

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366001	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2025
NAME OF PROVIDER OR SUPPLIER Harmar Place Rehab & Extended Care		STREET ADDRESS, CITY, STATE, ZIP CODE 401 Harmar Street Marietta, OH 45750	

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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704</p> <p>Based on medical record review, policy review and interview, the facility failed to notify the physician and responsible party of a resident change in condition. This affected one resident (#72) of three residents reviewed. The census was 71.</p> <p>Findings include:</p> <p>Closed medical record review revealed Resident #72 was admitted on [DATE] with diagnoses including sepsis, paraplegia, cancer and anxiety disorder.</p> <p>Review of the Incidents By Incident Type dated 02/14/25 to 05/14/25 revealed Resident #72 had one fall during staff assist on 05/06/25.</p> <p>Review of the admission Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #72 was cognitively intact for daily decision-making, was dependent on staff for toileting hygiene, bathing and dressing; required substantial-maximal assist with sit-to-stand, and was dependent on staff for chair/bed-to-chair transfers (the ability to come to a standing position from sitting in a chair or on side of the bed). The resident also had a fall prior to admission.</p> <p>Review of the Incident Report: Fall During Staff Assist dated 05/06/25 at 8:00 A.M. revealed the nurse was notified from the Certified Nurse Assistant (CNA) #34 the resident's knees gave out while she was helping transfer the resident to the toilet earlier in the shift. Upon assessment, small abrasion to left knee was noted and resident complained of slight back pain that worsens with movement. The fall occurred at 8:00 A.M. and the physician was not notified until 12:52 P.M. and the responsible party notification had no time as to when this occurred.</p> <p>Review of the SNF/NF to Hospital Transfer Form (Transfer Form) dated 05/06/25 at 2:27 P.M revealed the resident was sent to the emergency room due to a fall. The document indicated the physician and the son were both notified; however, there was no time documented of when this occurred.</p> <p>On 05/14/25 at 11:50 A.M. interview with the Director of Nursing verified the responsible party and physician were not notified timely of Resident #72's fall.</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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the policy: Notification and reporting of change in health status, illness, injury and death of a resident revised 12/27/23 revealed the administrator or designee shall immediately inform the resident, consult with resident's physician, the resident's sponsor or authorized representative in accordance with state and local laws and regulations when there is: an accident involving the resident which results in injury including the potential for requiring physician interventions. The notification should include a description of the circumstances and cause, if known, and a notation of change and any intervention taken shall be documented in the medical record.</p> <p>This deficiency represents an incidental finding of non-compliance investigated under Complaint Number OH00165620.</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704</p> <p>Based on closed medical record review, policy review, and interview, the facility failed to timely report and provide adequate, necessary and timely care for Resident #72 following a fall during a staff assisted transfer resulting in a delay of treatment for newly diagnosed compression vertebra fractures. This affected one resident (#72) of three residents reviewed for accidents. The census was 71.</p> <p>Actual Harm occurred on 05/06/25 at approximately 9:00 A.M. when Certified Nurse Assistant (CNA) #34 failed to notify the licensed nurse that Resident #72 sustained a fall during a staff assisted transfer resulting in a delay in treatment. The resident complained of back pain (intermittent, aching, moderate pain with protective body movements/posture associated with the pain) following the incident. However, the resident was not transferred to the hospital until 2:30 P.M. (five and a half hours after the incident) where he was diagnosed with and received treatment for compression fractures of his thoracic spine.</p> <p>Findings include:</p> <p>Closed medical record review revealed Resident #72 was admitted to the facility on [DATE] with diagnoses including cancer, history of falls, impaired mobility and paraplegia. The resident discharged to home on 05/10/25.</p> <p>Review of the Fall Risk Evaluation dated 03/03/25 revealed Resident #72 was at high risk for falls.