STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365014	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brethren Retirement Community	750 Chestnut Street Greenville, OH 45331

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 46613 Based on observation, a resident representative interview, and staff interview, the facility failed to ensure residents were provided a dignified dining experience when residents were not provided meals timely. This affected three (#19, #47, and #53) of ten residents observed in the 500 Hall dining room. The facility census was 69. Findings included: Observation on 03/05/25 from 11:37 A.M. to 1:13 P.M. revealed, at 11:37 A.M., staff assisted residents to the 500 Hall dining room and started to serve the residents drinks. Observation at 11:58 A.M. revealed 10 residents to be sitting in the dining room. Observation at 12:04 P.M. revealed staff started to serve residents their lunch trays in the dining room and meal trays were delivered to the rooms of the residents who did not come to the dining room for lunch. Observation at 12:35 P.M. revealed three (#19, #47, and #53) residents out of the 10 residents in the dining room had not been served a lunch tray while the other seven residents were actively eating their meals or had finished their meals and were leaving the dining room. Observation at 12:40 P.M. revealed Resident #19 received her lunch tray. Observation at 12:44 P.M. revealed Resident #53 received one chicken tender and was informed by Dietary Aide (DA) #477 the mashed potatoes with gravy she requested were being delivered from the kitchen. Observation at 12:46 P.M. revealed Resident #53's mashed potatoes and gravy were delivered to the resident. Observation at 1:13 P.M. revealed Resident #47 left the dining room without receiving a meal tray. Interview on 03/05/25 at 12:36 P.M. with Licensed Practical Nurse (LPN) #475 confirmed Resident #19, Resident #47, and Resident #53 had not received a lunch meal tray while the other seven residents in the dining room were eating or had already finished their meals. LPN #475 also confirmed meal trays were served to residents in their rooms prior to all the residents being served at the same time in the dining room. Interview on 03/05/25 at 12:38 P.M. with DA #477 confirmed Resident #19, Resident #47, and Resident #53 were not served a lunch tray at the same time as the seven other residents in the dining room. Interview on 03/05/25 at 1:17 P.M. with Resident #53's brother stated the residents who eat in the dining room normally have to wait 45 minutes or more to be served meals once they are brought to the dining room.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365014	A. Building B. Wing	03/06/2025

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 35031 Based on observation, staff interview, and policy review, the facility failed to ensure wheelchairs were maintained in a clean and sanitary manner. This affected one (#1) of five reviewed for wheelchair cleanliness. The facility census was 69. Findings include: Observation on 03/03/25 at 9:58 A.M. revealed Resident #1's wheelchair had a thick coating of food particles on the left side covering the lower rails and the left side of the seat cushion. Observation and interview on 03/04/25 at 2:43 P.M. with Certified Nurse Aide (CNA) #491 verified the appearance of Resident #1's wheelchair during the observation. CNA #491 stated it was the responsibility of the third shift CNAs to clean resident wheelchairs. Interview on 03/04/25 at 3:00 P.M. with Chief Clinical Officer #505 provided additional verification of the appearance of Resident #1's wheelchair. Review of the undated policy titled, Cleaning and Disinfection of Resident-Care Equipment, revealed resident-care equipment will be cleaned.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46613 Based on medical record review, resident representative interview, staff interview, and policy review, the facility failed to ensure care conferences were completed as required. This affected one (#32) of one residents reviewed for care conferences. The facility census was 69. Findings included: Review of the medical record for Resident #32 revealed an admitted [DATE] with diagnoses of dementia, osteoarthritis, congestive heart failure, and chronic kidney disease stage III. Review of Resident #32's Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #32 had severely impaired cognition and required partial/moderate staff assistance with toilet hygiene, bed mobility, transfers and substantial/maximum assistance with bathing. Review of the medical record for Resident #32 revealed no documentation to support the facility conducted a care conference since the initial care conference in June 2024. Interview on 03/03/25 at 3:23 P.M. with Resident #32's representative stated the facility had not held a care conference with the resident and representative in a very long time. Interview on 03/06/25 at 10:52 A.M. with the Administrator confirmed there was no evidence of a care conference held for Resident #32 since the initial care conference in June 2024. Review of the facility policy titled, Care Planning-Resident Participation, revealed the facility supports the resident's right to be informed of, and participate in, his or her care planning and treatment (implementation of care). The policy revealed the facility would honor the resident's right to participate with establishing the expected goals and outcome of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.

