STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366000	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER: Sycamorespring of Miamisburg		STREET ADDRESS, CITY, STATE, ZIP CODE: 2164 E Central Ave Miamisburg, OH 45342	

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** THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on medical record review, review of hospital records, review of a facility investigation, staff and family interviews, review of a video recording, and review of the facility policy, the facility failed to provide adequate assistance while transferring a resident resulting in an avoidable fall and failed to ensure staff timely report a fall when it occurred. This resulted in Actual Harm to Resident #78 on 08/25/25 when staff failed to provide adequate assistance when transferring the resident from a wheelchair to the bed which resulted in the resident falling to the floor, then staff assisted the resident back to bed without reporting the fall. Resident #78 was subsequently transferred to the hospital on [DATE] for treatment of a fractured femur to the left leg. This affected one (#78) of three residents reviewed for accidents. The facility census was 93. Findings include: Review of the medical record for Resident #78 revealed an admission date of 04/01/23 with diagnoses including vascular dementia, with other behavioral disturbance, unspecified fracture of left femur, subsequent encounter for closed fracture with routine healing, and major depressive disorder. Review of the Discharge Return Anticipated Minimum Data Set (MDS) assessment dated [DATE] for Resident #78 revealed the resident had severe cognitive impairment, and was dependent on staff assistance with all transfers. Review of the care plan for Resident #78 dated 09/01/25 revealed the resident is at risk for falls related to impaired mobility with interventions to assist resident with transfers, repositioning, and mobility. The care plan also revealed the physician and responsible party are to be notified of all falls. Review of the Radiology report dated 09/01/25 at 8:33 A.M. for Resident #78 revealed there Is a fracture Involving left distal femur with minimal displacement. Review of the progress note for Resident #78, with a created date of 09/02/25 at 5:45 P.M., late entry for 08/25/25 at 10:39 P.M. from Registered Nurse (RN) #301, revealed two Certified Nursing Assistants (CNA's) were transferring Resident #78 from the wheelchair to the bed. Once the resident was on the edge of the bed, she slipped off the edge of the bed onto the floor. Review of the emergency room notes dated 09/01/25 revealed Resident #78 had pain on movement of left hip because of femur fracture, brace on place. Resident #78 placed on intravenous (IV) fluids and IV blood pressure medications. Review of the hospital note dated 09/04/25 revealed surgeon spoke with Resident #78 ' s daughter and decided on nonoperative management. Review of an Incident Inter-Disciplinary Team (IDT) note for Resident #78 dated 09/04/25, completed by the Assistant Director of Nursing (ADON) #343 revealed staff were transferring Resident #78 on 08/25/25 at 10:05 P.M. when staff lost gait control and lowered her to the floor. X-rays were completed on 09/01/25 and the results showed a fracture to the left femur and resident was sent to the emergency room. Review of the witness statement dated 09/02/25 from CNA #473 revealed Resident #78 was successfully transferred then skid off the bed onto the floor. Review of the witness statement dated 09/02/25 from CNA #483 revealed while pivoting Resident #78 to (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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