STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365577	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prestige Gardens Rehabilitation and Nursing Center	755 South Plum Street Marysville, OH 43040

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, observation, review of facility policy and review of manufacture guidelines, the facility failed to ensure an assessment or evaluation for a reasonable accommodation of need regarding a bed handrail was completed. This affected one resident (#43) out of three residents reviewed for accommodation of needs. The facility census was 63.Findings Include:Review of the medical record for Resident #43 revealed an admission date of 02/24/25. Diagnoses included total retinal detachment of left eye, asthma, chronic ischemic heart disease, and acute on chronic systolic heart failure.Review of the plan of care dated 02/25/25 revealed Resident #43 required a two person assist for transfers. The plan of care also identified the resident had behaviors related to refusals of treatment and preferred the bed in the highest position despite education on risks of injury due to falling. Interventions included educating the resident on risks of keeping the bed in the highest position and encouraging safe mobility.Review of physician orders revealed an order for an air mattress to the bed with monitoring of placement every shift for skin prevention dated 10/20/25.Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition with a Brief Interview for Mental Status score of 13. The resident required assistance for bed mobility, transfers, toileting, dressing, and hygiene and utilized a wheelchair for mobility.Review of the medical record revealed no documented assessment, care plan intervention, or evaluation of the resident's request for handrails to address fear of falling.Observation and interview on 04/27/26 at 2:10 P.M., Resident #43 stated he would like handrails on his bed due to a fear of falling out of bed. He stated staff informed him that state would not allow handrails and reported he had been asking for approximately one year. He stated the facility had not completed an assessment to determine if handrails would be appropriate. An observation during the interview revealed the resident had an air mattress in place and there were no handrails.Interview on 04/27/26 at 2:36 P.M., the Administrator and Director of Nursing (DON) stated that residents with pressure reducing air mattresses automatically did not have handrails due to risk of entrapment. She stated the facility did not complete individual risk assessments for handrails when an air mattress was in use and that the resident's fear of transfers had been known since admission.Interview on 04/27/26 at 3:24 P.M., Administrator stated he was not aware of the resident's fear of falling, despite staff reports indicating prior knowledge. He stated there were no assessments in place to evaluate the appropriateness of handrails and would review the chart for additional information.Interview on 04/28/26 at 9:55 A.M., Administrator stated he spoke with Resident #43 who confirmed the ongoing fear of falling since admission. He stated staff confirmed awareness of the concern and that review of the medical record revealed no documentation of assessment or interventions related to the request for handrails. He further stated that manufacturer guidelines for the air mattress did not prohibit the use of handrails and indicated that use of bedrails should be based on an individualized assessment of the resident's physical and mental status. He stated the guidelines indicated bedrails may be used if needed to prevent fall related injury and if the resident was deemed safer with them. He confirmed that handrails were placed on the resident's bed following surveyor intervention and that a restraint assessment would be completed. He confirmed the resident was independently (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365577	A. Building B. Wing	04/30/2026

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	capable of maneuvering in bed and that handrails would be appropriate.Review of facility policy and manufacturer guidance related to bed safety and the Easy Air mattress revealed that decisions regarding the use of bedrails should be based on an individualized assessment of the resident's physical and mental status.Review of the facility policy titled, Bed Safety revealed that if bedrails are needed to prevent fall related injury, they may be used based on facility assessment and the resident's safety needs. The guidance further indicated that the use of bedrails is not prohibited with the mattress and should be determined by the facility.This deficiency represents non-compliance investigated under Complaint Number 2624876.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, staff interview, and facility policy review, the facility failed to timely assess a resident after a fall and timely document the fall in the residents medical record. This affected one (Resident #14) out of three residents reviewed for falls. The facility census was 63.Findings Include: Review of the medical record for Resident #14 revealed an admission date of 08/23/24. Diagnoses included Huntington's disease, hypothyroidism, constipation, and dementia.Review of the fall risk assessment dated [DATE] revealed the resident was at risk for falls.Review of the plan of care dated 08/26/24 revealed the resident was at risk for falls due to increased need for assistance with bed mobility and transfers, Huntington's disease, overactive bladder, and history of falls. Interventions included ensuring the call light was within reach, use of bolsters to the left side and bottom of the bed, dycem to the wheelchair, ensuring the resident was sitting fully back in the wheelchair prior to transfers, use of a floor mat to the left side of the bed, maintaining a low bed, use of nonskid footwear, supervision while in the bathroom, and staff to remain with the resident while in the bathroom.Observation on 04/28/26 at 2:18 P.M. revealed Resident #14 began to shake and fell out of bed onto a floor mat, onto her back. The bed was in the low position. Staff did not immediately respond until this surveyor alerted staff. Two staff members then assisted the resident back into bed with a two person assist. The resident was not immediately assessed when found on the floor or when she was back in bed, and vital signs were not obtained. Interview on 04/28/26 at 2:58 P.M., Licensed Practical Nurse (LPN) #58 stated that the resident had Huntington's disease and had increased shaking over the past week. He stated he obtained assistance and completed a two person assist to return the resident to bed. He stated that no vital signs were taken immediately after the fall and at the time of the interview, had still not been completed. He stated an as needed (PRN) pain medication was administered after the fall but had been requested prior to the fall. He stated the resident had a care plan related to behaviors and a floor mat and reported that staff typically did not complete a fall assessment if the resident was found on the floor mat next to the bed.Review of Resident #14's nurse's notes on 04/29/26 at 7:38 A.M. revealed no documentation regarding the fall that occurred on 04/28/26.Review of the nurse's notes dated 04/29/26 at 8:40 P.M. revealed the resident was found lying next to the bed and was assessed for injury with no injury noted, range of motion was within normal limits, and the resident denied pain.Interview on 04/28/26 at 3:21 P.M., the Administrator and Regional Nurse #500 stated that the resident frequently got out of bed and this was considered a behavior. They stated that if staff observed the resident getting out of bed, they would not complete a fall assessment or obtain vital signs. They stated that if the fall was unwitnessed, staff should complete a fall assessment, vital signs, and a head to toe assessment. They further stated that if the resident was found on the fall mat, staff would typically not complete a fall assessment even if the fall was not witnessed.Review of facility policy titled Falls - Clinical Protocol, revised September 2012, revealed the facility required staff to assess and document all falls, including obtaining vital signs, assessing for injury, neurological status, pain, and changes in condition. The policy required staff to identify possible causes of the fall within 24 hours, document contributing factors, and implement interventions to prevent recurrence. The policy further required monitoring and follow up after a fall, including ongoing assessment of the resident's condition and response to interventions.This deficiency represents non-compliance investigated under Master Complaint Number 2990783 and Complaint Number 2734881.