</p> <p>Review of the care plan: At Risk for Falls revised 04/14/25 revealed Resident #72 was at risk for falls and required one to two staff assist with toileting and transfers. The resident's level of assistance with transfers was changed to two staff assistance following a fall that occurred on 05/06/25) per the Director of Nursing.</p> <p>Review of the discharge Minimum Data Set 3.0 dated 05/02/25 revealed Resident #72 was cognitively intact for daily decision-making and required partial to moderate (staff) assist with sit-to-stand (the ability to come to a standing position from sitting in a wheelchair, chair or side of the bed).</p> <p>Review of the Kardex dated 05/03/25 revealed staff were to implement the following for Resident #72: one to two assistance with toileting, avoid clutter, encourage non-slip footwear when out of bed, ensure walker/cane within reach, call light in reach, adequate low glare light, frequent items within reach, two person assist with transfers and use caution during transfers and bed mobility to prevent striking arms, legs and hands against any sharp or hard surfaces.</p> <p>Review of the ADL Task List-Transferring dated 05/03/25 through 05/06/25 revealed Resident #72 required limited to extensive (staff) assistance with transfers.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Review of the Incident Report: Fall During Staff Assist dated 05/06/25 revealed Certified Nurse Aide (CNA #34) had reported to the nurse that Resident #72's knees gave out while helping him transfer from toilet to wheelchair earlier in the shift. Injury resulting from the fall was a small abrasion to the left knee and complaints of slight back pain that worsens with movement. Predisposing physiological factors included gait imbalance and situation factors included ambulating with assist during transfer. The resident's physician was notified of the incident at 12:52 P.M. on 05/06/25. Further review revealed no documented evidence as to why the CNA did not notify the nurse immediately or when the family/responsible party was notified.</p> <p>Review of the Vitals and Pain Only Evaluation dated 05/06/25 at 12:52 P.M., revealed Resident #72 complained of intermittent, aching, moderate pain rated five out of 10, the resident had exhibited protective body movements/posture vocal complaints of pain. Non-medicated interventions included change in position and PRN medication administered.</p> <p>Review of the electronic Medication Administration Record (MAR) dated May 2025 revealed Resident #72 received Tramadol (pain medication) 50 milligrams for pain rated a six out of 10 (1-10 pain scale).</p> <p>Review of Resident #72's hospital documentation dated 05/06/25 revealed the resident was undergoing chemotherapy and radiation therapy for the last nine days with back pain associated with his treatment. Today he slipped in front of the toilet, sliding down and hitting his back. The resident reported his back pain was worse than baseline at that time. Review of the computed tomography (CT) results including thoracic spine revealed new changes involving superior endplate of T12 and T11 as well as inferior endplate of T 10 with background of substantial osteopenia. Findings were compatible with acute/subacute mild compression fracture of T12 and more mild-to-moderate acute/subacute compression fracture of the superior endplate of T11 and inferior endplate of T10. There may be some progression of bony metastasis with some ill-defined lucencies seen along the inferior endplate of T10 and superior endplate of T 11 which was questioned as well although findings may all just be posttraumatic with bony fragmentation. Recommendations included to wear back brace due to several fractures of the back and follow up with physician within a week.</p> <p>Review of CNA #34's incident statement dated 05/06/25 revealed during the transfer from Resident #72's chair to the toilet, his knees 'lost strength' bending very fast and hard hitting the wall. After that incident he was feeling a lot of pain on his lower back and during the transfer to his bed at. At 12:00 P.M. Resident #72 expressed much pain during the transfer.</p> <p>Review of an incident statement dated 05/14/25 revealed at approximately 1:30 P.M., Licensed Practical Nurse (LPN) #44 informed Registered Nurse (RN) #46 that Certified Nurse Aide (CNA) #34 had just reported to her that Resident #72 was complaining of a backache and that earlier in the day while in the bathroom, she had assisted him to stand up from the wheelchair and as he was holding onto the grab bar his knees buckled and he sat back down in the wheelchair. The statement included RN #46 spoke with CNA #34 and reminded her that all incidents were to be reported when they happen.