STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365695	A. Building B. Wing	08/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Doylestown Health Care Center	95 Black Drive Doylestown, OH 44230

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 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed record review, interview, review of a facility Self-Reported Incident (SRI) and associated investigation, review of a corrective discipline record and policy review, the facility failed to ensure Resident #68 received timely comprehensive assessment and intervention following a fall with injury. Actual Harm occurred on [DATE] when Resident #68, who was assessed as severely cognitive impaired and at high risk of falls, sustained a fall and was not properly assessed after the fall. Following the fall, the resident experienced pain rated a 10 on a pain scale of 1 to 10 with 10 being the most severe pain and was assessed to have non-verbal indicator of pain including screaming, crying, agitation, combativeness and groaning. On [DATE] (five days after the fall) an x-ray revealed a right hip fracture which the facility correlated to the fall on [DATE]. This affected one resident (#68) of three residents reviewed for falls. The census was 66. Findings include: Review of the closed medical record for Resident #68 revealed an admission date of [DATE] with diagnoses of vascular dementia with other behavioral disturbances, Alzheimer's disease, paroxysmal atrial fibrillation, restlessness and agitation, anxiety disorder, severe dementia with agitation, and repeated falls. Resident #68 expired at the facility on [DATE]. Review of the Minimum Data Set (MDS) 3.0 significant change assessment dated [DATE] revealed Resident #68 was severely cognitive impaired, had other behavioral symptoms recorded on one to three days during the assessment, utilized a walker and wheelchair, and required partial/moderate assistance with bed mobility and transfers. Resident #68 was ordered hospice services. Review of the fall care plan dated [DATE] revealed Resident #68 was high risk for falls related to confusion, deconditioning, gait and balance problems, incontinence, and lack of awareness of safety needs. Interventions included educating the resident, family, and caregivers about safety reminders and what to do if a fall occurred and to follow the facility fall protocol. Review of the Fall Risk assessment dated [DATE] revealed Resident #68 was disoriented at all times, had a history of falls, attempted to stand from chair and used a wheelchair. Review of a late-entry health status note created on [DATE] at 8:23 P.M. for an effective date of [DATE] at 11:00 P.M. authored by Licensed Practical Nurse (LPN) #74 revealed an alarm was sounding in Resident #68's room. Upon observation, the nurse noted the resident sitting on the floor beside the bed on the mat. Resident #68's bed was in the low position with the bed pad still under her, and it looked as if she slid out of bed. The note included Resident #68 had no injuries and no complaints of pain at the time of incident. Resident #68 was put back to bed and she rested without distress. The note further stated the resident had been changed and repositioned throughout the night and had no complaints of discomfort. There was no evidence that Resident #68's vital signs or neurological checks were obtained, range of motion was assessed, or the physician, hospice, or resident's family was notified of the fall. Review of the health status note dated [DATE] timed 12:44 P.M. authored by the Director of Nursing (DON) revealed Resident #68 was seen by Physician #84. The note stated there were no new orders. Review of the orders-administration note dated [DATE] timed 7:20 P.M. revealed Resident #68 was administered a dose of Hydromorphone (a narcotic pain medication) one (1) mg by mouth as needed for pain/dyspnea. The note referenced Resident #68 complained of bilateral knee pain. Review of the [DATE] Medication Administration Review (MAR) for Resident #68 revealed the resident reported a pain level of eight out of 10 on the pain scale when administered as needed Hydromorphone 1 mg on [DATE] at 7:20 P.M. Review of the health status note dated [DATE] timed 7:24 P.M. revealed Resident #68 complained of bilateral knee pain. However, there was no visible sign of edema, redness, or discoloration. Scheduled pain medications given and as needed dose given. Review of the orders-administration note dated [DATE] timed 12:14 A.M. revealed Resident #68 was administered Ativan oral 0.5 mg tablet by mouth for anxiety/agitation. Resident #68 was lying in bed yelling for momma. The note indicated one-to-one, television, snacks had been provided. Resident #68 was checked and changed for incontinent care, and the resident refused to go to the restroom. With interventions, resident began becoming tearful. The note additionally referenced music was also attempted, and all interventions were without positive effect. Review of the health status note dated [DATE] timed 6:09 A.M. revealed vital signs of blood pressure 108/58, pulse 60, and respirations 16, temperature 98.4 degrees Fahrenheit (F) and 95% pulse oxygen saturation on room air. Resident #68 was alert and oriented to person only. She was confused to time, place and situation. Resident #68 refused to leave her clothes or brief on. When staff verbalized step-by-step what they were going to do, the resident became combative and kicked at staff with both legs. Resident #68 was provided reassurance with positive

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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)

