STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365717	A. Building B. Wing	06/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Convalarium of Dublin	6430 Post Rd Dublin, OH 43016

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. **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 reviews, staff and resident interviews, hospital record reviews, incident investigation reports, and policy reviews, the facility failed to ensure two staff were present during resident transfers and failed to utilize a mechanical lift for the transfer. This affected one resident (Resident #06) of three residents reviewed for mechanical lift transfers. Actual harm occurred on 04/30/26 when Resident #06, who required the use of a mechanical lift assisted by two staff members for transfers, was picked up by one staff member, Certified Nursing Assistant (CNA) #206, and transferred from the shower chair to the bed. CNA #206 did not utilize the assistance of a mechanical lift and performed the transfer by himself. This resulted in an acute comminuted overlapping left humeral diaphyseal fracture and required hospitalization and surgical intervention to repair. The facility census was 83. Findings include:Review of the medical record for Resident #06 revealed an admission date of 8/16/24. Diagnoses included chronic congestive heart failure, hypertension, and generalized muscle weakness. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had a Brief Interview of Mental Status (BIMS) score of 12, did not have any hallucinations, delusions, or behaviors, had no range of motion impairment in upper of lower extremities and utilized a wheelchair for mobility. Resident #06 required substantial maximal assistance with toileting hygiene, showering, and dressing and was dependent for sit to stand, chair to bed and tub shower transfers. Resident #06 had no falls since admission. Review of the significant change Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #6 had moderate cognitive impairment and was dependent on staff assistance for all mobility, showering, transferring in and out of the tub or shower, sit-to-stand transfers, and chair or bed to chair transfers. Review of physician orders revealed no order for how Resident #06 was to be transferred. Review of Resident #06's care plan revealed on 01/05/26 Resident #06 required the use of a stand-up lift and assistance of two staff members (to transfer). This intervention was revised on 05/02/26 documenting Resident #06 required a Hoyer lift and two-person assistance for transfers. This intervention was revised again on 05/08/26 documenting Resident #06 required a mechanical lift and two-person assistance for transfers. Review of physical therapy orders dated 03/25/26 revealed Resident #06 required two-person assistance for transfers, as well as increased time and verbal cues to advance her lower extremities. Review of Resident #06's Kardex Report (summary of a resident's current plan of care, medical interventions, and tasks) dated 04/30/26 revealed Resident #06 required substantial or maximal assistance with chair-to-bed, bed-to-chair, and sit-to-stand transfers. Review of the incident report dated 04/30/26 at 8:30 P.M. completed by Licensed Practical Nurse (LPN) #105 revealed Resident #06 complained to CNA #206 of pain in her left arm following a transfer from her shower chair to her bed by CNA #206. An injury was reported to Resident #06's left upper arm with pain described as an eight out of 10. Reported predisposing environmental factors included assistive devices not in use. No other predisposing physiological or situational factors were reported. Review of a physician progress note dated (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Actual harm Residents Affected - Few	04/30/26 at 8:58 P.M. revealed Resident #06 was seen for a primary telehealth appointment at the request of facility staff due to resident-reported left forearm pain after being transferred into her bed. Resident #06 reported she was unable to move her left arm. This physician note did not include new orders for imaging, laboratory tests, or other treatments. Review of a nursing progress note dated 04/30/26 at 11:22 P.M. revealed LPN #105 examined Resident #06 due to a complaint of left arm pain. The assessment was completed and no significant findings were noted; vital signs were obtained and within normal limits. Resident #06 was given an as-needed (PRN) pain medication (Tylenol [analgesic] 325 milligrams [mg], two tablets every six hours as needed for pain) for reported pain six out of 10. LPN #105 notified the facility certified nurse practitioner (CNP) and received new orders for one-time only application of a Lidocaine patch to Resident #06's left arm and an X-ray of the same arm. Review of the radiology interpretation dated 05/01/26 at 12:18 P.M. revealed Resident #06 had X-rays of her left shoulder, left humerus, left elbow, left