STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365202	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carecore at Lima LLC	599 South Shawnee Street 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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45751 Based on observation, interview, and policy review, the facility failed to maintain a safe environment regarding the wheelchair ramp in the front of the building. This had the potential to affect all residents in wheelchairs who would potentially use the ramp. The facility identified 39 residents who used wheelchairs. Additionally, the facility failed to ensure the floor of the shower in the secured unit was free of broken tiles. This affected one (#63) of one reviewed for falls related to broken tiles. The facility census was 80. Findings include: 1. Observation on 09/23/24 at 8:22 A.M. revealed a gap of approximately five inches irregularly shaped exposing stone and grass growing from the gap of broken concrete at the top of the wheelchair ramp coming into the building. Wheelchair ramp is located to the right of the building off the front porch area. Several cracks and open areas in the concrete on the front porch area observed as well. Observation on 09/25/24 at 2:28 P.M. of Resident #12 being pushed in wheelchair by State tested Nursing Assistant (STNA #140) on the wheelchair ramp outside of the front entrance revealed the wheelchair went down the ramp without difficulty. When STNA #140 attempted to push Resident #12 up the ramp the wheelchair wheels stuck at the top of the ramp in the gap and the resident jerked forward in the wheelchair. STNA #140 attempted to get the resident over the gap five times before the wheelchair got over the ramp. Interview on 09/25/24 at 10:13 A.M. with Resident #61 revealed the resident stated she had trouble getting over the gap/crack in the concrete at the top of the wheelchair ramp coming into the building. Resident #61 stated she needs help to get over the crack/gap. Resident #61 stated she has no problems wheeling herself around throughout the facility. Interview on 09/25/24 at 2:30 P.M. with STNA #140 verified Resident #12's wheelchair wheels got stuck in the gap of concrete and it took five times to get the resident over the crack. Review of the policy titled, Homelike Environment, revised February 2021 revealed residents are provided with a safe, clean, comfortable environment. 44815 (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: 365202	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/26/2024
NAME OF PROVIDER OR SUPPLIER Carecore at Lima LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 599 South Shawnee Street Lima, OH 45804	

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of the medical record for Resident #63 revealed an admitted [DATE] with diagnoses of encephalopathy, repeated falls and unsteadiness on feet. Review of the quarterly MDS assessment dated [DATE] revealed Resident #63 had impaired cognition, mobilized with a walker, required supervision or touching assistance for chair to bed transfer, substantial/maximal assistance for tub/shower transfer, and for shower/bathing self. Further review revealed she had one fall without injury since the previous assessment. Review of the current care plan for Resident #63 revealed she was at risk for falls related to dementia. Interventions included assisting in positioning and comfort as needed and observe daily and report any observed unsafe conditions. Review of the facility's incident report dated 03/10/24 revealed a State tested Nurse Aide (STNA) called the nurse to assist with Resident #23 off the floor in the shower. STNA stated Resident #63 slipped out of the shower chair. Review of an Interdisciplinary Team (IDT) progress note dated 03/11/24 revealed Resident #63 was in the shower and slipped out of the chair stating she had soap in her eyes. Resident #63's fall was witnessed by staff. No injuries were noted. Review of the facility's incident report dated 06/08/24 revealed the nurse was notified by the STNA that Resident #23 slipped out of the shower chair to the floor landing on her behind. Review of an IDT progress note dated 06/11/24 revealed Resident #63 was in the shower and slid off the chair onto the floor. STNA was present during the shower. Resident #63 was assessed and no injuries were noted. A floor mat was on the floor. Interview on 09/25/24 at 8:10 A.M. with STNA #162 revealed the tile in the shower on the secured unit was very slippery and there was broken tile and if staff used the shower chair everyone falls because the wheel on the shower chair caught in the broken tile. STNA #162 was aware of falls in the shower for Resident #63 and Resident #50. STNA #162 stated there was a third resident who fell in the shower but she could not recall who it was. Further interview with STNA #162 revealed she was with Resident #63 when Resident #63 caught her foot in a broken tile and fell before the shower began. STNA #162 stated Resident #63 was sent for x-rays but had no injuries. Concurrent observation of the shower revealed two areas of broken tiles, one jagged and affecting four tiles, and one where it appeared most of all four tiles were missing. STNA #162 stated it was the jagged broken area where Resident #63 caught her foot. STNA #162 stated she reported the broken tiles to the previous maintenance director. Observation and interview on 09/25/24 at 9:13 A.M. with Maintenance Director (MD) #104 revealed he worked at the facility for approximately two months and was not aware of any broken tiles in the shower on the secured unit. MD #104 confirmed the floor tiles were 2 inches by 2 inches and there were two areas with broken tiles. The jagged area was irregularly shaped and measured approximately 3.5 inches by 2.25 inches and affected three tiles. The second area measured 4 inches by 4 inches and affected four tiles. (continued on next page)

