

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

Printed: 07/18/2026  
Form Approved OMB  
No. 0938-0391

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>365626                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                     | (X3) DATE SURVEY<br>COMPLETED<br><br>01/15/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Bellbrook Health and Rehab                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1957 North Lakeman Drive<br>Bellbrook, OH 45305 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                              |                                                 |
| F 0921<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Many                        | <p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>Based on observation, staff interview, and review of facility policy, the facility failed to ensure areas of the facility were in good repair. This had the potential to affect all 34 residents residing in the facility. Findings include: Observation of the facility's outdoor courtyard on 01/13/26 at 11:59 A.M. revealed a square raised planter box that was filled with soil had a corner that was broken and coming apart. The broken corner had exposed rusty nails. A small inoperable portable heater was on the concrete next to the planter box. A wooden fence enclosing the courtyard was loose and was falling toward the courtyard. A bag of sand was holding a section of the fence up. A wooden picnic table was covered in peeling paint, and the wood appeared to be deteriorating. Interview and observation with the Administrator on 01/14/26 at 9:03 A.M. confirmed the courtyard had a planter box that was broken, coming apart and had exposed rusty nails, there was portable heater sitting in the courtyard, and the wooden fence was loose and falling toward the courtyard. The Administrator confirmed residents have access to the courtyard. Review of the facility's policy titled Homelike Environment dated February 2021 revealed the facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflects a personalized, homelike setting. These characteristics include a clean, sanitary and orderly environment. This deficiency represents non-compliance investigated under Complaint Numbers 2566940 and 2581568.</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

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| <p>F 0761</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Some</p>                | <p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, interviews, record review, and policy review. the facility failed to secure and store medications appropriately. This affected one of two medication carts observed and the facility identified there were four medication carts. This affected Resident #11 and had the potential to affect 13 residents whose medications were stored in the 300-hall medication cart. The facility census was 34. Findings include:</p> <p>1. Observation on 01/12/26 from 10:39 A.M. to 10:45 A.M. revealed Licensed Practical Nurse (LPN) #141 walked away from medication cart for the 300-hall and rounded the 200-hall corner, and the medication cart was unlocked. The medication cart was not in sight of LPN #141.</p> <p>Interview on 01/12/26 at 10:45 A.M. with LPN #141 confirmed the medication cart was unlocked when he walked away and out of sight.</p> <p>Observation and interview on 01/13/26 at 10:49 A.M. of the medication cart for the 300-hall with LPN #152 revealed the following findings: There were five white pills out of packing in the second drawer. The third drawer had a pink sticky substance in middle part of the drawer and eight bottles of medications had the pinky substance on them. There were two single pills, one beige and one white pill, out of packaging in the third drawer. There was one capsule out of packaging in the bottom drawer.</p> <p>2. Review of medical record for Resident #11 revealed admission date of 08/23/22. Diagnoses included dementia without behaviors. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident had impaired cognition.</p> <p>Observation on 01/12/26 at 10:55 A.M. in Resident #11's room revealed he was laying in bed with his bedside table on his left side. There was a medication cup present on the bedside table within his reach.</p> <p>Interview and observation on 01/12/26 at 10:59 A.M. with Regional Clinical Nurse (RCN) #174 verified there was unattended medication on the bedside table in Resident #11's room. RCN #174 picked up the medication cup and asked Resident #11 about them. Resident #11 informed her the nurse had left the medication on the bedside table earlier in the morning. RCN #174 verified there were six pills in the medication cup and removed them from the room.</p> <p>Review of the policy titled Medication Labeling and Storage dated 2001 revealed the facility stores all medications and biologicals in locked compartments under proper temperatures, humidity and light controls. Medications and biologicals are stored in the packaging, containers, or other dispensing systems in which they are received. Compartments containing medications and biologicals are locked when not in use. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner.</p> |                                                                                              |                                                 |

