STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366380	A. Building B. Wing	07/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Indianspring of Oakley	4900 Babson Place Cincinnati, OH 45227

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, interview with home health staff, and review of the facility policy, the facility failed to ensure appropriate information was communicated to resident family and home health provider upon discharge. This affected one (Resident #271) of three residents reviewed for discharge rights. The facility census was 123 residents. Findings include: Review of the medical record for Resident #271 revealed an admission date of 01/28/25 with diagnoses including protein-calorie malnutrition, malignant neoplasm of breast, acute kidney injury, dehydration, adult failure to thrive, iron deficiency anemia and intellectual disabilities. Resident #271 discharged from the facility back to her group home on [DATE]. Review of the Minimum Data Set (MDS) assessment for Resident #271 dated 01/31/25 revealed the resident had severe cognitive impairment, was frequently incontinent of bowel and occasionally incontinent of bladder, was dependent on staff assistance with activities of daily living (ADLs), was at risk for the development of pressure ulcers, but had no pressure ulcers. Review of a nurse progress note for Resident #271 dated 04/20/25 revealed staff identified a new open area to the resident's sacrum. The nurse cleansed the area with normal saline and applied barrier cream and a dressing. The nurse notified the resident's physician and obtained a treatment order for the wound. Review of the weekly wound progress note for Resident #271 dated 05/04/25 revealed the resident had a stage II sacral pressure ulcer which measured 1.8 centimeters (cm) in length by 1.2 cm in width by 0.1 cm in depth. The wound was round with a pink wound bed and a small amount of serous drainage. Review of the physician orders for Resident #271 revealed the wound care order upon the resident's discharge from the facility on 05/05/25 was to cleanse the wound with normal saline, pat dry, apply collagen and cover with a foam dressing or ABD pad secured with tape. Review of the discharge summary for Resident #271 dated 05/05/25 for Resident #271 which was provided to the resident's family and the home health Case Manager (CM) #999 revealed the resident had no skin impairment and the summary did not include the current physician's order for wound care. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record documents for Resident #271, which included the resident's profile, discharge physician orders summary report, and attending physician progress notes dated 03/10/25 and 04/04/25 revealed all documents were printed by the outside home health agency on 05/11/25 at 8:57 A.M. Review of the home health nurse intake notes for Resident #271 dated 05/13/25 revealed the resident's sacral wound measured 4.0 cm in length by 4.5 cm in width by 0.2 cm in depth. Interview on 06/25/25 at 5:10 P.M. with the Director of Nursing confirmed the Discharge summary dated [DATE] for Resident #271 indicated the resident did not have any skin impairment and the discharge medication list did not include the resident's wound care order on the date of discharge. The DON confirmed the facility made a referral for Resident #271 to have home health nursing but was unable to verify if the facility notified the home health agency of the resident's actual discharge date . Interview on 06/26/25 at 11:39 A.M. with Home Health Nurse (HHN) #995 confirmed the home health care referral from the facility for Resident #271 came on 05/10/25 and the resident's discharge physician orders were printed on 05/11/25. She said the home health care agency called the family and CM #999 on 5/11/25 to schedule the initial nursing visit with the resident and the family said to call back on 05/12/25. The initial visit for Resident #271 from the home health nurse took place on 05/12/25. Phone interview on 06/27/25 at 9:00 A.M. with Home Health Community Care Coordinator (HCCC) #950 verified the home health agency did not receive confirmation from the facility that Resident #271 had discharged on 05/05/25 until 05/10/25, and if the notification came after 5:00 P.M. the orders would not be processed until the following day. HCCC #950 further confirmed the home health agency was part of the facility's parent organization and the home health agency had access to the resident's electronic medical record and could generate needed resident documents such as physician orders, but the facility was required to notify the home health agency when a resident's discharge date was determined and/or when the resident discharged . HCCC #950 verified the timestamp for Resident #271's discharge physician orders being printed was 05/11/25. Review of the policy titled Discharge Planning revised November 2016 revealed when a resident's discharge was anticipated, the facility would develop and implement a discharge plan that focused on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions.

