STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366094	A. Building B. Wing	07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Continuing Healthcare of Gahanna	167 North Stygler Road Gahanna, OH 43230

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review, staff interview, review of the facilities Self-Reported Incidents (SRI) and review of the facility abuse policy, the facility failed to timely report an allegation of staff-to-resident physical abuse to the State Survey Agency, Ohio Department of Health. This affected one (Resident #88) out of three residents reviewed for abuse. The facility census was 87.Review of the closed medical record for Resident #88 revealed an admission date of 12/31/24 and a discharge date of 06/19/25. Diagnoses included chronic respiratory failure, psychosis, mood disorder, chronic pancreatitis, and repeated falls. Review of the quarterly Minimum Data Set (MDS) assessment, dated 06/19/25, revealed Resident #88 had minimal cognitive impairment. Review of the hospital documentation dated 06/19/25 revealed Resident #88 was sent out from the facility regarding a fall with injuries. While at the hospital, Resident #88 reported he was forced out of his chair by facility staff and this was the reason he fell. Resident #88 was documented as having two rib fractures, a right humerus fracture, and right axillary artery damage. This information was uploaded to the Resident #88's electronic medical record on 06/24/25. Review of the facility's SRIs from 06/19/25 to 07/14/25 revealed there was no SRI involving Resident #88's allegation of physical abuse. Interview with the Administrator and Director of Nursing (DON) on 07/15/25 at 4:10 P.M. verified no knowledge of abuse made by Resident #88. They stated a facility-associated staff member uploads the hospital records into the resident's medical record. The Administrator and DON verified the physical abuse allegation of staff-to-resident was not reported to the State Survey Agency. Review of the undated facility policy titled Abuse, Mistreatment, Neglect, Exploitation, and Misappropriation of Resident Property revealed all allegations of suspected abuse will be reported to the State Agency immediately, or no later than two hours after the allegation was made. This was an incidental finding during the course of the complaint investigation.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and review of the facilities abuse policy, the facility failed to investigate an allegation of staff-to-resident physical abuse. This affected one (Resident #88) of three residents reviewed for abuse. The facility census was 87.Review of the closed medical record for Resident #88 revealed an admission date of 12/31/24 and a discharge date of 06/19/25. Diagnoses included chronic respiratory failure, psychosis, mood disorder, chronic pancreatitis, and repeated falls. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #88 had minimal cognitive impairment. The resident was assessed as having one fall with major injury, and required supervision or touching assistance from staff with toileting, bathing and the used of a wheeled walker for ambulation. Review of the hospital documentation from 06/19/25 revealed Resident #88 was sent out from the facility regarding a fall with injuries. While at the hospital, Resident #88 reported he had been forced out of his chair by facility staff resulting him to fall. Resident #88 had two rib fractures, a right humerus fracture, and right axillary artery damage. This hospital information was uploaded to Resident #88's electronic medical record on 06/24/25. The facility was unable to provide an investigation regarding Resident #88's allegation of staff-to-resident physical abuse. Interview with the Administrator and Director of Nursing (DON) on 07/15/25 at 4:10 P.M. verified they did not investigate Resident #88's allegation of staff-to-resident physical abuse. The Administrator and DON denied knowledge of abuse allegation made by Resident #88 and stated the hospital records are uploaded by a facility-associated staff member who worked offsite from the facility. Review of the undated facility policy titled Abuse, Mistreatment, Neglect, Exploitation, and Misappropriation of Resident Property revealed all allegations of suspected abuse will be investigated. This was an incidental finding discovered during the complaint investigation.

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and staff interviews, the facility failed to ensure Minimum Data Set (MDS) assessments accurately reflected the resident's falls in the facility. This affected two (#91 and #99) out of the six residents reviewed for falls. The facility census was 87.1. Closed record review for Resident #99 revealed the resident was admitted to the facility on [DATE] and had diagnoses which included muscle wasting and history of falling. Record review for Resident #99 revealed the resident had a fall on 06/18/25 in which he scraped his elbow, had a fall on 06/22/25 in which he sustained an abrasion to the left side of his nose, and had a fall on 06/24/25 which resulted in two fractures of the lumbar spine, a closed head injury, a hematoma to the left thigh, and a laceration to the right side of his eye. Additionally, the resident had a fall on 06/26/25 and was admitted to the hospital with acute blood loss anemia. Review of the discharge Minimum Data Set (MDS) assessment, dated 06/26/25, revealed Resident #99 was assessed to have had one fall with no injury, no falls with injuries including minor or major injury since admission of the prior MDS assessment whichever was more recent. Interview with the Administrator and Director of Nursing (DON) on 07/14/25 at 2:10 P.M. confirmed Resident #99 had experienced four falls from 06/18/25 through 06/26/25 and had suffered minor and major injuries resulting from the falls and confirmed these falls should have been captured on the discharge MDS assessment dated [DATE]. 