

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366250	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/14/2026
NAME OF PROVIDER OR SUPPLIER Kimes Nursing and Rehab LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 75 Kimes Lane Athens, OH 45701	
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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed medical record review, hospital documentation review, facility policy review, and interview, the facility failed to timely identify and obtain necessary medical intervention for Resident #160 following a fall. This resulted in Immediate Jeopardy and Actual Harm on 06/24/26 beginning at 4:00 P.M. when Resident #160 sustained an unwitnessed fall from bed. On 06/24/26 at approximately 6:00 P.M., Certified Nursing Assistant (CNA) #56 reported to Licensed Practical Nurse (LPN) #120 the resident appeared tired. No assessment was conducted, and Resident #160 was left to rest. On 06/24/26 at approximately 9:00 P.M., CNA #56 returned to the resident's room and notified LPN #120 Resident #160 appeared pale. On 06/25/26 at approximately 1:06 A.M., Resident #160's blood pressure was 80/51 mmHg (hypotensive) with a pulse of 52 beats per minute (bradycardic). Blood pressure medication was ordered to be held at that time and the physician instructed staff to send the resident (to the hospital) for evaluation if distress developed. However, no additional assessment, increased monitoring or further medical intervention was documented until 6:30 A.M. On 06/25/26 at 6:30 A.M. Resident #160 was observed in bed with pale appearance, blood around his mouth, making gurgling noises with respirations and he was unable to clear secretions. The resident appeared agitated. Vital signs included blood pressure was 82/40 mmHg (hypotensive), body temperature 92.4 degrees Fahrenheit (F) (hypothermic), respirations elevated at 21 breaths per minute, oxygen saturation (low) 88% on room air, and heart rate recorded as 100 beats per minute (tachycardic). The resident's pupils were pinpoint and non-reactive. Resident #160 was transferred to a local hospital, where diagnostic imaging revealed an acute left C4 anterior fracture, a large abdominal wall hematoma, and acute respiratory failure. The resident required two units of blood for acute blood loss anemia. Resident #160 was subsequently transferred to another hospital, where the resident was intubated and admitted to the Intensive Care Unit. This affected one (Resident #160) out of four residents reviewed for injury of unknown origin and changes in condition. The facility census was 60. On 07/02/26 at 11:03 A.M., the Director of Nursing (DON) was notified Immediate Jeopardy began on 06/24/26 when the facility failed to identify, provide timely assessment and treatment and necessary medical intervention for Resident #160 following a fall. On 06/25/26 at 6:30 A.M. Resident #160 was transferred to the hospital where he was subsequently intubated and admitted to the Intensive Care Unit. The Immediate Jeopardy was removed on 07/06/26 when the facility implemented the following corrective actions:-On 07/02/26 Registered Nurse Clinical Consultant (RNCC) #320 conducted an investigation into Resident #160's cause of injuries (fall history, incident reports, nursing documentation, staff assignments, skin/body assessments review).-On 07/02/26 the DON and Assistant Director of Nursing (ADON) #238 completed a facility-wide audit of all 55 residents for injuries, bruising, and change in conditions after falls/incidents.-Beginning 07/02/26 the DON and ADON #238 would lead/participate in daily clinical Stand-up/Morning Meeting reviewing falls, injuries (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	away and that he did not look well. Upon entering the resident's room, he was pale, had blood around his mouth and was making gurgling sounds. The resident (who was previously noted to be cognitively intact) could not voice what was going on at that time. While attempting to obtain vital signs, the resident was agitated. Resident #160 did feel cool to the touch and when his temperature read 92.4 degrees F, she checked it on herself, and it came back normal. LPN #210 stated in her opinion Resident #160's condition did not appear to have been something that just occurred and she was surprised the night shift nurse did not send him to the emergency room. Emergency medical services (EMS) were then contacted and Resident #160 was transported to a local hospital. Review of an undated signed statement completed by CNA #56 (related to the fall on 06/24/26) revealed, When I arrived LPN #259, the day shift nurse informed me that Resident #160 had fallen and to get a floor mat for him. I went and got the floor mat and placed it on the right side of his bed. He was in bed at this time; I changed him because he was incontinent. He appeared tired so after incontinence care, I let him rest. Approximately 9:00 P.M. I returned to the room and alerted LPN #120 that Resident #160 looked pale. I took his vital signs and gave them to the nurse; she verbalized that she would communicate the results to MD #500. She then informed me that MD #500 requested us to monitor Resident #160 and not to send him to the emergency room at this time. At approximately 1:00 A.M. on 06/25/26, I took his vital signs again and they were the same as it was the first time. At approximately 5:45 A.M. I checked his vital signs again and it was similar so I reported that to LPN #120 and she verbalized that she would inform the day shift nurse. Interview on 06/30/2026 at 12:53 P.M. with Resident #160's sister revealed the resident had been living at home on his own prior to his nursing