STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365147	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Oaks Health Center	4114 North State Route 376 NW McConnelsville, OH 43756

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and facility policy review, the facility failed to ensure physician's orders were followed for three (Residents #27, #89, and #91) of seven residents reviewed for physician's orders. The facility census was 88.Findings include: 1. Review of the medical record revealed Resident #27 was admitted to the facility on [DATE] with diagnoses including left foot amputation, sepsis, type II diabetes mellitus, chronic ulcer of the left foot, end stage renal disease, dialysis dependent, heart disease, and hypertension. Review of the quarterly Minimum Data set (MDS) assessment completed 11/06/25 revealed Resident #27 had a Brief Interview for Mental Status (BIMS) score of 15 of 15, indicating the resident was cognitively intact. Review of resident #27's medical record revealed an order dated 11/06/25 for a daily weight once a day for Resident #27.Review of Resident #27's medical record revealed no documentation of weights being obtained on 11/13/25, 11/17/25, and 11/29/25.Review of Resident #27 orders dated 11/29/25 revealed an order for insulin aspart 100 units/milliliter (ml) flex pen, inject 18 units subcutaneously before meals for type two diabetes mellitus.Review of Resident #27 orders revealed an order dated 12/10/25 for NovoLog 100 units/ml flex inject as per sliding scale: if 121-200 give 2 units; 201-250 give 4 units; 251-300 give 6 units; and 301-350 give 8 units; 351-400 give 10 units subcutaneously before meals and at bedtime for type two diabetes mellitus. If blood sugar is greater than 400 notify medical director immediately.Record review including progress notes, Medication Administration Record (MAR) and Treatment Administration Record (TAR) for November and December 2025 revealed no documented evidence that Resident #27 receiving insulin aspart on 11/15/25 and 11/28/25 and no documented evidence Resident #27 received NovoLog 11/15/25, 12/08/25, and 12/09/25. In addition, there was no documented evidence Resident #27 had a blood sugar check as ordered by the physician on 12/08/25 after 8:36 A.M. and on 12/09/25 after 5:43 P.M.2. Record review revealed Resident #89 was admitted to the facility on [DATE] with diagnoses including Alzheimer's, dementia, gastro-esophageal reflux disease, anxiety, hyperlipidemia, and benign prostatic hyperplasiaReview of Resident #89 MDS assessment completed on 08/21/25 revealed a BIMS score of 9 of 15, indicating moderate cognitive impairment.Review of Resident #89's physician's orders revealed an order dated 09/18/25 for buspirone oral tablet 10 milligram (mg) give one tablet by mouth once daily for anxiety, and order dated 09/19/25 for amlodipine tablet 5 mg give one tablet by mouth one time a day related to hypertension, and an order dated 09/19/25 for aspirin tablet chewable 81 mg give one tablet by mouth one tine a day related to atherosclerotic heart disease of native coronary artery without angina pectoris.Review of Resident #89 October 2025 MAR revealed no documented evidence of aspirin 81 mg, amlodipine 5 mg, and Buspirone 10 mg being administered to Resident #89 on 10/04/25, 10/11/25, 10/12/25, 10/14/25, and 10/15/25.3. Review of the closed medical record revealed Resident #91 was admitted to the facility on [DATE] with diagnoses including heart disease, pancytopenia, anemia, bradycardia, hypertension, peripheral vascular disease, hyperlipidemia, anxiety, and hypokalemia,Review of Resident #91's physician's orders revealed an order dated 11/14/25 for levothyroxine 75 micrograms (mcg) give one tablet by mouth one time a day for hypothyroidism.Review of Resident #91's October 2025 MAR revealed no documented evidence levothyroxine was administered to the resident on 10/09/25, 10/24/25, 10/29/25, and 10/30/25. Interview on 12/15/25 at 3:00 P.M. with the Director of Nursing (DON) confirmed there was no documented evidence Resident #27, Resident #89, and Resident #91 received their medications on the above specified dates, and no documented evidence daily weights were obtained for Resident #27 on 11/13/25, 11/17/25, and 11/29/25 as ordered by the physician.Review of the undated facility policy titled Medication Administration revealed medication must be administered as ordered in accordance with manufacturer specifications. The MAR will be signed after medications are administered. For those medications requiring vital signs, record the vital signs onto the medication administration record. Physicians will be notified timely of medication omissions. This deficiency represents noncompliance investigated under Complaint Number 2612904.