STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366282	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Knolls of Oxford	6727 Contreras Road Oxford, OH 45056

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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

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 0689 Level of Harm - Actual harm Residents Affected - Few	THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NONCOMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY.Based on observation, medical record review, incident report review, review of witness statements, staff interview, and review of facility corrective action documentation, the facility failed to ensure residents who require staff assistance and use of a mechanical lift for transfers were safely transferred without injuries. Actual harm occurred to Resident #4 on 07/24/25 when two staff members were transferring the resident using a mechanical (Hoyer) lift, when during the transfer, one of the staff members pressed a wrong button causing the resident to fall out of the lift. Subsequently, Resident #4 sustained a laceration to the back of the right leg which required an emergency room (ER) visit to obtain four internal stitches and 10 external stitches. This affected one (#4) of two residents reviewed for accidents. The census was 44. Findings include:Review of Resident #4's medical record revealed an admission date of 01/11/16. Diagnoses included generalized weakness and unsteadiness on the feet with a need for assistance with personal care.Review of the annual Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 10/17/25, revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS assessment revealed the resident was dependent on chair-to-bed and bed-to-chair transfers. Review of Resident #4's care plan revealed a focus area revised 11/19/24 which indicated the resident had the potential for harm/injury related to falls. Interventions directed staff to transfer the resident with a mechanical (Hoyer) lift with two staff.Review of Resident #4's progress notes included a health status note dated 07/24/25 which revealed the resident had a fall at 11:15 A.M. while being transferred to the recliner in the Hoyer (lift). The resident was unsure what happened, and the certified nurse aides (CNAs) indicated the resident refused to use proper hand placement within the Hoyer lift. The note indicated Resident #4 was sent to the ER and returned to the facility with 10 external stitches and four internal stitches in the popliteal fossa (back of the knee). Review of an incident report dated 07/24/25 indicated Resident #4 had a fall during a transfer in her room. Licensed Practical Nurse (LPN) #1 was called to the resident's room, and she observed the resident lying on her left side in front of the recliner. Further review revealed a skin tear was observed on the back of the resident's right leg at the popliteal fossa when emergency medical services (EMS) staff were transferring her. The resident was sent to the ER for evaluation of a skin tear to the back of the right knee and received 10 external stitches and four internal stitches. The report indicated recommendations were to encourage and educate the resident on proper hand placement during mechanical lift transfers.Review of CNA #2's witness statement as part of the 07/24/25 incident report revealed she was transferring Resident #4 to the recliner, and the resident did not have proper positioning of her arms in the mechanical lift sling and as a result, the resident slid through the mechanical lift sling. Review of CNA #3's witness statement as part of the 07/24/25 incident report revealed Resident #4 would not put her hands in the proper position in the mechanical life sling, and while moving the resident to the chair, the resident fell through the mechanical lift sling, hitting the floor. During an interview on 12/10/25 at 1:45 P.M., CNA #3 stated she usually worked on the assisted living side but would pull shifts if needed on the long-term care (LTC) side. She stated she never used a mechanical lift before and was training with CNA #2, who told her what to do for the mechanical lift. CNA #3 stated she did what she (CNA #2) told her to do step-by-step, and as they were bringing Resident #4 off the bed to sit in the recliner, the resident flipped backwards. She stated she did not know what happened. During an interview on 12/10/25 at 2:47 P.M., CNA #2 stated when she and CNA #3 went to put Resident #4 in her recliner for lunch, they put the pad under the resident and lifted her. CNA #2 stated while moving the resident to the recliner, she pushed the wrong button which put the resident in a lying position instead of a sitting position, so the resident went back farther and flipped out of the sling. During an interview on 12/11/25 at 9:35 A.M., CNA #2 stated she was very upset when Resident #4 flipped out of the sling, and she must have forgotten she pushed the wrong button until later. CNA #2 stated the resident's arms were in the wrong place because they wanted the resident to hold on to the bar in front of her, but Resident #4 would not, and they went ahead and moved the resident because it was not required for her to hold on to the bar. CNA #2 stated it was her fault for pushing the wrong button and she did not mean to do it and felt really bad that it happened. During an interview on 12/10/25 at 3:12 P.M., LPN #1 stated one of the CNAs said a nurse was needed in Resident #4's room, and she observed the resident on her left side in front of the recliner. LPN #1 stated she assessed the resident for any injuries while calling 911 from the resident's room because she did not want to