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	365014	A. Building B. Wing	03/06/2025

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46613 Based on medical record review, staff interview, and review of facility policies, the facility failed to ensure pressure ulcer care treatments were initiated timely and wound assessments were thoroughly completed to prevent the worsening of a pressure ulcer. Actual harm occurred to Resident #12 when the resident was readmitted to the facility with a stage II pressure ulcer (partial-thickness skin loss with exposed dermis) on assessment and no treatment orders were implemented until concerns were voiced by the resident's representative several days later. This resulted in Resident #12's pressure ulcer worsening to a stage III pressure ulcer (full-thickness skin loss) and associated deterioration and drainage. This affected one (#12) of three residents reviewed for pressure ulcers. The facility census was 69. Findings included: Review of the medical record for Resident #12 revealed an admitted [DATE] with diagnoses including diabetes mellitus, osteoarthritis, hypothyroidism, hypertension, atrial fibrillation, and congestive heart failure. Further review of Resident #12's medical record revealed the resident was discharged to the hospital on 01/17/25 and readmitted to the facility on [DATE]. Resident #12 was hospitalized again on 02/06/25 and readmitted to the facility on [DATE]. Review of Resident #12's annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #12 had moderate cognitive impairment and was dependent on staff for transfers, bed mobility, and toilet hygiene. Review of Resident #12's weekly wound evaluation dated 01/22/25 revealed the resident was readmitted to the facility from the hospital with a stage II pressure ulcer to the coccyx which measured 10.0 millimeters (mm) long by 10.0 mm wide by 4.0 mm deep. Further review revealed the physician and resident representative were notified and a treatment order was given. Review of Resident #12's physician orders revealed no documentation to support an order for wound care treatment on 01/22/25. Review of a nursing progress note dated 01/28/25 at 12:26 P.M. revealed Resident #12's daughter expressed concerns regarding the wound nurse practitioner assessing the open area to Resident #12's coccyx. Further review revealed a nurse requested the physician or wound nurse practitioner see Resident #12 as soon as possible. Review of Resident #12's weekly wound evaluation dated 01/28/25 revealed the pressure ulcer to Resident #12's coccyx had worsened and treatment was ordered. The evaluation did not have documentation to support measurements were completed. Review of a nursing progress note dated 01/29/25 at 1:45 P.M. revealed a new treatment order was received and the wound nurse practitioner would follow Resident #12. Review of Resident #12's physician orders revealed an order dated 01/29/25 to pack the coccyx wound with Vashe soaked gauze and cover with border foam two times per day and as needed. (continued on next page)

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	365014	A. Building B. Wing	03/06/2025