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview and review of the facility policy, the facility failed to assess, observe, and document care of a left arm fistula site and an external central venous catheter (CVC) dialysis access site for Resident #27. This affected one (Resident #27) of one resident reviewed for dialysis care and services. The facility census was 88.Findings include:Review of the medical record revealed Resident #27 was admitted to the facility on [DATE] with diagnoses including left foot amputation, sepsis, type II diabetes mellitus, chronic ulcer of the left foot, end stage renal disease, dialysis dependent, heart disease, and hypertension. Review of the quarterly Minimum Data set (MDS) assessment completed 11/06/25 revealed Resident #27 had a Brief Interview for Mental Status (BIMS) score of 15 of 15, indicating the resident was cognitively intact. Resident #27 received dialysis and had a diagnosis of end stage renal disease. Review of the physician's orders for Resident #27 revealed an order dated 11/17/25 for dialysis every Monday, Wednesday, and Friday.Review of Resident #27 orders, medication administration record (MAR), treatment administration record (TAR), progress notes, and care plan revealed no documented evidence Resident #27's CVC and/or fistula were assessed by facility staff.Interview on 12/11/25 at 8:33 A.M. with Resident #27 revealed she attended dialysis every Monday, Wednesday and Friday. Resident #27 stated she has been going to dialysis for about a year and had been a resident at the facility for approximately two years. Resident #27 stated she had a dialysis access point, two of them, one in her left upper chest accessible by a CVC, and the other a fistula in her left arm. Resident #27 stated, if she is remembering correctly, her fistula was placed about six months ago, and the CVC was placed a year ago.Observation on 12/11/25 at 8:33 A.M. revealed a fistula present on Resident #27 left extremity, near the radial artery. Observation revealed an external dialysis catheter Dura Flow CVC in Resident #27's left upper chest with two lumens, one red and one black, with gauze and Tegaderm present.Interview on 12/15/25 at 2:53 P.M. with Director of Nursing (DON) confirmed Resident #27's medical record does not reflect assessment or monitoring of Resident #27's dialysis access cites.Review of the undated facility policy titled Dialysis - [NAME] Oaks revealed ongoing assessment and oversight of the resident before, during, and after dialysis treatments including monitoring of the resident's condition during treatments, monitoring for complications, implementation of appropriate interventions and using appropriate infection control practices. The facility will ensure that the physicians order for dialysis include the type of access for dialysis (e.g. graft, arteriovenous shunt, external dialysis catheter) and location.This deficiency represents non-compliance investigated under Complaint Number 2612904.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and facility policy review, the facility failed to obtain a urinalysis for Resident #23 when ordered by the nurse practitioner. This affected one (Resident #23) of five residents reviewed for incontinence. The facility census was 88.Findings include:Review of the medical record revealed Resident #23 was admitted to the facility on [DATE] with diagnoses including traumatic brain injury with loss of consciousness, hemiplegia, hypokalemia, chronic pain, chronic kidney disease stage three, stress incontinence, and irritable bowel syndrome.Review of the quarterly Minimum Data Set (MDS) assessment completed 09/15/25 revealed Resident #23 was cognitively intact, displayed no behaviors, and was always incontinent of urine.Review of Resident #23's orders revealed an order placed on 11/21/25 for a urinalysis and culture and sensitivity one time for dysuria.Review of Resident #23's progress notes revealed a note authored by the Director of Nursing (DON) on 11/21/25 at 1:14 P.M. stating resident complains of (c/o) burning with urination; notified nurse practitioner (NP) at this time. A new order was received for urine culture and sensitivity (C&S). Resident #23 aware and in agreement at this time.Review of Resident #23's Medication Administration Record (MAR) revealed on 11/22/25 at 8:37 A.M. the resident's urinalysis was collected.Review of Resident #23's medical record including lab results, progress notes, physician notes, and physician's order as well as the facility infection control log for November 2025 revealed no results for Resident #23's urinalysis and no notification to the ordering provider regarding lack of lab results.Interview on 12/10/25 at 2:20 P.M. with Licensed Practical Nurse (LPN) #605 confirmed Resident #23 urinalysis does not appear to have been resulted, and she was unsure if it was collected. LPN #605 stated she would check with the lab. Interview on 12/10/25 at 2:59 P.M. with LPN #605 confirmed that the lab did not receive a urine specimen for Resident #23, and no provider was contacted. Review of the policy titled Lab Notification, effective 11/01/25, revealed it is the policy of the facility to timely notify the resident physicians or other providers of lab results. This deficiency represents non-compliance investigated under Complaint Number 2612904.