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	06/22/2026

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 - 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents were safely transported to outside medical appointments. This affected one (#66) of three residents reviewed for outside medical transportation. The facility census was 83.Findings include:Review of the medical record for Resident #66 revealed an admission date of 01/09/25. Diagnoses included heart failure, hypertensive heart and chronic kidney disease with heart failure and with stage five chronic kidney disease, Type II diabetes, anemia, end stage renal disease, obstructive and reflux uropathy, spinal stenosis cervical region, atrial fibrillation, hyperlipidemia, hypertension, and dependence on renal dialysis.Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #66 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderate cognitive impairment. Resident #66 had no psychosis, no verbal or physical behaviors, and no rejections of care. Resident #66 used a wheelchair for mobility and required dialysis. Review of the care plan initiated 04/10/26 revealed Resident #66 had end stage renal disease (ESRD) and received hemodialysis.Review of the progress note dated 06/11/26 at 6:23 A.M. revealed, per report from staff, Resident #66 was picked up at approximately 5:00 A.M. for his dialysis appointment. About 10 minutes later, staff notified the nurse that the resident had fallen from his electric wheelchair into a ditch. Emergency medical services (EMS) were called, and the resident was transported to local hospital for further evaluation.Review of the EMS run report dated 06/11/26 at 5:06 A.M. revealed Resident #66 was found lying supine (lying flat on back, facing upward) in a grassy area next to the bike path complaining of right-sided rib pain. The resident stated the rib pain was worse when he took a deep breath. The primary impression was acute pain due to trauma. The resident noted the pain was less once he was moved. Resident #66 was transported to the local hospital for evaluation. Review of the facility's fall incident report dated 06/11/26 for Resident #66 revealed the predisposing environmental factors included poor lighting.Review of the hospital notes dated 06/11/26 revealed Resident #66 was admitted to the hospital for a fall. Imaging results were negative for acute fractures. An observation on 06/17/26 at 10:20 A.M. of the path taken from the facility to the dialysis center, with Staffing Coordinator (SC) #155, revealed SC #155 exited the facility through the front door, down the wheelchair ramp into the parking lot, across the facility parking lot, then up ramp to the sidewalk, which led to a short bridge, and then down another sidewalk into an Assisted Living (not part of the facility) facility parking lot. SC #155 then walked through the parking lot to an asphalt sidewalk, which was in an S shaped curve and led to the crosswalk at the street. Concurrent interview with SC #155 revealed it was in the area of the S shaped curve that Resident #66 went straight instead of turning in the curve. When the resident's wheelchair hit the grass, the wheelchair tipped over and Resident #66 fell into the ditch in front of the drain. SC #155 stated Resident #66 fell on his right side. Further observation revealed a rough, uneven patch of blacktop at the area SC #155 stated Resident #66 fell. SC #155 verified Resident #66 fell in the S shaped curved area where there was a rough, uneven patch of blacktop. Further observation on 06/17/26 at 2:53 P.M. of the path taken from the facility to the dialysis center, with the Director of Nursing (DON), revealed there were no streetlights (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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