home admission. There had been concerns related to his inability to care for himself. The resident was hospitalized and then admitted to the facility for placement. During the interview, the family member voiced concerns the resident was supposed to receive therapy after being admitted, but that was never provided. Following admission (date not provided), family had visited and found the resident in bed wearing only an incontinence brief. At the time of this visit they observed a large bruise on the resident's side and had taken a photo of the bruise. The sister revealed on 06/24/26 she had a voicemail from the facility asking her to return the call at her earliest convenience, there was no urgency in the call. She stated she received another phone call on 06/25/26 (again no urgency) just asking her to call back when she could. The resident's sister stated she received a second call on 06/25/26 from the hospital for permission to administer blood to him. The sister stated this was how she learned of the fall that occurred on 06/24/26. The sister stated the resident had a large hematoma to his side, pneumonia and a fractured C4. He needed taken to a larger hospital for treatment. Upon her arrival to the hospital, the resident had been intubated due to difficulty breathing on his own. On 06/30/26 at 3:00 P.M., interview with the DON confirmed a lack of skin assessments following the fall on 06/09/26 when staff noted bruising to the abdominal/side area. Interview on 07/01/26 at 11:30 A.M. with LPN #120 revealed she worked on 06/24/26 from 6:00 P.M. until 06/25/26 at 6:00 A.M. At the beginning of her shift, the off-going nurse reported Resident #160 had slid out of the bed onto the floor. The LPN stated she did go in to see Resident #160 (unable to recall time) during the beginning of her shift, and she felt he appeared to be at his baseline (which included lethargy). The LPN revealed the CNA did report the resident seemed different from normal and she did call the physician (time not recalled) who told her to discontinue his blood pressure medication and monitor the resident. The LPN stated she did go back and check on the resident after speaking with the physician and did check his vital signs, although she verified there was no documented evidence of this. Review of the facility undated policy titled Change in a Residents Condition or Status, revealed the facility would promptly notify the physician of changes in resident's physical/mental (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	condition. The charge nurse would notify the physician when there had been an accident involving the resident, discovery of injuries of unknown source, a need to alter resident's medical treatment significantly, and need to transfer resident to hospital. This deficiency represents non-compliance investigated under Complaint Number 3063687. This deficiency is an example of continued non-compliance from the survey dated 06/02/26.		

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the governing body failed to ensure measures were in place to prevent the facility from being without a licensed nursing home administrator who had an active license to practice in the State of Ohio following the resignation of the previous administrator to maintain uninterrupted administrative oversight. This had the potential to affect all 60 residents residing at this facility. Findings include: Observation at the time entrance to the facility on [DATE] at 11:20 A.M. revealed there was no licensed nursing home administrator present in the facility. At the time of entrance, Corporate Staff #89 (who was licensed as an Administrator in another state but not licensed in Ohio) was available to assist the surveyor. On 06/26/26 at 11:20 A.M. interview with Corporate Staff #89 revealed the facility previous Administrator had resigned earlier on this date. During the interview, Corporate Staff #89 revealed the facility owner, Owner #51 was a licensed nursing home administrator in the State of Ohio, and he would be at the facility next week (06/29/26). During the interview Corporate Staff #89 also revealed the facility did not have a full-time onsite Director of Nursing but were using an Interim DON who was out of State who was reachable by phone. On 06/26/26 at 3:00 P.M. interview with the previous Administrator revealed he had resigned on this date and stated his resignation was due to multiple concerns he had identified including Owner #51's direction to terminate the facility DON the previous week leaving the facility with no full-time onsite nursing oversight and the use of a corporate clinical director who was in another state. Online licensure verification for Owner #51, completed on 06/26/26 and contained on Nursing Home Administrator License Detail (website) revealed Owner #51's nursing home administrator's license was inactive as of inactive as of 04/01/26. Information obtained from the Board of Executives of Long-Term Services and Supports (BELTSS) during the onsite investigation verified Owner #51 did not have an active administrator's license in the State of Ohio and that his license had been inactive since 04/01/26. A Board Executive provided evidence of communication with Owner #51 on 04/20/26 related to the license being inactive since 04/01/26. The Board Executive denied evidence of Owner #51's attempts to re-activate his administrator's license between 04/20/26 and 06/29/26. On 06/29/26 at 11:45 A.M. interview with Owner #51 revealed the previous Administrator had put in his 30-day notice on 06/19/26 with his last day to be 07/17/26. He stated the facility was in the process of hiring a new administrator for the facility