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #12's treatment administration record (TAR) for January 2025 revealed no documentation to support treatment to Resident #12's pressure ulcer to coccyx was initiated until 01/29/25. Review of a wound nurse practitioner progress note dated 02/03/25 revealed documentation of an initial visit for Resident #12's coccyx wound with measurements of 2.0 centimeters (cm) long by 2.0 cm wide by 1.4 cm deep. Further review revealed the wound had 40 percent (%) slough (non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture) and a moderate amount of serous drainage (watery, clear, or slightly yellow/tan/pink fluid that has separated from the blood and presents as drainage). Further review of the note indicated new treatments orders were given. Review of Resident #12's physician orders revealed an order dated 02/06/25 to cleanse the coccyx wound with wound cleanser, apply collagen to the wound bed, pack the wound with Vashe soaked gauze, and cover with bordered foam two times per day and as needed. Further review revealed a new treatment order was given 02/25/25 to cleanse the wound with wound cleanser, apply Santyl to the wound bed, pack with Vashe soaked gauze, and cover with bordered foam daily. Review of a wound nurse practitioner progress note dated 02/24/25 revealed Resident #12 continued with a stage III pressure ulcer to the coccyx with measurements of 2.0 cm long by 2.0 cm wide by 2.0 cm deep with 90% slough and a treatment in place. Interview on 03/06/25 at 11:27 A.M. with the Director of Nursing (DON) confirmed the medical record for Resident #12 did not contain documentation to support a wound treatment was initiated on 01/22/25 when Resident #12 was noted to have a stage II pressure ulcer to the coccyx. The DON also confirmed Resident #12's pressure ulcer worsened to a stage III pressure ulcer on 01/28/25 and verified there was no full assessment of the wound between 01/22/25 and 02/03/25 to determine the wound size. Review of the policy titled, Pressure ulcers/skin breakdown - Clinical Protocol, revised April 2018, revealed nursing staff and practitioner will assess and document an individual's significant risk factors for developing pressure ulcers. In addition, the nurse shall describe and document or report a full assessment of the pressure sore including location, stage, length, width, and depth, presence of exudates or necrotic, pain assessment, resident's mobility status, and current treatments. Further review revealed the physician will order pertinent wound treatments. Review of the policy titled, Wound Care, revised October 2010, revealed the purpose was to provide guidelines for the care of wounds to promote healing. Staff are to verify there is a physician's order for the procedure.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46613 Based on medical record review, staff interviews, and policy review, the facility failed to ensure pharmacy recommendations were reviewed by the physician and failed to ensure physician responses to pharmacy recommendations were accurate. This affected two (#11 and #31) of the five residents reviewed for medications. The facility census was 69. Findings included: 1. Review of the medical record for Resident #11 revealed an admitted [DATE] with diagnoses of dementia, Parkinson's disease, asthma, chronic obstructive pulmonary disease (COPD), depression, and anxiety. Review of Resident #11's quarterly Minimum Data Set (MDS) assessment, dated 02/14/25, revealed the resident had severe cognitive impairment, required partial/moderate staff assistance with bathing and bed mobility, substantial/maximum assistance with toilet hygiene and transfers and received antipsychotic and antidepressant medications. Review of Resident #11's physician orders revealed an order dated 09/06/23 for the antidepressant medication duloxetine 60 milligrams (mg) one tablet by mouth every bedtime. Resident #11 also had physician orders dated 09/09/24 for the cognitive-enhancing medication memantine 10 mg one by mouth every evening and an order dated 09/30/24 for the cognitive-enhancing medication Aricept five (5) mg one tablet by mouth daily. Review of the medical record for Resident #11 revealed a pharmacy recommendation dated 07/17/24 which noted a gradual dose reduction (GDR) for the antidepressant medication mirtazapine 15 milligram (mg) by mouth daily and duloxetine 60 mg by mouth daily was recommended. Review of the form revealed no documentation to support the facility completed the GDR or notified the physician of the pharmacy recommendation. Review of the pharmacy recommendation dated 11/06/24 revealed a recommendation to titrate the memantine daily dose by 5 mg every week until a maximum daily dose of 20 mg in divided doses was reached. Review of the form revealed no documentation to support the physician reviewed the recommendation. Interview on 03/06/25 at 10:13 A.M. with Administrator confirmed the facility did not have documentation to support the physician reviewed the pharmacy recommendations for Resident #11 dated 07/17/24 and 11/06/24. 35031 2. Review of the medical record for Resident #31 revealed an admitted [DATE]. Diagnoses include anxiety and depression. Review of the quarterly MDS assessment dated [DATE] revealed Resident #31 was mildly cognitively impaired. (continued on next page)

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	365014	A. Building B. Wing	03/06/2025