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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 observation, record review, facility policy review and interview, the facility failed to implement fall interventions, as determined necessary by the comprehensive care plan for Resident #13. This affected one resident (#13) of three residents revealed for falls. The census was 66. Findings Include: Review of the medical record for Resident #13 revealed an admission date of 09/24/24 with diagnoses of history of falling, atrial fibrillation, anxiety disorder, moderate dementia with agitation, difficulty walking, lack of coordination, cognitive communication deficit, multiple fractures of ribs, intracapsular fracture of right femur, and fracture of facial bones. Resident #13 resided on the secured, memory care unit. Review of a health status note dated 06/23/25 timed 10:44 A.M. revealed Resident #13 was heard yelling for help, this time resident was sitting on floor with legs bent, knees bent in front of her, and back leaning against side of bed. Resident #13 had no injuries. Resident #13 denied any new pain. The resident was assessed and assisted off floor with gait belt and two assist. Resident #13 was transferred to the wheelchair with an alarm and brought into the dining room with staff observation. The DON, nurse practitioner, and the resident's family were notified. Review of the health status note dated 06/23/25 timed 3:05 P.M. revealed an intervention blue mat to left side of bed and Dycem (a non-slip material) was ordered to be placed at the edge of the bed to help prevent sliding off bed. Review of Resident #13's physician's orders revealed an order dated 06/23/25 for Dycem to be placed to the edge of the resident's bed. Review of the health status note dated 06/27/25 timed 3:31 P.M. revealed at 1:50 P.M., Resident #13's alarm was sounding, and the resident could be heard saying help. The nurse and CNA went to room and found the resident lying on floor beside the bed on her back and buttocks, with her head towards the bathroom. The CNA reported she had just toileted the resident five minutes earlier and had laid the resident in bed per her request. A behavioral tech saw Resident #13 slide out of bed onto floor and onto her buttocks and then into a lying position on the floor and did not see Resident #13 hit her head. Resident #13 had no complaints or signs or symptoms of pain or discomfort. The note concluded that a new order for a body pillow to the outside of the bed was to be used while the resident was in bed. Review of Resident #13's physician's orders revealed an order dated 06/28/25 for a full body pillow to be used to the left (open) side of the bed each shift. Review of the fall care plan revised on 06/28/25 revealed Resident #13 was a risk for falls related to dementia and poor safety awareness. Interventions included: body pillow on bed next to resident and gripper on the edge of the bed. There was no evidence Resident #13 removed fall interventions from her bed. Review of the Minimum Data Set (MDS) 3.0 quarterly assessment dated [DATE] revealed Resident #13 was severely cognitively impaired, had continuous inattention and disorganized thinking, use a walker, was independent with bed mobility, required supervision or touching assistance with walking 10 feet, required partial/moderate assistance with oral hygiene, and upper body dressing, and required substantial/maximal assistance with toileting, bathing, and lower body dressing. Review of the Fall Risk assessment dated [DATE] revealed Resident #13 had intermittent confusion, had a history of falls, and used a wheelchair. Resident #13 was assessed as high risk of falls. Observation on 08/05/25 at 11:47 A.M. revealed Resident #13 was sitting in a wheelchair in the secured memory care dining room next to an activity assistant during an activity. Resident #13 was sitting quietly. At 12:05 P.M., Resident #13 attempted to rise from her wheelchair while in the dining room. The alarm on the wheelchair sounded and a housekeeper assisted the resident back into her wheelchair. At 2:15 P.M., Resident #13 was lying in bed, asleep. The full body pillow was lying across the recliner seat next to the resident's bed and Dycem was not on the edge of either side of the bed. Assistant Director of Nursing (ADON) #87 was notified that the resident's body pillow was missing from the left side of her bed. CNA #80 was observed putting the body pillow to the left side of Resident #13 underneath the bottom sheet. Interview, during the observation, with CNA #80 revealed CNA #80 did not assist Resident #13 to bed after lunch. Interview on 08/05/25 at 2:25 P.M. with CNA #82 revealed CNA #82 had assisted the resident of bed and the resident was supposed to have the body pillow underneath her body sheet to prevent the resident from falling. Interview on 08/05/25 at 2:39 P.M. with LPN #81 verified Resident #13 did not have Dycem on either side of the bed while the resident was in bed. Interview on 08/05/25 at 2:48 P.M. with CNA #80 verified Resident #13's body pillow had been sitting on the resident's recliner and not in the bed with the resident. Interview on 08/11/25 at 2:05 P.M. with the DON verified it was her expectation that if a fall intervention was listed on the care plan, the intervention would be in place for the resident. Review of the facility policy, Fall Prevention and Fall Management, revised