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	11/06/2025

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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRCTED PRIOR TO THIS SURVEY Based on record review, staff interview, resident interview, review of the Emergency Medical Services (EMS) run report, review of the hospital documentation, and facility policy review, the facility failed to timely report a fall, failed to complete a timely and thorough resident assessment, and failed to ensure timely care and treatment after a fall. This resulted in Actual harm on 10/12/25 at 12:00 A.M. when Resident #52 fell out of bed and was assisted back into bed by staff without a thorough assessment. On 10/13/25 at 9:15 A.M., Resident #52 screamed out in pain with care, was thoroughly assessed, complained of bilateral leg pain, had x-rays completed, required EMS transportation to the hospital, and was diagnosed with bilateral femur fractures requiring surgical intervention on 10/14/25. The facility census was 68. Review of Resident #52's medical record revealed an admission date of 06/21/22. Diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting the right non dominant side, type two diabetes mellitus, morbid obesity due to excess calories, dementia, and anxiety. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #52 had moderately impaired cognition. Resident #52 required substantial to maximal assistance for toilet hygiene and showering and was always incontinent of bowel and bladder, required substantial to maximal assistance for bed mobility and was dependent for chair to bed or bed to chair transfers. Review of the care plan dated 06/29/22 revealed Resident #52 was at risk for falls including a concern for falls with injury related to decreased mobility, weakness, unsteadiness, hemiplegia/hemiparesis of the right side, and presence of bilateral artificial knees. Interventions included ensuring the call light is within reach, have commonly used articles within reach, non-skid strips to the exit side of the bed, and encourage the resident to ask for assistance. Review of the fall risk assessment dated [DATE] revealed Resident #52 was at risk for falls. Risk factors identified included Resident #52's need for assistance with elimination, inability to ambulate, inability to move from a seated to a standing position, and unsteadiness requiring staff assistance for stabilization. Review of the progress notes for 10/12/25 revealed nothing regarding the resident putting legs over side of bed or of the fall. Review of the progress note dated 10/13/25 and timed at 12:51 P.M. written by Licensed Practical Nurse (LPN) #165 revealed Resident #52 was complaining of pain to her bilateral legs with movement during care. Upon assessment, Resident #52 stated she had bilateral hip pain that extended to her knees. The nurse practitioner was notified, and new orders were received for stat (immediate) x-rays of bilateral hips and knees. The orders were placed and family was notified via voice message. Review of the progress note dated 10/13/25 at 2:51 P.M. entered by the Assistant Director of Nursing (ADON) indicated Resident #52 had swung both of her legs to the side of the bed and was holding onto the assist bar when she began to slide down. A nearby aide heard her and came to attempt to stop her from sliding but was unable to and assisted the resident to her knees. Additional staff assisted and a mechanical lift was used to get the resident back into bed. The nurse practitioner and family were notified. Review of the progress note dated 10/13/25 at 9:47 P.M. written by Registered Nurse (RN) #187 documented x-ray results were received for Resident #52. The on call physician was notified of the results, and an order was received to send Resident #52 to the emergency department for treatment. The family and Director of Nursing (DON) were notified. Review of the EMS run report dated 10/13/25 revealed they received a call from the facility at 9:24 P. M. requesting assistance with transporting a resident to the hospital. The report indicated upon arrival, they were met by nursing staff who stated Resident #52 had bilateral femur fractures. The staff reported Resident #52 had a fall the previous night, but they could not find a report for the fall. Due to complaints of pain, x-rays were completed and confirmed bilateral femur fractures. Interview with Resident #52 revealed she remembered falling the night before. Resident #52 reported a pain level of a nine out of ten and 50 micrograms (mcg) of fentanyl was administered for pain control. Resident #52 was transported to the Emergency Department (ED) for treatment. Review of the hospital documentation dated 10/13/25 revealed Resident #52 suffered a fracture of the left mid-femoral shaft with lipohemarthrosis (fat and bone escape from bone marrow into the joint space), and a comminuted right distal femur fracture noted above the right knee arthroplasty with the posterior fragment displaced one full width. Resident #52 underwent an open reduction and internal fixation (ORIF) of both legs on 10/14/25. Resident #52 was discharged from the hospital and returned to the facility on [DATE]. Review of the facility fall log revealed Resident #52 suffered a