and a few different people were contacted and on 06/23/26 a person had agreed to a 90-day contract to be an Interim Administrator beginning prior to 07/17/26. When the previous Administrator left of 06/26/26, they reached out to the Interim Administrator to see if she could start immediately, but the earliest she could start was on 07/07/26. During the interview, Owner #51 stated he was licensed in Ohio as an Administrator, but there was a misunderstanding/mistake about his licensing period and had reached out to the licensing board to follow-up. Owner #51 revealed he was currently in the process of getting his license active as of this date. During the interview, Owner #51 failed to provide evidence the facility had measures in place to ensure uninterrupted services of an administrator were in place. Additional observations throughout the onsite investigation on 06/30/26 revealed there was no licensed nursing home administrator with an active Ohio license onsite to provide administrative oversight. Owner #51 provided evidence his nursing home administrator's license was active on 07/01/26. This was verified by a Board of Executives of Long-Term Services and Supports (BELTSS) executive. This deficiency represents non-compliance investigated under Complaint Number 3056219.		

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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 closed record review, hospital record review, interview, and facility policy review, the facility failed to investigate an injury of unknown origin when Resident #160 was found to have an abdominal wall hematoma and a closed fracture (fx) of the left fourth cervical vertebrae (C-4). This affected one (Resident #160) of four residents reviewed for injury of unknown origin and change in condition. The facility census was 60. Findings include:Review of the closed record revealed Resident #160 was admitted to the facility on [DATE] with diagnoses including osteomyelitis, need for assistance with personal care, atrial fibrillation, and cirrhosis of the liver.Review of physician orders for June 2026 revealed an order to observe for bleeding, decolorization to skin, changes in mental status and vital signs. A progress note is to be made and physician notified.Review of Resident #160's care plans dated 06/08/26 revealed Resident #160 required (staff) assistance with activities of daily living including bed mobility, transfers, and ambulation due to muscle weakness and debility. Resident #160 was at risk for falls/injury related to decreased mobility, episodes of incontinence, medication use, and impaired awareness of deficits. Intervention dated 06/09/26 revealed to monitor, document, report for 72 hours post fall, report to physician for any signs and symptoms of pain, bruises, change in mental status and neuro checks as ordered. Additionally, Resident #160 was receiving anticoagulant therapy related to diagnosis of atrial fibrillation with intervention dated 06/08/26 to monitor, observe, report any adverse reactions, labs per order and notify physician of results.Review of Resident #160's admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #160 was cognitively intact and was dependent on staff for toileting hygiene, personal hygiene, and bathing. The assessment revealed Resident #160 required substantial maximum assistance with transfers and bed mobility. Ambulation was not assessed on the MDS. Review of an incident follow-up note dated 06/10/26 at 10:39 A.M. created by Licensed Practical Nurse (LPN) #259 (from a fall on 06/08/26) revealed Resident #160 had some bruising to his right side of the abdomen. No complaints of pain or discomfort noted. There was no documentation pf the cause of the bruising or a comprehensive assessment including measurements or description of the bruise. There was no mention of any physician notification of bruising. There was no investigation started for the bruise to see if it was related to the fall that occurred. Review of Medical Director #500's progress notes dated 06/12/26 and 06/15/26 revealed no mention of falls and/or bruising to right abdomen.Review of a nursing progress note dated 06/25/26 at 6:30 A.M. created by LPN #210 documented she was called to Resident #160's room via staff. Resident #160 was lying in bed, pale in color, with blood around his mouth. He had gurgling noises during respirations and was unable to clear his throat when cued. His speech was soft, low and garbled at this time. Resident #160 had agitation and attempted to remove the blood pressure cuff and pulse oximeter while obtaining vital signs. Resident #160's blood pressure was 82/40 mmHg, temp was 92.4 degrees F, respirations were 21 breaths per minute, pulse at 100 beats per minute and oxygen saturations at 88 percent. HIs pupils were pinpoint and non-reactive. Resident #160 was transferred to hospital. There was no skin assessment or documentation of bruising contained in this note.Review of a nursing progress note dated 06/25/26 at 1:30 P.M. created by LPN #210 revealed she received report from emergency room and Resident #160 had bilateral pleural effusions, acute blood loss and acute respiratory failure. Resident #160 was being transferred to another hospital.Review of Resident #160's hospital notes dated 06/25/26 revealed he had abdominal wall hematoma, bilateral pleural effusions, acute blood loss anemia, hemorrhagic disorder due to extrinsic circulating anticoagulants, acute respiratory failure with hypoxia, and a closed (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	displaced fracture of the fourth cervical (C-4) vertebra. Recommendations at that time included rewarming, broad spectrum antibiotics, abdominal