forearm, and left wrist due to pain from bumping her arm into her bedside railing. The findings were reported to be an acute, oblique fracture through the proximal left humerus, and degenerative changes at the acromioclavicular joint. No other fractures, sprains, dislocations, or other signs of injury were noted. Review of a physician progress note dated 05/01/26 at 2:02 P.M. revealed Resident #06's X-ray results demonstrated an acute angled fracture of the proximal humerus with associated degenerative changes of the acromioclavicular joint. Continued review of this progress note revealed Resident #06 reported that during her shower, a male aide (CNA #206) manually transferred her to her bed by lifting her under her armpits instead of using a Hoyer lift as required. Resident #06 reported her left arm struck the bedside rail and subsequently developed pain in her left shoulder. Review of a nursing progress note dated 05/01/26 at 2:53 P.M. revealed Resident #06's X-ray results came back and documented a left humerus fracture. Registered Nurse (RN) #179 notified Resident #06's physician and emergency contact, and Resident #06 was sent to the emergency room for evaluation and treatment. Review of hospital documentation revealed Resident #06 was admitted to the hospital from [DATE] to 05/05/26. Review of the emergency room intake documentation revealed Resident #06 had an acute comminuted overlapping left humeral diaphyseal fracture requiring hospital admission and surgery to repair. Further review of hospitalization records revealed a description of the fracture as fairly severe. Continued review of the trauma consultation on 05/01/26 at 8:44 P.M. revealed Resident #06 would require an open reduction, internal fixation (ORIF) surgery to repair the fracture, with surgery scheduled for 05/02/26. The description also stated that Resident #06 reportedly had a fall on 04/30/26 and landed on her left arm causing the fracture. Review of occupational and physical therapy evaluations completed in the hospital on [DATE] and 05/03/26, respectively, revealed Resident #06 normally transferred with a Hoyer lift versus a standing pivot transfer, required maximum two-person assistance with sitting-to-lying and lying-to-sitting bed mobility, and was unable to safely progress with sit to stand transfers. Review of the hospitalization trauma service progress notes dated 05/04/26 at 7:39 A.M. revealed a statement regarding the injury: Pathologic fracture due to a combination of osteopenia (low bone density, but not low enough to be osteoporosis) and trauma that alone would not have caused the fracture and Vitamin D level 56 - no replacement needed. No further interpretation regarding the cause of the fracture was reported in this progress note. Review of facility incident investigation revealed a statement from CNA #206 dated 05/04/26 regarding the incident on 04/30/26. Per CNA #206's statement, CNA #206 took Resident #06 to the shower per her usual shower schedule. After Resident #06's shower was completed, CNA #206 reported he took Resident #06 back to her room in the wheeled shower chair and transferred Resident #06 into her bed. CNA #206 reported after putting Resident #06 in her bed, she complained of pain in her left shoulder and CNA #206 immediately notified the floor nurse. Continued review of the facility incident investigation revealed a statement from an unknown employee dated 05/01/26. The employee reported asking Resident #06 how she hurt her arm. Resident #06 reported to the employee that CNA #206 lifted Resident #06 out of her shower chair and put her in her bed. Resident #06 reported that when CNA #206 tried to lift her over the (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	bedside rail, CNA #206 bumped her arm into it. Continued review of the facility incident investigation revealed a communication note between Assistant Director of Nursing (ADON) #177 and CNA #206. In the interview with ADON #177, CNA #206 stated he would confirm a resident's transfer status with a nurse if he was unsure. When asked what CNA #206 would do if a nurse was not available, CNA #206 reported he would seek additional assistance and perform a two-person assisted transfer. CNA #206 revealed he did not use a gait belt when he transferred Resident #06 out of the shower chair as Resident #06 informed him, she had been working with therapy and only required minimal assistance. CNA #206 denied hitting or bumping Resident #06's arm during the transfer, and stated Resident #06 did not complain of pain until after the transfer occurred. CNA #206 stated he believed Resident #06 required one-person assistance and stated he routinely provided Resident #06's cares. Interview on 05/27/26 at 10:33 A.M. with Resident #06 revealed she normally requires a Hoyer lift for transfers because she cannot walk or stand independently and had been working with physical and occupational therapies to