

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365741	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/25/2026
NAME OF PROVIDER OR SUPPLIER  Ashtabula County Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE  5740 Dibble Road Kingsville, OH 44048	

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	<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> THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on observation, medical record review, review of a facility investigation, hospital records, facility policy, manufacturer's instructions, and interview, the facility failed to identify and implement comprehensive, individualized and adequate fall interventions to prevent a fall with injury during resident care. This affected one resident (#77) of three residents reviewed for accidents/incidents who required use of a shower gurney. The facility identified 32 residents (#3, #5, #11, #12, #21, #25, #27, #28, #29, #30, #33, #37, #41, #42, #43, #58, #59, #61, #62, #67, #77, #79, #81, #87, #89, #93, #94, #101, #103, #104, #112 and #114) who required a shower gurney for bathing. The facility census was 115. Actual Harm occurred on 01/11/26 at 3:00 P.M. when Resident #77, who was dependent on staff for showers and transfers and required substantial to maximum assistance with rolling left and right, fell from a shower gurney (a shower bed on wheels) onto the floor after Agency Certified Nursing Assistant (ACNA) #719 (only staff present in the shower room) rolled the resident away from her on the shower gurney to remove an incontinence brief and mechanical lift sling (a device used to transfer residents by use of a sling from surface to surface). As a result of the fall, Resident #77 experienced pain, an abrasion/hematoma (swelling of clotted blood within the tissues) to the right eyebrow, skin tears and/or abrasions to the top left hand, the left great toe, the right second, third, fourth and fifth toes, the right shoulder, and discoloration of the right hand and leg. Subsequently, Resident #77 was transferred and admitted to the hospital with septic shock (a life-threatening condition caused by dangerously low blood pressure and organ failure) and bilateral subdural hematomas (bleeding in the brain). The resident was hospitalized from [DATE] to 01/20/26 (nine days). Findings include: Review of the medical record for Resident #77 revealed an admission date of 07/25/25. Resident #77 had diagnoses including traumatic subdural hemorrhage (bleeding in the brain) without loss of consciousness (dated 01/12/26), hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, chronic obstructive pulmonary disease (COPD), and heart failure. Review of quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #77 had moderate cognitive impairment and impairment to his bilateral upper and lower extremities. The resident was dependent on staff for toileting, hygiene, showers, transfers and dressing, and required substantial to maximum (staff) assistance with rolling left and right. Review of quarterly Fall Risk assessment dated [DATE] completed by Unit Manager Licensed Practical Nurse (LPN) #680 revealed Resident #77 was not at risk for falls. The assessment revealed the resident was forgetful and dependent on toileting needs including checks and changes and had no history of falls. Review of nursing note dated 01/11/26 at 7:20 P.M. completed by LPN #692 revealed the shower room call light was going off when the aide alerted LPN #692 that Resident #77 fell. LPN #692 entered the shower room and saw the resident on the floor lying on his right side with his right arm tucked beneath him, and head facing</p> <p>(continued on next page)</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  Facility ID: 365741	If continuation sheet Page 1 of 8

