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	04/21/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on record review and staff interview, the facility failed to ensure a resident's physician was notified when a medication ordered for the treatment of hypotension (low blood pressure) was not available to be administered as ordered. This affected one (Resident #89) of three residents reviewed for medications. The facility census was 87. Findings include:Record review for Resident #89 revealed an admission date of 03/09/26 with diagnoses including chronic obstructive pulmonary disease (COPD), acute on chronic respiratory failure with hypoxia, malignant neoplasm (cancer) of an unspecified part of an unspecified bronchus/ lung, dependence on supplemental oxygen, heart failure, syncope (dizziness) and collapse, sepsis, and shock. Review of progress notes for Resident #89 revealed on 03/21/26 Resident #89 was discharged to the hospital for an evaluation following an unwitnessed fall with complaints of hip pain after the fall. Review of Resident #89's Discharge Summary from the hospital with a discharge date of 03/31/26 at the time of 10:58 A.M. revealed she was returning to the facility with an order for Midodrine (medication used to treat symptomatic orthostatic hypotension) 10 milligrams (mg) three times a day before meals. The hospital records indicated Resident #89 was last given Midodrine 10 mg by mouth (po) as ordered three times a day, with last dose administered on 03/31/26 at 10:22 A.M. The next scheduled dose would have been due at 5:00 P.M. Review of Resident #89's physician's orders revealed the resident's initial order for the Midodrine written on 03/31/26 was for the resident to receive 10 mg po three times a day (TID) for her blood pressure. Review of Resident #89's medication administration record (MAR) for March 2026 revealed the facility set up the administration times for the Midodrine 10 mg three times a day as AM, Mid, and HS. On 03/31/26 the Mid dose was not administered and a code 9 was marked in the box. The legend at the end of the MAR identified the code 9 meant other/ see progress notes. Review of Resident #89's nurses' progress notes revealed a nurse's note dated 03/31/26 at 5:10 P.M. that indicated the scheduled dose of Midodrine 10 mg due at that time was not able to be administered as ordered due to the facility waiting on the pharmacy to deliver that medication. Review of Resident #89's MAR for April 2026 revealed the resident was not documented to have received her scheduled doses of Midodrine for either the AM dose or the mid-day dose on 04/01/26. The first documented dose of Midodrine given to the resident was on 04/01/26 for her scheduled HS dose. Further review of Resident #89's progress notes revealed a nurse's note dated 04/01/26 at 8:13 A.M. (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

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	04/21/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that indicated the resident's Midodrine 10 mg was not administered as ordered for her blood pressure as the medication had been ordered and not available for administration. There was no documented evidence in the progress notes of the physician having been notified of the resident not receiving her Midodrine 10 mg, as ordered three times a day since 03/31/26, due to it not being available. On 04/20/26 at 3:50 P.M., an interview with the Director of Nursing (DON) revealed she was not able to find any evidence of Resident #89's physician being notified of Resident #89's Midodrine not being given as ordered during the evening hours of 03/31/26 or the morning and noon hours of 04/01/26. The DON verified it was not given as ordered due to the Midodrine not being made available by their contracted pharmacy. The DON stated she would have expected the resident's physician to be notified when a medication was not available for administration as ordered. The DON verified the findings on the March and April 2026 MARs. This deficiency resulted from incidental findings during investigation of Complaint Number 2976676.