increase her strength and mobility. Resident #06 stated on 04/30/26, CNA #206 was assisting her with her shower as he normally did when he worked on her hall. Resident #06 stated CNA #206 lifted her up out of the chair by himself without a Hoyer or other mechanical lift, without using a gait belt, and without the assistance of another person. Resident #06 stated CNA #206 had attempted to transfer her like this one other time before without incident but reported on 04/30/26 it resulted in a fall. Resident #06 stated her arm went down and hit something, maybe the metal part on the bed but was not able to describe the incident with certainty. Resident #06 denied concerns of abuse, neglect, or other mistreatment by CNA #206 or other staff members. Interview on 05/27/26 at 2:20 P.M. with Therapy Director (TD) #208 confirmed at the time of the incident on 04/30/26, Resident #06 required two-person assistance with a gait belt for all transfers. TD #208 confirmed any strengthening exercises being done in PT/OT sessions were not to be completed by nurses or aides during routine care. TD #208 confirmed the incident on 04/30/26 occurred because the aide performing the transfer did not follow therapy orders. Interview on 05/28/26 at 9:49 A.M. with LPN #101 confirmed she was immediately notified of Resident #06's new complaint of pain following a transfer from her shower chair to her bed on 04/30/26 and instructed the floor nurse, LPN #105, to begin an investigation into the new onset of pain. LPN #101 stated further investigation was completed by ADON #177 and she (LPN #101) re-educated staff on where to confirm a resident's transfer status in the electronic medical record and the therapy communication binders at each nurse's station. LPN #101 confirmed during this training, all clinical staff were educated it is their responsibility to confirm a resident's transfer status before performing a transfer. LPN #101 confirmed staff are to ask the floor nurse, unit manager, or other administrative staff for clarification of transfer orders if there is a discrepancy between the electronic medical record and the therapy communication binder. Interview on 05/28/26 at 9:59 A.M. with ADON #177 confirmed Resident #06 complained of pain in her left arm following an improper transfer with one-person assistance from her shower chair to her bed on 04/30/26. ADON #177 confirmed that the CNP was immediately notified and gave new orders for one-time only lidocaine patch to be applied to her left arm for pain management and X-rays of the left arm. ADON #177 confirmed Resident #06 received the X-ray on 05/01/26 around 11:00 A.M. and received the interpretation at 2:53 P.M. on the same day, at which time Resident #06 was sent to the hospital for further evaluation and treatment. ADON #177 confirmed an investigation began on 04/30/26 when Resident #06 complained of new pain in her left shoulder following the transfer. ADON #177 confirmed the accident investigation did not change when the fracture was identified. ADON #177 stated the injury was likely caused when CNA #206 transferred Resident #06 with one-person assistance without a gait belt or mechanical lift and did not follow current therapy orders for two-person assistance. Telephone interview on 05/28/26 at 11:13 A.M. with CNA #206 confirmed he provided Resident #06's shower on 04/30/26 as he has done on every shift he has worked on Resident #06's unit. CNA #206 confirmed he thought Resident #06 required one-person assistance with transfers after checking the electronic medical record. CNA #206 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	confirmed he lifted Resident #06 up underneath her armpits and did not use a gait belt during the transfer. CNA #206 confirmed Resident #06 did not fall and was not injured during the transfer. CNA #206 confirmed immediately after being put in her bed, Resident #06 reported pain in her left shoulder. CNA #206 confirmed he immediately notified the floor nurse and continued his shift. CNA #206 confirmed he was not aware Resident #06 had a fracture of her left humerus or any other injury that caused the pain in her shoulder. CNA #206 confirmed he completed his 7:00 P.M. to 7:00 A.M. shift on 04/30/26 - 05/01/26, was later suspended on 05/01/26, and his employment was terminated on 05/13/26. Review of the Therapy Communication Binder on Unit 1 on 05/28/26 at 11:26 A.M. confirmed Resident #06's transfer status as of 05/07/26 was listed as two-person assistance using a mechanical Hoyer lift and was non-weightbearing on her left upper extremity. Interview on 05/28/26 at 4:50 P.M. with Director of Nursing (DON) #153 stated this fracture was likely caused because CNA #206 did not transfer Resident #06 correctly based on Resident #06's active therapy orders for transfer status and facility procedure for one-person assistance with transfers. An interview was conducted on 05/29/26 at 10:34 A.M. with