STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365685	A. Building B. Wing	09/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
O'Neill Healthcare North Ridgeville	38600 Center Ridge Rd North Ridgeville, OH 44039

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 - 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. (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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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of incident log, review of witness statements, and staff interviews, the facility failed to properly transfer a resident which caused an injury. This affected one (#69) of the three residents reviewed for transfers. The census was 128.Findings Include: Review of the medical record for Resident #69 revealed an admission date of 07/16/24. Diagnoses included Parkinson's Disease, dementia, muscle weakness and brain stem stroke syndrome.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #69 was cognitively impaired. The resident required substantial to maximum assistance for bed-to-chair transfers.Review of weekly skin checks dated 01/08/25 and 01/15/25, revealed no new skin issues identified.Review of the incident log revealed Resident #69 had a skin tear incident on 01/18/25 at 9:15 P.M.Review of a witness statement dated 01/18/25 and authored by former Certified Nursing Assistant (CNA) #700, revealed she used the sit-to-stand on Resident #69 and when they placed the resident on the side of the bed, the resident complained of leg pain. When former CNA #700 looked down, the resident was bleeding and so got the nurse.Review of a witness statement dated 01/18/25 and authored by CNA #750, revealed they went to put Resident #69 in bed and do a check and change. CNA #750 asked CNA #700 for assistance with the sit-to-stand lift. Resident #69 complained of pain in her left leg. CNA #750 lifted the resident's pant leg and saw blood on the resident's pants and there was a cut. She notified the nurse.Review of an undated witness statement by the former Director of Nursing (DON), now Regional Director of Clinical Services (RDCO) #600, revealed Resident #69's husband requested a meeting to review the laceration from 01/18/25. RDCO #600 met with the resident's husband, daughter and son. They reviewed the positioning of the wheelchair, the mechanical (sit-to-stand) lift and the environment with them. They discussed edema to her legs and potential for injury related to the mechanical lift leading to the laceration on the outer aspect of her leg. The resident had reported she felt pressure on her leg during the transfer and when the CNA went to reposition her leg in the bed, there was blood on her hand, and she notified the nurse. After reviewing the incident, it was determined the laceration occurred during the transfer. The resident was changed from a sit-to-stand mechanical lift to a Hoyer mechanical lift to prevent further injury.Review of nurse's progress note recorded as a late entry on 01/19/25 at 5:02 A.M., revealed Resident #69 returned from the emergency room (ER) at 1:45 A.M. with diagnoses of laceration with 14 sutures. The resident's leg was wrapped with non-adherent dressing, kerlix and an ace wrap. The resident also returned with Hibclens cleaning solution and an order for bacitracin ointment (over the county antibiotic ointment). The resident's leg was elevated. There were no correlating progress notes documented about the incident which led to the ER visit and the resident receiving the 14 sutures. Review of a physician order dated 01/19/25 for Resident #69, revealed the resident was ordered to have right lower leg sutures covered with Bacitracin external ointment 500 unit/grams (gm) every shift for laceration/wound for five days and monitor for infection. The order was discontinued 01/24/25. Review of the physician progress note dated 01/19/25 and authored by the Physician #500, revealed Resident #69 was assessed with a laceration on the leg. Physician #500 documented the staff notified him the prior day, but they did not know how the laceration happened. A photograph of the laceration was sent to him, and he thought it needed to be repaired. Resident #69 was sent to the ER where sutures were applied. The resident was assessed with leg swelling; skin was warm and dry with laceration and a wound present.Review of a nurse's progress noted dated 01/20/25 at 5:13 A.M. for Resident #69, revealed the nurse spoke with Resident #69's husband about the incident on 01/18/25 resulting in a laceration to right lower leg, the origin of the laceration, the education that was provided to staff to prevent further injury and the treatment being provided. Review of physician orders dated 01/20/25 for Resident #69, revealed the resident's bed frame was to be padded for safety, Tubi grips (elasticated tubular bandages to help with swelling/edema) were to be in place and wheelchair legs were to be removed prior to transfers. Review of physician orders dated 01/22/25 for Resident #69, revealed the resident was ordered to have the right lower leg cleansed with Hibiclens solution, bacitracin applied to the wound, covered with abdomen (ABD) pad, wrapped with Kerlix daily and monitor for signs and symptoms of infection. The order was discontinued on 02/02/25. Review of the facility's Concern Log dated 01/22/22, revealed Resident #69's family was concerned with the resident's transfer status which resulted in a skin tear. The resolution included therapy evaluating the resident's transfer status and transfer status changed to a Hoyer transfer. The wheelchair leg and bedframe were padded, and nursing staff competency was completed. The comments