STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365745	A. Building B. Wing	01/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Swanton Valley Rehabilitation and Healthcare Cente	401 W Airport Hwy Swanton, OH 43558

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 Note: The nursing home is disputing this citation.	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, medical record review, staff interview, and facility policy review, the facility failed to ensure fall interventions were implemented and thorough post-fall investigations were conducted. This affected one (#2) of three residents reviewed for fall prevention in a facility census of 79. Findings include: Review of the medical record revealed Resident #2 was admitted to the facility on [DATE]. Diagnoses included malignant neoplasm of the upper right lobe lung and bronchus, acute and chronic respiratory failure with hypoxia and hypercapnia, type II diabetes mellitus, chronic obstructive pulmonary disease, hypertension, pneumonia, bacteremia, congestive heart failure, atrial fibrillation, generalized anxiety, major depression, shortness of breath and chronic fatigue. Review of the most current Minimum Data Set (MDS) assessment revealed Resident #2 was assessed with moderately impaired cognition, utilized a wheelchair for mobility, required supervision/touching assistance with activities of daily living, partial to moderate assistance with toileting and chair/bed transfer, was always continent of bowel and bladder, had no falls since admission, and was not at risk for pressure ulcer development with no skin breakdown. In addition, the resident received oxygen therapy and hospice services. Review of fall risk assessments completed on 11/17/25, 12/23/25, and 12/26/25 revealed Resident #2 was assessed at high risk for falls. Review of Resident #2's nursing plan of care revealed a revision on 11/20/25 to address the resident's activity of daily living (ADL) self-care performance deficit related to congestive heart failure, chronic fatigue, generalized weakness. Interventions included the resident required a one person assist with transfer and toileting. Further review revealed, on 12/07/25, a nursing plan of care was revised to address Resident #2's episodes of bladder and bowel incontinence related to congestive heart failure, and diabetes. Interventions included to administer medications per physician order, assist with toileting needs, periodically evaluate the resident's pattern of urination and episodes of incontinence, and report if the resident had no output. In addition on 12/07/25, a plan of care was revised addressing Resident #2's risk for falls related to decreased strength and endurance, functional problems, generalized weakness, history of falls, needs assistance with ADLs. Interventions included to educate the resident and family to call for assistance before transferring, keep food/fluids within reach, implement preventative fall interventions/devices, maintain the call light within reach, educate the resident to use the call light, maintain needed items within reach, monitor for changes in mobility, and provide non-skid footwear. Review of a fall occurrence evaluation dated 12/23/25 at 9:00 P.M. revealed Resident #2 was found on the floor in her room by her bed, sitting on her buttocks. Resident #2 indicated she was attempting to use the bathroom when the fall occurred and no injury was documented. Interventions included to educate the resident and family to call for assistance before transferring, keep food/fluids within reach, and provide non-skid footwear. There was no intervention to include attempting a toileting schedule or assistant to bathroom which was the nature of the resident's fall. Review of a (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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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	post fall risk evaluation dated 12/23/25 noted Resident #2 to have sustained previous falls, used a crutches, cane or walker, assessed with weak gait. Review of a fall occurrence evaluation dated 12/26/25 at 4:00 A.M. noted Resident #2 was discovered by staff passing in hall and noticed the resident scooting along on the floor. Resident #2's mask was sitting on resident's bed, and the bedside commode and walker were at the resident's bedside. Resident #2 indicated she was using the bathroom when she got shaky and sat on the floor so she did not fall and hurt herself. Vital signs were taken, a head-to-toe assessment was performed, and all findings were within normal limits with no new injuries or skin issues noted. Further review revealed the facility initiated a fall protocol with interventions including to educate the resident and family to call for assistance before transferring, keep food/fluids within reach, and provide non-skid footwear. There was no intervention to include a toileting schedule or assistant to use the bathroom which was the nature of the resident's fall. In addition, there was no documentation indicating interventions in place at the time of the fall when the resident was last observed or whether the resident's call light was activated or not. Observation on 12/30/25 at 1:40 P.M. noted Resident #2 seated on the bedside. Resident #2 was noted with anti-embolism stockings applied to the bilateral lower extremities with the socking toes dangling from the feet and not securely in place. There were no slip resistant footwear was applied to the resident's feet. Observation on 12/31/25 at 3:35 A.M. revealed Resident #2 was seated on the bedside commode with no slip resistant footwear applied. At 3:36 A.M., interview with Licensed Practical Nurse (LPN) #300 revealed she was unaware the resident was up at the bedside without supervision. LPN #300 indicated Resident #2 was to be assisted by staff to transfer from the bed and not to self-transfer. On 12/31/25 at 8:35 A.M., interview with the Director of Nursing (DON), during a review of Resident #2's medical record, verified no interventions were implemented to determine Resident #2 