2. Review of the medical record for Resident #91 revealed an admission date of 05/27/25 and a discharge date of 06/21/25. Diagnoses included vascular dementia. Record review revealed Resident #91 sustained an unwitnessed fall on 05/29/25 at approximately 5:00 P.M. in her room while walking back from the bathroom. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] and the Discharge MDS assessment dated [DATE] revealed Resident #91 was coded as having no falls since admission. Interview on 07/17/25 at 8:43 A.M. with the Director of Nursing confirmed Resident #91 fell on [DATE] and the MDS assessment was inaccurate as it did not indicate Resident #91 fell in the facility. This was an incidental finding discovered during the course of the complaint investigation. This deficiency is an example of continued non-compliance from the survey dated 03/12/25.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and staff interviews, the facility failed to ensure new interventions to prevent falls were added to the care plan timely. This affected one (#99) of six residents whose care plans were reviewed for falls. The facility census was 87.Closed record review for Resident #99 revealed the resident was admitted to the facility on [DATE] and had diagnoses which included difficulty walking and history of falling. The resident was discharged from the facility on 06/26/25. Review of the comprehensive care plan, dated 06/06/25, revealed Resident #99 was at risk for falls and injuries as evidenced by history of, may not always recognize own needs or limitations, metabolic encephalopathy, Parkinson’s disease, cognitive deficits, and history of amnesia. The goal was for Resident #99 to be free from falls/injuries over the next 90 days. The interventions did not change from the baseline care plan. Interventions dated 06/06/25 included to anticipate needs – provide prompt assistance, ensure lighting was adequate and areas were free of clutter, and ensure call light was within reach and answer promptly. No new goals or interventions were added to Resident #99’s care plan from 06/07/25 to 06/26/25. Review of the facility’s Resident Fall Quality Assurance (QA) Checkoff Tool, completed on 06/19/25, revealed Resident #99 suffered a fall on 06/18/25 at 6:31 P.M. The root cause of the fall was the resident forgot to lock the wheeled walker and tried to sit down. The new intervention was for a visual reminder to lock the wheeled walker before sitting. Resident #99's care plan was not updated with new intervention following the fall. Review of the facility’s Resident Fall QA Checkoff Tool, not dated, revealed Resident #99 suffered a fall on 06/24/25 at 2:55 P.M. The root cause was unsteady gait, urinary tract infection (UTI) being treated with antibiotic medication. Staff were not nearby or providing care at the time of the fall because they were at the nurse’s station. The new intervention was close observation and neuro-checks initiated after returning from the hospital. Keep within sight while awake. Resident #99's care plan was not updated with new intervention following the fall. Interview with the Administrator and Director of Nursing (DON) on 07/14/25 at 2:10 P.M. confirmed Resident #99's care plan was not updated to reflect the new fall interventions on 06/19/25, 06/22/25, and 06/24/25. The Administrator and DON stated someone from their corporate office updated Resident #99's fall care plan on 07/14/25 and confirmed this was 18 days after Resident #99 was discharged from the facility. Review of the facility policy titled “Fall Management” dated July 2024 revealed the facility is required to update the care plan with individualized interventions following a fall. This was an incidental finding during the course of the complaint investigation. This deficiency is an example of continued non-compliance from the survey dated 03/12/25.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed medical record review, review of hospital records, staff interviews, and review of the facility policy, the facility failed to ensure Resident #99's continuity of care information from the hospital to the facility was reviewed and implemented. This resulted in Immediate Jeopardy and the potential for serious life-threatening injuries, negative health outcomes and/or death on [DATE] when Resident #99 returned from the hospital with injuries sustained from a fall including two new fractures of the spine, a closed head injury, a hematoma of the left thigh, and anemia which required ongoing evaluation and treatment which was not identified or implemented by facility staff. Consequently, the resident sustained an additional fall on [DATE] and was admitted to the hospital where he was found to have acute blood loss anemia requiring a transfusion with packed red blood cells. This affected one (Resident #99) of six residents reviewed for continuity of care upon return from the hospital. The facility census was 87. On [DATE] at 12:10 P.M., the Administrator, Director of Nursing (DON), Regional Director of Clinical Operations (RDCO) #900 were notified Immediate Jeopardy began on [DATE] when Resident #99 returned to the facility from the hospital with injuries sustained from a fall and instructions for ongoing evaluation and treatment which were not identified or implemented by the facility. Licensed Practical Nurse (LPN) #501 re-admitted Resident #99 and failed to assess and provide continuity of care to Resident #99. Resident #99 had a closed head injury, two spinal fractures, laceration to right eye requiring glue to close it, a large hematoma to left proximal hamstring measuring 8.5 centimeters (cm) in length by 4 cm wide. The hospital recommended following up with the primary care physician within a day due to anemia and his hemoglobin needed to be closely monitored. There was no evidence the physician was updated on Resident #99's return to the facility and the physician never assessed the resident between [DATE] and [DATE]. LPN #501 wrote the only injury was laceration to the right eye and stated there were no other injuries. Upon interview with LPN #501, Administrator, and DON, they stated they were unaware of the hospitals' After Visit Summary (AVS) and were unaware LPN #501 stated she didn't have time to read the AVS which listed all the resident's injuries. The facility failed to identify multiple bruises on Resident #99's entire body from [DATE] to [DATE]. On [DATE], Resident #99 fell at the facility and was sent to the hospital due to injuries sustained. The emergency room notes identified Resident #99 had bruising over the entire body. Resident #99's anemia worsened and required a blood transfusion. The hospital note indicated that the anemia was probably caused by the large hematoma to the left proximal hamstring. The Immediate Jeopardy was removed on [DATE] when the facility implemented the following corrective actions: On [DATE], Resident #99 was sent to the hospital and did not return to the facility. On [DATE], the Administrator held a Quality Assurance and Performance Improvement (QAPI) meeting with the DON, and Medical Director #910 to discuss the Immediate Jeopardy template and plan of removal. On [DATE], RDCO #900 provided in-service training to the DON and Administrator on the facility's admission readmission process. The training included the importance of conducting accurate and thorough skin assessments upon admission or readmission, reviewing the hospital AVS to ensure that all new orders and recommendations are appropriately followed within 72 hours of admission, and promptly notifying the attending physician up on the resident's return to the facility. On [DATE], the Administrator reviewed the facility's Admission/readmission Checklist. No changes were made. Admission/readmission trends will be brought to the QAPI and reviewed monthly with Medical Director #910.I Beginning on [DATE], all residents who were admitted /readmitted to the facility will be reviewed during the next clinical meeting which was held Monday through Friday. The interdisciplinary team (IDT) will evaluate the admission admission/readmission, review documentation in the medical record to ensure skin impairments, including but not limited to bruising, lacerations, and discoloration are documented appropriately, and the AVS. The IDT members include the Administrator, DON, Social Worker, and Director of Rehabilitation. The DON/Designee will ensure all appropriate orders are in place within 72 hours of admission/readmission to the facility. The IDT will validate the skin assessment is documented correctly by rechecking the resident's skin the day after admission/readmission to the facility. Beginning on [DATE], the DON/designee will conduct random audits of five residents' records per week for four weeks to ensure ongoing compliance with skin assessments and documentation practice. Any discrepancies will be addressed immediately with re-education and corrective action as needed. Results of the audit will be reviewed weekly with the IDT. After the initial four-week period, the facility will evaluate compliance trends. If sustained compliance is demonstrated, monitoring will continue

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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 medical record review, review of hospital records, review of fall investigations, staff interviews, and review of facility policy for falls, the facility failed to timely assess and develop comprehensive plans of care for residents with a history of falls prior to admission, failed to complete thorough fall investigations and implement timely and appropriate interventions for the residents with falls in the facility resulting in injuries. This resulted in Immediate Jeopardy when Resident #99 had four falls in eight days resulting in the resident being sent to the hospital on two occasions and suffering injuries including a closed head injury on 06/24/25, two fractures of the lumbar spine on 06/24/25, a large hematoma to the left thigh on 06/24/25, and acute blood loss anemia resulting from falls which required a blood transfusion on 06/26/25; and when Resident #88 had two falls in seven days resulting in the resident being admitted to the hospital on two separate occasions and suffering injuries including a closed head injury on 06/11/25, abrasions to the chin, shoulder and left face on 06/11/25, a shoulder with acute pain on 06/11/25. multiple rib fractures on 6/19/25, a fracture to the right