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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. Based on medical record review, review of staff witness statements, review of hospital records, review of facility Interdisciplinary Team (IDT) fall follow-up notes, staff interview, review of online clinical resources per Medline Plus Medical Encyclopedia, and review of the facility policy, the facility staff failed to safely and properly position a resident in bed during incontinence care. Actual Harm occurred on 05/30/25 when Certified Nursing Assistant (CNA) #521 rolled Resident #108 who was in a raised bed away from the aide and onto the floor, resulting in a right nondisplaced intertrochanteric hip fracture which required a hospital admission and subsequent surgical repair of the right hip fracture on 06/02/25. This affected one (Resident #108) of three residents reviewed for falls. The facility census was 123 residents. Findings include: Review of the medical record for Resident #108 revealed an admission date of 01/09/25 with diagnoses including end stage renal disease, left below the knee amputation (BKA), diabetes mellitus, and intellectual disabilities. Review of the occupational therapy (OT) evaluation for Resident #108 dated 01/11/25 revealed attempts to assist with rolling the resident at bed level required two sets of hands to maintain safety. Review of the fall risk assessment for Resident #108 dated 04/26/25 revealed the resident was at high risk for falls. Review of the care plan for Resident #108 dated 05/02/25 revealed the resident had an activities of daily living (ADL) self-care performance deficit related to impaired mobility, impaired balance, and left BKA. Interventions included resident was totally dependent for bed mobility with the assistance of two staff. Review of the x-ray report for Resident #108 dated 05/31/25 revealed the resident had a nondisplaced right intertrochanteric (hip) fracture. Review of the Minimum Data Set (MDS) assessment for Resident #108 dated 06/01/25 revealed the resident was moderately cognitively impaired and section GG revealed the resident was dependent with rolling right to left (the ability to roll right to left and back and return to lying back on bed). Dependent was defined in the MDS as helper does all of the effort, and resident does none of the activity, or the assistance of two or more helpers is required to complete the activity. Review of a witness statement regarding Resident #108 dated 06/01/25 per Licensed Practical Nurse (LPN) #419 revealed on 05/30/25 the nurse was in the hallway near the resident's room and was conducting medication administration when she heard a loud noise. CNA #521 told the nurse the resident had fallen out of bed while the aide was providing care. CNA #521 told the nurse while the resident was lying flat, he was coughing and had fallen out of bed. Upon LPN #419's arrival to Resident #108's room, the resident was lying on a floor mat with his right side extended straight out. The nurse assessed the resident who denied pain and/or hitting his head. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of a witness statement regarding Resident #108 dated 06/02/25 per CNA #521 revealed on 05/30/25 at approximately 8:00 P.M. to 8:15 P.M. the aide went into Resident #108's room to change the resident's incontinence brief. CNA #521 paused the resident's tube feeding, removed his soiled brief, rolled him onto his right side, and then used the draw sheet to position him in the center of the bed. CNA #521 was standing on the left side of the bed (if looking at bed from the foot of the bed). The bed was positioned at the waist height of the aide. As CNA #521 was cleaning the resident's buttocks, Resident #108 began coughing uncontrollably. CNA #521 immediately stopped providing care and the resident continued to cough very roughly and then fell off the bed and onto the fall mat located on the right side of the bed. CNA #521 immediately notified Resident #108's nurse of the fall. LPN #419 assessed Resident #108 and lowered the bed to put the resident back to bed with the assistance of another aide. Resident #108 started coughing so hard it had caused him to vomit. Resident #108 was sitting up in his bed at this time and complained of pain in his right hip but refused to go to the hospital. LPN #419 offered Resident #108 pain medication. CNA #521 frequently checked on Resident #108 throughout the night and he remained awake most of the night. Review of hospital notes for Resident #108 dated 06/02/25 revealed the resident presented to the emergency department via squad from facility with a report of a fall out of bed on 05/30/25. The resident had an x-ray of the right femur completed in the morning of 05/31/25 at the facility indicating a nondisplaced intertrochanteric fracture. Review of the facility fall timeline regarding Resident #108's fall on 05/30/25 revealed the resident had surgical repair of a right hip fracture on 06/02/25. Review of the IDT follow-up note regarding Resident #108 dated 06/04/25 revealed on 05/30/25 at approximately 