STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365812	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellspring Health Center	8000 Evergreen Ridge Drive Cincinnati, OH 45215

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** Based on record review, staff interview, review of the facility's investigation and policy review, the facility failed to provide adequate physical assistance for a resident who was dependent on staff for toileting, personal hygiene, and bed mobility. Actual Harm occurred on 01/19/26 at approximately 6:00 P.M. when one staff member was providing incontinent care to Resident #39 while in bed. Certified Nursing Assistant (CNA) #250 rolled Resident #39 to his left side and the resident fell from the bed onto the floor. Resident #39 had fractures to his right humerus (upper arm bone), right coronoid (elbow), left femur (upper leg bone), and left patella (kneecap). This affected one (Resident #39) of three residents reviewed for falls. The census was 48.Findings Include:Resident #39 was admitted to the facility on [DATE]. Diagnoses included osteoarthritis, hypokalemia, congestive heart failure, hypertensive heart and chronic kidney disease, low tension glaucoma, dementia, vitamin D deficiency, atherosclerotic heart disease, chronic kidney disease, thrombocytopenia, polyneuropathy, hyperlipidemia, cardiomyopathy, anxiety disorder, irritable bowel syndrome, major depressive disorder, hypertensive heart disease, and atrial fibrillation.Review of Resident #39's care plan, dated 02/21/25, revealed a care plan for activities of daily living (ADL) self-care performance. Interventions included Resident #39 was totally dependent on two staff with use of draw sheet to scoot up toward the head of his bed. Also, Resident #39 was dependent on staff for toileting hygiene.Review of Resident #39's Minimum Data Set (MDS) assessment, dated 01/31/26, revealed he was cognitively intact, had an impairment to both sides of his upper and lower extremities. He was dependent on staff assistance for toilet hygiene, upper body dressing, lower body dressing, putting on/taking off footwear, personal hygiene, and bed mobility. Review of Resident #39's fall risk assessment, dated 07/24/25, revealed he scored a 12. A score above ten meant Resident #39 was at risk for falls.Review of Resident #39's ADL Task documentation, dated 01/14/26 to 01/19/26 documented Resident #39 required the assistance of two people for bed mobility and hygiene.Review of Resident #39's Incident Report, dated 01/19/26, revealed CNA #250 was completing peri-care for Resident #39 in his bed. She assisted him with rolling to his left side, away from her, while she cleaned him. Resident #39's hand lost strength and he fell from the bed. The incident report documented that Licensed Practical Nurse (LPN) #200 was contacted to assess Resident #39. LPN #200 took his vital signs, which were within normal limits, and then received assistance from a second person to use the mechanical lift and place him back in bed. Resident #39 had a hard lump to the right humerus near his elbow where Resident #39 complained of pain, rating it a nine on a one to ten scale. A stat X-ray was ordered and education was provided to the staff related to positioning during care. The incident report documented Resident #39's care plan instructed Resident #39 was to have the assistance of two staff during care at all times. Review of Resident #39's progress note, dated 01/19/26, revealed Resident #39 refused to go to the emergency room after the fall, so the X-ray was ordered by the physician to be completed in the facility. Resident #39 (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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NAME OF PROVIDER OR SUPPLIER Wellspring Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 8000 Evergreen Ridge Drive Cincinnati, OH 45215	

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(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	and his power of attorney were notified.Review of Resident #39 progress note, dated 01/20/26, revealed a delay in X-ray service at the facility. There was swelling and continued pain to Resident #39's right arm. Resident #39's power of attorney was notified and all parties agreed to send the resident to the emergency room for further evaluation.Review of Resident #39's hospital documentation, dated 01/20/26, revealed X-rays were performed and Resident #39 had a right distal humerus supracondylar traverse closed fracture, right coronoid non-displaced fracture, left distal femur supracondylar closed fracture, and left patella fracture. The documentation confirmed the injuries occurred when he slipped off the bed while changing brief.During an interview on 02/13/26 at 1:45 P.M., the Director of Nursing (DON) confirmed Resident #39's Kardex/ADL assistance tracking documented Resident #39 needed the assistance of two people for toilet hygiene and bed mobility tasks. The DON also confirmed since 02/21/24, he needed the assistance of two people for bed mobility, which is in his care plan. She stated it was the nurse aide's judgement at the time of peri-care, to determine if the resident needed a second person for safety. She confirmed he had impairments on both sides of his upper and lower extremities and that he needed two-person assistance when he was being transferred via mechanical lift.During an interview on 02/13/26 at 1:55 P.M., Resident #39 stated it's about 50/50 if the facility had two staff with him or not when providing incontinent care or cleaning him in his bed. He confirmed the day of his fall, he was turned in bed by one staff, she was cleaning him, his hand gave out, and then he fell to the ground. He felt he fell from a long distance, but in reality, the bed was in a normal height position. He stated he was in a lot of pain. He confirmed he didn't want to go to the hospital at first, but after X-ray didn't come, he was fine with going to the hospital.During an interview on 02/13/26 at 2:30 P.M., LPN #200 stated she was the nurse on duty when Resident #39 fell and got injured. She stated she was called to the room to assess Resident #39 prior to being moved; his vital signs were fine, and the only pain he was expressing was in his right arm. She stated she was not sure what his care levels were for staffing at the time of the fall, but confirmed there was only one aide (CNA #250) assisting with his care when he fell. She called for a stat X-ray order because Resident #39 did not want to go to the emergency room; this was agreed upon by Resident #39's POA as well. By 01/20/26, the X-ray still had not been done so she called the physician and POA again; they agreed to send him to hospital, because some swelling and pain were still present.An attempt was made to interview CNA #250 on 02/13/26 at 2:39 P.M. She was not available for an interview; a voicemail message was left and no call was returned during the survey.Review of the policy titled Fall Prevention Program, dated 09/10/25, revealed a fall was defined as an event in which an individual unintentionally comes to rest on the ground, floor, or other level, but not as a result of an overwhelming external force. The event may be witnessed, reported, or presumed when a resident is found on the floor or ground, and can occur anywhere. Upon admission, the nurse will complete a fall risk assessment along with the admission assessment to determine the resident's level of fall risk. When a resident experiences a fall, the facility will: assess the resident, complete a post fall assessment, complete an incident report, notify the physician and family, review the resident care plan and update as indicated, document all assessments and actions, and obtain witness statements in the case of injury. This deficiency represents non-compliance investigated under Complaint Number 2724402.