

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365786	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/25/2025
NAME OF PROVIDER OR SUPPLIER Villa Georgetown Rehabilitation and Healthcare Cen		STREET ADDRESS, CITY, STATE, ZIP CODE 8065 Dr Faul Road Georgetown, OH 45121	

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)
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33023</p> <p>THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY.</p> <p>Based on medical record review, family interview, staff interview, review of the facility therapy to nursing communication form and review of facility policy, the facility failed to provide adequate staff assistance during transfers to prevent falls. This resulted in actual harm on 01/15/25 at approximately 12:25 P.M. to Resident #100 when Certified Nursing Assistant (CNA) #20 completed a hands-on transfer of the resident from the wheelchair to the bed without the assistance of additional staff. Resident #100 sustained a fall to the floor during the transfer, resulting in a left femur fracture. This affected one resident (#100) of three residents reviewed for falls. The facility census was 84.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #100 revealed an admitted [DATE]. Diagnoses included cerebral infarction (stroke), spastic hemiplegia (causes muscle tightness and involuntary contractions on one side of the body), diabetes mellitus, epilepsy, seizures, depression, anxiety, foot drop (difficulty lifting the front part of the foot), and hypertension.</p> <p>Review of the Minimum Data Set (MDS) assessment for Resident #100 revealed no information for this resident due to the length of stay in the facility.</p> <p>Review of the care plan, dated 01/14/25, revealed Resident #100 had an activities of daily living (ADLs) self-performance deficit and required staff assistance related to hemiplegia, foot drop, cerebral infarction, and overall medical condition. Interventions included total staff dependence with transfers and the resident required the assistance of one or more staff with transfers.</p> <p>Review of the facility Therapy to Nursing Communication Form, dated 01/14/25 and completed by Physical Therapy Assistant (PTA) #40, revealed Resident #100 had left-sided hemiplegia due to a previous cerebral infarction and was evaluated to need two staff assistance for all transfers. Further review revealed Licensed Practical Nurse (LPN) #10 acknowledged the communication on 01/14/25.</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
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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a nursing progress note, dated 01/15/25 at 12:35 P.M., revealed LPN #30 immediately responded to the room of Resident #100 after hearing her screaming in pain. Upon arrival, she witnessed CNA #20 and Resident #100 both on the floor, after an attempted transfer. Further review revealed Resident #100 was screaming in excruciating left hip pain. LPN #30 documented she was unable to complete an assessment due to the position of both CNA #20 and Resident #100. In addition, the note documented Resident #100 stated that during the transfer, both of their legs (Resident #100 and CNA #20) had gotten tangled, causing them both to fall to the floor.</p> <p>Review of a nursing progress note, dated 01/15/25 at 4:25 P.M., revealed Resident #100's father reported to LPN #30 via telephone correspondence that the resident had a fractured left hip and would be awaiting an orthopedic consultation at the hospital.</p> <p>Review of the Fall Investigation note for Resident #100, dated 01/16/25, revealed Resident #100 had a fall with major injury related to staff assisting the resident and both falling to the floor when the resident's legs became entangled with CNA #20. It further stated the resident's left lower extremity range of motion was abnormal, as she was unable to move it due to extreme pain.</p> <p>Review of CNA #20's written statement, dated 01/16/25, revealed Resident #100 wanted to get into her bed from her wheelchair. Their legs became tangled during the transfer, which caused both of them to fall.</p> <p>Interview on 02/22/25 at 8:24 A.M. with Resident #100's family member revealed the resident sustained a fractured left hip, requiring the placement of a metal rod in her left leg, as a result of the fall on 01/15/25. He further added that the resident transferred to another facility following her hospitalization .</p> <p>A telephone interview on 02/22/25 at 10:40 A.M. with CNA #20 revealed she was seven months pregnant at the time of the incident with Resident #100. CNA #20 stated she was informed Resident #100 was a one-person staff assist for transfers, but did not confirm this information. CNA #20 stated during Resident #100's transfer, their legs become entangled, causing both of them to fall to the floor. She verified she was the only staff member in the room at the time of the fall and further confirmed Resident #100 began screaming in pain after the fall to the floor. CNA #20 denied knowledge of the therapy communication form, completed on 01/14/25, which indicated Resident #100 was to be a two-person staff assist with transfers.</p> <p>An interview on 02/22/25 at 11:50 A.M. with LPN #30 revealed she had responded to Resident #100's room on 01/15/25 when she heard the resident screaming in pain. LPN #30 verified Resident #100 had fallen after CNA #20 attempted to transfer her alone.</p> <p>An interview on 02/22/25 at 12:10 P.M. with the Director of Nursing (DON) confirmed the therapy communication form completed on 01/14/25 indicated Resident #100 required two-person staff assistance with transfers due to her medical conditions. The DON verified Resident #100's fall occurred after this assessment had been completed and acknowledged by LPN #10 and only one staff (CNA #20) assisted with the resident's transfer at the time of the fall on 01/15/25. The DON further confirmed the facility received report from the father of Resident #100 on 01/15/25 that the resident's left hip was fractured and required surgical intervention. The DON revealed the facility did not have hospital records related to the incident because the resident did not return to the facility.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility policy titled, Falls, 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 falling.</p> <p>Review of the undated facility policy titled, Activities of Daily Living (ADLs), revealed appropriate care and services would be provided for residents who were unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with mobility (transfer and ambulation).</p> <p>The deficiency was corrected on 02/17/25 when the facility implemented the following corrective actions:</p> <p>On 01/15/25 at approximately 12:25 P.M., LPN #30 assessed Resident #100, who was noted with pain and abnormal range of motion (ROM). Resident #100 was transferred to the hospital for further evaluation and treatment.</p> <p>On 01/15/25, the DON or designee updated Resident #100's plan of care to include assistance of two-staff with transfers.</p> <p>On 01/15/25, the DON or designee re-assessed Resident #100's fall risk and determined the resident remained at low risk for falls.</p> <p>On 01/15/25, the DON or designee educated all licensed nursing staff on ensuring communication between therapy and matched the resident's care plan and Kardex (system for organizing resident information). Review of the nursing in-service sign in sheets confirmed the education was provided.</p> <p>On 01/21/25, the DON or designee reviewed the therapy evaluations for all residents to ensure the level of assistance recommended by the therapy department matched the resident's care plan and Kardex. No discrepancies were identified.</p> <p>Beginning on 01/24/25, the DON or designee will audit four residents weekly for four weeks to ensure therapy recommendations for assistance with transfers were communicated to the nursing department and matched the resident's care plan and Kardex. The audits will be reviewed weekly by the Quality Assurance and Performance Improvement (QAPI) committee for trends and recommendations.</p> <p>Telephone interview on 02/25/25 at 12:00 P.M. with LPN #10, LPN #110, and Registered Nurse (RN) #100 confirmed the facility provided mandatory education on ensuring therapy recommendations were properly communicated and documented. In addition, education was provided on proper transfers and utilizing the required staff assistance level identified for each resident.</p> <p>Review of the facility audits from 01/24/25 through 02/17/25 revealed there were no further concerns identified.</p> <p>Review of two (#12 and #74) additional open resident records revealed no related concerns.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00162046.</p>