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the form titled, Consultant Pharmacist Recommendations, dated 12/06/24, revealed a notation to consider a GDR of Resident #31's antianxiety medication lorazepam 0.5 mg by mouth once daily and antianxiety medication buspirone 5 mg by mouth three times daily. The recommendation was marked as contraindicated with the reasons noted as previous attempts caused symptom recurrence and/or worsening, additional attempts may increase the risk of decompensating due to history of psychiatric instability, and target symptoms persist. The form was signed on 12/18/24. Review of Resident #31's behavior monitoring documentation revealed only five notations of anxiousness or restlessness and two panic episodes in the timeframe between 10/01/24 to 11/30/24. Interview on 03/05/25 at 4:30 P.M. with Chief Clinical Officer #505 confirmed the GDR responses on Resident #31's Consultant Pharmacist Recommendations document dated 12/06/24 were not accurate as the resident had not been at the facility for long and the GDRs recommenced for the resident would have been the first attempts to the facility's knowledge. Review of the policy titled, Medication Regimen Review Practice Guide, dated December 2024, revealed nursing management will review the signed recommendations and process any orders.

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	365014	A. Building B. Wing	03/06/2025

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46613 Based on medical record review and staff interview, the facility failed to ensure recommendations for gradual dose reductions of psychotropic medications were attempted or completed as required. This affected one (#11) of five residents reviewed for medications. The facility census was 69. Findings included: Review of the medical record for Resident #11 revealed an admitted [DATE] with diagnoses of dementia, Parkinson's disease, asthma, chronic obstructive pulmonary disease (COPD), depression, and anxiety. Review of Resident #11's quarterly Minimum Data Set (MDS) assessment, dated 02/14/25, revealed the resident had severe cognitive impairment, required partial/moderate staff assistance with bathing and bed mobility, substantial/maximum assistance with toilet hygiene and transfers, and received antipsychotic and antidepressant medications. Review of the medical record for Resident #11 revealed a physician order dated 09/06/23 for the antidepressant medication duloxetine 60 milligrams (mg) one tablet by mouth every bedtime. Review of the medical record for Resident #11 revealed a pharmacy recommendation dated 07/17/24 which noted a gradual dose reduction (GDR) for duloxetine 60 mg by mouth daily was recommended. Review of the form revealed no documentation to support the facility completed or attempted the GDR. Interview on 03/06/25 at 10:13 A.M. with the Administrator confirmed the facility did not have documentation to support a GDR was attempted or completed for Resident #11 per pharmacy recommendations on 07/17/24. Review of the policy titled, Medication Regimen Review Practice Guide, dated December 2024, revealed nursing management will review the signed recommendations and process any orders. 35031

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	365014	A. Building B. Wing	03/06/2025

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44076 Based on observation, staff and resident interview, nurse practitioner interview, and medical record review, the facility failed to ensure residents received specialized rehabilitative services as determined by their comprehensive plan of care to assist them to attain, maintain or restore, their highest practicable level of physical, mental, functional and psycho-social well-being. This affected one (#28) of two residents reviewed for activities of daily living. The census was 69. Findings include: Review of the medical record for Resident #28 revealed an admitted [DATE]. Diagnoses included hemiplegia following a stroke affecting the left dominant side, depression, type two diabetes mellitus, and congestive heart failure. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #28 was cognitively intact, required assistance with eating, and was dependent for toileting hygiene, bed mobility, and transfers. Review of Resident #28's care plan revealed the resident was at risk due to left hemiplegia, poor balance, and inability to bear weight on the legs and potential medication side effects. Interventions included providing activities that promote exercise and strength building if bedbound and physical therapy consultation for strength and mobility. Further review of the resident's care plan revealed the resident had a focus area of being resistive to care but no evidence of refusing care. Review of a physician note dated 07/22/24 revealed Resident #28 continued to require extensive assistance from staff and requested physical and occupational therapy. Further review of the assessment revealed the resident had increased weakness. Review of a progress note dated 07/29/24 revealed Resident #28 refused to get out of bed and physical therapy came to his room to discuss his desire to ambulate. Further review revealed the resident needed to get out of bed five days in a row for a therapy evaluation. Review of Resident #28's progress note dated 02/02/25 revealed a request was made to the physician for routine pain medication due to increased stiffness and yelling out in pain with movement. Observation and interview on 03/03/25 at 10:57 A.M. with Resident #28 revealed he was laying in his bed on his back. The resident's left arm was bent at the elbow and his palm was flat against his chest. Resident #28 stated he was unable to move his left arm, was able to slowly bend his right lower extremity, and had minimal movement of the left lower extremity. Resident #28 stated he had been in therapy in the past, but it had been some time. Interview on 03/05/25 with Director of Rehabilitation Services (DRS) #705 revealed Resident #28 refused therapy services on multiple occasions. The last evaluation was in November 2024 and he had refused services. (continued on next page)