bowel and bladder habits or toileting schedule. The DON confirmed Resident #2 sustained falls related to self-transferring to the toilet and bedside commode, and according to the fall investigation documentation for the falls occurring on 12/23/25 and 12/26/25, no information was obtained to determine fall interventions in place at time of fall, when Resident #2 was last observed, or if the call light activated at time of the falls. Review of facility falls policy, dated September 2021, revealed based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falls. The staff, with the input of the attending physician, will identify appropriate interventions to reduce the risk of falls. If a systematic evaluation of a resident's fall risk identifies several possible interventions, the staff may choose to prioritize interventions. If falling recurs despite initial interventions, staff will implement additional interventions, or indicate why the current approach remains relevant. If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature or category of falling, until falling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable. If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions.This deficiency represents non-compliance investigated under Complaint Number 2689209.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, and staff interview, the facility failed to ensure interventions were implemented to address bladder incontinence and ensure incontinence care was provided in a timely manner. This affected one (#1) of three residents reviewed for bowel and bladder incontinence in a facility census of 79. Findings include: Review of the medical record for Resident #1 revealed the resident was admitted to the facility on [DATE]. Diagnoses included post-polio syndrome, Bell's palsy, osteoarthritis, muscle weakness, and bilateral myopia. Review of the most current Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 was assessed with intact cognition, rejected care four to six days during the seven day look back period, had bilateral upper and lower extremity range of motion impairments, was dependent on staff for the completion of activities of daily living, was always incontinent of bowel and bladder, and was at risk for pressure ulcer development with no skin impairment recorded. Review of a nursing plan of care dated 01/07/25 revealed a focus area was implemented to address Resident #1's episodes of bladder and bowel incontinence related to generalized weakness. Interventions included to assist the resident with toileting needs, periodically evaluate the resident's pattern of urination and episodes of incontinence, provide disposable incontinence products, provide peri-care after each incontinent episode. There were no scheduled toileting or a frequency to check for incontinence included or documented in the medical record. Review of a nursing plan of care dated 01/09/25 revealed a focus area was implemented due to Resident #1's refusal of care, showers, supplements, and treatments. Interventions included to approach the resident in a calm manner to avoid frustration and behavior escalation, encourage the resident to ask questions when concerned about medical condition, encourage the resident to participate in care, explain the potential adverse effects of refusals of care and offer alternatives when possible, monitor behavior episodes and attempt to determine underlying cause, monitor and document episodes of inappropriate behaviors, notify the physician/nurse practitioner/physician assistant when behaviors persist or will not deescalate, and provide a structured schedule for daily care when possible. Review of a bowel and bladder assessment completed on 10/20/25 revealed Resident #1 scored as a potential candidate for scheduled toileting. Further review of the medical record revealed no documentation to address attempts to schedule toileting for Resident #1.Observation and interview on 12/30/25 at 8:05 A.M. noted Resident #1 alert and awake in bed. Resident #1 stated she was currently incontinent of urine and was last checked for incontinence at 4:30 A.M. by the night staff. On 12/30/25 at 9:20 A.M., interview with Licensed Practical Nurse (LPN) #301 revealed she was working as Resident #1 certified nurse aide (CNA). LPN #301 stated she assumed care for Resident #1 at 5:00 A.M. that day and confirmed she had not checked the resident for incontinence. LPN #301 stated Resident #1 was incontinent with some chronic excoriation to the buttock and should be checked every two hours. LPN #301 stated Resident #1 would generally call out when she needed changed. Observation and interview on 12/30/25 at 9:48 A.M., revealed Registered Nurse (RN) #400 and LPN #301 went to assist Resident #1 with incontinence care. LPN #301 verified she had not asked Resident #1 if she needed checked for incontinence care until that time. RN #400 stated residents are to be checked every two hours per facility protocol. LPN #301 confirmed Resident #1 required incontinence check and changes, but was unable to indicate Resident #1's toileting schedule. RN #400 and LPN #301 repositioned Resident #1, removed her disposable incontinence brief, and noted the resident to be incontinent of a moderate amount of urine. Resident #1's bilateral buttocks were noted with areas of excoriated tissue. LPN #301 cleansed Resident #1's perinium and buttock with disposable (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wipes and applied a barrier ointment. RN #400 and LPN #301 then placed Resident #1 in a clean incontinence brief. On 12/30/25 at 12:35 P.M., interview with the Director of Nursing (DON) revealed Resident #1 frequently refused all aspects of care. The DON confirmed Resident #1 did not have an established toileting schedule in place as described in the bowel and bladder assessment and should have been asked if she needed checked or changed on 12/30/25. This deficiency represents non-compliance investigated under Master Complaint Number 2706213, Complaint Number 2702593, Complaint Number 2689209, and Complaint Number 2652724.