binder, C collar, blood transfusion, and stabilization prior to transfer to another hospital. Review of Resident #160's hospital notes from the second hospital he was transferred to revealed Resident #160 was experiencing shock, presumed hemorrhagic, suspected acute hematoma within the right anterior rectus abdominus muscle, aspiration pneumonia, and a left C-4 transverse process fracture involving the transverse foramen. Resident #160 was intubated for airway protection. Interview on 06/30/26 at 3:00 P.M. with the Director of Nursing (DON) confirmed a thorough investigation (for injuries of unknown origin) had not been completed following the hospital identification that Resident #160 had an abdominal hematoma, and a C-4 fracture. Review of the facility undated policy titled Abuse, Neglect, Misappropriation policy and protocol revealed injuries of unknown source were a violation that requires reporting. The policy included the facility shall initiate investigation immediately including resident interview, witness interviews, staff interviews, record review, clinical assessment review, video/security review if available, environmental assessments, and a timeline reconstruction. Review of the facility undated policy titled Change in a Residents Condition or Status, revealed facility would promptly notify the physician of changes in resident's physical/mental condition. The charge nurse would notify the physician when there had been an accident involving the resident, discovery of injuries of unknown source, a need to alter resident's medical treatment significantly, and need to transfer resident to hospital. This deficiency represents non-compliance investigated under Complaint Number 3063687.		

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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	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 closed record review, fall investigation review, facility policy review and interview, the facility failed to develop and implement a comprehensive and individualized fall prevention program for Resident #160 and failed to ensure the resident was fully assessed and provided with timely, updated interventions to prevent additional falls from occurring. This affected one resident (Resident #160) of four residents reviewed for falls. The facility census was 60. Findings include: Review of the closed medical record revealed Resident #160 was admitted to the facility on [DATE] with diagnoses including osteomyelitis, need for assistance with personal care, atrial fibrillation, and cirrhosis of the liver. Review of a Fall Risk Evaluation dated 06/07/26 revealed the resident was assessed to be at low risk for falls with a fall risk score of five (5). Review of a nursing progress note dated 06/08/26 at 8:30 A.M., created by Licensed Practical Nurse (LPN) #210 revealed the nurse was down the hall during medication administration and heard a loud thud along with the sound of a walker banging against the floor. Resident #160 was lying on the floor with his head and shoulders resting against the bathroom door with his walker to his right. Resident #160 stated he hit his head on the bathroom door. The resident's bed was soiled and Resident #160 said he could not find his urinal. The urinal was on the tray table to the right side of resident's bed. Resident #160 was assessed during this time. The note revealed the resident had no complaints of pain, and an assessment was within normal limits. Resident #160 was assisted from floor to a wheelchair with the assistance of two staff. The note revealed Resident #160 was provided education on the importance of using his call light and waiting for assistance. The resident was also provided signage to the bathroom door with a reminder to press call-light and ask staff for assistance for all transfers. Review of Medical Director (MD) #500's progress note dated 06/08/26 documented Resident #160 was status post fall without any injuries. A fall risk assessment dated [DATE] revealed the resident was assessed to be at high risk for falls with a score of 11. A plan of care dated 06/08/26 revealed Resident #160 required (staff) assistance with activities of daily living including bed mobility, transfers, and ambulation due to muscle weakness and debility. The resident also had a care plan related to risk for falls/injury related to decreased mobility, episodes of incontinence, medication use, and impaired awareness of deficits. Fall interventions dated 06/08/26 included call light was to be in reach and encourage the resident to use it for assistance as needed and keep commonly used items within reach. The care plan was updated on 06/09/26 to monitor, document, report for 72 hours post fall, report to physician for any signs and symptoms of pain, bruises, change in mental status and neuro checks as ordered. Review of an incident follow-up note dated 06/09/26 at 10:36 A.M. created by LPN #259 (from the fall on 06/08/26) revealed Resident #160 had with some bruising to his right side of the abdomen. The nurse documented the resident had no complaints of pain. Record review revealed there were no measurements or additional assessment of the bruising at this time and no information as to the cause of the bruising contained in the note. Record review revealed Resident #160 fell again on 06/09/26 at 9:25 P.M. Certified Nursing Assistant (CNA) #310 entered the resident's room to see Resident #160 slip off the bed. The note revealed a new intervention following this fall was to place the resident's bed in the lowest position when occupied. No vital signs post fall were documented nor was there a skin assessment completed. Review of a