Administrator #188 and DON #153 to review past non-compliance and plan of correction documents related to the incident on 04/30/26. Administrator #188 confirmed a root cause analysis was conducted on 05/08/26 and final review and approval of the plan of correction was reviewed and approved by the Quality Assurance Performance Improvement (QAPI) team on 05/28/26. DON #153 confirmed there have been no identified issues of the weekly audits of resident transfers. DON #153 confirmed gait belts have been added to the rooms of every resident that required assistance with transfers. DON #153 confirmed therapy communication binders have been implemented and are being audited and updated regularly. Administrator #188 confirmed CNA #206 was suspended on 05/01/26 pending the outcome of the investigation and was terminated on 05/13/26. Review of the policy titled Activities of Daily Living (ADLs), Supporting, reviewed 08/2025, indicated appropriate care and services will be provided to residents who are unable to carry out ADLs independently, including appropriate support and assistance with mobility (transfer and ambulation, including walking). The policy indicated interventions to improve or maximize a resident's functional abilities will be in accordance with their assessed needs, preferences, stated goals, and recognized standards of practice. The deficient practice was corrected on 05/13/26 when the facility implemented the following corrective actions: On 05/08/26, a Root Cause Analysis was conducted by the Administrator, ADON #177, Unit Manager #1 (LPN #101), Unit Manager #2 (RN #134), MDS Coordinator (LPN #115), and Therapy Director (TD #208), concerning the fracture obtained by Resident #06. On 05/08/26, education was provided by LPN #101 to all clinical staff on how to review the Kardex, where to verify a resident's transfer status, and who to contact if there is a discrepancy in the resident's record. On 05/08/26, TD #208 identified 31 residents in the facility that could potentially be impacted by this deficient practice. On 05/08/26 the facility ordered 50 gait belts and placed them in rooms of residents who require any type of assistance with transfers. On 05/08/26, an ad Hoc Quality Assurance Performance Improvement team meeting occurred with the Administrator, Medical Director and ADON #177. On 05/11/26, clinical staff education and training was conducted by ADON #177, Unit Managers, and the Therapy Director on proper lifting and Hoyer lift techniques. On 05/13/26, audits were implemented by DON #153 and/or the designee to determine if staff were maintaining compliance with functional transfer and assist levels, audit schedule was three times weekly on five residents per day for four weeks. The audit results will be sent to the QAPI team and schedule adjusted based on results. This deficiency represents non-compliance investigated under Complaint Number 3007002.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and review of facility policy, the facility failed to ensure tracheostomy care procedures were followed as indicated during routine tracheostomy care. This affected one, (Resident #43), of four residents reviewed for respiratory care services. The facility census was 83.Findings include:Review of Resident #43's electronic health record revealed the resident was admitted to the facility on [DATE] with diagnoses that included chronic respiratory failure with hypoxia, encephalopathy, nontraumatic subarachnoid hemorrhage, Type Two Diabetes Mellitus, and tracheostomy status. Resident #43's electronic health record revealed a Brief Interview for Mental Status (BIMS) score was unable to be calculated due to the resident's status of being rarely or never understood, though the resident's cognition was noted to be severely impaired as of the Minimum Data Set (MDS) assessment completed on 04/22/26.Review of Resident #43's physician orders revealed tracheostomy care orders dated 03/17/26 for the following: tracheostomy care every night shift and as needed, change the inner cannula every night shift and as needed, change tracheostomy ties every Thursday night and as needed, and suction the tracheostomy to maintain a patent airway every shift and as needed.Observation on 05/27/26 at approximately 10:10 A.M. of tracheostomy care provided to Resident #43 by Respiratory Therapist (RT) #140 revealed RT #140 removed the old/soiled tracheostomy dressing and inner cannula, and then inserted a new inner cannula and applied a new tracheostomy dressing without washing hands and changing gloves between removal of the soiled tracheostomy dressing and the insertion of the new inner cannula into Resident #43's tracheostomy site.Interview on 05/27/26 at 10:12 A.M. with Respiratory Therapist (RT) #140 revealed they were unsure if they needed to remove their gloves, wash hands, and don new gloves after removing the soiled tracheostomy dressing and before continuing to replace