

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365574	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/15/2026
NAME OF PROVIDER OR SUPPLIER  Crandall Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on medical record review, review of hospital records, review of a self-reported incident (SRI), and interview, the facility failed to ensure Resident #54 was safely transferred in a mechanical lift to prevent fall with major injury. Actual harm occurred on 12/15/25 at approximately 1:10 P.M. when Resident #54, who was cognitively impaired and dependent on staff to transfer, sustained a fall from a mechanical lift device during a staff assisted transfer that resulted in a subarachnoid hemorrhage (brain bleed), which the hospital physician noted had the potential to be a serious and life-threatening condition. The facility identified the fall occurred as a result of human error as staff did not ensure the loop of the sling was properly secured prior to lifting Resident #54 out of her chair during the transfer. This affected one resident (#54) out of five records reviewed for falls and transfer assistance. The facility census was 110. Findings include: Review of the medical record for Resident #54 revealed an admission date of 10/23/18 with diagnoses including history of falling, Alzheimer's disease, dementia, hypertension, anxiety, major depressive disorder, age-related physical debility, and abnormal posture. Review of the physician's orders for Resident #54 revealed an order dated 11/21/24 for a mechanical lift for all transfers. Review of the activities of daily living (ADL) care plan revised 12/15/25 revealed Resident #54 demonstrated an impaired ability to complete activity of daily living (ADL) activity without assistance due to Alzheimer's dementia, glaucoma, and osteoarthritis. Interventions included, but were not limited to, mechanical lift for all transfers (revised 12/15/25). Review of a fall plan of care revised 12/15/25 revealed Resident #54 was at-risk for falls due to Alzheimer's dementia, overall debility, confusion, impaired safety awareness, impaired mobility, and poor vision. Interventions included, but were not limited to, maintaining a safe environment (revised 12/15/25), monitor, anticipate, and intervene regarding possible factors that may facilitate a fall (revised 12/15/25), notify physician of all falls and injuries (revised 12/15/25), and complete a fall risk assessment on admission, quarterly, and as needed (revised 12/15/25). Review of the facility's incident report dated 12/15/25 at 1:10 P.M. revealed Resident #54 was lying on the floor on her back with her legs and left upper body over the bottom of the mechanical lift device. Resident #54 had visible blood from an open area to the left side of the forehead with an accompanying lump measuring approximately five centimeters (cm) in circumference. The lift device was removed from underneath Resident #54, the wound to the head was cleaned and dressed, and Resident #54 was assisted to bed by three staff (with no indication as to how this transfer from the floor to the bed occurred). Resident #54 also had deep purple coloration to right lateral pointer finger (second digit). Resident #54 was not able to verbalize whether she was in pain but displayed indicators of pain while on the floor. This incident report failed to mention that Resident #54 fell from a mechanical lift device during a staff assisted transfer. Review of the nurse's note</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  365574	Facility ID:  365574  If continuation sheet Page 1 of 4