plan of care dated 06/09/26 revealed Resident #160 had an actual fall (did not identify if the plan was created prior to or after the fall on 06/09/26) with no injury due to poor balance, and unsteady gait. Interventions initiated on 06/09/26 included to (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	check range of motion post fall and notify the Medical Director promptly for any negative findings, continue interventions on the at-risk plan, determine and address causative factors of the fall, monitor/document, and report as needed for 72 hours to the Medical Director any signs or symptoms of pain, bruises, change in mental status, new onset of confusion, sleepiness, inability to maintain posture, and agitation. Neuro checks as ordered, visual reminder to resident to use call light before getting up. Review of an Interdisciplinary Team note dated 06/10/26 revealed the root cause of the fall (not specific to the fall on 06/08/26 or 06/09/26) was that Resident #160 was weak, unsteady, and having delusions. Interventions included to monitor and document for 72 hours and any pain, bruising, and changes in mental status were to be reported to physician. There was no evidence the facility implemented any fall/safety interventions at this time to address the resident's weakness, unsteadiness or delusions. Review of MD #500's progress note dated 06/10/26 revealed no mention of bruising to right abdomen and/or falls/fall risk or safety needs. Review of a nursing progress note dated 06/10/26 at 6:40 A.M. created by Assistant Director of Nursing (ADON) #238 revealed Resident #160 required help with walking, transferring and toileting more than usual. Resident #160 had required staff assistance since admission to safely transfer and ambulate. There was no evidence of new fall risk and/or safety interventions being initiated at this time to address this change in the resident's condition. Review of an incident follow-up note dated 06/10/26 at 10:39 A.M. created by LPN #259 revealed Resident #160 had some bruising to the right side of his abdomen. However, there was no additional information as to what the bruising was from or measurements/description of the bruise. Review of Resident #160's admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #160 was cognitively intact and was dependent on staff for toileting hygiene, personal hygiene, and bathing. The assessment revealed Resident #160 required substantial maximum (staff) assistance with transfers and bed mobility. Ambulation was not assessed on the MDS. Resident #160 was frequently incontinent with bladder function and occasionally incontinent with bowel function. Review of MD #500's progress notes dated 06/12/26 and 06/15/26 revealed no mention of falls and/or bruising to resident's right abdomen. Review of MD #500's progress note dated 06/17/26 revealed Resident #160 had two falls and questioned ataxia (a neurological condition that causes poor muscle control and clumsiness). There was no mention of bruising to right abdomen and no plan for treatment or follow-up related to possibly ataxia or other safety/fall risk needs. Record review revealed Resident #160 had an unwitnessed fall on 06/24/26 at 4:00 P.M. The note revealed Resident #160 slid out of bed onto the floor. He denied hitting his head. He stated he was trying to get up. Vital signs were blood pressure 106/60 mmHg, temperature at 96.6 degrees F, pulse at 70 beats per minute, respirations at 18 breaths per minute and oxygen saturations at 90 percent on room air. No skin assessment was completed. Neurological assessments (neuro check) were started; however, only one neuro check was completed. During an interview on 06/30/26 at 1:40 P.M., LPN #210 revealed she reported to work on 06/25/26 she received information from LPN #120 (the off-going nurse) that Resident #160 had experienced a fall on 06/24/26 with no injuries. LPN #210 said that the day shift Certified Nursing Assistant (CNA) reported to her that she needed to come and see Resident #160 right away and that he did not look well. Upon entering his room, the resident was pale, had blood around his mouth and was making gurgling sounds. Emergency medical services (EMS) were contacted and the resident was transported to a local hospital. During an interview on 06/30/26 at 3:00 P.M., the Director of Nursing (DON) confirmed fall investigations completed following the resident's falls on 06/08/26, 06/09/26 and 06/24/26 were not thorough/complete and failed to include comprehensive skin assessments and/or vital sign monitoring. In addition, the DON also confirmed there should have been additional details documented related to the fall that occurred on (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	06/09/26. There was a lack of evidence the facility thoroughly reviewed each fall to ensure timely, necessary and effective new fall risk/safety interventions were initiated to prevent additional falls likely contributing to the fall on 06/24/26 and subsequent hospitalization. During an interview on 07/01/26 at 1:09 P.M., MD #500 stated he could not say for sure if he was aware of Resident #160's bruise or the falls he sustained, but felt the nurses most likely told him. Review of the facility undated policy titled Falls, Fall Risk Managing, revealed staff would identify interventions related to resident specific risks and causes to try and prevent resident from falling and try to minimize complications from falling. Staff would monitor and document interventions. This deficiency represents non-compliance investigated under Complaint Number 3063687. This deficiency is also an example of continued non-compliance from the survey dated 06/02/26.		

