosed with subarachnoid hemorrhage, closed fracture of the left orbit, closed fracture of the zygomatic arch (cheek bone), and closed fracture of the maxillary sinus. Resident #78 was present at the hospital at 11:00 A.M. on 04/12/26, indicating a neurological check at the facility at 11:00 A.M. on 04/12/26 would not be possible. Interview with Administrator #81 on 05/19/26 at 1:35 P.M. confirmed there was documentation on the facility's Neurological Assessment Flow Sheet at 11:00 A.M. on 04/12/26. Administrator #81 also confirmed that the time of admission according to hospital records was 9:54 A.M. on 04/12/26. Review of facility policy titled Falls – Clinical Protocol (revised September 2012) states that staff, with physician guidance, will follow up on any fall with associated injury until the resident is (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stable and delayed complications such as subdural hematoma have been ruled out or resolved. Review of facility policy titled Neurological Assessment (revised October 2010) revealed the neurological assessments are indicated following an unwitnessed fall. The policy states that the date and time of the (assessment) should be documented in the resident's medical record. Review of facility policy titled Charting Errors and/or Omissions (revised December 2006) states an accurate medical record shall be maintained by the facility. The policy states if an error is made while recording data in the medical record, staff are to line through the error with a single line and correct the error. 2. Review of the medical record for Resident #54 revealed an admission date of 01/13/22. Diagnoses included metabolic encephalopathy, diabetes, emphysema, dysphagia, and vascular disease. Review of the plan of care dated 06/21/22 revealed resident was at risk for falls with interventions to anticipate needs, ensure the call light was in reach, call for assistance, ensure the bed was in the lowest position, ensure resident wore appropriate footwear when ambulating, obtain laboratory services as ordered, remove bed remote, provide a reacher, and evaluate and treat. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #54 was cognitively impaired and required substantial/maximum assistance from staff for activities of daily living and mobility. Review progress notes dated 04/25/26 at 9:30 P.M. revealed the resident was heard yelling for help. Staff observed the resident to be lying on his side on the floor and complained of pain to the right lower extremity and his head, and stated the pain had a rating of seven out of 10 (zero being no pain and 10 being the worst pain). The resident was unable to perform range of motion exercises with the lower extremities due to pain. Emergency services were contacted and the resident was transported to the hospital for evaluation. A note dated 04/25/26 at 11:05 P.M. revealed MedOne (Physician group) was notified and the resident had requested to go to the hospital. A note dated 04/26/26 at 4:38 A.M. revealed the resident was at the hospital and a note at 7:30 A.M. revealed the resident returned from the hospital with a diagnosis of closed head injury. Neurological checks were to be initiated upon his return and the resident was to be monitored for increased confusion, vomiting and headache. Review of the hospital paperwork included the hospital timeline including an arrival to the emergency room on [DATE] at 10:23 P.M. and he was discharged from the emergency room on [DATE] at 6:46 A.M. During the hospital visit, a head computed tomography scan (CT) and x-ray of the knee were completed. Review of the Neurological assessment form revealed checks were to be completed every 15 minutes for one hour, every hour for 4 hours, then every 4 hours for 19 hours. Resident #54's form dated 04/25/26 revealed they were initiated then completed at 9:30 P.M., 9:45 P.M., 10:00 P.M., 10:15 P.M., and 11:15 P.M. and on 04/26/26 at 12:15 A.M., 1:15 A.M., 2:15 A.M., 3:15 A.M., 7:15 A.M., and 11:15 A.M. After the 11:15 A.M. entry, it was marked hospital and no other neurological checks were completed. Review of the 11:15 P.M. neurological assessment documentation noted the resident had a blood pressure of 122/70, a temperature of 98 degrees Fahrenheit, a pulse of 76 beats per minute and respirations of 18 breaths per minute. The 12:15 A.M. neurological assessment documentation noted the resident had a blood pressure of 124/82, a temperature of 98 degrees Fahrenheit, a pulse of 78 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	beats per minute and respirations of 18 breaths per minute. The 1:15 A.M. neurological assessment documentation noted the resident had a blood pressure of 126/78, a temperature of 98 degrees Fahrenheit, a pulse of 78 beats per minute and respirations of 18 breaths per minute. The 2:15 A.M. neurological assessment documentation noted the resident had a blood pressure of 126/72, a temperature of 98 degrees Fahrenheit, a pulse of 82 beats per minute and respirations of 18 breaths per minute. The 3:15 A.M. neurological assessment documentation noted the resident had a blood pressure of 132/74, a temperature of 98 degrees Fahrenheit, a pulse of 82 beats per minute and respirations of 18 breaths per minute. The assessments all also noted the resident was alert, had an appropriate pain response, was able to move his right and left upper extremities and his left lower extremity, and the residents pupils were equal and reactive to light. The assessments from 04/25/26 at 11:15 P.M. through 04/26/26 at 3:15 A.M. were all initialed with letters consistent with Registered Nurse (RN) #230's initials. Interview on 05/18/26 at 1:49 P.M. with RN #230 revealed she found Resident #54 on the ground after the fall. RN #230 reported she had assessed the resident for injuries and contacted 911 for emergency transport to the hospital. She reported she conducted an assessment which included a neurological assessment and confirmed she did not complete any additional neurological checks as the resident had then transferred to the hospital. Interview on 05/18/26 at 2:10 P.M. with Regional Nurse #250 confirmed the neurological assessments documented on the form did not match the times the resident was at the facility and confirmed he was hospitalized for several of the neurological checks that were documented as completed. Interview on 05/18/26 at 2:20 P.M. with RN #210 confirmed she did not do any neurological assessments when Resident #54 returned from the hospital. She confirmed she did not check his neurological status and denied filling out the neurological assessment form. Interview on 05/18/26 at 3:00 P.M. with the Administrator and Regional Director of Operations confirmed the neurological assessment form for Resident #54 had entries during the residents hospitalization and confirmed the form contained documentation errors. Review of facility policy titled Neurological Assessment (revised October 2010) revealed the neurological assessments are indicated following an unwitnessed fall. The policy states that the date and time of the (assessment) should be documented in the resident's medical record. Review of facility policy titled Charting Errors and/or Omissions (revised December 2006) states an accurate medical record shall be maintained by the facility. The policy states if an error is made while recording data in the medical record, staff are to line through the error with a single line and correct the error.