STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366360	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vineyards at Concord, The	119 West High Street Frankfort, OH 45628

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. (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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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and facility policy review, this facility failed to report resident to resident abuse as well as injury of unknown origin to the appropriate agencies. This affected one (Resident #106) of the four residents reviewed for abuse and injuries. The facility census was 19. Findings include:Review of the medical record for Resident #106 revealed an admission date of 08/14/2025 and a discharge date of 10/14/2025. Diagnoses included Alzheimer's disease, muscle weakness, anxiety, and adult failure to thrive. Review of the plan of care dated 08/15/2025 and revised 10/15/2025 for Resident #106 revealed this resident was at risk for falls. Interventions included to anticipate and meet residents needs, ensure a safe environment and floors are from spills, and clutter. Review of Resident #106's admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 11 out of 15 indicating an moderately impaired cognition for daily decision making abilities. Resident #106 was noted to experience impairment to one lower extremity.Review of the nursing progress note dated 08/24/2025 at 7:00 A.M. created by a agency nurse revealed, Resident complained of right foot pain on his foot noted to be discolored and swollen. Family notified at 6:34 A.M. of resident transfer to the local hospital for evaluation and treatment.Review of the nursing progress note dated 08/24/2025 at 6:43 P.M. author unknown revealed, Resident alert and oriented yelling out for help repeatedly. Staff members responding to resident and providing assistance with repositioning and reassurance for comfort with no effect noted. Resident complained of headache and pain to the right foot. Right side of Resident #106's face swollen and bruising noted to right eyelid. Right foot elevated with surgery shoe in place, edema and bruising noted to toes when this nurse questioned resident concerning edema to face. Resident #106 resident stated, that's what happens when you are punched in the face. Responded to this writer about injury to foot It was stomped on. Will continue to monitor for further injuries related to inched that occurred at 2:50 A.M. this morning.Review of the hand written note titled Investigation and dated 08/24/2025, no time noted revealed, Writer was informed of incident regarding Resident #106 and Resident #70. After reviewing staff incident report, both residents were interviewed, Resident #106 was resistant to questioning and only responded to the question, How did you hurt your foot? Resident #106 claimed This is what happens when you kick someone. Resident #106 didn't respond to questions of who she kicked but did say maybe when I asked her if she had kicked the couch? Resident #106 did not respond when asked if Resident #70 had hit her or if she was hurt? Resident #70 said well when asked if he hit her and then the same when asked if she hit him, but did call her names during interview. Brief Interview for Mental Status (BIMS) were reviewed, No further investigation is warranted Completed and signed by the Administrator. Review of a facility staff had written statement no date or time noted created by Certified Nursing Assistant (CNA) #306 revealed Female resident was aggravating and yelling at other resident calling him names. I heard female resident yell and I went to to ask her what she needed she stated He hit me. I proceeded to ask male resident if he had hit her, he stated, She kicked me. I then assessed both residents with the charge nurse. No injuries were noticed to male resident. There was a small cut on female residents lip, I wiped clean the cut with a clean cloth. I kept both residents separated from each other for the resident of my shift. Review of the nursing progress note dated 09/03/2025 at 1:24 P.M. created by the Directed of Nursing revealed, Dark Purple and red bruising noted to the top of the right hand, across knuckles. Resident States, I must have hit something, Review of the History and Physician progress note dated 09/04/2025 no time noted revealed, Right hand with significant edema and bruising. Continued review revealed, Patient sustained metatarsal fractures of the second, third, fourth, and fifth metatarsals in a recent fall. Review of the nursing progress note date 09/06/2025 at 11:09 A.M. author unknown revealed, Resident complained of left elbow and left hip pain. Provider notified with new orders for by mouth pain medication, topical pain medication relief. Provider also notified of right hand x-ray results.Review of the nursing progress note dated 09/11/2025 at 10:00 A.M. author unknown revealed, Resident is presently at the hospital. Resident #106 is now noted to have a severe complicated fracture in her hip and they are not sure if this is old or new. Interview on 11/10/2026 at 2:20 P.M. with the Administrator revealed he completed a investigation for the incident between Resident #106 and Resident #70 and at that time found there to be no reason for any additional investigation. The Administrator claimed he did not submit this incident as a Self-Reported Incident due to there being no concern for abuse. The Administrator also confirmed he did not submit a report or investigation for Resident #106's injured right

