STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366167	A. Building B. Wing	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Anderson, The	8139 Beechmont Ave Cincinnati, OH 45255

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 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** 47985 Based on record review and interview, the facility failed to thoroughly investigate an allegation of abuse. This affected one resident (#44) of one resident reviewed for abuse. The facility census was 88. Findings included: Record review revealed Resident #44 was admitted to the facility on [DATE] with diagnoses including schizophrenia, cerebral infarction, and vascular dementia. Review of a Facility Reported Incident (FRI) submitted on 05/15/24 revealed Resident #44 alleged an aide hit her on the hand while in the bathroom and told her she should be able to care for herself. Review of the FRI revealed the allegation was unsubstantiated because staff spoke with Resident #44 who stated the aide was a younger aide and she was really good and was not trying to be mean. Additionally, another staff member who entered the room during the alleged incident was interviewed and stated the incident did not occur. Interview on 08/31/24 at 1:25 P.M. with the Director of Nursing (DON) verified she did not have evidence of an investigation being completed. The DON stated there were no witness statements, additional staff or resident interviews. The DON stated the Administrator completed the investigation via phone but did not document the investigation and there was no staff re-education completed to ensure staff were aware of the abuse policy. Review of a policy titled Abuse (dated 08/01/18) revealed different types of incidents should be investigated, a staff member should be responsible for initial reporting, investigation, and reporting to proper authorities. This deficiency represents incidental findings of non-compliance investigated under Complaint Number OH00156609.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47985 Based on closed medical record review, hospital record review, review of information from the Cleveland Clinic regarding hypotension, and interviews, the facility failed to ensure staff identified a change in condition for Resident #22 when the resident experienced hypotension (low blood pressure) and diaphoresis (sweating especially to an unusual degree as a symptom of disease) and failed to notify the physician of the resident's hypotension and diaphoresis resulting in a delay in care and treatment. This resulted in Immediate Jeopardy and the potential for serious life-threatening harm beginning on [DATE] at 3:15 P.M. when Resident #22, who had a history of hypertension (high blood pressure), had a blood pressure of ,d+[DATE] millimeters of mercury (mm/Hg) which was not reported to the physician and no treatment was provided. Resident #22's family member requested the resident be sent to the hospital for evaluation on [DATE] at 7:33 P.M. (four hours after the resident first exhibited a decline in condition) due to the resident's continued hypotension and diaphoresis. Resident #22 was admitted to the hospital on [DATE] with diagnoses of septic shock and encephalopathy and expired at the hospital on [DATE]. This affected one (#22) of four residents reviewed for falls. The facility census was 88. On [DATE] at 11:42 A.M., President #218, Director of Nursing (DON), and Assistant Director of Nursing (ADON) #226 were notified Immediate Jeopardy began on [DATE] at 3:15 P.M. for Resident #22, when staff failed to inform the resident's physician of a change in condition when Resident #22 began to complain of pain, was diaphoretic, and hypotensive thereby delaying care and treatment, until Resident #22's family arrived to the facility and requested the resident be sent to the emergency department for further evaluation. Consequently, Resident #22 was admitted to the hospital with diagnoses of septic shock, hypotension, and hypothermia. The resident expired at the hospital on [DATE]. The Immediate Jeopardy was removed on [DATE] when the facility implemented the following corrective actions: On [DATE] at 1:15 P.M., the facility will continue with its staff education and monitoring program specifically to ensure that any and all pertinent policies and procedures regarding resident changes in condition to ensure staff are implementing them as directed to prevent the same actions, situations, and/or practices from occurring in the future, by conducting in-service education via the employee communication system which will include all clinical employees. This was completed on [DATE] at 1:15 P.M. and included eight Registered Nurses (RN), 22 Licensed Practical Nurses (LPN) and 35 State tested Nursing Assistants (STNA). Education will be ongoing. On [DATE] at 2:00 P.M., ADON #226 sent out the education notification immediately to alert nursing staff to notify the physician immediately when a change of resident condition occurs. On [DATE] at 2:00 P.M., the DON completed counseling and education with LPN #185 regarding proper documentation and communication with physician regarding resident change in condition. (continued on next page)