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	04/21/2026

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and policy review, the facility failed to ensure a resident's baseline care plan was developed and the resident and/ or their representative received a copy of the baseline care plan within 48 hours of admission. This affected one (Resident #89) of three residents reviewed for care plans. The facility census was 87. Findings include:Review of Resident #89's closed medical record revealed and admission date of 03/09/26 with diagnoses including chronic obstructive pulmonary disease, sepsis, shock, malignant neoplasm (cancerous tumor) of an unspecified part of an unspecified bronchus/ lung, heart failure, pneumonia, dependence on supplemental oxygen, unspecified fall, and fracture of the nasal bones. Review of Resident #89's admission Observation Assessment (nursing admission assessment) dated 03/09/26 revealed the nurse admitting the resident failed to document any part of the assessment for the resident upon her admission. The last page of the assessment included a place to document if the resident and /or family had been given a copy of the Admission/ Baseline Care Plan Summary and that section was also left blank. Review of Resident #89's Baseline Care Plan dated 03/09/26 revealed minimal documentation was completed on that form. It did identify the resident's primary language as being English and her allergies as being to be determined but the rest of the baseline care plan was blank. Further review of Resident #89's medical record revealed there was a second Baseline Care Plan that was dated 03/13/26. That baseline care plan was mostly complete with only a few sections on the form not being completed. It was not signed as having been received by the resident or her representative and was not completed within the 48 hours of admission. Further review of Resident 89's medical record revealed a care plan was initiated on 03/10/26 for a fall with injury, discharge planning, and full code advance directive. On 03/11/26 care plan diagnoses were added for potential for alteration in activities. This care plan did not meet the requirement of a comprehensive care plan in place of a baseline care plan within 48 hours of admission. On 04/20/26 at 11:35 A.M., an interview with the Director of Nursing (DON) revealed she was not able to find evidence of a baseline care plan being developed for Resident #89, upon her admission to the facility on [DATE]. The DON confirmed nurses were not completing the residents' baseline care plans within 48 hours following admission as required. The DON stated she had educated the nurses and was trying to take that on herself to make sure they were done, but there were not enough hours in the day to keep up with everything she needed to get done. The DON identified and verified another baseline care plan had a creation date of 03/13/26, but that was not completed within the 48 hours of admission and no further evidence of care planning to meet the requirement. Review of the facility's policy titled Care Plans Baseline dated November 2025 revealed a baseline plan of care to meet the resident's immediate needs should be developed for each resident within 48 hours of admission. The interdisciplinary team (IDT) would review the healthcare practitioner's orders and implement a baseline care plan to meet the resident's immediate care needs. The baseline care plan would be used until the staff could conduct the comprehensive assessment and develop an interdisciplinary person-centered care plan. The resident and their representative would be provided a summary of the baseline care plan. This deficiency is based on incidental findings discovered during the course of this complaint investigation.

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	04/21/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure comprehensive care plans addressed bladder and bowel incontinence and toileting assistance for Resident #27, #82 and #89. This affected three (Resident #27, #82, and #89) of three residents reviewed for care plans. The facility census was 87. Findings include:1. Review of Resident #27's medical record revealed she was admitted to the facility on [DATE]. Diagnoses included congestive heart failure (CHF), chronic kidney disease- stage thee, hypertension, and edema. Review of Resident #27's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident did not have any communication issues and was cognitively intact. Resident #27 was dependent on staff for toileting hygiene and required substantial/ maximum assist with toilet transfers. Resident #27 was frequently incontinent of bladder and always continent of bowel. Review of Resident #27's care plans with a date initiated of 10/26/25 and last revised on 04/01/26, revealed no care plan in place to address urinary incontinence or assistance required with activities of daily living (ADL's) to include toileting assistance. 2. Review of Resident #82's medical record revealed he was admitted to the facility on [DATE]. Diagnoses included Parkinson's disease, adult-onset diabetes mellitus, COPD, and hypertension. Review of Resident #82's admission MDS assessment dated [DATE] revealed the resident had unclear speech and was usually able to make himself understood. Resident #82 had minimal difficulty hearing and was usually able to understand others. Cognition was moderately impaired. Resident #82 required substantial/ maximum assistance with toileting hygiene and toilet transfers and was always incontinent of bladder and bowel Review of Resident #82's active care plans with date initiated 02/26/26 and last revised 03/04/26, revealed no care plan in place to address incontinence. There were no interventions to address his toileting needs or his known incontinence. 3. Review of Resident #89's closed medical record revealed she was admitted to the facility on [DATE]. Diagnoses included COPD, acute on chronic respiratory failure, malignant neoplasm (cancerous tumor) of an unspecified part of an unspecified bronchus or lung, heart failure, dependence on supplemental oxygen, chronic kidney disease- stage three, muscle weakness, syncope and collapse, and an unspecified fall. Resident #89 discharged from the facility on 04/11/26. Review of Resident #89's quarterly MDS assessment dated [DATE] revealed the resident did not have any communication issues and was cognitively intact. Resident #89 was dependent on staff for toileting hygiene and required a substantial/ maximum assist with toileting transfers and was frequently incontinent of bladder and always continent of her bowel. Review of Resident #89's care plans with a date initiated of 03/10/26 revealed no care plan in place to address urinary incontinence or needing assistance with toileting needs through date of discharge of 04/11/26. On 04/21/26 at 8:50 A.M., an interview with the DON verified the findings for Resident #27, #82 and (continued on next page)