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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. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview and facility policy review, this facility failed to ensure all injuries of unknown origin was investigated. This affected one (Resident #106) of the four residents reviewed for injuries. The facility census was 19. Findings include:Review of the medical record for Resident #106 revealed an admission date of 08/14/2025 and a discharge date of 10/14/2025. Diagnoses included Alzheimer's disease, muscle weakness, anxiety, and adult failure to thrive. Review of the plan of care dated 08/15/2025 and revised 10/15/2025 for Resident #106 revealed this resident was at risk for falls. Interventions included to anticipate and meet residents needs, ensure a safe environment and floors are from spills, and clutter. Review of Resident #106's admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 11 out of 15 indicating an moderately impaired cognition for daily decision making abilities. Resident #106 was noted to experience impairment to one lower extremity.Review of the nursing progress note dated 08/24/2025 at 7:00 A.M. created by a agency nurse revealed, Resident complained of right foot pain on his foot noted to be discolored and swollen. Family notified at 6:34 A.M. of resident transfer to the local hospital for evaluation and treatment.Review of the nursing progress note dated 08/24/2025 at 6:43 P.M. author unknown revealed, Resident alert and oriented yelling out for help repeatedly. Staff members responding to resident and providing assistance with repositioning and reassurance for comfort with no effect noted. Resident complained of headache and pain to the right foot. Right side of Resident #106's face swollen and bruising noted to right eyelid. Right foot elevated with surgery shoe in place, edema and bruising noted to toes when this nurse questioned resident concerning edema to face. Resident #106 resident stated, that's what happens when you are punched in the face. Responded to this writer about injury to foot It was stomped on. Will continue to monitor for further injuries related to inched that occurred at 2:50 A.M. this morning.Review of the hand written note titled Investigation and dated 08/24/2025, no time noted revealed, Writer was informed of incident regarding Resident #106 and Resident #70. After reviewing staff incident report, both residents were interviewed, Resident #106 was resistant to questioning and only responded to the question, How did you hurt your foot? Resident #106 claimed This is what happens when you kick someone. Resident #106 didn't respond to questions of who she kicked but did say maybe when I asked her if she had kicked the couch? Resident #106 did not respond when asked if Resident #70 had hit her or if she was hurt? Resident #70 said well when asked if he hit her and then the same when asked if she hit him, but did call her names during interview. Brief Interview for Mental Status (BIMS) were reviewed, No further investigation is warranted Completed and signed by the Administrator. Review of a facility staff had written statement no date or time noted created by Certified Nursing Assistant (CNA) #306 revealed Female resident was aggravating and yelling at other resident calling him names. I heard female resident yell and I went to to ask her what she needed she stated He hit me. I proceeded to ask male resident if he had hit her, he stated, She kicked me. I then assessed both residents with the charge nurse. No injuries were noticed to male resident. There was a small cut on female residents lip, I wiped clean the cut with a clean cloth. I kept both residents separated from each other for the resident of my shift. Review of the nursing progress note dated 09/03/2025 at 1:24 P.M. created by the Directed of Nursing revealed, Dark Purple and red bruising noted to the top of the right hand, across knuckles. Resident States, I must have hit something, Review of the History and Physician progress note dated 09/04/2025 no time noted revealed, Right hand with significant edema and bruising. Continued review revealed, Patient sustained metatarsal fractures of the second, third, fourth, and fifth metatarsals in a recent fall. Review of the nursing progress note date 09/06/2025 at 11:09 A.M. author unknown revealed, Resident complained of left elbow and left hip pain. Provider notified with new orders for by mouth pain medication, topical pain medication relief. Provider also notified of right hand x-ray results. Review of the nursing progress note dated 09/11/2025 at 10:00 A.M. author unknown revealed, Resident is presently at the hospital. Resident #106 is now noted to have a severe complicated fracture in her hip and they are not sure if this is old or new. Interview on 11/10/2026 at 2:20 P.M. with the Administrator revealed he completed a investigation for the incident between Resident #106 and Resident #70 and at that time found there to be no reason for any additional investigation. The Administrator claimed he did not submit this incident as a Self-Reported Incident due to there being no concern for abuse. The Administrator also confirmed he did not submit a report or investigation for Resident #106's injured right hand or fractured

