STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366498	A. Building B. Wing	06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Liberty Station Health Campus	5348 Newtown Drive Liberty Twp, OH 45011

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** THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY.Based on record review, staff interview, hospital record review, policy review and review of the facility investigation documents, the facility failed to provide assistance with bed mobility during incontinence care resulting in a resident falling out of bed and sustaining injuries. This resulted in Actual Harm on 04/14/26 when Certified Nursing Assistant (CNA) #110 was providing personal care to Resident #52 without the appropriate level assistance. She rolled the resident away from her in the bed resulting in Resident #52 rolling off the bed onto the floor. Resident #52 was sent to the hospital where he was diagnosed with a comminuted nasal bone fracture and abrasions to his facial area, right knee, right upper arm and right hip. This affected one (Resident #52) of the three residents reviewed for falls. The facility census was 38.Findings include: Record review revealed Resident #52 was admitted on [DATE]. Diagnoses included hemiparesis and hemiplegia following nontraumatic intracerebral hemorrhage affecting left non dominant side, paroxysmal atrial fibrillation (a-fib), hypertensive heart failure, diabetes, and skin cancer. The resident was transferred to the hospital on [DATE] and never returned to the facility. Review of a plan of care dated 01/30/26, revealed Resident #52 was at risk for falls related to left side weakness, impaired mobility, osteoarthritis, and the need for assistance with personal care. Interventions included bolsters, allowing rest breaks during transfers as needed, using utilize a grabber tool, keeping call light within reach, therapy to evaluate and treat as needed and no-skid footwear. Review of the most recent Minimum Data Set (MDS) assessment completed on 02/08/26, revealed Resident #52 was cognitively intact and was dependent on staff for transfers and required substantial or maximal assist with bed mobility.Review of the Occupational Therapy (OT) note for Resident #52 dated 03/31/26, revealed Resident #52 required moderate assistance for positioning within the bed. Resident #52 reported increased fatigued and wanted to end his therapy session. Review of the nursing progress note dated 04/14/26 at 6:41 A.M. and authored by Licensed Practical Nurse (LPN) #207, revealed CNA #110 reported Resident #52 had a witnessed fall at 6:41 A.M. Resident #52 was rolled out of bed on the left side of the bed during care and the nurse found Resident #52 on the floor facing the nightstand. The resident hit his head and nose. A neurological (neuro) assessment was completed and was within normal limits for the resident. Vital signs were assessed and Resident #52 reported his pain was an eight (zero to ten scale where zero is no pain and 10 is severe pain) to his head, nose and right arm. Two nurses transferred Resident #52 back to the bed. A skin assessment revealed open areas to right side of the nose measuring 0.5 centimeters (cm) by 0.5 cm, right anterior knee measuring 0.5 cm by 0.5 cm and right upper, outer arm measuring five cm x 0.5 cm. LPN #207 notified the medical director, the Assistant Director of Nursing (ADON) and Resident #52's family. Resident #52 was sent to hospital. Review of the Post Fall Investigation Tool dated 04/14/26 at 6:41 A.M., revealed CNA #110 was changing Resident #52 in the bed when he rolled off the side of the bed to the floor. Resident #52 had weakness and fatigue, and was on antihypertensives, diuretics and narcotics. Review of the nursing progress note for Resident #52 (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 - Actual harm Residents Affected - Few	dated 04/14/26 at 5:13 P.M. authored by Registered Nurse (RN) #126, revealed the resident was admitted to the hospital with diagnosis of closed fracture to right nasal bone. Review of the hospital History and Physical dated 04/14/26, revealed Resident #52's chief complaint was a mechanical fall and nosebleed. The resident sustained a fall while he was getting rolled in the bed, and per a computerized tomography (CT) scan of his head, the resident was diagnosed with a comminuted displaced bilateral nasal bone fracture and was admitted to the hospital. Review of the witness statement by CNA #110 dated 04/14/26 and collected by the Director of Nursing (DON) via telephone, revealed CNA #110 was changing the resident and the resident was grabbing the bar on the bed which was normal practice. CNA #110 reported when she was getting ready to finish, the resident stated his arm was hurting. CNA #110 stated Resident #52 's hand let go and he slid right out of bed onto the floor. CNA #110 immediately got the nurse to evaluate the resident. Review of the witness statement by LPN #207 dated 04/14/26 and collected