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	365014	A. Building B. Wing	03/06/2025

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/06/25 at 11:23 A.M. with the Director of Nursing (DON) and DRS #705 stated Resident #28 would voice he wanted assistance from therapy to improve his activities of daily living (ADLs) but when therapy staff would come to provide treatment the resident would refuse. The DON and DRS #705 acknowledged there was no documentation regarding Resident #28's refusal of therapy services. DRS #705 acknowledged therapy services could be provided for bedbound residents. Interview on 03/06/25 at 12:06 P.M. with Certified Nurse Practitioner (CNP) #704 verified Resident #28 had a decline in the mobility and increased atrophy of his left arm. CNP #704 stated she was not aware therapy had not been offered in his room, and it would be her expectation the resident would receive bedside services.

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	365014	A. Building B. Wing	03/06/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44076 Based on observation, medical record review, staff interview, facility policy review, and review of the Centers for Disease Control and Prevention (CDC) website, the facility failed to ensure residents on infection control precautions had appropriate signage posted, failed to ensure adequate personal protective equipment (PPE) was worn for care provided to residents on infection control precautions, and failed to ensure PPE was properly disposed of after use. This affected three (#12, #38, and #179) of three residents reviewed for infection control precautions. The facility census was 69. Findings include: 1. Review of the medical record for Resident #179 revealed an admitted [DATE]. The resident was admitted with diagnoses including atrial fibrillation, herpes simplex virus (HSV-1), and right hip dislocation. Review of Resident #179's physician orders revealed the resident was ordered contact isolation for a diagnosis of Clostridium difficile (C. diff) with a start date of 02/28/25 and end date of 03/03/25. Further review of an additional order dated 03/03/25 revealed Resident #179 was in contact isolation for a diagnosis of HSV-1. Observation and interview on 03/03/25 at 10:23 A.M. revealed no infection control sign posted on or near Resident #179's room. Upon knocking and proceeding to enter Resident #179's room, Certified Nurse Aide (CNA) #558 called to the surveyor and explained anyone entering Resident #179's room required personal protection equipment (PPE). CNA #558 verified there was no signage on the door to indicate Resident #179 was in isolation. CNA #558 proceeded to find a sign and was observed taping it to Resident #179's door. Interview on 03/03/25 at 10:28 A.M. with Licensed Practical Nurse (LPN) #620, at the nurse's station, revealed Resident #179 was in isolation for C. diff and required a gown and gloves for both staff and visitors entering the resident's room. LPN #620 was unaware there was no sign posted on or near Resident #179's room. Observation and interview on 03/03/25 at 10:37 A.M. with CNA #558 revealed, upon entering Resident #179's room, there were two white gowns hanging on plastic hooks on the closet door. CNA #558 shared she had been in the room earlier in the day, but denied one of the gowns was hers. CNA #558 stated the gowns were not to be reused and she acknowledged there was no bag or container for soiled linens in the room. Interview on 03/06/25 at 8:17 A.M. with the Director of Nursing (DON) revealed Resident #179 did not have an active case of C. diff when she was admitted but did have an active case of HSV-1. The DON verified transmission based precautions should have been initiated upon the resident's admission. 2. Review of the medical record for Resident #38 revealed an admitted [DATE]. The resident was admitted with diagnoses including neuropathy, atrial fibrillation, reflux and hypertension. (continued on next page)