humerus on 06/19/25, and an injury to the right axillary artery on 06/19/25. This affected three (Residents #88, #91, and #99) of six residents reviewed for falls. The facility census was 87. On 07/16/25 at 12:10 P.M., the Administrator, Director of Nursing (DON), and Regional Director of Clinical Operations (RDCO) #900 were notified Immediate Jeopardy began on 06/04/25 when Resident #99 was admitted to the facility with a history of falls and injuries and was not timely assessed and a comprehensive plan or care was not timely developed. Resident #99 fell four times at the facility on 06/18/25, 06/22/25, 06/24/25, and 06/26/25 without the facility completing thorough fall investigation, implementing timely and appropriate interventions, updating the care plan, and increasing the supervision of the resident. On 06/24/25, Resident #99 fell suffering a closed head injury, two fractures of the lumbar spine, and a large hematoma to the left thigh and on 06/26/25, acute blood loss anemia resulting from falls which required a blood transfusion. Resident #88 had multiple falls at the facility including on 06/11/25 and 06/19/25 without the facility completing thorough fall investigations to evaluate the root cause of the falls, implementing appropriate interventions, updating the care plan, and increasing the supervision of the resident. On 06/11/25, Resident #88 fell, sustaining a large hematoma on left side of forehead and cheek, abrasion of shoulder, unable to bear weight and required hospitalization from 06/11/25 to 06/17/25 to treat closed head injury, abrasions to chin, shoulder, left face, and shoulder with acute pain. On 06/19/25, Resident #88 fell again, sustaining a right humerus fracture, multiple rib fractures, and concern for right axillary artery injury and required hospitalization. The Immediate Jeopardy was removed on 07/18/25 when the facility implemented the following corrective actions: On 06/19/25, Resident #88 was sent to the hospital and did not return to the facility. On 06/26/25, Resident #99 was sent to the hospital and did not return to the facility. On 07/16/25, the Administrator held a Quality Assurance and Performance Improvement (QAPI) meeting with the DON and Medical Director #910 to discuss the Immediate Jeopardy template and plan of removal. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 07/16/25, Regional Minimum Data Set (MDS) Coordinator #920 educated MDS Coordinator #100 regarding the facility’s fall management program which included an individualized fall prevention for each resident identified at risk and updating the care plan with each fall event to ensure new interventions are implemented appropriately and the physician is notified of each fall event. On 07/16/25, MDS Coordinator #100 reviewed the care plans of 13 residents who were currently active in the facility and had experienced a fall in the last 30 days to ensure adequate interventions are in place and care plans are up to date with interventions. On 07/16/25, RDCO #900 educated the Administrator and DON on completing thorough fall investigations to include completing risk management, conducting witness interviews if applicable, updating care plans with appropriate fall interventions, identifying root cause analysis, and post fall interdisciplinary notes (IDT) for all fall events. On 07/16/25, the clinical interdisciplinary team (IDT) will review all residents who experience a fall event during the next scheduled clinical IDT meeting which is held Monday through Friday. This meeting includes the Administrator, DON, Social Worker, and Director of Rehabilitation. The clinical IDT will complete a thorough post-fall investigation, including a root cause analysis (RCA) to determine contributing factors and intervention opportunities. The clinical IDT will ensure the individualized intervention opportunity is updated to reflect in the fall care plan with the goal of reducing the recurrence. The DON with champion the meeting and ensure compliance with documentation, investigation/RCA determination, care plan updates, and intervention implementation. Any identified concerns will result in immediate staff training and, if appropriate, progressive disciplinary action. On 07/16/25, the Administrator reviewed the facility’s Fall Management and Care Plan Revision policies. No changes were made. Fall trends will be brought to QAPI and reviewed monthly with Medical Director #910. On 07/17/25, the DON/Designee completed in-service training for all 22 licensed nursing staff focused on fall management. This included completing a fall Situation, Background, Assessment, and Recommendation (SBAR), incident report within the medical record and fall related details. Nurses are responsible for the direct care of the resident at the time of the fall. The medical records for Resident #20, Resident #71, Resident #101 were reviewed for falls, appropriate fall follow up, appropriate fall interventions, and appropriate supervision with no identified concerns. Random interviews on 07/18/25 with Registered Nurse (RN) #150, Licensed Practical Nurse (LPN) #350, LPN #930, and MDS Coordinator #100 verified they had been in serviced on the fall management program and policy. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Although the Immediate Jeopardy was removed, the facility remained out of compliance at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility is still in the process of implementing their corrective action plan and monitoring to ensure on-going compliance. Findings include: 1 Record review for Resident #99 revealed the resident was admitted to the facility on [DATE] and had diagnoses which included metabolic encephalopathy, Parkinson’s disease, muscle wasting and atrophy, muscle weakness, difficulty walking, history of falling, altered mental status, and glaucoma. Review of the hospital progress note, dated 05/26/25, revealed Resident #99 presented to the hospital for confusion, hallucinations, and recurrent falls at home from standing height including one that morning while in the shower. No injuries were noted on extensive imaging. Review of the baseline care plan, dated 06/04/25, revealed Resident #99 was at risk for falls. Interventions were to anticipate needs-provide prompt assistance, ensure lighting was adequate, care areas were free of clutter, and ensure call light was within reach and answered promptly. Review of the facility’s Clinical Risk Assessment tool, dated 06/05/25, revealed Resident #99 was assessed at high risk for falls. The resident had not fallen in the three months prior to the assessment despite being documented to have fallen on the morning of 05/26/25. Review of the comprehensive care plan, dated 06/06/25, revealed Resident #99 was at risk for falls and injuries as evidenced by history of, may not always recognize own needs or limitations, metabolic encephalopathy, Parkinson’s disease, cognitive deficits, and history of amnesia. The goal was for Resident #99 to be free from falls/injuries over the next 90 days. The interventions did not change from the baseline care plan. Interventions dated 06/06/25 included to anticipate needs – provide prompt assistance, ensure lighting was adequate and areas were free of clutter, and ensure call light was within reach and answer promptly. No new goals or interventions were added to Resident #99’s care plan from 06/07/25 to 06/26/25. Review of the admission MDS assessment dated [DATE] revealed Resident #99 had mildly impaired cognition. Resident #99 did not have any falls since admission or in the month prior to admission to the facility. Review of the progress note, dated 06/18/25, revealed Resident #99 fell in the main lobby trying to sit down in a chair without assistance. The resident scraped his right elbow, and it was cleaned and left uncovered. The Power of Attorney (POA) was contacted, and a voice message was left, and the Nurse Practitioner (NP) #940 was notified. Resident #99 was in bed with the bed in its lowest position and the call light within reach. The facility completed two fall risk assessments on 06/18/25 for Resident #99. LPN #310 assessed Resident #99 at a high risk for falls and LPN #350 assessed Resident #99 at a risk for falls. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility’s Resident Fall Quality Assurance (QA) Checkoff Tool, completed on 06/19/25, revealed Resident #99 suffered a fall on 06/18/25 at 6:31 P.M. The root cause of the fall was the resident forgot to lock the wheeled walker and tried to sit down. The new intervention was for a visual reminder to lock the wheeled walker before sitting. The care plan was to be updated timely with new interventions added based on the cause of the fall. The fall was to be included in the monthly QA committee tracking with trends reviewed for repeated falls, location patterns, and staffing. No witness statements were provided with the fall investigation, and the care plan was not updated with new interventions following the fall. No QA committee minutes were available for review. Review of the progress note, dated 06/22/25, revealed staff notified the nurse Resident #99 was observed sitting on the floor in the room in front of the bed. The resident denied being in pain at the time. Resident #99 unable to explain what happened. Resident #99 had an abrasion to the left side of his nose. The abrasion was cleansed with normal saline, area dried, and triple antibiotic ointment was applied and then left open to air. Vital signs were within normal limits for Resident #99. Resident #99 was able to move all extremities. Physician and POA made aware. The intervention was to always keep in view of staff at nurse’s station. Review of the facility’s Resident Fall QA Checkoff Tool, not dated, revealed Resident #99 suffered a fall on 06/22/25 at 2:00 P.M. The root cause was Resident #99 was attempting to self-transfer. The new intervention was to keep Resident #99 within sight of staff while awake. The care plan was to be updated timely with new interventions added based on the cause of the fall. The fall was to be included in the monthly QA committee tracking with trends reviewed for repeated falls, location patterns, and staffing. The environment was not checked for hazards. No information regarding the location of the resident’s call light was included. No witness statements were provided with the fall investigation, and the care plan was not updated with new interventions following the fall. No QA committee minutes were available for review. Review of the SBAR (Change of Condition) Fall Event note, dated 06/24/25, revealed Resident #99 fell on [DATE] at 2:55 P.M. The location of the fall was in the room next to the bed and was unwitnessed. The resident had an “accident” and was trying to get wet clothes off when he fell off the bed and into the wall. Review of the hospital After Visit Summary notes, dated 06/24/25, revealed multiple injuries were found. The laceration near the eye was repaired with glue. There were two new back fractures, and they will not need any intervention as they were not in a concerning area of the spine but will cause pain. There was a large collection of blood called a hematoma in the muscle of the left hamstring which was likely causing pain as well as potential difficulty walking. Follow-up with an orthopedic surgeon. It was imperative no additional falls occurred as the resident was on blood thinning medication. Diagnoses included closed head injury, spine fracture, lacerations, anemia, and contusion. Review of the progress note, dated 06/25/25 at 6:30 A.M., revealed Resident #99 came back from the hospital the day prior. No further concerns as the laceration around his eye was glued up. Continue monitoring. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility’s Resident Fall QA Checkoff Tool, not dated, revealed Resident #99 suffered a fall on 06/24/25 at 2:55 P.M. The root cause was unsteady gait, urinary tract infection (UTI) being treated with antibiotic medication. Staff were not nearby or providing care at the time of the fall because they were at the nurse’s station. The new intervention was close observation and neuro-checks initiated after returning from the hospital. Keep within sight while awake. The care plan was to be updated with interventions based on the cause of the fall. The fall was to be included in the monthly QA committee tracking with trends reviewed for repeated falls, location patterns, and staffing. The environment was not checked for hazards. No information regarding the location of the resident’s call light was included. No witness statements were provided with the fall investigation, and the care plan was not updated with new interventions following the fall. No QA committee minutes were available for review. The fall was documented as not being related to toileting despite the resident falling while trying to remove wet clothing from an “accident”. The progress notes nor the QA Checkoff Tool explained what type of “accident” Resident #99 had. Review of the late entry SBAR (Change of Condition) note, dated 06/26/25, revealed Resident #99 had an unwitnessed fall in his room while attempting to ambulate without assistance. Review of the late entry progress note, dated 06/26/25, revealed Resident #99 had a fall with bruising and swelling to the right arm. Resident complaining of pain with a score of eight out of 10 (on a pain scale ranging from zero indicating no pain and ten being the most severe pain). Staff nurse administered as needed pain medication, and this nurse ordered STAT (urgent) X-ray to rule out fractures. Review of the progress note, dated 06/26/25, revealed Resident #99 fell and his wife insisted for him to be taken to the hospital. Resident #99’s right hand was swollen, and he had a skin tear on the back of his head, bruises on his right eye, and bruises on right thigh. Resident #99 was transported to hospital. Review of the hospital progress notes, dated 06/26/25 through 07/12/25, revealed Resident #99 was admitted to the hospital on [DATE] following frequent falls with subsequent bruising. Resident #99 had acute blood loss anemia with his Hemoglobin (Hgb) (a protein in red blood cells that carries oxygen throughout the body) level of 7.9 grams per deciliter (g/dl) dropping from the last hospitalization, which the Hgb went 9.6 on 06/24/25. Subsequently the Hgb dropped even further in the hospital on [DATE] and required a transfusion of packed red blood cells. The anemia appeared to be related to a left leg hematoma from a fall. Review of the facility Resident Fall QA Checkoff Tool, completed on 06/27/25, revealed Resident #99 suffered a fall on 06/26/25 at 6:30 P.M. The root cause was Resident #99 transferred himself without assistance after being placed in bed in a low position. The resident was transported to the hospital by request of his wife. The care plan was to be updated timely with new interventions added based on the cause of the fall. The fall was to be included in the monthly QA committee tracking with trends reviewed for repeated falls, location patterns, and staffing. The environment was not checked for hazards. No information regarding the location of the resident’s call light was included. No witness statements were provided with the fall investigation, and the care plan was not updated with new interventions following the fall. No QA committee minutes were available for review. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 07/14/25 at 10:15 A.M., the Administrator and DON denied knowledge of any falls with major injuries occurring in the facility in the past three months. The Administrator stated she had just begun working at the facility a couple weeks prior and had asked specifically about falls with major injuries and was told there had not been any. During an interview on 07/14/25 at 2:10 P.M., the Administrator and DON confirmed all falls were to be investigated with new interventions implemented based on the determined cause of the fall and interventions were to be added to the care plan. They confirmed there had not been any new interventions added to the care plans following Resident #99’s falls on 06/18/25, 06/22/25, or 06/24/25 before the resident was sent to the hospital on [DATE] following an additional fall. They confirmed Resident #99 had fallen on 06/24/25 and sustained injuries which included a closed head injury, two new back fractures, anemia, and a