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>On 05/14/25 at 11:50 A.M., interview with the Director of Nursing (DON) verified the above incident was a fall and should have been reported immediately. The DON verified CNA #34 did not immediately report the resident's fall, she moved the resident without the nurse assessing him first and it wasn't until approximately 1:30 P.M. per Registered Nurse (RN) #46's statement that LPN #44 was notified of the incident. Once CNA #34 went to LPN #44 and told her what had happened earlier in her shift, the nurse assessed the resident and the resident was transferred to the hospital for evaluation (at approximately 2:30 P.M. on 05/06/25). The DON verified the investigation had contradictions in the time frames and statements. The DON verified she did not have the investigation completed, was educating staff and obtaining statements as of today during the survey in regards to Resident #72's fall.</p> <p>On 05/14/25 at 1:37 P.M., interview with CNA #34 revealed on 05/06/25 just after breakfast around 9:00 A.M. she was assisting Resident #72 to the bathroom. While assisting the resident to stand she asked him to hold onto the grab bar, at which time his knees buckled and he fell back into the wheelchair. CNA #34 stated she called for assistance and CNA #50 helped to stand the resident up and sat him back on the toilet. CNA #34 stated she asked CNA #50 if she should report this incident and was told if he didn't end up on the floor, it was not considered a fall. At that point, CNA #34 stated she finished toileting the resident and assisted him back into his wheelchair. CNA #34 stated when she went to check on him after lunch he stated he was having more back pain than normal and had facial grimacing. At that point, CNA #34 informed the nurse of what had happened that morning after breakfast and the nurse went to the resident's room. CNA #34 stated she could not remember if she was using a gait belt or had a hold of the gait belt at the time of the fall. CNA #34 stated Resident #72 had been improving and able to transfer with just one assist; however, he had started some radiation chemotherapy treatments and seemed to be weaker and required more staff assistance. CNA #34 stated Resident #72 was not a fall risk but if he was there were to always be two caregivers. CNA #34 verified she did not report Resident #72's fall immediately to her charge nurse as the fall was not reported for over four hours.</p> <p>On 05/14/25 at 2:35 P.M., interview with CNA #50 revealed on 05/06/25 she was asked to help get Resident #72 to the bathroom but when she entered the room he was already sitting on the toilet completely dressed. CNA #50 stated the resident did not have a gait belt on and she helped stand him up so they could pull down his pants. CNA #50 stated once on the toilet she left the room. CNA #50 verified there was no gait belt used and did not know at the time that Resident #72 had fallen back into his wheelchair prior to or after CNA #34 asking for her help.</p> <p>Review of the policy: Falls Management dated 01/14/14 revealed if a resident falls, despite interventions, the following was to occur: Resident will be fully assessed by a licensed nurse and if deemed safe by a nurse, the resident would be lifted/assisted into bed or wheelchair to be further assessed. The facility would notify the physician and resident family member as soon as practicable. In the event of a head injury or suspected fracture, the physician and family member will be notified immediately. Staff were then to determine what preventable measures were to be put into place to protect resident against another fall and implemented as soon as possible.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00165620.</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</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** 28704</p> <p>Based on observation, medical record review, policy review, and interview, the facility failed to develop and implement a comprehensive and individualized fall prevention program to ensure fall interventions were implemented for Resident #28 and to ensure Resident #72 and Resident #75 were provided adequate assistance with transfers. This affected three residents (#28, #72, and #75) of three residents reviewed for accidents. The census was 71.</p> <p>Actual Harm occurred on 05/06/25 at approximately 9:00 A.M. when Certified Nurse Assistant (CNA) #34 was transferring Resident #72, who was a high risk for falls and increased risk of injury related to falls, to the toilet by herself without the use of a gait belt, the resident's knees buckled and the resident fell back into the wheelchair resulting in new compression fractures to the thoracic spine with associated increased complaints of intermittent, aching, moderate pain with protective body movements/posture.