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	365014	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #38's admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition. Review of a progress note dated 03/02/25 revealed Resident #38 tested positive for Influenza Type A. Review of a physician order dated 03/02/25 revealed an order for Resident #38 to be in droplet precautions due to a diagnosis of Influenza Type A. Observation and interview on 03/03/25 at 1:45 P.M. revealed a sign on Resident #38's door indicating the resident was on enhanced barrier precautions. CNA #509 was observed approaching Resident #38's door to answer an activated call light. CNA #509 stated she was told she had to wear a surgical mask upon entering the room and a box of surgical masks were observed outside Resident #38's room. DNA #509 then entered the room. Observation and interview on 03/03/25 at 1:48 P.M. revealed CNA #509 exited Resident #38's room still wearing the surgical mask. CNA #509 verified she did not remove or change her mask upon exiting the resident's room. Interview on 03/03/25 at 1:52 P.M. with the DON revealed she was not aware droplet precautions had not been initiated for Resident #38. Review of the facility policy titled, Isolation-Initiating Transmission-Based Precautions, dated August 2019, revealed transmission-based precautions are utilized when a resident meets the criteria as having an infectious disease. Review of the CDC website at, https://www.cdc.gov/infection-control/hcp/basics/transmission-based-precautions.html, revealed a webpage titled, Transmission-Based Precautions, dated 04/03/24. The webpage revealed to use droplet precautions for patients known or suspected to be infected with pathogens transmitted by respiratory droplets that are generated by a patient who is coughing, sneezing, or talking. Further review revealed everyone must clean their hands, including before entering and when leaving the room, make sure their eyes, nose, and mouth are fully covered before room entry, and remove face protection before room exit. 46613 3. Review of the medical record for Resident #12 revealed an admitted [DATE] with diagnoses of diabetes mellitus, osteoarthritis, hypothyroidism, hypertension, atrial fibrillation, and congestive heart failure. Review of Resident #12's annual MDS assessment dated [DATE] revealed the resident had moderate cognitive impairment and was dependent upon staff for transfers, bed mobility, and toilet hygiene. Review of a wound nurse practitioner assessment dated [DATE] revealed Resident #12 was assessed with a stage III pressure ulcer (full-thickness skin loss) which measured 2.0 centimeters (cm) long by 2.0 cm wide by 1.4 cm deep with 40 percent (%) slough (non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture) present. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365014	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brethren Retirement Community	750 Chestnut Street Greenville, OH 45331

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #12's physician orders revealed an order dated 02/25/25 to cleanse the wound with wound cleanser, apply Santyl to the wound bed nickel thick, lightly pack the wound with Vashe soaked gauze, and cover with bordered foam daily and as needed. Observation on 03/05/25 at 3:01 P.M. of Resident #12's room revealed an enhanced barrier precaution sign sitting near Resident #12's sink and an isolation cart with personal protective equipment located outside of Resident #12's room door. The observation revealed Licensed Practical Nurse (LPN) #475 washed her hands and put on gloves. LPN #475 proceeded to complete Resident #12's wound care as ordered. LPN #475 was observed taking off her gloves and washing her hands. Interview on 03/05/25 at 3:10 P.M. with LPN #475 confirmed she did not put on a gown when she completed Resident #12's wound care. LPN #475 confirmed Resident #12 had an enhanced barrier precaution sign sitting by the sink in her room. LPN #475 stated staff never wore a gown when providing wound or incontinence care to Resident #12. Review of the facility policy titled, Enhanced Barrier Precautions, revealed it was the policy of the facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms (MDRO). Enhanced barrier precautions refers to the use of a gown and gloves for use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at risk for MDRO acquisition (those with wounds or indwelling devices). The policy revealed an order for enhanced barrier precautions would be obtained for residents with any wounds and/or indwelling medical devices (central lines, hemodialysis catheters, urinary catheters, feeding tubes, or tracheostomy/ventilator tubes) even if the resident is not known to be infected or colonized with MDRO.