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| F 0812<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Some                        | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observations, staff interviews and facility policy review, the facility failed to ensure frozen foods were stored at appropriate temperatures. This has the ability to affect all residents except 11 residents (#1, #2, #3, #4, #6, #7, #19, #21, #23, #27, and #43) who did not receive food from the kitchen. The facility census was 34. Finding include: Interview and observations on 01/12/26 from 8:50 A.M. to 8:52 A.M. with Dietary Manager (DM) #127 revealed the kitchen's freezer had quit working the previous afternoon. He shared a repair company was called and the part which went out was under warranty and a new one was ordered. He acknowledged the food remained in the freezer and he stated the plan was to keep the food in the freezer with the door closed to help maintain temperature. The walk-in freezer's temperature was 28 degrees Fahrenheit and there was food stored in boxes on the shelves which included hamburger patties, bulk, french fries and vegetables which were in various states of thawing. DM #127 verified the food in the freezer was no longer frozen. The facility identified Residents #1, #2, #3, #4, #6, #7, #19, #21, #23, #27, and #43 had physician orders to be nothing by mouth. Review of the facility policy titled Food and Storage dated 2001 revealed frozen foods are maintained to keep the food frozen solid. |                                                                                              |                                                 |

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| <p>F 0576</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>Ensure residents have reasonable access to and privacy in their use of communication methods.</p> <p>Based on observation, resident and staff interviews, record review and policy review, the facility failed to provide residents privacy for telephone calls. This affected one (Resident #50) of 17 residents reviewed for telephone calls. The facility census was 34. Findings include: Review of the medical record for Resident #50 revealed an admission date of 01/08/26. Diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, anxiety disorder, post-traumatic stress disorder, and depression. The admission Data Collection form dated 01/09/26 revealed Resident #50 was alert and oriented times four. Observation and interview on 01/12/26 at 10:57 A.M. revealed Resident #50 was at the 300-Hall nursing station. Resident #50 was utilizing a walker, using the desk telephone for personal call with multiple residents in the hallway. Business Office Manager (BOM) #102 stated the residents were usually given the cordless telephone from the front desk but Resident #50 was using the regular desk telephone at this time. Observation and interview on 01/13/26 at 10:22 A.M. with Licensed Practical Nurse (LPN) #152 revealed Resident #50 came up to the 300-Hall nursing station desk and asked if she could call her father. LPN #152 then handed her the desk telephone. LPN #152 stated that was the only telephone Resident #50 has to use; there was no private telephone. Resident #50 was talking on the telephone with another resident sitting in a wheelchair at the desk, directly next to her while she was talking on the telephone. Interview on 01/13/26 at 2:42 P.M. with Resident #50 confirmed she does not get offered any private area or private telephone when she would like to make a personal call and was given the desk phone at the nursing station. Resident #50 confirmed she would prefer a private area for her personal telephone calls. Interview on 01/14/26 at 1:35 P.M. with Registered Nurse (RN) #165 stated the cordless telephone at the main nursing station was used for residents to make private calls. RN #165 verified the telephone does not work on the 300-hall. Interview on 01/14/25 at 1:35 P.M. with Maintenance Director (MD) #128 stated the cordless telephone does not work on the 300-hall. Review of the admission packet dated 2020 revealed the resident has the right to have reasonable access to the use of a telephone, and a place in the facility where calls can be made without being overheard.</p> |                                                                                              |                                                 |