</p> <p>Findings include:</p> <p>1. Closed medical record review revealed Resident #72 was admitted to the facility on [DATE] with diagnoses including cancer, history of falls, impaired mobility and paraplegia. The resident discharged to home on 05/10/25.</p> <p>Review of the Fall Risk Evaluation dated 03/03/25 revealed Resident #72 was at high risk for falls.</p> <p>Review of the care plan: At Risk for Falls revised 04/14/25 revealed Resident #72 was at risk for falls and required one to two staff assist with toileting and transfers. The resident's level of assistance with transfers was changed to two staff assistance following a fall that occurred on 05/06/25) per the Director of Nursing.</p> <p>Review of the discharge Minimum Data Set 3.0 dated 05/02/25 revealed Resident #72 was cognitively intact for daily decision-making and required partial to moderate staff assist with sit-to-stand (the ability to come to a standing position from sitting in a wheelchair, chair or side of the bed).</p> <p>Review of the Kardex dated 05/03/25 revealed staff were to implement the following for Resident #72: one to two assistance with toileting, avoid clutter, encourage non-slip footwear when out of bed, ensure walker/cane within reach, call light in reach, adequate low glare light, frequent items within reach, two person assist with transfers and use caution during transfers and bed mobility to prevent striking arms, legs and hands against any sharp or hard surfaces.</p> <p>Review of the ADL Task List-Transferring dated 05/03/25 through 05/06/25 revealed Resident #72 required limited to extensive assistance with transfers.</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>Note: The nursing home is disputing this citation.</p>	<p>Review of the Incident Report: Fall During Staff Assist dated 05/06/25 revealed Certified Nurse Aide (CNA #34) had reported to the nurse that Resident #72's knees gave out while helping him transfer from toilet to wheelchair earlier in the shift. Injury resulting from the fall was a small abrasion to the left knee and complaints of slight back pain that worsens with movement. Predisposing physiological factors included gait imbalance and situation factors included ambulating with assist during transfer. The resident's physician was notified of the incident at 12:52 P.M. on 05/06/25. Further review revealed no documented evidence as to if a gait belt was used during the transfer or when the family/responsible party was notified.</p> <p>Review of the Vitals and Pain Only Evaluation dated 05/06/25 at 12:52 P.M., revealed Resident #72 complained of intermittent, aching, moderate pain rated five out of 10, the resident had exhibited protective body movements/posture vocal complaints of pain. Non-medicated interventions included change in position and PRN medication administered.</p> <p>Review of the electronic Medication Administration Record (MAR) dated May 2025 revealed Resident #72 received Tramadol (pain medication) 50 milligrams for pain rated a six out of 10 (1-10 pain scale).</p> <p>Review of Resident #72's hospital documentation dated 05/06/25 revealed resident was undergoing chemotherapy and radiation therapy for the last nine days with back pain associated with his treatment. Today he slipped in front of the toilet, sliding down and hitting his back. The resident reported his back pain was worse than baseline at that time. Review of the computed tomography (CT) results including thoracic spine revealed new changes involving superior endplate of T12 and T11 as well as inferior endplate of T10 with background of substantial osteopenia. Findings were compatible with acute/subacute mild compression fracture of T12 and more mild-to-moderate acute/subacute compression fracture of the superior endplate of T11 and inferior endplate of T10. There may be some progression of bony metastasis with some ill-defined lucencies seen along the inferior endplate of T10 and superior endplate of T11 which was questioned as well although findings may all just be posttraumatic with bony fragmentation. Recommendations included to wear back brace due to several fractures of the back and follow up with physician within a week.</p> <p>Review of CNA #34's incident statement dated 05/06/25 revealed during the transfer from Resident #72's chair to the toilet, his knees 'lost strength' bending very fast and hard hitting the wall. After that incident he was feeling a lot of pain on his lower back and during the transfer to his bed at. At 12:00 P.M. Resident #72 expressed much pain during the transfer.