9:00 P.M., CNA #521 notified the nurse that Resident #108 was on the floor. The nurse responded and observed Resident #108 lying on his right side on the floor mat on the left side of the bed. CNA #521 reported while she was providing care the resident experienced an excessive coughing episode during which his upper body shifted causing him to roll off the left side of the bed and onto the floor mat. Resident #108 stated to staff that he fell out of bed, landing on his right shoulder and denied hitting his head. The initial assessment revealed no apparent physical injuries or changes to range of motion or level of consciousness. Resident #108 complained of pain to the right shoulder. Staff assisted Resident #108 off the floor and back into bed without incident via lift sheet. The assessment did not indicate the need for emergency transfer, and Resident #108 indicated he did not want to go to the hospital. The nurse called the on-call physician and was directed to administer as needed Tramadol (pain medication) and routine Tylenol, continue neurochecks, continue to monitor and call back if there are any changes. When Resident #108 complained of increased pain, staff notified the nurse practitioner who gave an order for x-rays of the right shoulder and the right femur. The x-rays showed a right femur fracture. The on-call NP gave an order to send Resident #108 to the hospital for an evaluation. The IDT follow up indicated a new intervention status post fall would be to include side rails to the resident's bed to assist independence with bed mobility. Review of additional written information regarding Resident #108's fall provided by the Director of Nursing (DON) on 06/27/25 revealed the resident's care plan indicated the resident required extensive assistance of one person with bed mobility from 01/09/25 to 05/02/25. On 05/02/25 the fall IDT met and revised the care plan for Resident #108. During this revision the nurse clicked the intervention for total dependence times two staff in Resident #108's electronic medical record, but then immediately revised the intervention to read total dependence times one staff. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview on 06/26/25 at 11:05 A.M. with LPN #450 confirmed Resident #108 had experienced a decline in condition prior to the fall out of bed on 05/30/25 and should have been a two-person assist. Interview on 06/26/25 at 3:15 P.M. with CNA #185 confirmed when you are providing care by yourself you should never roll a resident away from you. CNA #185 confirmed residents should be rolled towards you to prevent them from falling out of bed. Interview on 06/26/25 at 5:25 P.M. with CNA #521 confirmed she frequently provided care to Resident #108. CNA #521 stated she was providing care to Resident #108 by herself on 05/30/25 when she rolled Resident #108 onto his left side (his below the knee amputation side) and away from where the aide was standing. CNA #521 confirmed Resident #108 fell out of the raised bed and onto the floor of the opposite side of the bed where the aide was standing. CNA #521 stated she was unable to prevent Resident #108 from falling. Interview on 06/30/25 at 3:18 P.M. with LPN #419 confirmed she was passing medications on 05/30/25 when CNA #521 told her that Resident #108 had fallen out of bed. LPN #419 stated she found Resident #108 lying on the floor on his right side. LPN #419 further confirmed she assessed the resident while he was on the floor and saw no signs or symptoms of injury, and she and another aide assisted Resident #108 back into bed. Once in bed, Resident #108 began vomiting. LPN #419 confirmed Resident #108 refused to go the hospital for an evaluation. LPN #419 called the resident's provider regarding the fall and gave an update on the resident's condition and received orders for pain medication which she administered to Resident #108. LPN #419 confirmed by the morning of 05/31/25 Resident #108 was complaining of increased pain to the right leg, and she notified the provider who gave an order for an x-ray. Review of an online clinical resource titled Turning Patients Over in Bed: Medline Plus Medical Encyclopedia undated at: https://medlineplus.gov/ency/patientinstructions/000426.htm#:~:text=Standing%20with%20one%20foot%20ahead,the%20person's%20hip%20toward%20you revealed the following steps should be followed when turning a resident in bed: explain to the resident what you are planning to do so they know what to expect, encourage the person to help if possible, stand on the opposite side of the bed the resident will be turning towards, move the patient towards you, step around to the other side of the bed, ask the resident to look towards you (this will be the direction in which the person is turning.) Review of the facility policy titled Fall and Accident Management dated June 2019 revealed the facility would identify residents at risk for falls and would implement interventions to reduce the risk of injuries, falls, and other accidents. This deficiency represents noncompliance investigated under Complaint Number OH00166410.