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| <p>F 0580</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on staff interview, policy review and record review, the facility failed to notify the provider and resident representative of a resident's change in condition. This affected one (Resident #9) of one resident reviewed for notification of change. The facility census was 34. Findings include: Review of the medical record for Resident #9 revealed an admission date of 10/19/22. Diagnoses included epilepsy. The Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #9 had moderately impaired cognition. The care plan, last revised on 10/17/25, revealed Resident #9 had impaired neurological status related to seizure disorder. Interventions included to monitor and report any seizure activity, monitor environment if involuntary muscle movements place the resident at risk for injury, monitor for need of padding to side rails or wheelchairs, monitor vital signs as needed, and report abnormal to physician. Review of Resident #9's progress notes dated 01/07/25 to 01/14/25 revealed no documentation of Resident #9 having a seizure or notification to the resident representative or provider of Resident #9 having a seizure. Interview on 01/13/26 at 7:05 A.M. with Licensed Practical Nurse (LPN) #149 stated Resident #9 had a seizure last night (01/12/26) around the start of his shift. LPN #149 confirmed the oxygen was being administered to Resident #9 at two and a half liters. LPN #149 stated Resident #9 doesn't need the oxygen, he only put it on due to Resident #9 seizing last night. Interview on 01/14/26 at 7:29 A.M. with the Director of Nursing (DON) confirmed no documentation in Resident #9's record of seizure that happened on 01/12/26 and no documentation of notification to provider or resident representative. The DON also confirmed no order for oxygen in Resident #9's record. Interview on 01/14/26 at 8:11 A.M. with LPN #149 stated Resident #9's seizure from 01/12/26 lasted about five minutes. When Resident #9 was lying on his back, he was having difficulty breathing, then gave Resident #9's order for scheduled Keppra (anti-seizure medication). LPN #149 applied oxygen when Resident #9 started to have the seizure, LPN #149 said the other LPN (#141) got an order from the provider for oxygen while he was in the room. Interview on 01/14/26 at 1:15 P.M. with Nurse Practitioner (NP) #178 confirmed she was not notified of Resident #9 having a seizure on 01/12/26 until this morning (01/14/26). NP #178 stated if she was made aware of Resident #9's seizure on 01/12/26, they would have ordered for labs to be drawn. Interview on 01/14/26 at 10:05 AM with LPN #141 revealed Resident #9 had a seizure on 01/12/26 that lasted about five to ten minutes. LPN #141 confirmed he did not notify the provider, and did not speak to the provider about the oxygen. Review of the policy titled Acute Condition Changes Clinical Protocol, dated 03/2018, revealed the nursing staff will contact the physician based on the urgency of the situation. The staff and physician will discuss possible causes of the condition change based on factors including resident history, current symptoms, medication regimen, and diagnostic test results. If necessary, the physician will order diagnostic tests and evaluate the patient directly.</p> |                                                                                              |                                                 |

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| <p>F 0657</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review, resident and staff interviews, and policy review, the facility failed to ensure resident care conferences occurred quarterly with the Interdisciplinary Team and the resident and/or resident representative. This affected three (#8, #9, and #34) of three residents reviewed for care conferences. The facility census was 34. Findings include: 1. Review of the medical record for Resident #34 revealed an admission date of 04/01/14. Diagnoses included diffuse traumatic brain injury, disease of digestive system, diabetes mellitus, dysphagia, and major depressive disorder. The Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #34 had severe cognitive impairment. The care plan revealed Resident #24 was a long term resident with no plans to discharge at this time. Interventions included to review with resident at least quarterly for any changes in discharge planning needs. Review of Resident #34's medical record revealed Resident #34 had one care conference held in the year of 2025, which was on 07/17/25. There were no care conferences held the first (01/2025 to 03/2025), second (04/2025 to 06/2025), and fourth quarter (10/2025 to 12/2025) of 2025. Interview on 01/13/26 at 7:16 A.M. with MDS Coordinator #155 confirmed Resident #34 had only one coare conference on 07/17/25 for the year of 2025. There were no care conferences held for Resident #34 for the first, second, and fourth quarter of 2025. 2. Review of the medical record for Resident #9 revealed an admission date of 10/19/22. Diagnoses included epilepsy, cerebral infarction, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, and major depressive disorder. The Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #9 was cognitively intact. Review of Resident #9's medical record revealed there was no third quarter 2025 (07/2025 to 09/2025) care conference for Resident #9. Interview on 01/12/26 at 9:44 A.M. with Resident #9 revealed he could not remember any care conferences he attended or was asked to attend. Interview on 01/13/26 at 7:16 A.M. with MDS Coordinator #155 confirmed no care conference was completed for Resident #9 in the third quarter of 2025. 3. Review of the medical record for Resident #8 revealed an admission date of 11/03/24. Diagnoses included chronic obstructive pulmonary disease, nonrheumatic aortic stenosis and chronic atrial fibrillation. The MDS 3.0 assessment dated [DATE] revealed Resident #8 had moderately impaired cognition. The care plan revealed Resident #8 was a long term resident with no plans to discharge. Interventions included to review with resident at least quarterly for any changes in discharge planning needs. Review of Resident #8's medical record revealed there was no first quarter (01/2025 to 03/2025) care conference for 2025. Interview on 01/13/2026 at 7:16 A.M. with MDS Coordinator #155 confirmed no care conference was completed for Resident #8 for the first quarter of 2025. Review of the facility's admission packet dated 2020 revealed the resident right to participate in the development and implementation of his or her person centered plan of care. Review of the policy titled Resident Participation Assessment Care Plans dated 2001 revealed the resident and his or her representative are encouraged to participate in the resident's assessment and in the development and implementation of the resident's care plan.</p> |                                                                                              |                                                 |