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On [DATE] at 2:00 P.M., the facility will continue to ensure there are systems in place to complete ongoing assessments of residents' health status when they experience a change in condition as evidenced by the following: When a resident has a change in condition, if indicated, the nurse may complete a Change of Condition Assessment in Point Click Care; the form is located under the Assessments tab in the resident electronic medical record. The change of condition includes along with any labs, analysis, x-rays, notification with physician date and time along with notification of responsible party date and time. After the completion of the assessment, if indicated, the attending physician will be notified immediately. Change of condition assessment form has been activated and implemented. The facility will continue to ensure that staff notify the attending physician immediately for any potential changes in treatment when a change in condition occurs. This is implemented and effective. Beginning on [DATE] at 2:00 P.M., all 90 residents in the facility will have a head-to-toe assessment and will be assessed for abnormal vital signs, abnormal change in mental status, any skin issues, and complaints of pain by 7:00 P.M. on [DATE]. This will be done by the attending charge nurses. Results will be noted in resident's chart and a progress note will be completed. If there are any signs of change in condition the physician will be notified immediately, and the change of condition assessment will be completed. The facility will continue to both assess and reassess all current residents for potential changes in condition, notification of physician, and any needed revisions to the plan of care to ensure potential issues are appropriately addressed and followed through on. This action was verified by the surveyor with record reviews for Residents #28 and #29. On [DATE] at 2:00 P.M., education will be provided to each nurse 1:1 and the employee will be shown the policy and procedure for the change in condition and the physician of notification. The employee will be shown where to find the change of condition assessment and the information it requires. The employee will demonstrate back showing how to find the assessment and where the policy is located. This education will be completed by the start of each nurse's next shift. This will be completed by ADON #226 for dayshift staff and RN #194 for nightshift staff. On [DATE] at 3:00 P.M., the charting guideline policy was reviewed by the DON and ADON #226 to include changes reflective of electronic charting. Information removed consisted of paper documentation and frequency of monitoring systems. The changes now adhere to our current frequency and monitoring systems and inclusive of the change in condition assessment. On [DATE], interview with LPN #210 at 8:52 A.M., STNA #248 at 8:58 A.M., LPN #214 at 9:00 A.M., LPN #253 at 10:31 A.M., and LPN #282 at 10:36 A.M. revealed the staff had received education and in-service training on change in condition, physician notification, and documentation and were knowledgeable about the facility's procedures and processes. On [DATE] at 9:30 A.M., the facility began implementation of the change in condition assessment information to be reviewed during daily morning clinical meeting. It will begin on this date and time and will be ongoing indefinitely. On [DATE] at 9:30 A.M., the quarterly Quality Assurance and Performance Improvement (QAPI) meeting is scheduled and will take place to include all day shift supervisors, MDS, Director of Therapy, Director of Nursing, Assistant Director of Nursing, Director of Food Services, Director of Environmental Services, Social Services, Activity Director, Medical Director, and the Administrator. During this meeting, we will address the revised policy on change in condition and physician notification. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Beginning on [DATE], the DON or designee will perform auditing of any change of condition in the facility. The audit will consist of three random residents, twice a week for four weeks and will be monitored monthly for three months. We will be auditing that a change of condition assessment was completed based off our review in clinical meeting from the 24-hour report. All changes to a resident condition will be communicated with families or power of attorney's when it occurs. Although the Immediate Jeopardy was removed on [DATE], 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 was continuing to educate staff and was in the process of completing and reviewing audits to determine if further action is required and monitoring to ensure on-going compliance. Findings include: Closed record review revealed Resident #22 was admitted to the facility on [DATE] with diagnoses including type II diabetes, chronic obstructive pulmonary disease, weakness, dementia, and hypertension. Review of the order summary revealed Resident #22 had an order in place for assist of two for bed mobility and Hoyer lift for transfers ([DATE]) and an order for Tylenol oral tablet 325 milligrams (mg) give two tablets by mouth every six hours as needed for pain ([DATE]). Review of a care plan dated [DATE] revealed Resident #22 had an activity of daily living (ADL) self-care performance deficit related to impaired balance and obesity. Interventions included two staff assistance with any care given while resident is in bed ([DATE]), resident is totally dependent on two staff to turn and reposition in bed as necessary ([DATE]), resident is totally dependent on two staff to provide shower ([DATE]), to provide a sponge bath if a shower cannot be tolerated ([DATE]), and resident is totally dependent on two staff for transferring with a mechanical lift ([DATE]). Review of a quarterly Minimum Data Set (MDS) assessment collected on [DATE] revealed Resident #22 had mildly impaired cognitive