large hematoma in the left thigh muscle which they were not aware of. An incident report had not been completed for the fall Resident #99 sustained on 06/24/25 which resulted in the fall not being documented on the fall incident log and the fall care plan implemented for Resident #99 did not contain individualized interventions based on the resident was assessed to be at a fall risk. During an interview on 07/15/25 at 11:40 A.M., the Administrator and DON stated they could not locate QA meeting minutes for review. During an interview on 07/15/25 at 4:05 P.M., the DON confirmed she had taken over as the Director of Nursing for the facility around the beginning of June 2025. The DON stated the previous DON had handled resident fall incidents and she was still learning the process of what to do when residents fell. The DON confirmed the new intervention implemented following Resident #99’s fall on 06/24/25 did not address the resident having an “accident,” and it did not explain what type of accident that caused Resident #99 to be wet. 2 Review of the closed medical record for Resident #88 revealed an admission date of 12/31/24 and a discharge date of 06/19/25. Diagnoses included chronic respiratory failure, unspecified psychosis, mood disorder, chronic pancreatitis, and repeated falls. Review of the quarterly MDS assessment, dated 06/19/25, revealed Resident #88 had minimal cognitive impairment. Resident #88 had one fall with major injury and was assessed to require supervision or touching assistance with toileting, bathing and the use of a wheeled walker for ambulation. Review of Resident #88’s falls from 04/22/25 to 06/10/25 revealed Resident #88 fell on [DATE], 05/02/25, and 05/24/25 and sustained no major injuries. The facility did not have any fall investigations and did not implement timely and appropriate fall interventions for the falls on 05/02/25 and 05/24/25. Review of the fall risk observation tool dated 05/24/25 revealed Resident #88 was at high risk for falls following multiple fall events in the past. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the care plan dated 05/24/25 identified Resident #88 was at risk for falls due to decreased mobility and history of actual falls with a left shoulder fracture. The goal was for Resident #88 to not sustain major injury due to a fall. Interventions included to anticipate and meet the resident’s needs (01/01/25), call light within reach (01/01/25), encourage the resident to use call light for toileting needs (01/09/25), encourage the resident to lock wheelchair brakes during transfers (03/26/25), encourage to use wheelchair when feeling tired (03/14/25), ensure the resident was wearing appropriate footwear (01/01/25), follow facility fall protocol (01/01/25), new wheelchair provided (04/21/25), and visual reminder to use wheeled walker (03/05/25). Resident #88 also had a care plan in place for a fall with actual injuries. There were no additional interventions from 04/22/25 to 06/18/25. Review of the progress note dated 06/11/25 at 5:30 A.M. revealed Resident #88 was found lying on the floor in his bathroom, and the resident was unable to state what had happened. Resident #88 was assessed and had a large hematoma on the left side of his forehead, bruised and swollen cheek, and abrasion on the left shoulder. It also stated the resident was unable to bear weight when assisted off the floor. Review of the progress note dated 06/11/25 at 11:09 A.M. revealed the writer spoke with the emergency room (ER) nurse and Resident #88 was admitted to the hospital for observation. It stated he had a large hematoma on the left side of his face and a few lacerations. Resident #88 did not return to the facility from this hospital stay until 06/17/25. The facility was unable to provide a fall investigation for Resident #88’s fall on 06/11/25. It is unknown if the fall interventions were in place at the time of the fall and there were no witness statements and information on the last time he was checked on by staff to determine how long he laid in the bathroom, what type of footwear he was wearing at the time of the fall, if he used wheelchair or walker, and if his call light was activated for assistance. Review of the hospital records dated 06/17/25 revealed Resident #88 was admitted to the hospital due to fall and hyperglycemia (elevated blood sugar). Resident #88 hit his head and there was swelling to the left side of his face. His Glasgow Coma Scale (GCS) was 14 (indicating a mild acute traumatic brain injury) and was slow to respond to questions so they admitted Resident #88 to the hospital. CT imaging of head, thoracic, lumbar, chest and maxillofacial and x-rays of pelvic revealed no acute fractures. There was a hematoma in the left frontal skull, and a periorbital edema on the left side. There was 15 millimeters (mm) rounded area of increased attenuation within the face in the face on the left lateral to the maxilla, which could represent hematoma. There was minor blunt trauma to the chest, abdomen and pelvis. Resident #88 returned to the facility on [DATE]. There were no new interventions implemented for Resident #88 upon return from the hospital. The progress note dated 06/17/25 stated Resident #88 was walking with a wheeled walker. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The progress note dated 06/18/25 at 7:52 P.M. revealed the facility nurse was called to the hallway leading to the dining room where Resident #88 was found on the floor bent over his walker leaning on the right side. Upon assessment, the resident’s range of motion to his upper and lower extremities were limited with an abrasion to his right elbow. Resident #88 was not wearing appropriate footwear at the time of the fall. There was a late entry progress note dated 06/24/25 at 9:02 A.M. which was written for 06/20/25 at 9:02 A. M. stated Resident #88 had been sent to the hospital for evaluation related to a shoulder fracture. The facility was unable to provide a fall investigation for Resident #88’s fall on 06/18/25. It is unknown if the fall interventions were in place at the time of the fall. Review of the hospital records dated 06/19/25 revealed Resident #88 was admitted to the hospital for management of a non-ST elevated myocardial infarction, closed fracture of multiple ribs on the right side, closed fracture of the right humeral neck, and injury to the right axillary artery. During an interview on 07/15/25 at 11:20 A.M., the Administrator and Director of Nursing (DON) verified fall investigations were not completed for Resident #88’s falls on 05/02/25, 05/24/25, 06/11/25 and 06/18/25. The DON stated she start working as the DON beginning of June of 2025. The DON confirmed the previous DON had handled resident fall incidents and she was still learning the process of what to do when residents fell. The DON stated she was not aware she needed to complete fall investigations. The Administrator and DON verified there were no witness statements obtained for the falls and no additional information could be provided related to Resident #88’s falls on 05/02/25, 05/24/25, 06/11/25, and 06/18/25. 3 Review of the closed medical record for Resident #91 revealed an admission date of 05/27/25. Resident discharged to home on [DATE]. Diagnoses included vascular dementia (moderate, with mood disturbance), chronic obstructive pulmonary disease (COPD), colostomy status, and protein-calorie malnutrition. Review of the therapy evaluation dated 05/28/25 identified Resident #91 had a history of five falls in the past year, including one with a head strike prior to entering the facility. Review of the fall prevention care plan initiated on 05/28/25 revealed Resident #91 was at risk for falling and injuries. Interventions included ensuring adequate lighting and a clutter-free environment, encouraging Resident #91 to ask for assistance, and ensuring the call light was within reach. The care plan was not updated after Resident #91 fell on [DATE]. Review of the progress dated 05/29/25 revealed Resident #91 sustained a fall at approximately 5:00 P.M. in her room after walking back from the bathroom. The fall was unwitnessed. A nurse’s progress note documented a change in condition, notification of the physician and responsible party, and recorded post-fall vital signs. Review of the fall risk assessment dated [DATE] at 6:35 P.M. revealed no fall had occurred and provided a risk score of five, indicating the resident was at risk for falls. This fall risk assessment was completed after the nursing progress note written stating Resident #91 fell in his bathroom. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility was unable to provide a fall investigation for Resident #91’s fall on 05/29/25. Review of the admission MDS assessment dated [DATE] revealed Resident #91 had impaired cognition. Resident #91was totally dependent on staff for sit-to-lying, lying-to-sitting, chair-to-chair transfers, and toileting hygiene. Resident #91 had no history of falls in the last month prior to admission and did not have any falls since admission. The MDS assessment did not capture Resident #91’s fall on 05/29/25. Review of the care conference note dated 06/03/25 revealed it did not reference Resident #91’s fall and stated Resident #91 was ambulating safely and independently with a walker. During an interview on 07/16/25 at 9:07 A.M., the DON confirmed there was no fall investigation completed for Resident #91’s fall on 05/29/25., no new interventions were implemented, and the fall risk assessment was inaccurate as it should have been Resident #91 did have a fall. Review of the facility policy titled “Fall Management” revised 07/2024 revealed the facility will provide a safe environment for all residents by implementing a fall management program. This program includes fall risk assessments, individualized care plans, staff education, and post-fall evaluations. The facility will conduct fall risk assessments upon admission, quarterly, with fall events, and with significant changes. The resident’s care plan will be updated based on reassessment findings. Develop and individualized fall prevention plan for each resident identified at risk. Update the care plan with each fall event to ensure that any new risks or necessary interventions are addressed. Document the fall incident in the resident’s medical record, including the circumstances of the fall, injuries, and any interventions implemented. Complete an incident report as per facility policy. The IDT will review fall incidents to determine contributing factors, implement appropriate interventions, and adjust the resident’s care plan accordingly. IDT will review the fall incidents during Quality Assurance and Performance Improvement (QAPI) meetings. This deficiency represents non-compliance identified during the investigation of Complaint Number OH00167114 and OH00166188. This deficiency is an example of continued non-compliance from the survey dated 03/12/25.