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

Printed: 07/18/2026  
Form Approved OMB  
No. 0938-0391

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| <p>F 0677</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review, observations, policy review, and staff and resident interviews, the facility failed to ensure a resident who was dependent on staff for personal hygiene and bathing received adequate assistance with nail care. This affected one (#11) of 12 residents reviewed for activities of daily living (ADL). The facility census was 34. Findings include: Review of the medical record for Resident #11 revealed admission date of 08/23/22. The resident was admitted with diagnoses including stroke, dementia without behaviors, type two diabetes mellitus, depression, anxiety and polyneuropathy. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #11 was cognitively impaired. Resident #11 was dependent upon staff for personal hygiene and toileting. Review of the care plan revealed Resident #11 had a physical functioning deficit with interventions which included nail care as needed. Observation and interview on 01/12/26 at 11:01 A.M. revealed Resident #11's fingernails had extended approximately one eighth of an inch beyond his fingertips. His nails were observed to be encrusted with a dark brown substance. Resident #11 stated staff had not offered to clean and trim his nails and acknowledged he would like assistance with nail care. Observation and interview on 01/13/26 at 11:36 A.M. with Certified Nurse Assistant (CNA) #118 verified Resident #11's fingernails were long and dirty. She stated another CNA had told her she would take care of his nails. She added she would clean them and inform the nurse Resident #11's nails needed cut, explaining Resident #11 was diabetic and CNAs were unable to cut the nails of residents who were diabetic. Interview on 01/13/26 at 12:25 P.M. with Licensed Practical Nurse (LPN) #152 stated it was the expectation the CNAs to clean and trim a resident's nails during showers and/or bed baths. LPN #152 explained the residents who were diabetic, it would be the responsibility of the nurse or podiatrist to ensure they were trimmed. Observation on 01/14/26 at 8:34 A.M. revealed Resident #11's fingernails were clean, however; they remained uncut. Interview on 01/14/26 at 8:34 A.M. with the Director of Nursing (DON) revealed the DON was informed Resident #11's request for nail care. Review of the progress note dated 01/14/26 at 9:58 A.M. revealed Resident #11's fingernails were cut per his request, hands were washed with soap and water, rinsed and dried. Review of the facility policy titled Activities of Daily Living (ADLs) dated 2001 documented residents who were unable to carry out ADLs independently would receive appropriate support and assistance with hygiene (bathing dressing, grooming and oral care). This deficiency represents non-compliance investigated under Complaint Numbers 2573072 and 2703714.</p> |                                                                                              |                                                 |

