| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365202 | A. Building<br>B. Wing | 03/20/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Carecore at Lima | 599 South Shawnee Street<br>Lima, OH 45804 |

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 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, facility investigative document review, staff interview, and facility policy review, the facility failed to complete a thorough investigation for an allegation of misappropriation. This affected one (Resident #73) of three resident misappropriation allegations reviewed. The census was 71.Findings Include:Resident #73 was admitted to the facility on [DATE]. His diagnoses were muscle wasting and atrophy, chronic obstructive pulmonary disease, hypotension, hypo-osmolality and hyponatremia, severe sepsis, atherosclerotic heart disease,. hypothyroidism, hyperlipidemia, congestive heart failure, anxiety disorder, atrial fibrillation, obstructive and reflux uropathy, and major depressive disorder. Review of his Minimum Data Set (MDS) assessment, dated 02/20/26, revealed he was cognitively intact.Review of the Self-Reported Incident (SRI) dated 02/27/26, revealed Resident #73 reported on 02/26/26 at 4:45 P.M. that his medications were being taken. Resident #73 was being transported to the hospital at the time he made the allegation. The facility indicated they completed a thorough investigation and found the allegation to be unsubstantiated.Review of facility investigation packet for the SRI revealed they had no staff interview statements for this incident. Also, there was no interview statement completed with Resident #73 to determine what medications were taken, when they were taken, or any other information to gather specifics about the allegation he made.Interview with Director of Nursing (DON) on 03/20/26 at 1:30 P.M. and 2:20 P.M. and Unit Manager (UM) #112 on 03/20/26 at 2:20 P.M. confirmed they did not document any staff interview statements. UM #112 reported that she asked Resident #73 what medications he was talking about, and he mentioned his pain medications. She confirmed no one took a statement from him prior to leaving for the hospital, and no one contacted him or went to the hospital to gather a statement to specify information needed to do a thorough investigation. Review of the facility's Reporting and Investigating Abuse, Neglect, Exploitation, or Misappropriation policy, dated September 2022, revealed all reports of abuse, neglect, exploitation, or theft/misappropriation of resident property are thoroughly investigated by facility management. Findings of all investigations are documented and reported. The individual conducting the investigation as a minimum: reviews the documentation and evidence, reviews the resident's medical record to determine the resident's physical and cognitive status at the time of he incident and since the incident, observes the alleged victim, including his or her interactions with staff and other residents, interviews the person reporting the incident, interviews any witnesses tot he incident, interviews the resident or representative, interviews the resident attending physician as needed, interviews staff members (on all shifts) who have had contact with the resident during the period of the alleged incident, interviews the resident's roommate, family members, and visitors, interviews other residents to whom the accused employee provides care and services, reviews all events leading up to the alleged incident, and document in investigation completely and thoroughly. This deficiency represents non-compliance investigated under Complaint Number 2688587. |

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 |
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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 0627<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, family interview, staff interview, and facility policy review, the facility failed to include the resident's family/Power of Attorney (POA) in the discharge planning process. This affected one (Resident #72) of three resident discharges reviewed. The census was 71.Findings Include:Resident #72 was admitted to the facility on [DATE]. Her diagnoses were encephalopathy, peripheral vascular disease, unspecified protein calorie malnutrition, acute and chronic respiratory failure, emphysema, respiratory disorder, anxiety disorder, congestive heart failure, hypertensive heart and chronic kidney disease, atherosclerotic heart disease, major depressive disorder, hypertension, muscle weakness, osteoporosis, patient's non-compliance with other medical treatment, urge incontinence, overactive bladder, nicotine dependence, osteoarthritis, adjustment disorder, dependence on supplemental oxygen, nicotine dependence, and insomnia. Review of her Minimum Data Set (MDS) assessment, dated 10/16/25, revealed a Brief Interview of Mental Status Score (BIMS) of 10, indicating she had moderate cognitive impairment. Review of Resident #72 Care Conference document, dated 07/09/25, revealed the current discharge plan was for her to remain in the facility for long term placement. Resident #72 was in attendance; Resident #72's family was not in attendance.Review of Resident #72 care plan, dated 10/07/24, revealed regarding her discharge planning that she wishes the return to the community. But, on 10/07/24, the care plan reflected she was possible long term placement per power of attorney (POA). One of the interventions listed was that social services will meet with resident and family on admission to determine discharge plan.Review of Resident #72's progress note, dated 10/22/25, revealed the facility had Resident #72 meet with the physician assistant to discuss an upcoming discharge back home (it doesn't identify where home is located). The note stated the facility had Resident #72 and physician assistant sign the discharge packet prior to her discharge, which included all of her medication orders and orders for home health services. The discharge packet that was signed prior to her discharge and had the appropriate information in the summary.Review of Resident #72's progress notes, dated 10/17/25 to 10/25/25, revealed no evidence to support the facility consulted with Resident #72's family prior to being discharged on 10/25/25 when they picked her up.Interview with Resident #72's family member on 03/20/26 at 11:15 A.M. revealed she was not consulted for Resident #72's discharge, until the day Resident #72 was to be discharged ; she got a call from Resident #72 stating she needed to be picked up to go home. Resident #72's family member confirmed she is Resident #72's POA and she wanted to be up to date on all of her care and changes in care. She confirmed she had been notified of changes prior to this discharge, but it was very inconsistent. Interview with the Director of Nursing (DON) on 03/20/26 at 1:30 P.M. and 2:20 P.M. confirmed they did not discuss the discharge process with Resident #72's family prior to it occurring. The DON confirmed Resident #72's care plan reflected the POA had given (and the facility accepted) feedback on Resident #72 staying in the facility for long term placement, and that social services will meet with resident and family on admission to determine the discharge plan.Review of the facility's Discharge Planning Policy and Procedure, dated 07/28/25, revealed the facility is committed to ensuring that all resident discharges are conducted in a safe, person-centered, and compliant manner in accordance with CMS regulations. Discharges will be planned collaboratively with the resident, their representative, and the interdisciplinary team, with a focus on continuity of care, resident rights, and regulatory compliance. All discharges must be documented in the medical record, including resident and representative notification. This deficiency represents non-compliance investigated under Complaint Number 2688587. |