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed medical record review, hospital record review, and interview, the facility failed to ensure therapy services were provided as ordered for Resident #160 upon admission. This affected one (Resident #160) of four residents reviewed for therapy services. The facility census was 60. Findings include: Review of the closed medical record revealed Resident #160 was admitted on [DATE] with diagnoses including osteomyelitis, need for assistance with personal care, atrial fibrillation, and cirrhosis of the liver. Review of hospital records for Resident #160 dated 06/05/26 revealed the resident was ordered to discharge from the hospital on this date to a skilled nursing facility. Review of the discharge summary revealed under Activity Orders Resident #160 was to ambulate with assistance at least three times a day, out of bed to chair all day. Discharge orders included Physical and Occupational therapy to evaluate and treat. Review of Resident #160's physician's orders for June 2026 revealed no order was written (per discharge instructions) for physical and occupational therapy services. Review of Resident #160's care plans dated 06/08/26 revealed Resident #160 required (staff) assistance with activities of daily living including bed mobility, transfers, and ambulation due to muscle weakness and debility. The resident also had a plan of care identifying he was at risk for falls/injury related to decreased mobility, episodes of incontinence, medication use, and impaired awareness of deficits. Review of Resident #160's admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #160 was cognitively intact and was dependent on staff for toileting hygiene, personal hygiene, and bathing. Resident #160 required substantial maximum assistance with transfers and bed mobility. Ambulation was not assessed on the MDS. Resident #160 was frequently incontinent with bladder function and occasionally incontinent with bowel function. Review of a nursing progress note dated 06/10/26 at 6:40 A.M. created by Licensed Practical Nurse (LPN) #210 revealed Resident #160 had required more than usual help with walking, transferring, toileting. The note included to be receiving therapy services with goal to return home. Review of a nursing progress note dated 06/10/26 at 6:55 A.M. created by LPN #210 revealed Resident #160 was not currently being treated by therapy. Interview on 06/30/2026 at 12:53 P.M. with Resident #160's sister revealed the resident had been living at home on his own prior to his nursing home admission. There had been concerns related to his inability to care for himself. The resident was hospitalized and then admitted to the facility for placement. During the interview, the family member voiced concerns the resident was supposed to receive therapy after being admitted, but that was never provided. Interview on 06/30/26 at 2:00 P.M. with Director of Rehab #610 confirmed Resident #160 did not receive therapy at any point during his stay at this facility (admission [DATE] to discharge on [DATE]). During the interview Director of Rehab #610 stated he was informed by Admissions #600 that Resident #160 had been admitted for wound care and medication management and did not need therapy evaluation. Interview on 06/30/26 at 3:07 P.M. with Admissions #600 revealed when a resident is newly admitting to the facility, most of the time she would receive a referral package from the discharging facility with expected care and orders for that resident. Admissions #600 stated she had spoken with the case manager from the discharging hospital and asked the case manager if Resident #160 was coming to the facility to receive wound care and medication management. Admissions #600 also revealed that due to Resident #160's young age, she did not figure he was going to receive therapy services and told the therapy department that they did not need to see this resident when he admitted because therapy services were not ordered or required. During the interview Admissions #600 verified she did receive the referral information for Resident #160 and (continued on next page)		

Department of Health & Human Services
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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	verified there was information in this referral indicating this resident was to be evaluated by physical and occupational therapy and treat as needed. This deficiency represents noncompliance investigated under Complaint Number 3063687.		