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| <p>F 0684</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review and staff interviews, the facility failed to ensure a resident received adequate care and treatment for intravenous line placements, skin assessments, and a wound vac. This affected one (Resident #46) of five residents reviewed for hospitalization. The facility census was 34. Findings include: Review of Resident #46's medical record revealed an admission date of 08/05/25 with diagnoses including acute respiratory failure with hypoxia, anxiety disorder, tracheostomy status, and depression. The Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #46 had moderately impaired cognition, and dependent on staff with toileting and bathing. Resident #46 discharged from the facility on 08/12/25. Review of Resident #46's assessments from 08/05/25 to 08/12/25 revealed there were no wound or skin assessments completed upon admission or after. Review of Resident #46's physician orders dated 08/05/25 revealed wound vac to abdomen at 100 millimeters of mercury (mmHg) suction to be changed every Monday, Wednesday and Friday dayshift. The care plan dated 08/06/25 revealed wound vac to abdomen as per orders with settings as per orders. Resident #46 had an intravenous dressing and interventions included observe dressing, change dressing and record observations of site per physician orders. The progress note dated 08/07/25 at 2:24 P.M. revealed the wound vac applied to Resident #46's abdomen. Review of the Treatment Administration Record (TAR) revealed wound vac was applied on 08/07/25, and there were no further wound vac changes done. Physician orders revealed the wound vac should have been changed on Friday 08/08/25 and Monday 08/11/25. Review of Resident #46's progress notes dated 08/06/25 revealed Resident #46's intravenous (IV) pump continued to alarm when attempting to infuse via the peripheral line to the resident's right shoulder. The writer attempted to use the peripheral to the residents' left hand, and when attempting to flush, the resident stated that it was painful. Also noted some erythema to the area beneath the transparent dressing, so this access was removed. The Nurse Practitioner (NP) was notified. Peripheral IV to resident's left shoulder was flushed with no issues and the IV medications were continued via this access with no further issues noted. The NP note dated 08/08/25 revealed Resident #46 had three peripheral intravenous lines: a 20-gauge in the left wrist, a 20-gauge in the left shoulder, and a 18-gauge int he right forearm. The progress notes and TAR from 08/06/25 to 08/12/25 revealed no intravenous site care and monitoring of the access sites. Interviews on 01/14/26 at 10:25 A.M. with the Director of Nursing (DON) confirmed Resident #46 did not get skin/wound assessment done on admission through discharge. On 01/15/26 at 10:12 A.M., the DON confirmed Resident #46 had no wound vac changes done from 08/07/25 until discharge on [DATE]. The DON confirmed Resident #46 had no intravenous site care done from admission on [DATE] until discharge on [DATE]. This deficiency represents non-compliance investigated under Complaint Numbers 2589893 and OH00164513 (1367213).</p> |                                                                                              |                                                 |