by the DON via telephone revealed the nurse was called to Resident #52's room by CNA #110 who reported the resident rolled out of bed during care. The resident complained of his arm hurting and he let go of the bar. The resident was found on the floor between nightstand and bed. All assessments were completed and the resident was sent to the ER for further testing due to complaints of pain and hitting his head. All prior interventions were in place including bilateral mobility bars and bolsters to the mattress. The resident did not indicate any distress or change prior to fall. Baseline bed mobility was one person assist and immediate intervention was to provide two person care until therapy revaluated the resident. Review of Interdisciplinary Team (IDT) note for Resident #52 dated 04/16/26 at 8:16 A.M. and authored by the DON, revealed the resident had a witnessed fall out of bed during personal care. The staff member reported that she was on the right side of the bed (facing the bed from the feet) and when the resident rolled over, so she could get his brief changed, the resident rolled off the left side of the bed. The resident had weakness and deficits to his left side due to a stroke. Resident #52 had abrasions to his bridge of nose, right knee, right upper arm and right hip. Resident #52 complained of pain to his head, nose and right arm. The medical director was notified and ordered for the resident to be sent to the emergency room (ER) where the resident was admitted with nasal bone fracture. A new intervention included a two person assist when providing personal care. During an interview on 06/24/26 at 8:54 A.M., CNA #110 stated she was assigned to care for Resident #52 on 04/14/26. CNA #110 reported Resident #52 seemed weaker since his cancer spread. She requested help from another staff member to do his personal care, but the other staff member got called to assist a resident in another room, so she did the resident's incontinence care by herself. There were bars on the bed at time of fall and the resident would normally hold onto it. CNA #110 verified she rolled Resident #52 away from her during care and the resident fell out the bed. During an interview 06/25/26 at 4:00 P.M., the DON and Regional Clinical Support (RCS) #234 verified CNA #110 was providing personal care to Resident #52 when she rolled the resident away from her in the bed and the resident fell out of the bed causing the resident to have a fractured nose and was admitted to the hospital. The deficient practice was corrected on 04/23/26 when the facility implemented the following corrective actions: On 04/14/26, an ad hoc Quality Assurance and Performance Improvement (QAPI) meeting was held with the Administrator, DON, Assistant DON #324, and Medical Director #600 via phone to review the incident. On 04/14/26, Resident #52's care plan was updated to reflect enhanced interventions. The resident's care plan would reflect a two person assist for all care and add a scoop mattress to the resident's bed. On 04/16/26 at 1:49 P.M. the DON sent out a message via the phone broadcast system to all 48 care staff on safety during personal care and the revised bed mobility assistance. All staff were informed if/when Resident #52 returned from the hospital, he would require a two person assist with all care and when providing personal care to the residents, ensure there was enough room on the side of the bed to prevent a resident from rolling out of the bed. The DON verified all 48 staff read the outgoing education. The DON had all 48 staff acknowledge and sign the education prior to their next assigned shift which included fall management, fall preventions and change in condition. On 04/16/26, (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	the Therapy Department re-evaluated Resident #52's functional status and provided recommendations. On 04/16/26, the IDT met to discuss the incident and determine a root cause analysis (RCA) of Resident #52's fall on 04/14/26. The RCA revealed the resident experienced an unanticipated change in position during bed mobility while receiving personal care, resulting in the resident rolling beyond the left edge of the bed. At the time of the event, the resident's care was being provided consistently with his documented functional baseline and established bed mobility status. Following the fall, the IDT determined that adding scoop mattress to the bed and increasing bed mobility assistance to a two person assist during personal care would provide an additional layer of safety while the resident's functional status was reassessed by the therapy team. On 04/16/26, the DON, reviewed all residents to ensure the appropriate interventions remained individualized and reflective of each resident's functional status. Residents with similar care needs were reviewed by the DON for appropriate bed mobility interventions with staff guidance, and the care plans reviewed for accuracy. Additional interventions were implemented as clinically