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	04/21/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#89. The DON stated when she first started working as the facility's DON in March 2026, she noted the residents did not have basic care plans in place to address ADL's needs and toileting/ incontinence needs. She stated since she had been there, they started to audit the residents' records and have since added those care plans when appropriate. She did not update Resident #89's care plans, since she had already been discharged from the facility, but some of the other residents had been addressed. She acknowledged Resident #27 and #82 remained in the facility and were known to have incontinence. The DON stated neither residents' care plans had been updated to ensure they addressed their ADL needs to include toileting assistance or to address their known incontinence status. This deficiency is based on incidental findings discovered during the course of this complaint investigation.

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	04/21/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and review of facility policy, the facility failed to ensure contracted pharmacy services were provided to assure Resident #89's medications were delivered timely and administered as ordered. This affected one (Resident #89) of three residents reviewed for pharmacy services. The facility census was 87. Findings include: Review of the closed medical record for Resident #89 revealed an admission date of 03/09/26 with diagnoses including chronic obstructive pulmonary disease (COPD), acute on chronic respiratory failure with hypoxia, malignant neoplasm (cancer) of an unspecified part of an unspecified bronchus/ lung, dependence on supplemental oxygen, heart failure, syncope (dizziness) and collapse, sepsis, and shock. Review of Resident #89's progress notes revealed a nurse's note dated 03/21/26 at 10:20 A.M. that stated the resident had an unwitnessed fall in her room that resulted in complaints of left hip pain. A stat x-ray was ordered for the left hip with directions to send to the emergency room if the x-ray could not be obtained within two hours. The facility's nursing staff was unable to reach the mobile x-ray unit, and the resident was sent to the hospital where she was found to have a fractured left hip. She remained in the hospital until she was transferred back to the facility on [DATE], at approximately 11:57 A.M. Review of Resident #89's Discharge Summary from the hospital with a discharge date of 03/31/26 at the time of 10:58 A.M. revealed the resident was returning to the facility with an order for Midodrine (medication used to treat symptomatic orthostatic hypotension) 10 milligrams (mg) three times a day before meals. Her hospital records indicated the resident was given Midodrine 10 mg by mouth (po) as ordered three times a day, with last dose administered on 03/31/26 at 10:22 A.M. Her next scheduled dose would have been due at 5:00 P.M. Review of Resident #89's physician's orders revealed the resident's initial order for the Midodrine written on 03/31/26 was for the resident to receive 10 mg po three times a day (TID) for her blood pressure. A subsequent order for Midodrine was given on 04/01/26 to include parameters to hold the medication if her systolic blood pressure (top number of a blood pressure reading) was above 120 millimeters of mercury (mmHg). Review of Resident #89's medication administration record (MAR) for March 2026 revealed the facility set up the administration times for the Midodrine 10 mg three times a day as AM, Mid, and HS. On 03/31/26 the Mid dose was not administered and a code 9 was marked in the box. The legend at the end of the MAR identified the code 9 meant other/ see progress notes. Review of Resident #89's nurses' progress notes revealed a nurse's note dated 03/31/26 at 5:10 P.M. that indicated the scheduled dose of Midodrine 10 mg due at that time was not able to be administered as ordered due to the facility waiting on the pharmacy to deliver that medication. Further review of Resident #89's nurses' progress notes revealed a nurse's note dated 03/31/26 at 10:25 P.M. that indicated the resident was off the unit at that time and in route to the local emergency department via Emergency Medical Services (EMS) for an evaluation. The resident was indicated to be having complaints of shortness of breath and oxygen saturation levels at around 78-80 % (above 92% within normal limits). A nurse's progress note by the same nurse on 04/01/26 at 12:55 A.M. indicated the resident did not receive her dose of Midodrine that was scheduled to be given at HS, due to her being sent out to the emergency department (ED), Her nurses' progress notes revealed she returned to the facility on [DATE] at 7:15 A.M.Review of Resident #89's ED notes for her visit on 03/31/26 revealed the resident was given a dose of Midodrine 10 mg po, while at the hospital on [DATE] at 12:40 A.M. The ED note further indicated that the resident was hemodynamically stable upon her presentation to the ED with her blood pressure being similar to when she was discharged from her previous hospitalization on Midodrine. Her blood pressure did begin to decrease at the hospital, but once she received her dose of Midodrine she went back to her baseline. She was sent back to the facility with the diagnosis of shortness of breath in stable condition. Review of Resident #89's MAR for April 2026 revealed the resident was not documented to (continued on next page)