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| <p>F 0689</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</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> Based on observations, resident and staff interviews, record review, and policy review, the facility failed to ensure fall interventions were in place for a resident who had a history of falling. This affected one (Resident #9) of two residents reviewed for accidents. The facility census was 34. Findings include: Review of the medical record for Resident #9 revealed an admission date of 10/19/22. Diagnoses included epilepsy, cerebral infarction, and hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. The Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #9 had moderately impaired cognition and was dependent on staff for toileting, bathing, and personal hygiene. The care plan dated 11/07/23 revealed Resident #9 was at risk for falls related to impaired mobility. Interventions included bilateral fall mats to floor on each side of bed, call light in reach at all times when in bed, educate/remind to use call light prior to transfer, encourage resident to use call light for assistance for toileting needs, ensure personal items are within reach at all times, and sign hung at eye level to remind to use call light for assistance with toileting. The progress note dated 10/03/25 revealed Resident #9 had a fall. Review of Resident #9's fall investigation revealed an intervention of bilateral fall mats to each side of bed. Observation of Resident #9's room on 01/12/26 at 9:43 A.M. revealed Resident #9 was lying in bed and there were no fall mats on the floor. The fall mat was leaning against the wall near his bed. Observation on 01/12/26 at 12:01 P.M. revealed Resident #9 was lying in his bed with his eyes closed. There were no fall mats on the floor. Observation on 01/12/26 at 1:02 P.M. revealed Resident #9 was lying in bed and there was one fall mat on the floor on the right side only. Observation and interview on 01/12/26 at 1:17 P.M. with Resident #9 revealed he needed help with his adult briefs and the call light was not within his reach. The call light was lying on the floor of Resident #9's room next to the bed. On 01/12/26 at 1:22 P.M., Certified Nursing Assistant (CNA) #104 confirmed Resident #9's call light was not within reach. Observation and interview on 01/12/26 at 2:24 P.M. revealed Resident #9 was lying in bed and the fall mat was leaning on the wall and not on the floor next to his bed. CNA #104 confirmed Resident #9 was lying in bed and his fall mat was next to the wall and not on the floor beside Resident #9's bed. Observations on 01/13/26 at 7:50 A.M. and 10:24 A.M. revealed Resident #9 was lying in bed and there was one fall mat on the floor on the right side only. Review of the policy titled Call System, Residents dated 09/2022 revealed each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting, bathing facilities and from the floor. Review of the policy titled Falls and Fall Risk Managing dated 2001 revealed the staff will implement a resident centered fall prevention plan to reduce the specific risk factor of falls for each resident at risk or with a history of falls. This deficiency represents non-compliance investigated under Complaint Number 2703714.</p> |                                                                                              |                                                 |

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| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                              |                                                 |
| <p>F 0842</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>Based on record review, staff interviews, and observations, the facility failed to maintain an accurate medical record. This affected one resident (Resident #12) of 13 residents reviewed for accuracy of medical records. The facility census was 34. Findings include: Review of the medical record for Resident #12 revealed an admission date of 05/09/25. Review of a progress note dated 12/08/25 revealed the interdisciplinary team (IDT) met on that date to discuss an incident that occurred involving Resident #12 on 11/10/25. The team determined the resident had poor safety awareness and he was unaware of his transfer limitations. There were no progress notes in the chart on or around 11/10/25 describing the incident. Review of the active physician orders for 01/12/26 revealed a physician order dated 11/12/25 for a fall mat was to be placed to the left side of the Resident #12's bed when he is in bed, and its placement should be verified every day on each shift. Review of the treatment administration record (TAR) for November 2025, December 2025, and January 2026 revealed nursing staff documented the fall mat was in place at bedside for all shifts. On 01/14/26, Registered Nurse (RN) #165 signed the record confirming the fall mat was placed at Resident #12's bedside. Observations on 01/12/26 at 10:28 A.M. and 01/14/26 at 8:44 A.M. and 11:15 A.M. of Resident #12's room revealed there was no fall mat on either side of his bed while Resident #12 was lying in bed. Interview on 01/14/26 at 11:34 A.M. with RN #165 confirmed there was no fall mat placed at Resident #12's bedside. RN #165 then obtained a fall mat and placed it at the resident's bedside. Interview on 01/14/26 at 1:00 P.M. with the Director of Nursing (DON) revealed the IDT team met on 12/15/25 and determined that the fall mat was no longer an appropriate intervention and confirmed the order should have been discontinued on 12/15/25. Interview on 01/14/26 at 2:50 P.M. with Regional Clinical Nurse (RCN) #174 clarified the incident that occurred on 11/10/25 was a fall. RCN #174 confirmed a new order was received from the facility nurse practitioner for a fall mat to be placed to the left side of Resident #12's bed as an intervention to reduce the likelihood of injury from falls. RCN #174 confirmed the intervention was removed following the IDT meeting on 12/15/25 but the order remained active.</p> |                                                                                              |                                                 |