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F 0689  Level of Harm - Actual harm  Residents Affected - Few	<p>all junctures to make sure the pipe and fittings do not pull apart, and clean and lubricate casters monthly. Interview on 02/20/26 at 11:46 A.M. with the DON verified per the Operation Instructions for the shower gurney model used in incident involving Resident #77 and Agency CNA #719, the instructions stated, Do not roll user away from you unless there is a partner caregiver on the other side. She verified per the investigation, Agency CNA #719 reported she had rolled Resident #77 away from her when taking out the incontinence brief and mechanical lift sling and that she was the only staff member in the shower room. The DON confirmed staff were to not to roll residents on a shower gurney away from them during care unless they had another staff member on the other side. Interview on 02/23/26 at 1:58 P.M. with PCP/MD #723 revealed he was aware of the incident but was unable to know for a fact if it was caused by the wheel coming off the gurney or by the aide rolling the resident too far off the bed. He stated Resident #77 was very rigid requiring dependence of staff for all his care. It depended on the day if Resident #77 was cognitively intact or not as sometimes he was coherent and sometimes he was not. He was unable to provide any other details regarding the incident. Review of facility policy titled, Accidents and Incidents, last revised 05/22/24, revealed all accidents or incidents involving residents were investigated and reported to the administrator. The facility was to be in compliance with current rules and regulations governing accidents and/or incidents. Review of facility undated policy titled, Shower/Tub Bath, revealed the purpose of the procedure was to promote cleanliness, provide comfort and observe the condition of the residents' skin. The policy indicated to handle residents as gently as possible and not to rush the procedure. The procedure specified to never leave the resident unattended in the tub or shower and use the emergency call signal to summon assistance. There was nothing in the policy regarding ensuring staff did not roll residents away from them on a gurney unless there was another caregiver on the other side. The deficient practice was corrected on 01/27/26 when the facility implemented the following corrective actions: On 01/11/26, the Administrator and DON halted all gurney showers until MD #676 inspected and evaluated the equipment. There were no abnormal findings. On 01/11/26, the DON notified the staffing agency and requested the agency place Agency CNA #719 on the do not return (DNR) to the facility list. On 01/12/26, MD #676 implemented and conducted an audit of shower equipment that lubricated the wheels if needed, inspected the PVC tubing for hairline cracks and damage, checked all junctures to make sure pipe and fittings did not pull apart and checked tightness of fasteners. This audit was conducted by MD #676 daily for seven days, weekly for five weeks and then returned to the previous shower beds/chairs monthly maintenance and safety checklist. On 01/12/26, the Administrator, DON, ADON/RN #601, and MD #676 completed a re-enactment of the incident for an investigation of the root cause of the incident. On 01/12/26, a risk management meeting was held with Administrator, DON, ADON/RN #601, MD #676, Unit Manager/RN #602, Unit Manager/LPN #680, LPN #681, and MDS/RN #600 to discuss the incident, root cause, and interventions. On 01/12/26, the Administrator and DON met with Resident #77's granddaughter to review the investigation/re-enactment. On 01/13/26, MD #676 ordered new shower gurneys. On 01/15/26, the DON reviewed the facility investigation with PCP/MD #723. On 01/15/26, the Administrator updated Resident #77's daughter on the investigation. On 01/16/26, the Administrator and DON reviewed the facility policies including Accidents and Incidents last revised 05/22/24, and Shower/Tub Bath undated. On 01/20/26, the Administrator updated Resident #77's daughter to discuss Resident #77's return to the facility and interventions to be implemented. On 01/21/26, a Physical Therapy (PT) evaluation was completed by PT #729 and Occupational Therapy (OT) evaluation was completed by OT #728 for Resident #77. On 01/21/26, Unit Manager/LPN #680 changed Resident #77 to be a two-person gurney shower on weekdays. On 01/21/26, a risk management meeting was held with Administrator, DON, ADON/RN</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365741	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/25/2026
NAME OF PROVIDER OR SUPPLIER  Ashtabula County Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE  5740 Dibble Road Kingsville, OH 44048	
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	#601, MD #676, Unit Manager/RN #602, Unit Manager/LPN #680, LPN #681, and MDS/RN #600 to discuss the incident, interventions, changing gurney showers to weekdays with some exclusions, and discussed an upcoming staff in-service meeting scheduled 01/27/26. On 01/21/26, the Unit Manager/RN #602, Unit Manager/LPN #680 and LPN #681 updated the facility shower schedule to change all gurney showers with some exclusions to weekdays. On 01/26/26, ADON #601 updated the interview data sheets/incident/accident reports to provide more details to assist in finding the root cause of an incident. On 01/27/26 and on 01/29/26, an in-service with all nurses and CNAs was conducted by DON and ADON/RN #601 to review fall policy, bathing policy, safety including not rolling a resident away from staff only towards staff unless another staff member was on the other side, have a second staff member assist with gurney showers when needed, updated interview data sheets/incident/accident reports, change in shower schedules, and reporting any maintenance issues including on gurneys. On 01/29/26, MD #676 ordered new shower chairs. On 02/13/26, Interdisciplinary Team Meeting was held with Resident #77's daughter and granddaughter to discuss overall care. On 02/17/26, a risk management meeting was held with Administrator, DON, ADON #601, MD #676, Unit Manager/RN #602, Unit Manager/LPN #680, LPN #681, and MDS/RN #600 to discuss any feedback from in-service and review of all current interventions. On 02/20/26, the Administrator updated PCP/MD #723. This deficiency represents non-compliance investigated under Complaint Number 2730416.		