STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365894	A. Building B. Wing	03/31/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCV Health Care Facilities, Inc	411 Western Row Road Mason, OH 45040

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** THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NONCOMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on medical record review, facility investigation review, staff and resident interviews, and facility policy review, the facility failed to ensure a gait belt was in place to prevent a fall. This affected one (Resident #08) of three residents reviewed for accidents. The census was 61. Review of Resident #08's chart revealed Resident #08 admitted to the facility on [DATE] with diagnoses including but not limited to metabolic encephalopathy, hypertension, disorientation, unspecified osteoarthritis, muscle weakness, other abnormalities of gait and mobility, major depressive disorder, overactive bladder, other specified anxiety disorders, visual hallucinations, and allergic rhinitis.Review of Resident #08's admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was severely cognitively impaired and required moderate assistance with toileting, upper body dressing, rolling left and right, sitting to lying, lying to sitting, sitting to standing, chair transfers, and walking ten feet and required maximal assistance with showering, toilet transfers, and tub transfers. Resident #08 was dependent with lower body dressing and putting on and taking off footwear and required supervision with personal hygiene. Resident #08 had not had any falls since her admission to the facility but Resident #08 had a fall in the last month prior to admission to the facility.Review of Resident #08's fall risk assessment dated [DATE] revealed Resident #08 had fallen one to two times in the past six months. Resident #08 was unable to independently come to a standing position, exhibited loss of balance while standing, required hands on assistance to move from place to place, used an assistive device and had a decrease in muscle coordination. Resident #08 was at high risk for falls.Review of Resident #08's fall care plan dated 03/12/26 revealed Resident #08 was at risk for falls. Interventions included anticipate and meet the resident's needs, be sure the call light is within reach, encourage the resident to use the call light for assistance, provide a prompt response to all requests for assistance, encourage non skid footwear as ordered, follow facility fall protocol, provide maximum to moderate assistance with transfers and walking short distances, Resident #08 uses a walker and a wheelchair for long distances, assistance with wearing shoes when walking, review information post falls and attempt to determine the cause of falls, record possible root causes of falls, alter and remove any potential causes of falls, educate the resident, family and caregivers as to causes and orthostatic blood pressures for three days.Review of Resident #08's progress note dated 02/26/26 at 3:08 P.M. revealed a care conference was held with Resident #08, Resident #08's daughter, therapy and Social Services (SS) #90. Resident #08 needed minimal assistance to get in and out of bed and minimal to moderate assistance with standing. Resident #08 had been having pain in her left foot and therapy was working on leg strength and balance as Resident #08 leaned backwards when standing. Resident #08's discharge goal was to return to her single level condo where she resided alone. Resident #08 had used home health in the past.Review of Resident #08's progress note dated 03/05/26 at 2:38 P.M. revealed a care conference was with Resident #08, Resident #08's daughter, therapy, nursing, the dietician and SS #90. Resident #08 required contact to minimal assistance with bed mobility and (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	minimal assistance with transfers. Resident #08 leaned back when she stood up and therapy was working on balance. Resident #08 was walking 25 feet with the walker and therapy still needed to work on stairs. Resident #08 required minimal to moderate assistance with lower body dressing and toilet transfers. Review of Resident #08's occupational therapy progress note dated 03/06/26 revealed Resident #08 performed a toilet transfer requiring contact guard assistance using grab bars while needing constant verbal cueing for good sequencing. Review of Resident #08's physical therapy progress note dated 03/06/26 revealed Resident #08 performed git training with a two wheeled walker using contact guard assistance. Resident #08 also performed a sit to stand transfer from the recliner and wheelchair with minimal assistance to contact guard assistance. Review of Resident #08's fall risk assessment dated [DATE] revealed Resident #08 had fallen one to two times in the past six months. Resident #08 was unable to independently come to a standing position, Resident #08 exhibited loss of balance while standing and Resident #08 used an assistive device and Resident #08 had a decrease in muscle coordination. Resident #08 was at moderate risk for falls.Review of Resident #08's progress note dated 03/10/26 at 1:15 P.M. revealed Licensed Practical Nurse (LPN) #107 was informed by the Certified Nursing Assistant (CNA) #242 that Resident #08 had fallen in her room. Upon arriving, LPN #107 noted Resident #08 was on her back on the floor at the foot of the bed. A pillow was placed under Resident #08's head. CNA #242 stated Resident #08 fell backwards when walking with her to the bathroom. A head to toe assessment was completed for injuries. Vital signs were taken and neurological checks were initiated. Resident #08 was noted with a red raised area to the back of the head. Neurological checks were within normal limits and the physician was notified. A new order was put in place for shoes for ambulation. Resident #08's daughter was notified and was present. Resident #08's daughter requested Resident #08 be sent to the emergency room (ER) for evaluation and treatment.Review of Resident #08's neurological assessments from 03/10/26 at 2:00 P.M. to 03/13/26 at 11:15 P.M. revealed all neurological checks were within normal limits.Review of Resident #08's progress note dated 03/10/26 at 2:05 P.M. revealed emergency medical services (EMS) was called per Resident #08 and Resident #08's daughter's request.Review of Resident #08's progress note dated 03/10/26 at 2:18 P.M. revealed Resident #08 exited the facility with EMS by stretcher.Review of Resident #08's hospital note dated 03/10/26 revealed Resident #08 presented to the ER from the skilled nursing facility by EMS for a witnessed fall. Resident #08 was being assisted to the bathroom by staff when they took their hand off of her gait belt to open the door and she fell backwards and hit her head. Resident #08 denied loss of consciousness or vomiting. Resident #08 was at her baseline for mental status. Resident #08 noted some pain in the left side of her neck that had been present for a few days. Resident #08 was given Tylenol prior to leaving the skilled nursing facility. Further review of the hospital note revealed Resident #08 was awake and was at her baseline for neurological and mental status. Resident #08 had a small contusion of the occipital scalp and some tenderness of her left paraspinal musculature of her neck. A computed tomography (CT) of the head and neck did not show any significant acute traumatic injuries. The clinical impressions for the ER visit were listed as thyroid nodule incidentally noted on imaging study, fall initial encounter and injury of the head initial encounter.Review of the head CT without contrast dated 03/10/26 revealed No acute intracranial abnormality. Resident #08 had a two centimeter (cm) nodule on the left thyroid lobe. Review of Resident #08's progress note dated 03/10/26 at 6:09 P.M. revealed Resident #08 returned from the hospital. Resident #08 had a CT of the head and cervical spine. No new orders were given. Resident #08's daughter arrived before Resident #08. Neurological checks were continued per schedule and the physician was made aware of the resident's return.Review of Resident #08's progress note dated 03/10/26 at 10:14 P.M. revealed Resident #08 was alert and oriented to person, place and situation. Resident #08 was intermittently confused and forgetfulness was noted. Resident #08 was pleasant and cooperative to care. No signs or symptoms of respiratory distress or shortness of breath were noted. Resident #08 complained of left leg pain. Routine Tylenol was given and effective. Resident #08 remained on neurological checks. Resident #08's daughter requested that her (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	mother not be awakened for neurological checks and only wanted them to be done while awake. Resident #08 was resting quietly in bed with her call light and belongings in reach.Review of CNA #242's undated witness statement revealed CNA #242 was assisting a resident who needed to use the restroom on 03/10/26 at 1:15 P.M. The resident was using a walker and CNA #242 was walking beside her while providing guidance and support. CNA #242 had a hand on the resident at all times while assisting