

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365576	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/03/2025
NAME OF PROVIDER OR SUPPLIER Chillicothe Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1058 Columbus St Chillicothe, OH 45601	

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**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 medical record review, staff interview, and policy review, the facility failed to ensure the physician was immediately notified of a resident's change of condition. This affected one (#120) of three residents reviewed for change of condition. The facility census was 70. Findings include: Medical record review for Resident #120 revealed an admission date of 07/17/25 and was discharged on 07/19/25. Diagnoses included coronary artery disease, hydronephrosis, renal insufficiency, anxiety, depression, atrial fibrillation, and cardiomyopathy. Review of the five-day Medicare Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #120 was moderately cognitively impaired, and was partial to moderate assistance for toileting, bed mobility, and for transfers. Review of the progress note dated 07/19/25 at 12:19 A.M. revealed Resident #120 was yelling and the staff entered the room and found her on the floor next to the bed. The resident said she rolled out of the bed. The resident was assessed and had an open hematoma to the right lower leg. There was a knot to the right back of the head and small red area to the right eyebrow. Range of motion was within normal limits, and the resident complained of a headache, which Tylenol was administered, and the pain was relieved. The resident was assisted to get off the floor and was put in a Broda chair and taken out to the nursing station so she could be monitored. She was talking to the staff at the time. The family was called by telephone, the unit manager was notified by a text message, and the physician was notified via fax message. Neurological checks were started, and they were negative. During an interview on 08/28/25 at 11:00 A.M., Physician #200 stated he was not contacted regarding the unwitnessed fall of Resident #120 on 07/18/25. He stated the usual protocol was for the nurse to call to report an injury, including a bump in the back of the head. Physician #200 stated he was unaware of a fax sent from the facility on 07/18/25. During an interview on 08/28/25 at 11:33 A.M., Licensed Practical Nurse, (LPN), #65 revealed on 07/18/25 at approximately 11:15 P.M., Resident 120 was discovered on the floor near her bed. The resident's vital signs were within normal limits, and the resident had a small golf ball sized raised area on the back of her head. The resident had hematoma on her right leg and reddened right eyebrow. The resident was alert, reported no pain and stated she rolled out of bed. LPN #65 stated he faxed the information of the resident's fall, condition change and the initiation of neurological checks to the Physician #200 at approximately 11:30 P.M. He did not receive any return communication from Physician #200. LPN 65 stated he should have called Physician #200 after there had been no return communication. Review of the policy titled Changes in Resident's Condition or Status dated 02/01/21 revealed the facility will promptly notify the resident, his or her attending physician, and the resident's representative of changes in the resident's medical/mental condition. The deficient practice was corrected on 07/19/25 when the facility implemented the following corrective actions: On 07/19/25, the Director of Nursing (DON)/Designee conducted a comprehensive review of all current residents with similar risk profiles to ensure appropriate fall risk assessments were current and fall prevention protocols were in place. The assessment included review of notification procedures for all recent incidents to identify any patterns of communication protocol deviations. No additional concerns were identified during this comprehensive facility-wide evaluation, confirming that this incident represented an isolated occurrence of notification protocol deviation rather than a systemic care issue. Review of the documents revealed this was completed. On 07/19/25, the DON/Designee provided comprehensive re-education to all nursing staff regarding critical communication protocols. Physician Notification Requirements for Fall Incidents: It is essential all nursing staff understand the distinction between routine and urgent physician notification requirements following resident falls. When a fall results in ANY injury, including bruising, swelling, wounds, or head trauma, immediate telephone notification to the attending physician or on-call provider is required. Fax notification alone does not meet the standard for incidents involving injuries, as direct verbal communication allows for immediate clinical guidance and potential order modifications. This requirement ensures timely medical evaluation and intervention when indicated. Emergency Contact Notification Procedures: Staff must attempt to contact ALL listed emergency contacts when notifying families of significant incidents. When the primary contact cannot be reached directly, staff must make reasonable attempts to contact secondary contacts within the same timeframe. This includes calling alternative phone numbers, attempting contact with adult children or other designated contacts. Review of the documents</p>		