STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366426	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woods on French Creek Nursing & Rehab Center The	37845 Colorado Avenue Avon, OH 44011

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44454 THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on medical record review, resident and staff interview, review of x-ray images, review of orthopedic records, review of therapy notes, review of physician notes, and review of facility corrective action, the facility failed to ensure residents who required assistance with transfers were safely transported in their wheelchair to prevent injury. Actual harm occurred to Resident #10 when a dental provider staff member was transporting the resident in his wheelchair and pushed the resident's right foot into a door frame which resulted in excruciating pain and a subsequent distal posterior tibial fracture to the right foot. Resident #10 required orthopedic follow-up appointments, was required to wear a protective boot, and was non-weight bearing to the right foot until the fracture healed. This deficient practice affected one (#10) of three residents reviewed for accidents. The facility census was 70. Findings include: Review of Resident #10's medical record revealed an initial admitted [DATE]. Diagnoses included type II diabetes mellitus, congestive heart failure, chronic kidney disease, and anxiety. Review of the most recent quarterly Minimum Data Set assessment dated [DATE] revealed Resident #10 was cognitively intact. The resident utilized a wheelchair and was dependent on staff for mobility. Review of the physical therapy notes dated 06/26/24 revealed Resident #10 was being wheeled into the therapy gym by a dental assistant and the dental assistant ran the resident's right leg rest into the doorframe with the resident indicating he was in severe pain, and he felt like his foot was broken. The resident also stated it felt like when he previously broke the foot on the opposite leg. Nursing was notified and an order to obtain an x-ray was given. Review of the health status progress notes dated 06/26/24 and timed 11:42 A.M. revealed Resident #10 stated the dental assistant ran his right foot into the wall on the way to therapy. The resident was yelling out that the foot was broken. There was no redness, swelling, or warmth noted to the resident's right foot. The physician was notified and ordered an x-ray of the resident's right foot. (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 - Actual harm Residents Affected - Few	Review of Resident #10's x-ray results dated 06/26/24 revealed images were taken due to pain and trauma. Further review of the x-ray results revealed an acute distal posterior fibial fracture and mild soft tissue swelling. An x-ray of the right foot also identified a questionable fourth proximal phalanx fracture. A new order was given to consult with orthopedic care. Review of the orthopedic notes dated 06/27/24 revealed Resident #10 was seen for acute right ankle pain, ankle injury, and a closed fracture of the right ankle. The resident was instructed to wear a boot at all times and to remain non-weight bearing at all times. Review of the physician notes dated 07/15/24 revealed Resident #10 had been seen by dental and then his leg was jammed up and ended up having a fracture. The plan for care included as-need pain medication and follow-up with orthopedics. Interview on 03/26/25 at 10:24 A.M. with Resident #10 revealed, on 06/26/24, the resident saw a dentist in an examination room located in the facility. When the resident finished speaking with the dentist, the dental assistant offered to push him to therapy. While pushing the resident, the dental assistant turned her head to say something to another person and ran Resident #10's right foot into the doorframe of the therapy room. Resident #10 stated to the dental assistant that she broke his foot, the dental assistant tried to deny it was broken and then left the resident. Resident #10 stated he had excruciating pain once going back to his room and, ultimately, found out he had broken his right foot. Resident #10 reported having a walking-cast and being non-weight bearing until cleared by a physician. Resident #10 reported after many orthopedic appointments he was cleared to begin putting weight on his foot again. Interview on 03/26/25 at 11:44 A.M. with Registered Nurse (RN) #238 revealed she was working on the day Resident #10's foot was fractured. RN #238 stated a dental assistant had been pushing the resident from the examination room to the therapy room and jammed the resident's foot in the door. RN #238 stated Resident #10 reported excruciating pain, and x-rays were ordered which showed a fractured right foot. Interview on 03/27/25 at 8:43 A.M. with Physical Therapy Assistant (PTA) #382 revealed PTA #382 was scheduled to see Resident #10 on the date of the aforementioned incident (06/26/24). PTA #382 reported the resident had been in the examination room seeing the dentist. Afterwards, the dental assistant was pushing the resident and when she brought him around the corner, PTA #382 heard a thud and Resident #10 said, Ow, and was cursing and saying the dental assistant broke his foot. PTA #382 informed nursing and did not have the resident stand on the foot in case he did have a fracture. PTA #382 stated the resident ended up having a fracture from the incident, so therapy was limited after that due to the resident's non-weight bearing status. Interview on 03/27/25 at 3:04 P.M. with RN #349 revealed he helped with transporting residents to and from dental appointments on a regular basis. RN #349 reported it was common knowledge among staff that vendors were not to be transporting residents to and from appointments. As a result of the incident, the facility implemented the following corrective actions to correct the deficient practice by 06/27/24: On 06/26/24, Resident #10 was immediately assessed and the provider was updated by the Director of Nursing (DON). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 06/26/24, all residents seen by the dentist were interviewed and/or assessed by the facility Administrator and the DON to identify any concerns. No concerns were identified. On 06/26/24, all residents who were seen by the dentist were reviewed by the Administrator and the DON to determine if any special accommodation was needed for dental visits. On 06/26/24, Licensed Social Worker (LSW) #844 was educated by the Administrator that dental staff were to ask facility staff to assist with transporting residents to and from dental visits. On 06/26/24, an ad hoc Quality Assessment and Assurance (QAA) Committee meeting was held with the Administrator and the DON to review the incident investigation, internal action plan, and audit plan. On 06/27/24, dental staff were educated by the DON to ask facility staff to assist with transporting residents to and from dental visits. On 06/27/24, all nursing staff members were educated by the Administrator that dental staff were to ask facility staff to assist in transporting residents to and from dental visits. On 06/27/24, the Administrator initiated audits to observe dental visits to ensure dental staff were asking facility staff to assist with transporting residents to and from dental visits. Negative findings would be addressed immediately with reeducation provided and reported to the QAA Committee for review. The Administrator observed the next two dental visits on 08/21/24 and 01/31/25 with no concerns identified related to dental staff transporting residents. Interviews on 03/27/25 between 2:50 P.M. and 3:24 P.M. with LSW #844 and Certified Nurse Aide (CNA) #498 verified they were provided education regarding transportation of residents to and from dental visits. Staff interviewed possessed appropriate knowledge of the education provided by the facility. This deficiency represents non-compliance investigated under Complaint Number OH00162109.