her. As they approached the bathroom door, CNA #242 reached for the door knob to open the door while maintaining her hand on Resident #08 for support. At that moment, the resident began to lose balance and went down to the floor. The resident fell backward and struck her head on the floor. The incident occurred quick while CNA #242 was assisting the resident with the walker and maintaining support.Review of Resident #08's undated investigative summary signed by the Director of Nursing (DON) revealed Resident #08 fell at the facility on 03/10/26 at 1:15 P.M. The nurse was informed by CNA #242 that Resident #08 had fallen in her room. Upon arrival, the nurse noted Resident #08 was on her back on the floor at the foot of the bed. A pillow was placed under the resident's head. CNA #242 stated Resident #08 fell backwards when walking with Resident #08 to the bathroom. Per the interview with CNA #242, CNA #242 stated she did not have the gait belt on the resident. CNA #242 stated she opened the door and at that time Resident #08 leaned backwards and lost her balance. CNA #242 had her hand on Resident #08 but was unable to prevent the fall from occurring. CNA #242 stated she called for the nurse and placed a pillow under her head and stayed with Resident #08. The nurse assessed Resident #08 for injury, vitals were taken and neurological checks were initiated. Resident #08 was noted with a red raised area to the back of the head. Neurological checks were within normal limits and the physician was notified. A new intervention was put in place for Resident #08 to have shoes on for ambulation. Resident #08's daughter was notified by the resident and was present at the facility. Resident #08's daughter requested for Resident #08 to be sent to the ER for evaluation due to Resident #08 having a hematoma to the back of the head. Resident #08 was sent to the hospital at 2:15 P.M. Resident #08 returned to the facility on [DATE] at 6:00 P.M. and a head CT was completed at the ER and was negative. Resident #08 also had pain to the buttocks and lower back. Xrays of the lumbar spine and bilateral hips were completed on 03/11/26 and showed arthritis but no fracture or dislocation. The immediate intervention was footwear while ambulating and CNA #242 was educated on gait belt usage by LPN #107 and RN #44 on 03/10/26. An in-service for all nursing staff to review and sign on gait belt usage was completed.Review of Resident #08's progress note dated 03/11/26 at 10:25 A.M. revealed the interdisciplinary team (IDT) discussed Resident #08's fall from 03/10/26 where Resident #08 was noted on her back on the floor at the foot of her bed. A pillow was placed under Resident #08's head and the CNA stated Resident #08 fell backwards when walking with her to the bathroom. After a root cause analysis, the intervention for the fall was proper footwear during ambulation.Review of Resident #08's progress note dated 03/11/26 at 2:00 P.M. revealed the Director of Nursing (DON) spoke with Resident #08 regarding the 03/10/26 fall and how she was feeling. Resident #08 stated that she was anxious to ambulate at that time for fear of falling. Resident #08 stated that she was anxious and had a fear of falling prior to the recent fall. Resident #08 stated that she was having pain in her lower back and buttocks, but the Tylenol was effective. Resident #08 felt like her biggest barrier at that time was her anxiety and being worrisome. Resident #08 stated that her Lexapro helped but that was something she had been dealing with for a long time. Resident #08 was working with therapy on ways to help her anxiety.Review of Resident #08's progress note dated 03/12/26 at 2:29 P.M. revealed a care conference was held with Resident #08, Resident #08's daughter, the DON, dietician, therapy and SS #90. Resident #08 was able to sit to stand with contact guard and Resident #08's longest standing tolerance was 35 seconds. Resident #08 was seen by the physician on 03/10/26 and Resident #08 had an order for Tylenol. Resident #08 had a muscle relaxer and an x-ray on 03/11/26 which were negative for fractures. The DON discussed doing bladder scans as an option and Resident #08 was seen by psychiatry on 03/11/26. Psychiatry spoke with Resident #08 about her anxiety. ST was also working with Resident #08 on techniques to (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	help with anxiousness such as writing things down.Review of CNA #242's personnel file revealed CNA #242 was hired by the facility on 03/09/25. Further review of CNA #242's personnel file revealed CNA #242 had a first written warning disciplinary action