STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366338	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
National Church Residences Chillicothe	142 University Drive Chillicothe, OH 45601

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. Based on observations, interviews , record review and review of facility policy and procedure, the facility failed to ensure post fall interventions were in place for one resident (#14) out of three residents (#12, #14 and #22) reviewed for falls. The census was 34. Findings include:Review of medical record for Resident # 14 revealed readmission date of 12/9/25 with diagnoses including Alzheimer's disease, dementia , Type tTo Diabetes, chronic kidney disease and multiple sclerosis .Resident #14's quarterly Minimum Data Systems (MDS) revealed a Brief Interview of Mental Status BIMS score of six indicating severe cognitive deficits. Her care plan last updated on 03/16/26 revealed she was dependent on one to two staff members for activities of daily living; she used a wheelchair for transportation.Review of the facility's Incident Report log from 04/08/26 to 04/22/26 revealed Resident #14 experienced an unwitnessed falls on 04/08/26, 04/17/26 and 04/19/26.Review of Resident #14's nurse progress notes dated 11/01/26 to 04/22/26 revealed the falls occurred during multiple times of the day.Review of Resident #14 Care Plan last updated on 03/27/26 listed fall interventions to include call light within reach, wear non-skid foot wear, and wedge cushion to wheelchair for safety and positioning. Review of Resident #14 Post-Fall Investigative Summary 04/08/26 Resident #14 was found by nursing on the floor in front of her wheelchair in her room. It was determined resident was trying to get herself-dressed for bed. New fall intervention included maintenance to drop the back part of the seat of her wheelchair to inhibit her to get out of the chair alone. Review of Resident #14 Post-Fall Investigative Summary 04/17/26 was found on floor of room near her wheelchair. It was determined resident fell out of her wheelchair when attempting to pick up her pants on the floor. New post fall intervention included Reacher Grabber Tool.Review of Resident #14 Post-Fall Investigative Summary 04/19/26 was found on her bedroom floor by bed and chair. New post fall intervention included non-skid strips to floor in front of her bed for safety.Interviews on 04/23/26 at 9:00 A.M. with Registered Nurse (RN) #112 and Certified Nurse Aid (CNA) 116 confirmed Resident #14 is very confused and must be reminded to call for assistance and to not stand or try to walk, get out of her chair and go to the bathroom alone. She needs someone to assist her.Interview with Resident #14 on 04/22/26 at 10:00 A.M. confirmed Resident #14 is pleasantly confused and could not report the day of the week or what she had for breakfast.Observation at 10:45 A.M. on 4/23/26 of Resident #14 in her room sitting in wheelchair confirmed that resident did not have a wheelchair cushion in place and the back of wheelchair was not lowered. This was verified in a concurrent interview with Registered Nurse (RN) #112. Observation on 04/23/26 at 11:01 A.M. with Maintenance #118 observed Resident #14 in her wheelchair and confirmed the wheelchairs back part of the seat was not lowered and she did not have a wedge cushion in the wheelchair. Observation for 04/23/26 at 11:45 A.M. with RN #12, Director of Nursing (DON), and the Administrator could not locate a Reacher Grabber Tool in the resident's room.Observation on 04/23/26 at 12:13 P.M. with DON confirmed there were no slip strips in front of Resident #14's bed. While in the room a CNA found the Reacher Grabber Tool in Resident #14's closet on the top shelf under two blankets where resident was unable to reach it.Review of the Facility's, Falls Management Program Policy dated 04/2024 revealed the facility strives to create the safest (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	possible environment for residents, and promote culture of safety by minimizing the resident's risk, hazards and complications from falling. During completion of daily care routine, caregivers will observe the residents to ensure safety and fall preventions are in place as listed in the care plan.This deficiency repersents non-compliance investigated under Complaint Number 2974140.