STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365937	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ohman Family Living at Briar	15950 Pierce St Middlefield, OH 44062

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** Based on record review, interview review of the Stand Up (Chorus) Patient Lift Manual and facility policy review, the facility failed to provide adequate supervision/assistive devices to prevent avoidable accidents/falls. This affected one resident (Resident #10) out of four reviewed for accidents/falls. This had the potential to affect 48 residents (Resident # #3, #4, #5, #6, #10, #11, #14, #15, #17, #18, #19, #20, #23, #25, #26, #28, #30, #31, #32, #36, #38, #39, #41, #44, #46, #50, #52, #55, #57, #60, #61, #65, #70, #71, #73, #75, #77, #80, #82, #83, #84, #85, #87, #89, #95, #96, #103, #106) that required a Chorus (operated lift designed to safely transition individuals with limited mobility from sitting to standing for transfers) or mechanical lift for transfer. The facility census was 92.Findings include:Record review revealed Resident #10 admitted on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD), Stage IV pressure ulcer (Full thickness tissue loss with exposed bone, tendon or muscle. Slough may be present on some parts of the wound bed. Often include undermining and tunneling.) to the left buttock, neuromuscular bladder, tremor, unspecified convulsions, repeated falls, mild vascular dementia, and cognitive communication deficit.Review of the physician orders dated 01/12/22 revealed Resident #10 required a Chorus lift with two staff assistance for transfers and a wheelchair for mobility.Review of the Fall Risk Evaluation V2 dated 11/11/25 and completed by Former Licensed Practical Nurse (LPN) #483 revealed Resident #10 was at high risk for falls as he was confined to a chair, unable to stand, had diagnoses that placed him at high risk for falls as well as was on medications that increased his risk of falls.Review of the nurse's note dated 12/01/25 and completed by LPN #318 revealed Resident #10 had a witnessed fall and was lowered to the ground by Agency Certified Nurse Aide (CNA) #480. LPN #318 was informed by Agency CNA #480 that while transferring Resident #10 from the bed to the wheelchair, he lost strength and she was unable to hold him up and had to lower him to the floor. The nursing note revealed he had no injuries and/or signs of pain. Review of the fall investigation dated 12/01/25 and completed by LPN #318 revealed Resident #10 lost strength in his upper extremities during transfer and was lowered to the floor by Agency CNA #480.Review of the Kardex (brief overview of each resident) dated 12/01/25 revealed Resident #10 was to have two staff assist with the Chorus lift transfers.Review of CNA Transfer Inservice dated 12/23/25 and completed by Staff Development/ Registered Nurse (RN) #329 revealed education was provided to follow transfer orders in the Kardex in the electronic medical record or ask the nurse if needed.Review of the nurse's note dated 01/11/26 and completed by LPN #318 revealed Resident #10 had a witnessed fall when Agency CNA #481 lowered him to the floor due to him not being able to maintain balance while using the Chorus lift. The nursing note revealed he had no injuries and/or signs of pain. Review of the fall investigation dated 01/11/26 and completed by LPN #318 revealed Resident #10 was lowered to the floor by Agency CNA #481 due to not being able to maintain his balance. LPN #318 was called to the room and observed the resident sitting on the floor on his buttocks in front of his wheelchair. Resident #10 stated his footing was not correct and while transferring he was unable to hold on.Review of the Kardex dated 01/11/26 revealed Resident #10 was to have two staff assist with the Chorus lift transfers.Review of the email from Assistant (continued on next page)

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	Director of Nursing (ADON) #394 to Agency CNA #481 dated 01/12/26 revealed instructions to check the Kardex or ask staff for transfer status of residents. Agency CNA #481 responded she did ask for help, but everyone was busy. ADON #394 replied she would need to wait for help and follow the orders in the Kardex.Review of Physical Therapy Evaluation and Treatment Plan and completed by Physical Therapist (PT) #375 dated 01/29/26 revealed Resident #10 was performing bed mobility with physical therapy; the resident had not attempted out of bed activity.Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #10 was cognitively intact. He was dependent on staff for rolling and required maximum assistance for bed mobility. Resident #10 was dependent on staff for sit-to-stand and transfers.Review of the Care Plan dated 02/19/26 revealed Resident #10 was at risk for falls related to impaired mobility, impaired balance, medication use, diagnoses of morbid obesity, COPD, congestive heart failure (CHF), anxiety, depression, and tremors. Interventions included monitoring and medicating for pain, monitoring for signs of dizziness, pharmacy review of medications monthly, referring to physical and occupational therapy to evaluate and treat as needed.Review of Quarterly Fall Risk Evaluation V2 dated 02/19/26 and completed by MDS/ LPN #324 revealed Resident #10 continued to be at high risk for falls, was confined to a chair, unable to stand, had diagnoses that placed him at high risk for falls as well as was on medications that increased his risk of falls.Review of the nurse's notes dated 02/22/26 authored by LPN #318 revealed Resident #10 had a witnessed fall with Agency CNA #482 who yelled for help when attempting to transfer Resident #10 from the bed to the wheelchair. He was unable to stand and began sliding down. Resident #10 was lowered to the ground by Agency CNA #482 and LPN #318. Staff then assisted him off the floor with use of a mechanical lift (used to safely transfer residents who cannot bear weight and limited mobility between positions) into his wheelchair with two staff assist. The nursing note revealed he had no injuries and/ or signs of pain. Review of the fall investigation dated 02/22/26 revealed Agency CNA #482 yelled for someone to assist her. LPN #318 arrived at Resident #10's room and observed the resident on the edge of his wheelchair still attached to the Chorus lift. Agency CNA #482 stated she was attempting to transfer Resident #10 from his bed to his wheelchair when he was unable to continue to stand and began sliding down. LPN #318 and Agency CNA #482 lowered Resident #10 to the ground.Review of the Kardex dated 02/22/26 revealed Resident #10 required two staff assistance for all Chorus lift transfers.Review of the physician's order dated 02/22/26 revealed Resident #10 was changed from a Chorus lift to a mechanical lift for transfers.Review of Physical Therapy (PT), PT Recert, Progress Report and Updated Therapy Plan dated 03/02/26 signed by PT #375 revealed transfers and sit/stand not attempted due to medical or safety concerns. Interview with Resident #10 on 03/02/26 at 10:00 A.M. and on 03/03/26 at 9:16 A.M. revealed he had fallen three times because the agency aides were not locking the wheelchair causing the chair to move back as he went to sit down, and he stated only one staff member assisted him each time instead of two. He revealed he does not want to use the mechanical lift as he wanted to continue to utilize the Chorus lift.Interview with Director of Rehab #466 on 03/03/26 at 11:01 A.M. revealed Resident #10 had always required either a mechanical lift or a Chorus lift to transfer. She verified Resident #10 was to be have two staff assist for both types of transfers for this resident.Interview with the Director of Nursing (DON) 03/03/26 at 12:42 P.M. verified Resident #10 was to have two-staff assist with the Chorus lift. She verified that only one staff member had transferred him on 12/01/25, 01/11/26, and 02/22/26 and that he had fallen and/or was lowered to the floor. Interview with LPN #318 on 03/03/26 at 2:45 P.M. revealed she was working when Resident #10 fell on [DATE], 01/11/26 and 02/22/26 and verified only one aide went into the room to transfer Resident #10 with Chorus lift each time. She verified aides have access to and are supposed to check the Kardex prior to resident care. She stated all three aides were from agency. She revealed she attempted to give report to aides before they do resident care but sometimes, they get into the room before she was done with nursing report from the previous shift. She revealed Resident #10 was lowered to the ground each time and did not complain of any injuries. She stated one of the three incidents was because the aide did not (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	lock the wheelchair. Review of undated facility policy, Falls Prevention Program revealed the purpose of the program is to identify the root cause of a fall, so that an intervention being put in place is effective. Falls risk assessment to be completed and falls weekly meeting held. There was nothing in the policy in regard to the facility monitoring that interventions per physician orders and/ or in their plan were implemented. Review of the Stand Up (Chorus) Patient Lift Manual dated 05/07/18 revealed individuals that use the patient sling must be able to support the majority of their own weight; otherwise injury may occur.This deficiency represents non-compliance investigated under Master Complaint Number 2747582.