</p> <p>Review of an incident statement dated 05/14/25 revealed at approximately 1:30 P.M., Licensed Practical Nurse (LPN) #44 informed Registered Nurse (RN) #46 that Certified Nurse Aide (CNA) #34 had just reported to her that Resident #72 was complaining of a backache and that earlier in the day while in the bathroom, she had assisted him to stand up from the wheelchair and as he was holding onto the grab bar his knees buckled and he sat back down in the wheelchair. The statement included RN #46 spoke with CNA #34 and reminded her that all incidents were to be reported when they happen.</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>Note: The nursing home is disputing this citation.</p>	<p>On 05/14/25 at 11:50 A.M., interview with the Director of Nursing (DON) verified the above incident was a fall and should have been reported immediately. The DON verified CNA #34 did not immediately report the resident's fall, she moved the resident without the nurse assessing him first and it wasn't until approximately 1:30 P.M. per Registered Nurse (RN) #46's statement that LPN #44 was notified of the incident. Once CNA #34 went to LPN #44 and told her what had happened earlier in her shift, the nurse assessed the resident and the resident was transferred to the hospital for evaluation (at approximately 2:30 P.M. on 05/06/25). The DON verified the investigation had contradictions in the time frames and statements. The DON verified she did not have the investigation completed, was educating staff and obtaining statements as of today during the survey in regards to Resident #72's fall.</p> <p>On 05/14/25 at 1:37 P.M., interview with CNA #34 revealed on 05/06/25 just after breakfast around 9:00 A.M. she was assisting Resident #72 to the bathroom. While assisting the resident to stand she asked him to hold onto the grab bar, at which time his knees buckled and he fell back into the wheelchair. CNA #34 stated she called for assistance and CNA #50 helped to stand the resident up and sat him back on the toilet. CNA #34 stated she asked CNA #50 if she should report this incident and was told if he didn't end up on the floor, it was not considered a fall. At that point, CNA #34 stated she finished toileting the resident and assisted him back into his wheelchair. CNA #34 stated when she went to check on him after lunch he stated he was having more back pain than normal and had facial grimacing. At that point, CNA #34 informed the nurse of what had happened that morning after breakfast and the nurse went to the resident's room. CNA #34 stated she could not remember if she was using a gait belt or had a hold of the gait belt at the time of the fall. CNA #34 stated Resident #72 had been improving and able to transfer with just one assist; however, he had started some radiation chemotherapy treatments and seemed to be weaker and required more staff assistance. CNA #34 stated Resident #72 was not a fall risk but if he was there were to always be two caregivers. CNA #34 verified she did not report Resident #72's fall immediately to her charge nurse as the fall was not reported for over four hours.</p> <p>On 05/14/25 at 2:35 P.M., interview with CNA #50 revealed on 05/06/25 she was asked to help get Resident #72 to the bathroom but when she entered the room he was already sitting on the toilet completely dressed. CNA #50 stated the resident did not have a gait belt on and she helped stand him up so they could pull down his pants. CNA #50 stated once on the toilet she left the room. CNA #50 verified there was no gait belt used and did not know at the time that Resident #72 had fallen back into his wheelchair prior to or after CNA #34 asking for her help.</p> <p>Review of the policy: Falls Management dated 01/14/14 revealed if a resident falls, despite interventions, the following was to occur: Resident would be fully assessed by a licensed nurse and if deemed safe by a nurse, the resident would be lifted/assisted into bed or wheelchair to be further assessed. The facility would notify the physician and resident family member as soon as practicable. In the event of a head injury or suspected fracture, the physician and family member will be notified immediately. Staff were then to determine what preventable measures were to be put into place to protect resident against another fall and implemented as soon as possible.</p> <p>2. Medical record review revealed Resident #75 was admitted on [DATE] with diagnoses including Alzheimer's disease, dementia and osteoarthritis.</p> <p>Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #75 was severely impaired for daily decision-making and was dependent on staff for transfers.</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>Note: The nursing home is disputing this citation.