function, no behaviors, required dependence of staff for care for bathing, toileting, dressing, bed mobility, and transfers. Review of a Morse Fall Scale assessment completed on [DATE] revealed Resident #22 was a moderate risk for falling. Review of the medical record revealed the following vital signs for Resident #22: On [DATE] at 11:19 A.M., blood pressure (BP) was ,d+[DATE] mm/Hg; at 5:16 P.M., BP was ,d+[DATE] mm/Hg. On [DATE] at 10:14 A.M., BP was ,d+[DATE]mm/Hg; at 5:28 P.M., BP was ,d+[DATE] mm/Hg. On [DATE] at 9:34 A.M., BP was ,d+[DATE]; at 11:45 A.M., BP was ,d+[DATE] mm/Hg (prior to the resident's fall). The resident's body temperature was recorded on [DATE] at 6:15 P.M. as 97.6 degrees Fahrenheit (F) (location, forehead). (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Review of a nursing note dated [DATE] at 11:52 A.M. by Licensed Practical Nurse (LPN) #185 revealed a State tested Nursing Aide (STNA) informed the nurse Resident #22 was rolled out of bed while receiving a bed bath but did not hit her head during the fall. Upon entering the room, Resident #22 was found lying on her back on the floor next to the bed, she was alert and immediately assessed for pain. Resident #22 denied pain but did have abrasions to left index and middle fingers, vital signs were within normal limits, and resident was assisted back into bed with the assistance of four staff and neuro checks were initiated. The nurse called Resident #22's son and made him aware of the situation. Review of a Neurological Check assessment completed on [DATE] at 12:00 P.M. revealed Resident #22's blood pressure was ,d+[DATE] mm/Hg (normal blood pressure is ,d+[DATE] mm/Hg). Review of a Counseling Form completed on [DATE] at 12:15 P.M. by the DON with STNA #130 revealed the seriousness of the situation was explained, STNA #130 stated she attempted completing Resident #22's care by herself because she thought she could do it, and the DON instructed her to clock out and informed her she was terminated. Review of a Neurological Check assessment completed on [DATE] at 12:15 P.M. revealed Resident #22's blood pressure was ,d+[DATE] mm/Hg; an assessment completed at 3:15 P.M. revealed Resident #22's blood pressure was ,d+[DATE] mm/Hg, she was complaining of pain rated at four out of 10 and she was grimacing, withdrawing, or showing other non-verbal signs of pain. Review of a nursing note dated [DATE] at 3:40 P.M. by LPN #185 revealed Resident #22 was having complaints of increased pain to her left knee, the on-call provider was contacted and gave a new order for STAT (immediate) three-view x-ray of left knee. No new orders were received for pain management. There was no evidence the on-call provider was notified of the resident's low blood pressure (,d+[DATE] mm/Hg and ,d+[DATE] mm/Hg). Review of a medication administration record (MAR) for [DATE] revealed Resident #22 did not receive as needed Tylenol per orders when complaining of pain on [DATE]. Review of a Neurological assessment dated [DATE] at 4:15 P.M. revealed Resident #22's blood pressure was ,d+[DATE] mm/Hg; at 5:20 P.M. her blood pressure was ,d+[DATE] mm/Hg and at 6:21 P.M. her blood pressure was ,d+[DATE] mm/Hg. There was no evidence the resident's medical provider was notified. Review of a nursing note dated [DATE] at 7:01 P.M. by LPN #185 revealed Resident #22 had an x-ray completed to her left knee and was awaiting results. Resident #22 was very diaphoretic and stated she was cold. Vital signs were checked, blood glucose was checked, and no abnormalities noted. There was no evidence the resident's medical provider was notified of the resident's condition including the previous low blood pressure readings and diaphoresis. Review of a nursing note dated [DATE] at 7:33 P.M. by LPN #185 revealed Resident #22 was sent out to the hospital at the request of her family for further evaluation related to increased diaphoresis and pain all over. On-call provider was notified and gave the order to send to the emergency room for evaluation. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Review of a hospital History and Physical dated [DATE] revealed Resident #22 came to the hospital and presented with septic shock with hypothermia and encephalopathy, a history of extended-spectrum beta-lactamase (ESBL) (an enzyme produced by some bacteria that can make them resistant to certain antibiotics. ESBL producing bacteria are harder to treat and may require complex treatments) and had (urine) cultures pending, acute kidney injury, and elevated troponin levels with a history of coronary artery disease. Resident #22 suffered from a fall while at a nursing facility, afterwards they got her up and she was sweating and did not appear to feel well. During assessment, Resident #22 was confused and unable to answer questions regarding the day, month, year, or date. Review of a critical pulmonology note dated [DATE] revealed Resident #22 admitted to the emergency room after diaphoresis and low blood pressure. Resident #22 had been in her room with multiple blankets on and no air conditioning (at the nursing home). At the hospital her blood pressure continued to drop to ,d+[DATE] mm/Hg and her temperature was 95.4 degrees Fahrenheit. Review of a hospital note dated [DATE] revealed overnight, Resident #22 suffered from respiratory failure (related to aspiration while at the hospital) and worsened hypotension. She was placed on a ventilator. Review of a nursing note dated [DATE] at 11:51 P.M. by LPN #275 revealed Resident #22's son called and notified the facility Resident #22 expired. Interview on [DATE] at 12:51 P.M. with Resident #22's family revealed the evening of [DATE], they came to visit the resident, and she was very sweaty and disoriented. They stated this was abnormal for her and they had to request staff to send her to the hospital. Interview on [DATE] at 1:25 P.M. with the DON confirmed Resident #22 had an order and care plan interventions in place for assist of two which was not followed. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Interview on [DATE] at 2:31 P.M. with LPN #185 revealed on [DATE] after she had finished medication pass, the STNA came up the hall and informed her she was giving Resident #22 a bed bath and had rolled her out of the bed. The STNA stated she did not have a second person, and LPN #185 immediately educated the aide. LPN #185 stated she went to Resident #22 to assess her, her vitals were normal, she hadn't hit her head, but the cranial checks were started. LPN #185 stated she had notified the physician and the DON. LPN #185 stated Resident #22 was stable and had no complaints of pain once in bed. As the day progressed, Resident #22 complained of pain and was sweating really bad, so an order was received for an x-ray. After the x-ray was completed, Resident #22's son came in and was concerned so he requested Resident #22 be sent to the hospital for additional evaluation. LPN #185 stated Resident #22 started sweating in the afternoon, after lunch but before dinner. LPN #185 stated that is also when Resident #22 started to have low blood pressure. LPN #185 stated sometimes Resident #22 would have high blood pressure and sometimes it would be low. LPN #185 stated she could not recall how soon after Resident #22 became diaphoretic she contacted the provider, but no new orders were received for pain medication and the as needed Tylenol was not administered. LPN #185 stated low blood pressure was not concerning to her. When asked what diaphoresis and hypotension could be indicators for, LPN #185 stated it could be a sign of sepsis or a bleed. LPN #185 confirmed since Resident #22 had medical health problems and had been rolled out of bed earlier in the day, the hypotension and diaphoresis should have been more concerning. LPN #185 confirmed she did not request to send Resident #22 to the hospital prior to 7:33 P.M. (on [DATE]). LPN #185 stated she had been about to call the provider to update them on Resident #22's status when the family requested the resident to be sent to the hospital. Interview on [DATE] at 4:19 P.M. with the DON revealed the low blood pressure was not concerning because people can have numbers that low and be normal and would not be a reason to send someone to the hospital. The DON stated she could not comment on the combination of hypotension along with diaphoresis because she did not see it in person. The DON stated Resident #22 was always cold and there was nothing abnormal about her symptoms. The DON did confirm nursing notes did not display the resident's medical provider or physician were made aware of the diaphoresis or hypotension until Resident #22's son requested for her to be sent to the hospital. Interview on [DATE] at 9:45 A.M. with Physician's Assistant (PA) #400 (Resident #22's primary care provider) revealed he was made aware either on [DATE] or [DATE] because Resident #22 was a long-term patient and the last time he had seen her was the end of June (2024). PA #400 stated he remembers going to the facility on Wednesday ([DATE]) and he didn't see Resident #22 on point click care (PCC) and when he asked where she was, the facility staff explained to him that she passed away. PA #400 confirmed he was not made aware at the time of the fall on [DATE] due to not being on-call over the weekend of the incident. PA #400 stated a normal blood pressure for Resident #22 ranged from about ,d+[DATE] (systolic)/,d+[DATE] (diastolic). PA #400 confirmed Resident #22's vitals appeared to be stable on [DATE] until about 3:15 P.M. PA #400 revealed due to not being on-call, he was not made aware of the change in condition, but a provider should have been made aware of a change in Resident #22's blood pressure if other symptoms of something were present. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Interview on [DATE] at 10:56 A.M. with Nurse Practitioner (NP) #410 (works for the on-call medical provider company that cover the facility on weekends) revealed she was not aware Resident #22 had been rolled out of bed during care provided by one staff member on [DATE]. NP #410 stated after three in the afternoon (on [DATE]), she was called because Resident #22 had fallen out of bed and was complaining of knee pain. NP #410 stated she did order an x-ray. NP #410 confirmed she was not made aware of Resident #22 being diaphoretic or hypotensive. NP #410 stated she could not recall when she was made aware Resident #22 went to the hospital and she did not have access to the system to look. NP #410 stated if she had known during the afternoon phone call, she received regarding Resident #22's pain, that Resident #22 also was diaphoretic and hypotensive, since she was unaware of Resident #22's medical history, she would have sent the resident to the hospital for evaluation. Review of the Cleveland Clinic website (undated) revealed symptoms of low blood pressure include confusion or trouble concentrating and unusual changes in behavior. A low blood pressure is considered to be less than 90 for systolic and less than 60 for diastolic. This deficiency represents non-compliance investigated under Complaint Number OH00156609.