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>dated 12/15/25 at 3:56 P.M. revealed it was an exact replica of the nurse's summary contained in the incident report dated 12/15/25 at 1:10 P.M. Review of an incident witness statement dated 12/15/25, written by Certified Nursing Assistant (CNA) #500 revealed (during the transfer of Resident #54) the left bottom strap was not secured to the hook and Resident #54 fell to the floor before they could grab her. Review of incident witness statement dated 12/15/25, written by Certified Nursing Assistant (CNA) #501, revealed as they lifted Resident #54 into the air (to transfer), the strap came unclipped and Resident #54 went forward onto the floor. Review of hospital emergency room documentation dated 12/15/25 revealed Resident #54 arrived to the emergency room on [DATE] at 1:59 P.M. due to falling from a mechanical lift device at a nursing home. The emergency department history of present illness note indicated the mechanical lift was at the highest setting when Resident #54's fall occurred. Resident #54 received a computed tomography (CT) scan of the head while at the emergency room on [DATE] and the results indicated a subarachnoid hemorrhage (brain bleed). The hospital physician documented that this injury had the potential to be a serious and life-threatening condition. Resident #54's family elected not to treat Resident #54 in the hospital and the resident was discharged back to the facility on [DATE]. Review of a facility investigation of self-reported incident (SRI) tracking number 268640, created on 12/15/25 at 2:44 P.M., revealed Resident #54 fell from a mechanical lift during a staff assisted transfer. During the transfer, the left bottom loop of the sling came out of the hook on the mechanical lift, resulting in Resident #54 falling to the floor and hitting her head. Resident #54 was sent to the emergency department, where she was diagnosed with a facial laceration to the left side of the head and a brain bleed. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #54 was rarely or never understood and had severely impaired cognitive skills for daily decision making. The assessment revealed Resident #54 was dependent (on staff) for chair/bed-to-chair transfers and had experienced one fall with major injury since the previous assessment. On 01/12/26 at 9:01 A.M., an interview with the Administrator and Assistant Director of Nursing (ADON) #498 revealed the incident that occurred with Resident #54 (on 12/15/25) was just an unfortunate accident. On 01/12/26 at 12:07 P.M., Resident #54 was observed sitting in a wheelchair in the dining room. Resident #54 was not interviewable. On 01/12/26 at 12:13 P.M., an interview with CNA #500 confirmed Resident #54 fell (on 12/15/25) from the mechanical lift during a staff assisted transfer. CNA #500 stated she and another CNA operated the mechanical lift to transfer Resident #54 from a chair to bed. CNA #500 said after they lifted Resident #54 out of the chair, they went to remove the chair from underneath her and CNA #500 noticed the loop of the sling had come off the hook on the lift device. CNA #500 said before they had time to react, Resident #54 face planted on the floor. CNA #500 further stated after the fall, Resident #54 was assisted back to bed by staff members lifting her off the floor without using a mechanical lift device. CNA #500 said the loop of the sling was not properly secured prior to lifting Resident #54 out of her chair. On 01/12/26 at 12:57 P.M., an interview with CNA #501 confirmed Resident #54 fell to the floor (on 12/15/25) and hit her head while staff were performing a transfer with a mechanical lift. CNA #501 stated they lifted Resident #54 up into the air and the lift sling came unhooked from the clip on the mechanical lift. Resident #54 hit her head and had a cut on her head. On 01/12/26 at 1:29 P.M., an interview with Registered Nurse (RN) #504 verified on 12/15/25 Resident #54 was on the floor at the time of her assessment and she had a laceration to the head, which was cleaned and dressed. On 01/12/26 at 1:35 P.M., an interview with Licensed Practical Nurse (LPN) #503 revealed she was passing medications at the time of Resident #54's fall on 12/15/25 and was notified by a manager of the fall that occurred while the resident was being transferred. Resident #54 was assessed and displayed facial grimacing at the</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>time of the fall. However, Resident #54 was non-verbal and unable to verbalize pain. On 01/12/26 at 2:50 P.M., an interview with the Administrator revealed Resident #54's fall on 12/15/25 was an accident due to human error and not any sort of mechanical issue with the lift device. On 01/12/26 at 3:08 P.M., an interview with the Administrator verified Resident #54 had a brain bleed as a result of the fall from the mechanical lift that occurred on 12/15/25. The Administrator stated she did not think the transfer sling came unhooked from the mechanical lift, further clarifying that she thought CNA #501 did not ensure the sling was hooked securely before beginning the transfer. The Administrator said CNA #501 was talking and possibly distracted during the transfer, stating again that Resident #54's fall was an accident due to human error. On 01/12/26 at 4:34 P.M., an interview with the Director of Nursing (DON) revealed Resident #54's fall on 12/15/25 was caused by CNA #501 not double checking the loop was hooked onto the lift device before starting the transfer. Review of the facility's policy titled Procedure for Invacare Lift, dated 07/23/24, revealed two staff were required to operate the lift device and staff were to ensure the sling was hooked to the lift with the hooks facing the outside of the sling or away from the resident. The policy further stated it was the responsibility of the nursing aide to monitor the slings for rips, holes, fraying, or any other concerns with every use. Review of the facility's policy titled Invacare Lift Operating Instructions Policy and Procedure, dated 07/23/24, revealed the lifts were used to aide in the transfer of a resident who was not able to bear weight and a physician's order was required. Review of the facility's policy titled Fall Prevention Policy and Procedure, dated 07/22/24, revealed if a fall occurs, an incident report must be completed by the nurse, the physician and family would be notified in a timely manner, the incident would be discussed during morning report the following day, and interventions would be put in place as indicated. If the recommended intervention involves addressing an employees work performance, this will be referred to the staff development nurse for education or to the ADON for discipline as needed. The deficiency was corrected on 12/17/25 when the facility implemented the following corrective actions: On 12/15/25, Resident #54's physician was notified of the incident and new orders were given to transfer the resident to the hospital. On 12/15/25 by 1:59 P.M., Resident #54 was transferred to the emergency room for further evaluation and treatment. On 12/15/25, the mechanical lift device and transfer sling used at the time of the incident with Resident #54 were inspected by the facility's Maintenance Director and Assistant Director of Nursing for functionality with no concerns identified. On 12/15/25, the Administrator sent a mass text message to 62 Certified Nursing Assistants (CNAs), 29 Licensed Practical Nurses (LPNs), and 17 Registered Nurses (RNs) educating them on the need for two people for mechanical lift transfers and the need to monitor the resident and the equipment throughout the transfer process. On 12/15/25, Staff Educator #499 (who was also a LPN) educated 45 CNAs (out of 60 CNAs total) on the protocol for mechanical lift transfers and required a return demonstration to indicate understanding. The remaining 15 CNAs were educated by phone, have not worked in the facility since the incident, and would be required to perform a return demonstration upon arrival for their next scheduled shift at the facility. On 12/15/25 and 12/16/25, all mechanical lift devices and transfer slings throughout the facility were inspected by the facility's Maintenance Director and Assistant Director of Nursing (ADON) #498 for functionality and disposed of any slings with visible wear and tear. All mechanical lifts were functioning properly. On 12/17/25, Staff Educator #499 educated 27 LPNs (out of 30 LPNs total) and 12 RNs (out of 15 RNs total) on the protocol for mechanical lift transfers and required a return demonstration to indicate understanding. Two of the remaining three LPNs and two of the remaining three RNs were educated by phone, have not worked in the facility since the incident, and will be required to perform a return demonstration upon</p> <p>(continued on next page)</p>		

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