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	04/21/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have received her scheduled doses of Midodrine for either the AM dose or the mid-day dose on 04/01/26. The first documented dose of Midodrine given to the resident was on 04/01/26 for her scheduled HS dose. Further review of Resident #89's progress notes revealed a nurse's note dated 04/01/26 at 8:13 A.M. that indicated the resident's Midodrine 10 mg was not administered as ordered for her blood pressure as the medication had been ordered and not available for administration. Review of the facility's medication administration times revealed the scheduled times included rising, mid-day, evening, and HS. Rising was between 7:00 A.M. and 10:00 A.M., mid-day was between 11:00 A.M. and 1:00 P.M., evening was between 4:00 P.M. and 6:00 P.M., and HS was between 7:00 P.M. and 11:00 P.M. Review of the facility's medication inventory from their Omnicell (contingent medication dispensing system) Inventory list revealed there were a total of 116 different medications available for use when needed from their emergency contingency supply. Midodrine was not one of the medications readily available at any dose. Review of a posting of an Ohio Pharmacy Information sheet from the facility's contracted pharmacy revealed the pharmacy delivered to the facility Monday through Friday for new orders and refills. Cut off times on those days were 12:00 P.M. and 12:00 A.M. Saturdays, Sundays, and Holidays. New orders and refills had a cut off time at 12:00 P.M. and 5:30 P.M. A message under New Orders and Refill Requests at the bottom of the page revealed new orders/ refill requests received before 12:00 P.M. would arrive with the first scheduled delivery. New orders and refill requests received after 12:00 A.M. (Monday to Friday) and after 5:30 P.M. (Saturday, Sunday, and Holidays) would arrive on the first scheduled delivery the following day. New orders and refill requests received after the cut-off would arrive on the next scheduled delivery. On 04/20/26 at 3:05 P.M., an interview with the DON revealed the facility's pharmacy did make deliveries twice a day (once in the morning and once again in the evening). The DON stated she was not sure of the approximate times other than what she had been told by their pharmacist, which was morning and evening. The DON stated she and the Administrator were just discussing pharmacy issues they had been having at the facility. The DON did not elaborate on what those issues were. On 04/20/26 at 3:50 P.M., a follow up interview with the DON revealed she had been the facility's DON since March 2026. The DON stated she felt there was a definite issue with the pharmacy the facility was using. The DON stated there should not have been a reason Resident #89's Midodrine was not available for administration until the HS dose on 04/01/26. She felt maybe the first dose would not have been available, but the nurses definitely should have had the Midodrine available to administer for the morning and mid-day doses that were scheduled for 04/01/26. The DON confirmed the hospital had given the resident a dose of Midodrine 10 mg, while the resident was in the ED on 03/31/26. The DON stated she was still getting to know the ins and outs of the pharmacy they used. The DON stated she was not sure if they had a local pharmacy that could be used as a backup when medications needed to be drop shipped and received timelier than what their contracted pharmacy could do when it was necessary. On 04/21/26 at 9:43 A.M., an interview with Registered Nurse (RN) #200 revealed she remembered Resident #89 having an order to receive Midodrine while there but did not recall if it was ordered before or after her hospitalization. She denied she had any concerns with Midodrine not being available during the times she worked. She reported the pharmacy the facility used was a struggle sometimes. If they stayed on them (pharmacy), they would get the medication to them (facility). The pharmacy made two deliveries a day, once in the early morning (before 7:00 A.M.), and the other in the afternoon between 4:30 P.M. and 5:00 P.M. She reported they would have to send in requests for routine medication by 8:00 A.M. that day to get them delivered that evening. Any new medication orders would have to be submitted by noon, if it was to be delivered with the evening delivery. If they needed something right away, they would have to put the medication in as a stat order and then would receive it within four hours. She did not feel there was any reason Resident #89 could not have had her Midodrine delivered before the evening delivery on 04/01/26, if the order was received and placed at the time of the resident's re-admission on [DATE] at 11:57 A.M. RN #200 stated the nurse receiving the re-admission orders could have put the Midodrine in as a stat order and it would have (continued on next page)