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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** 47985 Based on review of the medical record, review of hospital records, and care plan review, observations, and interviews, the facility failed to provide adequate assistance with care resulting in a fall and failed to ensure fall interventions were in place. This affected two residents (#22 and #29) of four residents reviewed for falls. The facility census was 88. Findings include: 1. Record review revealed Resident #22 was admitted to the facility on [DATE] with diagnoses including type II diabetes, chronic obstructive pulmonary disease, weakness, dementia, and hypertension. Review of a quarterly minimum data set (MDS) collected on 07/26/24 revealed Resident #22 had mildly impaired cognitive function, no behaviors, required dependent care for bathing, toileting, dressing, bed mobility, and transfers. Review of a care plan dated 07/03/24 revealed Resident #22 had an activity of daily living (ADL) self-care performance deficit related to impaired balance and obesity. Interventions included two staff assistance with any care given while resident is in bed (06/23/23), resident is totally dependent on two staff to turn and reposition in bed as necessary (07/15/20), resident is totally dependent on two staff to provide shower (07/15/20), to provide a sponge bath if a shower cannot be tolerated (07/03/20), and resident is totally dependent on two staff for transferring with a mechanical lift (07/15/20). Review of the order summary revealed Resident #22 had an order dated 12/06/23 for assist of two for bed mobility and hoyer lift for transfers. Review of a Morse Fall Scale assessment completed on 08/02/24 revealed Resident #22 was a moderate risk for falling. Review of a nursing note dated 08/03/24 at 11:52 A.M. by Licensed Practical Nurse (LPN) #185 revealed a State tested Nursing Aide (STNA) informed the nurse Resident #22 was rolled out of bed while receiving a bed bath but did not hit her head during the fall. Upon entering the room, Resident #22 was found lying on her back on the floor next to the bed, she was alert and immediately assessment for pain. Resident #22 denied pain but did have abrasions to left index and middle fingers, vital signs were within normal limits, and resident was assisted back into bed with the assistance of four staff and neuro checks were initiated. The nurse called Resident #22's son and made him aware of the situation. Review of a nursing note dated 08/03/24 at 3:40 P.M. by LPN #185 revealed Resident #22 was having complaints of increased pain to her left knee, the on-call provider was contacted and gave a new order for STAT (emergent) three-view x-ray of left knee. Review of a nursing note dated 08/03/24 at 7:01 P.M. by LPN #185 revealed Resident #22 had an x-ray completed to her left knee and was awaiting results. (continued on next page)

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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	Review of a nursing note dated 08/03/24 at 7:33 P.M. by LPN #185 revealed Resident #22 was sent out to the hospital at the request of her family for further evaluation. The resident's on-call provider was notified and gave the order to send the resident to the emergency room for evaluation. Interview on 08/31/24 at 1:25 P.M. with Director of Nursing (DON) confirmed Resident #22 had an order and care plan interventions in place for assist of two which was not followed. 2. Record review revealed Resident #29 was admitted to the facility on [DATE] with diagnoses including cerebral infarction, history of falls, dementia, and hypertension. Review of an annual MDS completed on 06/12/24 revealed Resident #29's cognition was severely impaired, had no behaviors, and was dependent on staff for bathing, toileting, dressing, bed mobility and transfers. Review of orders dated 12/06/23 revealed Resident #29 should have assist of two for bed mobility and hoyer lift for transfers. Review of a care plan dated 10/13/22 revealed Resident #29 was at risk for falls related to incontinence, psychoactive drug use, and unaware of safety needs. Interventions included but were not limited to bolster in place to mattress (06/12/24), fall mats in place to both sides of the bed (06/12/24), and provide a safe environment (10/13/22). Observation on 08/31/24 at 11:51 A.M. of Resident #29 resting in bed revealed bolsters were not in place to her bed and the floor mats were leaning against the wall across from her bed. Interview on 08/31/24 at 11:59 A.M. with the DON confirmed the fall mats were not in place to both sides of Resident #29's bed nor were the bolsters in place. Review of a policy titled Accident Protocol (dated 02/12/10) revealed the DON will investigate and analyze all accidents to determine any causative factors and any changes in the resident's care plan. This deficiency represents non-compliance investigated under Complaint Number OH00156609.