the inner cannula and new dressing at the tracheostomy site. RT #140 stated respiratory staff at the facility haven't done it that way before, but maybe they should.Review of the facility policy titled Tracheostomy Care, revised April 2023 revealed instructions listed for the tracheostomy care procedure that begins with washing hands and putting exam gloves on both hands before removing old dressings and ties and then pulling the soiled gloves over the soiled dressing and discarding all items into the appropriate receptacle. Once the soiled gloves have been removed and properly disposed of, staff hands should be washed and new gloves applied before setting up the tracheostomy care kit and changing out the disposable tracheostomy tube inner cannula.This deficiency represents non-compliance investigated under Complaint Number 3009377.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, staff and resident interviews, and policy reviews, the facility failed to ensure accurate medical records. This affected one resident, (Resident #6), of six residents reviewed for medical record accuracy. The facility census was 83.Findings include:Review of the medical record for Resident #6 revealed an admission date of 8/16/24. She had diagnoses including chronic congestive heart failure, hypertension, and generalized muscle weakness.Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had a Brief Interview of Mental Status (BIMS) score of 12, did not have any hallucinations, delusions, or behaviors, had no range of motion impairment in upper of lower extremities and utilized a wheelchair for mobility. Resident #06 required substantial maximal assistance with toileting hygiene, showering, and dressing and was dependent for sit to stand, chair to bed and tub shower transfers. Resident #06 had no falls since admission. Review of the significant change Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #6 had moderate cognitive impairment and was dependent on staff assistance for all mobility, showering, transferring in and out of the tub or shower, sit-to-stand transfers, and chair or bed to chair transfers.Review of a therapy to nursing communication note dated 11/04/25 revealed a change in Resident #6's transfer status to manual intervention for sit-to-stand transfers.Review of Resident #6's care plan revealed an intervention initiated on 01/05/26 stated Resident #6 required the use of a mechanical lift with staff assist of two for all transfers. This intervention was changed on 05/08/26 to use of mechanical lift with staff assist of two for all transfers.Review of physical therapy orders dated 03/25/26 revealed Resident #06 required two-person assistance for transfers, as well as increased time and verbal cues to advance her lower extremities.Resident #6's medical record revealed Resident #6 was hospitalized from [DATE] around 3:00 P.M. to 05/05/26 around 6:00 P.M.Review of a nursing progress note dated 05/01/26 at 11:48 P.M. by Licensed Practical Nurse (LPN) #105 revealed Resident #6 received her shower as scheduled from the night shift aide (Certified Nursing Assistant [CNA] #206). Resident #6 was assisted back into her bed and complained of new pain in her left arm. Resident #6 was assessed by LPN #105 with no significant findings noted. LPN #105 reported the pain to the on-call Certified Nurse Practitioner (CNP) and received new orders for one-time-only application of a Lidocaine patch for pain relief and X-rays of the left arm. LPN #105 reported Resident #6 rested in her bed and slept through the night.Review of a therapy to nursing communication note dated 05/07/26 stated Resident #6's transfer status changed to Hoyer lift with staff assist of two for transfers.Interview on 05/28/26 at 3:40 P.M. with LPN #101 confirmed the nursing progress note was dated on 05/01/26 at 11:48 P.M. when Resident #6 was in the hospital.Interview on 05/27/26 at 2:20 P.M. with Therapy Director (TD) #208 confirmed the care plan intervention on 01/05/26 requiring use of a mechanical lift for sit-to-stand transfers was not consistent with the therapy orders at the time (orders on 11/04/25). TD #208 confirmed the care plan intervention on 01/05/26 requiring use of a mechanical lift for sit-to-stand transfers was not updated when therapy orders for transfers changed on 03/25/26. TD #208 confirmed the care plan intervention on 01/05/26 requiring use of a mechanical lift for sit-to-stand transfers was consistent with current therapy orders dated 05/08/26.Review of the policy titled Care Planning, reviewed 08/2025, stated the facility's care planning/interdisciplinary team is responsible for the development of an individualized comprehensive care plan for each resident. The policy defined the care planning/interdisciplinary care team to include speech, occupational, and recreational therapists as applicable.This violation represents non-compliance investigated under Complaint Number 3009377.