indicated. On 04/16/26, RCS #234 completed an audit of the prior 30-day incidents to determine if there were any similar incidents. No other issues were identified. On 04/16/26, as a measure of on-going compliance, the DON and/or designee will review two to three random residents Care Plans and interventions weekly for four weeks. The audits will be reviewed in monthly QAPI to determine if on-going monitoring should continue. On 04/16/26, RCS #234 reviewed the fall policy. No changes were indicated. On 04/23/26, the facility finalized and implemented a new SAFE STEPS (Screen Apply Follow through Evaluate Staff awareness, Timely response, Environmental safety, Plan of Care and Surveillance) tool. This tool was designed to strengthen consistency in how they assess, intervene, and respond to fall risks across all campuses. The tool would assist in reducing resident harm by tightening the processes and improving real time decision making. SAFE STEPS is designed to support, reinforce, and consistent risk identification and reassessment, guiding targeted individualized interventions, and strengthening team communication. As part of the SAFE STEPS tool, the facility also implemented a new admission Fall Risk Review for all residents which includes a Fall Tracking Tool which will be reviewed monthly by the DON/designee. Review of facility policy titled Fall Management Program Guidelines revised 05/31/17, the facility stived to maintain a hazard free environment, mitigate fall risk factors and implement preventative measures. The facility recognizes even the most vigilant efforts may not prevent all falls and injuries, but in those cases, intensive efforts will be directed toward minimizing or preventing injury. This deficiency represents non-compliance investigated under Complaint Numbers 2995454 and 2992690.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff interview, and policy review, the facility failed to ensure resident's medications were administered as ordered resulting in three errors out of 33 opportunities or a 9.09 percent (%) error rate. This affected one (#08) out of the two residents observed for medication administration. The facility census was 38.Findings include: Review of the medical record for Resident #08 revealed an admission date of 03/14/25 with medical diagnoses of hypertensive heart disease with heart failure, congestive heart failure, chronic obstructive pulmonary disease, thoracic pain, and anxiety. Review of Resident #08's quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #08 was cognitively intact and required supervision with eating, toilet hygiene, bathing and set-up assistance with bed mobility and transfers. Review of Resident #08's physician orders, revealed an order dated 12/17/25 for Flonase Allergy Relief (fluticasone propionate spray) 50 microgram (mcg) per actuation two sprays in each nostril daily and orders dated 06/19/26 for buspirone 7.5 milligram (mg) one tablet by mouth two times per day and Lidoderm (lidocaine adhesive patch 5%) apply one patch topically two times per day. Observation on 06/24/26 at 7:37 A.M. revealed Licensed Practical Nurse (LPN) #201 prepared Resident #08's medications for administration. LPN #201 was observed to place buspirone 10 mg tablet into Resident #08's medication cup. LPN #201 was unable to prepare Lidoderm patch for Resident #08 due to medication not being available for administration. At 7:50 A.M. LPN #201 was observed to administer medications to Resident #08 including buspirone 10mg tablet. LPN #201 was observed handing Flonase nasal spray to Resident #08 who self-administered five sprays into right nostril and four sprays into the left nostril. During an interview on 06/24/26 at 7:55 A.M., LPN #201 confirmed Resident #08 had not received Lidoderm patch as ordered because it was not available for administration. LPN #201 also confirmed she administered buspirone 10 mg tablet to Resident #08 instead of 7.5 mg tablet as ordered. LPN #201 also confirmed Resident #08 self-administered Flonase nasal spray and Resident #08 administered five sprays to right nostril and four sprays to left nostril. LPN #201 stated Resident #08 did not have an order to self-administer medications. Review of the facility policy titled, Medication Administration, revised November 2018, revealed medications administered as prescribed with food nursing principles and practices and only by persons legally authorized to do so. Medications were to be administered in accordance with written orders of the prescriber. The policy also stated if a medication with a current, active order cannot be located in the medication cart/drawer, other areas of the medication cart, medication room, and facility (e.g. other units) are searched, if possible. If the medication cannot be located after further investigation, the pharmacy is contacted or mediation may be removed from the emergency drug supply. This deficiency represents non-compliance investigated under Complaint Number 2995454.