STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365574	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crandall Nursing Home	800 S 15th St Sebring, OH 44672

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 0713 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or arrange emergency care by a doctor 24 hours a day. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34297 Based on record review and interview, the facility failed to ensure the physician was notified and responded timely to Resident #116's complaints of pain following a fall. This finding affected one (Resident #116) of three residents reviewed for falls. Findings include: Review of Resident #116's medical record revealed the resident was admitted on [DATE] with diagnoses including chronic obstructive pulmonary disease, major depressive disorder and essential tremors. Review of Resident #116's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited moderate cognitive impairment. Review of Resident #116's fall Incident form dated 11/11/24 at 7:50 P.M. revealed Certified Nursing Assistant (CNA) #918 reported she saw the resident in the Centrum (main television lounge area) when she saw the resident stand up and attempt to walk. Before she could reach her, the resident had fallen on the floor and landed on her right side. The alarm was present in the wheelchair and alarming. CNA #918 stated she did not hit her head. Review of Resident #116's fall Investigation/Follow-Up form dated 11/12/24 at 9:27 A.M. authored by Licensed Practical Nurse (LPN) #956 revealed CNA #918 reported she was in the Centrum when she saw the resident stand up and attempt to walk. Before she could reach her, she had fallen on the floor and landed on her right side. The alarm was present in the wheelchair and was alarming. See the nursing notes regarding the fall. Continue to encourage the resident to be in the Centrum when up in a wheelchair. Continue with current interventions in place which include one-hour visual checks, chair tender and falling star program. Review of Resident #116's progress note dated 11/12/24 at 3:05 A.M. revealed the resident was resting in the Centrum and denied any needs or complaints of pain. Neurological checks were unremarkable, and range of motion (ROM) was as per normal. Staff would continue to monitor. (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 0713 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #116's progress note dated 11/12/24 at 3:35 A.M. revealed the resident was assisted back to bed with the assist of two staff members and reported pain to the right hip/thigh area. The resident was able to move the leg with no swelling or bruising noted. A small bruise was noted below the knee. The resident did not rate the pain and the floor nurse to medicate the resident. The on-call service was contacted to ask for a X-ray and the answering service said to call the office in the morning. Review of Resident #116's progress note dated 11/12/24 at 8:49 A.M. revealed a call was placed to the physician to update on the resident's complaints of pain in the right hip and right leg area. New orders were received for an X-ray of the right hip, pelvic and right femur. Review of Resident #116's progress notes dated 11/12/24 at 8:52 A.M. revealed the resident's daughter was notified of the new orders and of complaints of right hip and right leg pain. Review of Resident #116's progress note dated 11/12/24 at 11:51 A.M. revealed at 11:30 A.M. the results of the X-ray was received and was noted with an acute subcapital hip fracture. A call was placed to the physician with orders to send the resident to the emergency department (ED). Interview on 01/14/25 at 10:30 A.M. with the Director of Nursing (DON) indicated the on 11/11/24, Resident #116 fell in the Centrum or common area and sustained a fracture at approximately 7:50 P.M. The DON stated the investigation revealed CNA #918 had observed the resident stand up and attempt to walk and subsequently fell on the floor on her right side. The DON confirmed the chair alarm was sounding, and the resident did not hit her head. He stated Resident #116 did not answer questions but was awake and alert. Interview 01/14/25 at 12:08 P.M. with Resident #116's daughter revealed concerns related to the resident being left in bed from the time of the fall until 12:30 P.M. the next day with a hip fracture. Telephone interview on 01/14/25 at 12:11 P.M. with CNA #918 revealed she was walking through the Centrum with a tray on 11/11/24 when she had observed Resident #116 trying to get out of her wheelchair. She stated she assisted the resident back into her wheelchair and then told her she would be with her in a second. She stated she felt the resident was settled back into her wheelchair, so she went to the food cart off the Centrum and placed a food tray on the cart. She stated as she turned, she heard Resident #116's chair alarm and the resident was almost on the floor. She stated it was a split second, and she did not see the actual fall but had observed as the resident fell to the floor. She stated she immediately went and got the nurse who was at the nursing station off the Centrum who then assessed the resident. CNA #918 indicated she did not observe any bruising or external rotation of Resident #116's legs and the resident did not complain of pain. She stated RN #856 assessed the resident and no injuries were noted so they helped the resident stand and placed her back into her wheelchair. CNA #918 revealed she took the resident to her room in the wheelchair and CNA #955 was going into the room to provide care to the resident. She was unaware of any other details. Interview on 01/14/25 at 12:40 P.M. with the DON indicated Resident #116 fell on [DATE] at 7:50 P.M., was assessed for injury and pain and nothing negative was identified. He stated on 11/12/24 at 8:49 A.M. the resident complained of pain and an X-ray was obtained which showed a left hip fracture. The DON confirmed Resident #116 was transferred to theER on [DATE] at 11:40 A.M. (continued on next page)

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F 0713 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Telephone interview on 01/14/25 at 2:44 P.M. with Registered Nurse (RN) #856 revealed she was at the nursing station on 11/11/24 when she heard the CNA call out for assistance. RN #856 confirmed she had observed Resident #116 lying on her right side by the wheelchair. The CNA indicated the resident attempted to walk out of the wheelchair and had fallen on her right side. RN #856 revealed the resident denied pain, did not have external hip rotation, was able to move her hip and was able to get back into her wheelchair and be toileted. RN #856 denied Resident #116 had any injuries noted and she denied the resident had reported she hit her head at any point. She revealed Resident #116's neurological checks were negative. She stated she called the daughter to report the fall. She stated she went home around 11:00 P.M. and had to come back into the facility for dayshift on 11/12/24. She could not state the exact time she left and returned to the facility. RN #856 revealed when she returned on the morning shift on 11/12/24 she was told in report the resident had reported complaints of pain around 4:00 A.M. to 5:30 A.M. and an X-ray of her hip was obtained. She stated she had assessed Resident #116 early in the morning at an unknown time and the resident was sleeping. She stated she went back into the room a short while later and the resident complained of pain. RN #856 revealed Resident #116's X-ray results came back, and she called the physician with the results of the left hip fracture and obtained an order to send the resident to the emergency room . She stated she called the daughter to let her know of the new orders. Telephone interview on 01/15/25 at 1:54 P.M. with the Administrator in attendance of RN #865 (nightshift nurse on 01/12/24) revealed she had the called the on-call physician when Resident #116 complained of pain and they told her to call the physician back in the morning. She confirmed Resident #116 was sleeping once she was put in bed and medicated for pain. She denied concerns with the resident's care. Interview on 01/15/25 at 2:06 P.M. with the Administrator and the DON indicated the facility attempted to call Resident #116's physician and they on-call agency refused to put the nurse through to the physician. The Administrator stated she felt it was because the on call answering service was not willing to disrupt the physician at night. Interview on 01/15/25 at 2:14 P.M. with the DON indicated the staff would call him if it was a critical emergency and Resident #116 did not have any signs of a broken hip during the night on 01/12/24. He revealed if she would have had any signs such as a rotated hip or screaming in pain, then they would have immediately sent her out to the hospital. He stated the facility staff felt they had called the physician, was told to call back in the morning, the resident was stable and no immediate needs were not addressed. This deficiency represents non-compliance investigated under Complaint Number OH00160374.