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interviews, and facility policy review, this facility failed to ensure resident falls were reported, investigated and fall care plans were in place. This affected four (Resident #106, #56, #70, and #78) of the four resident reviewed for falls. The facility census was 19. Findings include: 1. Review of the medical record for Resident #106 revealed an admission date of 08/14/2025 and a discharge date of 10/14/2025. Diagnoses included Alzheimer's disease, muscle weakness, anxiety, and adult failure to thrive. Review of the plan of care dated 08/15/2025 and revised 10/15/2025 for Resident #106 revealed this resident was at risk for falls. Interventions included to anticipate and meet residents needs, ensure a safe environment and floors are free from spills, and clutter. Review of the Fall Risk assessment dated [DATE] revealed a score of 20 indicating Resident #106 was at a high risk for falls. Review of the progress note dated 08/15/2025 at 12:43 A.M. created by Licensed Practical Nurse (LPN) #180 revealed Resident #106 rang her call light which was answered promptly. Resident #106 was observed sitting upright on the floor. Verbalized she fell out of the bed and her left knee was hurting. Range of motion was with in normal limit. Resident declined x-ray at this time. Review of the Initial Investigation/Incident/Accident Report dated 08/15/2025 at 12:00 A.M. revealed Resident #106 experienced a fall out of her bed and complained of her knee hurting. Corrective action preventative measures identified was to remind the resident to use her call light to ask for assistance prior to attempting to transfer. Review of the progress note dated 08/15/2025 at 10:30 A.M. created by Registered Nurse (RN) #305 revealed that Resident #106's family agreed to the use of a pull string tab alarm to alert staff of attempts to stand, which the resident has done five times today. Review of the progress note dated 08/20/2025 at 2:45 P.M. created by the Director of Nursing (DON) revealed Resident #106 attempted to stand with her legs placed over the arm of a chair and slid to the floor. No injury noted and assisted up and back into the chair without incident. Continued review of Resident #106's medical record revealed no incident report or investigation was completed for the incident that occurred on 08/20/2025 where Resident #106 slid out of the chair onto the floor. Review of Resident #106's admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 11 out of 15 indicating an moderately impaired cognition for daily decision making abilities. Resident #106 was noted to experience impairment to one lower extremity.Review of the progress note dated 09/01/2025 at 3:30 A.M. created by RN #310 revealed Resident #106 was taken to her room and laid down after repeatedly asking to go to bed. Resident #106 wanted back up saying she couldn't sleep in that bed. Left resident to see if she would lay back down. After about 5 minutes went back to check on resident who was on the floor crawling across the floor, had slid self off bed. Bed was in low position and fall mat was on the floor. Continued review of Resident #106's medical record revealed that a fall report and intervention was not completed for the incident that occurred on 09/01/2025. Review of physician orders for Resident #106 revealed no noted orders related to the tab string alarm that was put in place on 08/15/2025 as well as the low bed and fall mat next to the bed that was noted to be in place in the progress note from 09/01/2025.Interview on 11/10/2025 at 2:00 P.M. with the DON revealed when a resident is admitted to the facility a fall assessment is completed to determine if they are at risk for falls and the proper interventions would be implemented. The DON confirmed the falls that Resident #106 experienced on 08/20/2025 and 09/01/2025 did not have a fall report or investigation completed and all noted fall interventions including a pull string tab alarm, low bed, and a fall mat was not included in the plan of care and there were no physician orders for any of the fall interventions. 2. Review of the medical record for Resident #56 revealed an admission date of 04/19/2022. Diagnoses included anxiety, muscle weakness, and peripheral vascular disease. Review of the plan of care dated 08/05/2025 for Resident #56 revealed this resident was at risk for falls. Interventions include, if resident is a fall risk initiate fall risk precautions. No interventions were noted in this care plan. Review of Resident #56's Quarterly MDS 3.0 assessment dated [DATE] revealed this resident experienced long and short term memory problems, altered level of consciousness and displayed a severely impaired cognition for daily decision making abilities. Resident #56 was noted to experience impairments to the bilateral upper and lower extremities. Review of the progress note dated 10/20/2025 creator unknown revealed Resident #56 was observed lying on her left side on the floor. Alert and without injury from low bed. Vital signs within normal limits. Noted documentation for Neuro check. Interventions include to assist with incontinence care.Continued review of Resident #56's medical record revealed no evidence that the fall