form dated 03/10/26. The disciplinary action form stated CNA #242 assisted a resident to the restroom in her room on 03/10/26. The resident required hands on assistance with transfers and ambulation. While ambulating to the restroom, CNA #242 did not use a gait belt per facility policy. Corrective actions included CNA #242 will use a gait belt for all residents requiring hands on assistance for transfers and ambulation. The gait belt policy was reviewed and understood by CNA #242. The disciplinary action form was signed by CNA #242 and LPN Supervisor #26 on 03/13/26.Observation of Resident #08 on 03/31/26 at 11:30 A.M. revealed Resident #08 was sitting in her recliner in her room. Resident #08 appeared clean and appropriately dressed.Interview with Resident #08 on 03/31/26 at 11:30 A.M. revealed Resident #08 denied having any falls at the facility. Resident #08 denied having any falls while walking to the bathroom with staff at the facility. Resident #08 reported no concerns regarding the facility. Interview with the DON on 03/31/26 at 11:45 A.M. revealed CNA #242 was ambulating Resident #08 from the recliner in her room to the bathroom on 03/10/26 when CNA #242 went to open the door to the restroom and Resident #08 fell backwards onto the floor. The DON stated that Resident #08 hit the back of her head on the floor and CNA #242 yelled for the nurse while she remained with Resident #08. The DON also reported CNA #242 placed a pillow under Resident #08's head while waiting for the nurse. LPN #107 and RN #44 came to Resident #08's room and assessed Resident #08. The DON reported Resident #08's neurological check and vitals were within normal limits and Resident #08 was assisted into a chair. The DON reported Resident #08 had a area to the back of her head and the physician was contacted by LPN #107. The DON stated that Resident #08's physician was notified by LPN #107 and Resident #08's daughter arrived to the facility while the DON was on the telephone with the physician's office within minutes of the fall. The DON reported Resident #08's daughter was called by Resident #08 after the fall and LPN #107 had not called Resident #08's daughter because LPN #107 called Resident #08's physician prior to the daughter. The DON stated that LPN #107 told Resident #08's daughter that she would be right with her and Resident #08's daughter told the DON that she felt LPN #107 was dismissing her. The DON stated LPN 107 spoke with Resident #08's daughter and Resident #08's daughter wanted Resident #08 sent to the hospital. The DON reported Resident #08 was sent to the hospital at 2:15 P.M. and Resident #08 returned from the hospital at 6:00 P.M. The DON stated Resident #08 had a negative head CT at the hospital and no new orders. The DON reported Resident #08 had not fallen at the facility prior to the 03/10/26 fall and the facility investigated the fall and found that CNA #242 did not have a gait belt on the resident at the time of the fall. The DON verified Resident #08 required contact guard assistance and the use of a gait belt with ambulation and transfers. The DON confirmed that therapy also assessed Resident #08 prior to the fall on 03/10/26 and Resident #08 required contact guard assistance and the use of a gait belt for ambulation. The DON reported the facility also added an intervention for Resident #08 to have footwear during ambulation because Resident #08 was wearing gripper socks but no shoes at the time of the fall. The DON stated Resident #08 informed the facility that she walked better when wearing shoes. The DON stated the facility completed immediate education with CNA #242 on the gait belt policy on 03/10/26 and the facility completed education of all nurses, CNAs and therapy staff on the gait belt policy on 03/11/26. The DON also reported the facility initiated audits to ensure that staff were using gait belts when assisting residents with ambulation and transfers. The DON stated that she spoke with Resident #08's daughter on 03/11/26 and a care conference was completed on 03/12/26. Interview with the DON on 03/31/26 at 12:24 P.M. revealed the DON verified Resident #08 had a history of leaning backwards during ambulation prior to the fall on 03/10/26. Attempted to call CNA #242 on 03/31/26 at 12:30 P.M. with no response. Interview with Physical Therapist (PT) #700 on 03/31/26 at 2:11 P.M. revealed Resident #08 was assessed to use a gait belt with staff when ambulating at the time of her fall on 03/10/26. PT #700 stated Resident #08 had a history if leaning backwards while (continued on next page)

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