STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366462	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canal Winchester Care Center	6800 Gender Road Canal Winchester, OH 43110

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident record review, staff interviews, and review of facility policy, the facility failed to provide care and services to prevent falls. This affected two residents (Resident #15 and Resident #120) out of five residents reviewed for falls. The facility census was 100 residents.Findings include: 1. Review of the medical record revealed Resident #120 was admitted to the facility on [DATE] and had diagnoses that included pulmonary hypertension, dementia and spondylosis. The resident was discharged home from the facility on 10/10/25. Review of Resident #120's admission assessment on 09/27/25 revealed that she was at risk for falls and she was to have two-person assistance with bed mobility. Review of Resident #120's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed that Resident #120 had a Brief Interview for Mental Status (BIMS) score of 15, indicative of intact cognition. She was assessed as needing touch assistance for mobility and transfers. Review of Resident #120's baseline care plan dated 09/27/25 revealed that she was at risk for falls. An intervention initiated on 09/27/25 to help prevent falls revealed staff were to provide assistance with transfers and two-person assistance for bed mobility. Review of Resident #120's progress notes authored by Unit Manager #160 and dated 10/08/25 revealed that Resident #120 reported to nursing on 10/08/25 that on 10/01/25, she was lifted with a mechanical lift by an aide as she was getting weighed. Resident #120 stated that the mechanical lift strap broke while she was in the lift, which caused her to fall backwards onto the bed, jarring her neck and shoulder. Review of the fall investigation for Resident #120 dated 10/10/25 revealed that Certified Nursing Assistant (CNA) #150 was transferring Resident #120 on 10/01/25 via mechanical lift without additional assistance per the facility's policy. Resident #120 was fully assessed with no negative findings. An interview with CNA #150 on 12/04/25 at 12:47 P.M. confirmed that on 10/01/25, she lifted Former Resident #120 with a mechanical lift without any assistance from other staff members. (continued on next page)

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	An interview with the Director of Nursing (DON) on 12/04/25 at 1:05 P.M. revealed that his expectation was to always use two trained staff members when using a mechanical lift for a resident. The DON confirmed that the strap broke when Resident #120 was lifted by the mechanical lift while the resident was less than 6 inches in the air and the resident fell back on to the mattress with no injury. Review of a policy titled, Transferring- Using a Mechanical Lift, dated 09/28/25, revealed that at least two nursing assistants or other licensed and trained staff are needed to safely move a resident with a mechanical lift. This is not limited to transfers, but also may include repositioning. 2. Review of the medical record revealed Resident #15 was admitted on [DATE] with diagnoses that included heart failure, essential (primary) hypertension, cognitive communication deficit, malignant neoplasm of bladder, malignant neoplasm of right kidney renal pelvis, left bundle branch block, muscle weakness, other abnormalities of gait and mobility and ulcerative (chronic) rectosigmoiditis without complications. Review of Resident #15's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed that Resident #15 had a Brief Interview for Mental Status (BIMS) score of 05, indicative of impaired cognition. Review of Resident #15's care plan dated 10/28/25 revealed Resident #15 had an activities of daily living (ADL) self-care deficit related to malnutrition, adult failure to thrive, cancer history of right breast, kidney, and sigmoid colon, weakness, pain, as well as effects of medications per orders. Interventions included transfer with two-person physical assistance with gait belt, stand pivot transfer, and it noted the resident did not walk at baseline. Review of Resident #15's progress notes revealed on 11/24/25 Resident #15 fell in the weight station while being re-weighed. Resident #15 was eased down to the floor by staff and no major injuries were noted. Vital signs were within normal limits and recorded. Neuro checks were initiated, the primary care physician and family were notified. Safety precautions were in place and the call light was within reach. Review of Resident #15's 11/24/25 fall investigation revealed Licensed Practical Nurse (LPN) #180 was re-weighing Resident #15 at the weight station. Resident #15 was able to stand up from her wheelchair and moved herself to the weight scale with no issues. LPN #180 was standing at Resident #15's back at the time. Resident #15 lost her balance and was dropping to the floor while she was moving to her wheelchair. LPN #180 grabbed onto the residents back and called for assistance. Staff came and eased Resident #15 down to the floor. Resident #15's wheelchair was locked, grip socks were on both feet and no major injury was noted. Review of Resident #15's progress note dated 11/25/25 confirmed the interdisciplinary team (IDT) review of Resident #15's witnessed fall on 11/24/25. After review of the residents chart and interviews, it was noted that Resident #15 was in the weight room being weighed and lost her balance and was lowered to the floor. Resident #15 obtained no injury. Resident #15 complained of right knee pain but also stated she has arthritis pain. The Nurse Practitioner and family were made aware. Orders were placed to continue to monitor. A new intervention was in place to only weigh the resident in a wheelchair. All parties agreed with the plan of care. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/04/25 at 3:22 P.M. with LPN #180 confirmed he was assisting Resident #15 with getting her weight when she lost balance. LPN #180 stated he was using a gait belt and was the only staff member assisting Resident #15 at the time. Interview on 12/04/25 at 3:35 P.M. with the Director of Nursing verified after investigating Resident #15's fall on 11/24/25, LPN #180 was the only staff member assisting Resident #15 at the time and two staff were to assist the resident for transfers per her care plan. Review of the facility's policy titled Fall Management Guidelines dated 12/13/23 verifies the interdisciplinary team will review the resident's current care plan and interventions to ensure that the interventions are appropriate and review the resident's current care plan and interventions to ensure that the interventions are appropriate and the resident's post fall intervention(s) correlate to the root cause of the fall in an attempt to prevent future falls. This deficiency represents non-compliance investigated under Complaint Number 2679795.