</p>	<p>Review of the care plan; ADL (Activities of Daily Living) self-care performance deficit related to dementia and Alzheimer's disease dated 06/12/24 revealed the resident required extensive assistance of two staff for transferring chair-to-chair, and may use mechanical lift devices to and from bed.</p> <p>On 05/14/25 at 9:23 A.M., observation on the secured unit revealed CNA #35 and CNA #37 transferred Resident #75 by placing their arms under the residents axillary. CNA #35 and CNA #37 were then observed lifting the resident out of her wheelchair and placed her into a recliner chair in the lounge area. No gait belt was observed being used to transfer the resident.</p> <p>On 05/14/25 at 9:30 A.M., interview with LPN #52 stated staff were issued a gait belt and gait belts were readily available on the unit and in the residents' rooms.</p> <p>On 05/14/25 at 2:15 P.M., interview with CNA #37 verified Resident #75 was transferred without the use of a gait belt as described above.</p> <p>On 05/14/25 at 2:18 P.M., interview with CNA #35 verified Resident #75 was transferred without the use of a gait belt as described above.</p> <p>3. Medical record review revealed Resident #28 was readmitted on [DATE] with diagnoses including fracture, cancer, atrial fibrillation and high blood pressure.</p> <p>Review of the care plan: At Risk for Falls revised 04/23/25 revealed interventions including to wear his back brace as needed, keep frequent items in reach, foot buddy to wheelchair, keep walker/cane in reach and call for assist for all transfers. A new intervention to place a food buddy to wheelchair was implemented on 05/06/25.</p> <p>Review of the Fall Risk assessment dated [DATE] revealed Resident #28 was at high risk for falls.</p> <p>Review of the late entry dated 05/06/25 at 4:30 P.M. Progress Note revealed resident returned from emergency room with the following injuries after his fall this morning: lumbar (L-5) , thoracic 11 (T-11) and maxillary sinus fractures.</p> <p>Review of the Fall Evaluation dated 05/11/25 revealed resident was attempting to ambulate himself, was exit seeking and the nurse witnessed the fall. There was no injury and the resident was sent to the emergency room per physician order.</p> <p>Review of CNA #50's staff statement regarding Resident #28's fall revealed CNA #50 was sitting at the nurses' desk with LPN #44 and LPN #55 when they heard a noise (oxygen tank fell over) and when they went into the room the resident was laying on the floor. When the resident sat up, his nose was bleeding. The resident was sent to the hospital for evaluation. The staff statements dated 05/06/25 revealed no evidence the fall was witnessed.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366001	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2025
NAME OF PROVIDER OR SUPPLIER Harmar Place Rehab & Extended Care		STREET ADDRESS, CITY, STATE, ZIP CODE 401 Harmar Street Marietta, OH 45750	
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>Note: The nursing home is disputing this citation.</p>	<p>Review of the hospital documentation dated 05/06/25 revealed the HPI indicated the resident was being evaluated after a fall. The resident stated he was turning and caught his foot on his walker, tripping him and causing him to fall forward striking his face, head and left knee on the floor. Review of the Facial CT results dated 05/06/25 revealed displaced and comminuted fracture of the left maxillary sinus and mildly comminuted fracture of the intraorbital rim with a large amount of hemorrhage. Review of the T/L spine revealed acute moderate compression of the T-11 vertebrae compared to a previous scan completed on 04/12/25.</p> <p>On 05/14/25 at 10:38 A.M., interview with the DON verified the new intervention was for a foot buddy, she thought he tripped over the wheelchair not the walker and this intervention was not immediately implemented. The DON stated she needed to review and ensure appropriate interventions were in place for the resident to prevent future falls.</p> <p>On 05/14/25 at 10:47 A.M., observation revealed Resident #28 was in bed in the high position. The resident's eyes were closed and his walker was observed across the room next to his room door. The walker was not within reach of the resident. This was verified by the DON at the time of the observation.</p> <p>On 05/14/25 at 2:45 P.M., observation revealed Resident #28 was laying in bed with his bed in a high position, his walker was next to the door towards the hallway and personal items on over-bed table was against the wall near the bathroom. Neither of these things were within the resident's reach. Interview with CNA #50 verified the above at the time of the observation.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00165620.</p>		