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	04/21/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	been received within four hours. RN #200 denied the facility used a local pharmacy as a backup, and if that was needed, that would have been something the pharmacy set up on their end. Review of the facility's policy on Pharmacy Hours and Delivery Schedule revised August 2020 revealed a schedule of pharmacy hours and delivery times was established and posted in a visible area in the facility. It did not specify when the deliveries would occur only that the Administrator, Director of Nursing (DON), and provider pharmacy would establish a daily delivery and pick up schedule for medication orders.This deficiency represents non-compliance investigated under Complaint Number 2976676.

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	04/21/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and policy review, the facility failed to ensure a resident's medical record was complete and included all documentation required as part of the resident's admission into the facility. This affected one (Resident #89) of three resident records reviewed. The facility census was 87. Findings include:Review of the closed medical record for Resident #89 revealed an admission date of 03/09/26. Resident #89 was hospitalized on [DATE] then re-admitted to the facility on [DATE]. Diagnoses included chronic obstructive pulmonary disease (COPD), acute on chronic respiratory failure with hypoxia, pneumonia, malignant neoplasm of an unspecified part of unspecified bronchus/ lung, dependence on supplemental oxygen, heart failure, sepsis, shock, unspecified fall (03/09/26), fractured nasal bones (03/09/26), syncope and collapse, muscle weakness, and unspecified protein-calorie malnutrition. Diagnoses were updated on 03/31/26 to include an unspecified fracture of the left pubis, fracture of the superior rim of the left pubis, and fracture of the left pubis. Review of Resident #89's admission Observation assessment (nursing admission assessment) dated 03/09/26 revealed the admission observation assessment was blank and did not include any information on it that was collected as part of the resident's initial admission into the facility on that date. The only information documented on the assessment was that the resident's allergies were to be determined. All other sections on the assessment that were to include an assessment of the resident's vitals signs and review of her body systems were left blank. Review of Resident #89's progress notes revealed a nurse's note dated 03/21/26 at 10:20 A.M. that revealed the resident was found on the floor beside her closet. The resident was attempting to get her clothes when she fell. She complained of left hip pain and a new order was received to obtain a stat x-ray of her left hip. The order indicated if the stat x-ray of the left hip could not be obtained within two hours then the resident was to be sent to the emergency department (ED) for an evaluation. The facility was unable to reach the mobile x-ray unit and the resident was transferred to the ED to be evaluated. She was admitted to the hospital with a fractured left hip and did not return to the facility until 03/31/26. Review of Resident #89's admission Observation assessment for her re-admission into the facility on [DATE] at 11:57 A.M. revealed it was not completed in its entirety. It included more information that what was collected during her initial admission but was still missing the majority of her assessment and review of her body systems. Her vital signs were recorded, as well as her known allergies, and some other parts of the assessment were documented, but the majority of the assessment was left blank. On 04/20/26 at 11:35 A.M., an interview with the Director of Nursing (DON) revealed she was not able to find evidence of a completed admission Observation assessment for the resident's initial admission into the facility on [DATE]. She stated it looked like it was completed in the electronic medical record, but when she pulled it up it was blank. She acknowledged the admission observation assessments was a means to assess the resident's condition upon entry into the facility and to identify/ address any resident specific care needs. She further acknowledged the admission Observation assessment completed upon the resident's readmission to the facility on [DATE] was also missing assessment data. She reported the nurse admitting the resident should be the one who completed the admission Observation assessment, but it was not consistently being done. Review of the facility's policy on admission Assessments dated November 2025 revealed the purpose of the procedure was to gather information about the resident's physical, emotional, cognitive, and psychosocial condition upon admission for the purposes of managing the resident, initiating the care plan, and completing required assessment instruments, including the Minimum Data Set (MDS) assessment. The steps in the procedure directed them on how to conduct the admission assessment, a physical assessment, and any supplemental assessments. They were also to determine if a resident had existing advanced directives. If so, they were to initiate the process of (continued on next page)

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	04/21/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	obtaining a copy for the medical record. If not, provide the resident with information on his/ her rights to have advanced directives and initiate the process of establishing them. This deficiency is based on incidental findings discovered during the course of this complaint investigation.