

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365581	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/25/2025
NAME OF PROVIDER OR SUPPLIER Ohio Living Breckenridge Village		STREET ADDRESS, CITY, STATE, ZIP CODE 36855 Ridge Rd Willoughby, OH 44094	

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689</p> <p>Level of Harm - 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 record review and interview, the facility failed to conduct a safe resident transfer onto a transportation van to prevent a fall with injury for Resident #63. This affected one resident (#63) of three residents reviewed for falls. The facility census was 64. Actual harm occurred on 09/10/25 when Resident #63 fell forward out of his wheelchair onto the concrete ground while being transferred by staff onto a facility transportation van. This resulted in resident complaints of back pain and multiple skin tears and abrasions to the head, left elbow, and multiple fingers of each hand. The resident was transferred to the hospital and admitted with the presence of an acute re-bleed from a chronic subdural hematoma. Findings include: Review of the medical record for Resident #63 revealed an admission date of 07/16/24. Resident #63 had diagnoses including chronic lymphocytic leukemia of B-cell type, history of a traumatic subdural hemorrhage without loss of consciousness, spondylolysis of the cervical and lumbar region, and a subsequent encounter on 09/13/25 of a trace acute re-bleed of a subdural hemorrhage. Review of the John Hopkins Fall Risk Assessment Tool completed 02/10/25 revealed Resident #63 was at low fall risk. Review of the care plans revealed Resident #63 had the potential for functional status deficit related to a recent hospital stay for traumatic subdural hemorrhage without loss of consciousness, subsequent encounter started 07/17/24. Interventions initiated on 07/17/24 included keep bed in lowest position with brakes locked, keep environment free from clutter, keep personal items and frequently used items within reach, keep call light in reach at all times, respond to call light promptly and provide toileting assistance every two to three hours and as needed. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition. The assessment revealed Resident #63 was dependent on staff for toileting, dressing, transfers, and locomotion in a manual wheelchair. Review of a nurse's note dated 09/10/25 at 2:15 P.M. revealed Resident #63 was sitting in a wheelchair being transported by a facility van to a dental appointment in the accompaniment of his daughter. As transportation staff tried to pull Resident #63 in the wheelchair up onto the van's ramp with the resident facing outward away from the van, Resident #63 fell forward out of the wheelchair onto the concrete. Skin tears and abrasions were noted on the back of the resident's head, left elbow, and multiple fingers on each hand. The resident complained of back pain. The note indicated all paperwork was sent with the Emergency Medical Technicians (EMT's). Review of a facility fall investigation dated 09/10/25 revealed Resident #63 experienced a fall with injury while being transported by facility transportation into a transport van via a wheelchair using the van's side entry inclined wheelchair ramp. The van driver was unable to push the resident in the wheelchair up the ramp facing toward the van, so the driver turned the resident around and attempted to pull the resident backward up onto the inclined wheelchair ramp from behind. When this action was taken, the resident fell forward out of the wheelchair onto the ground. The daughter yelled out audibly when the event occurred which alerted surrounding staff. Immediately nursing and therapy staff responded to the scene. Resident #63 was found on the ground lying on his left side in front of the facility with an empty wheelchair behind the resident. The wheelchair accessible van was present with the side door open, and the inclined ramp was down. Only the resident, Resident #63's daughter and the transportation driver were at the scene when first responders arrived. Immediate assessment of the resident resulted in Resident #63's complaints of back pain and first aid was provided to areas of skin impairment. Emergency Medical Services (EMS) quickly arrived on the scene and took over care. The resident was transferred onto a gurney by EMTs and taken to the hospital. The hospital completed multiple computerized tomography (CT) scans which confirmed Resident #63's history of a chronic subdural hematoma and the presence of an acute re-bleed. Additional review of the fall investigation dated 09/10/25 revealed staff witness statements, first-hand account by the Director of Nursing (DON) and verbal witness reports from the resident and his daughter were utilized for investigation and root cause analysis. Follow-up intervention and information included the van driver was immediately removed from the transport assignment. Statements were collected from witnesses. The van driver's past completed education was reviewed. Thereafter, the van driver and all other facility drivers were provided with new education on safe wheelchair transport. Upon Resident #63's return from the hospital, PT and OT were ordered for evaluation and treatment for safe transport. Therapy recommended to only use the bus for wheelchair transport needs and no longer use the wheelchair accessible van with the</p>		