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Carecore at Lima LLC	599 South Shawnee Street Lima, OH 45804

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 09/25/24 at 2:46 P.M. with the Director of Nursing (DON) revealed she was aware of Resident #63's two falls in the shower and believed both falls were from Resident #63 slipping from the shower chair. The DON was not aware of any incident wherein Resident #63 fell in the shower due to cracked tiles. This deficiency represents non-compliance investigated under complaint OH0015799.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 35035 Based on record review, resident interview, staff interview, and review of facility policy, the facility failed to ensure comprehensive care plans were completed concerning all care areas for residents. This affected five residents (#22, #41, #57, #71, and #130) out of 25 residents reviewed for care plans. The facility census was 80. Findings include: 1. Record review for Resident #130 revealed the resident was admitted to the facility on [DATE]. Diagnoses for Resident #130 include polyneuropathy, gout, prostate cancer with metastasis to pelvic bone, and clostridium difficile, (c-diff). Review of Resident #130's Minimum Data Set (MDS) dated [DATE] was in progress at the time of survey. Review of Resident #130's hospital documents dated 09/12/24 revealed the resident had an indwelling catheter placed for the diagnosis of obstructive uropathy. Review of Resident #130's baseline care plan dated 09/20/24 revealed for the bladder assessment the resident was noted as having an indwelling catheter upon admission. Review of Resident #130's comprehensive care plans dated 09/20/24 revealed no focus for bladder or the indwelling catheter. Review of Resident #130's physician orders dating from 09/20/24 to 09/26/24 revealed no orders for the care or continuation of the indwelling catheter in the medical records. Review of Resident #130's Treatment Administration Records (TAR) dated 09/2024 revealed no documentation of catheter care being documented as completed. Interview on 09/23/24 at 9:10 A.M. with Resident #130 revealed the resident had the indwelling catheter inserted while he was at the hospital. Resident #130 stated he did not know what the plan was for the catheter or when the facility was going to be removing the catheter. Resident #130 stated he has asked his nurses about the catheter and they inform him, when he no longer needs the catheter it can be removed. Resident #130 stated he does receive catheter care regularly. Interview on 09/25/24 at 1:30 P.M. with State tested Nurse Aide (STNA) #156 revealed she performed catheter care for Resident #130. STNA #130 stated staff chart completion of care in the computer. STNA #156 stated she reported to the nurse she completed the catheter care and verified the aide knew the resident had an indwelling catheter due to the previous STNA's report. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Carecore at Lima LLC		STREET ADDRESS, CITY, STATE, ZIP CODE: 599 South Shawnee Street Lima, OH 45804	

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 09/25/24 at 1:35 P.M. with Registered Nurse (RN) #333 revealed the nurse works for the agency, not the facility. RN #333 stated she received the information in report Resident #130 had an indwelling catheter. RN #333 verified STNA #130 reported to her the catheter care was completed and there were no issues noted with the catheter. RN #333 stated she could not document the catheter care due no orders for the treatment in the records. RN #333 verified the resident had no focus in his care plans for the indwelling catheter. Interview on 09/25/24 at 1:45 P.M. with the Director of Nursing (DON) and Regional Registered Nurse (RRN) #275 verified Resident #130 had the indwelling catheter upon admission. The DON verified while the indwelling catheter was documented on the baseline care plans, there were no interventions, and the catheter was not on the comprehensive care plan. The DON verified there were no orders and no documentation in the medical records regarding the treatment for the indwelling catheter. 44815 2. Review of the medical record for Resident #22 revealed an admitted [DATE] with diagnoses of hemiplegia and hemiparesis, and need for assistance with personal care. Review of the comprehensive admission MDS assessment for Resident #22 revealed she had impaired cognition and an indwelling catheter. Review of the Admit/Readmit Review dated 07/09/24 and locked 07/17/24 revealed Resident #22 had a catheter. Review of the current comprehensive care plan revealed no bowel/bladder or catheter care area were included. Observation on 09/26/24 at approximately 10:00 A.M. revealed Resident #22 sitting in the common area with a catheter. Interview on 09/26/24 at 12:53 P.M. with MDS Coordinator #192 confirmed Resident #22 had a catheter and her care plan contained no care area for her bowel/bladder and catheter. 45751 3. Review of medical record for Resident #41 revealed an admitted [DATE] with diagnoses including but not limited to malignant neoplasm of glottis, acute respiratory failure with hypoxia, tracheostomy status, and dependence on supplemental oxygen. Review of MDS assessment dated [DATE] revealed the resident was cognitively intact. Resident #41 was on oxygen, required suctioning, and was on hospice. Resident #41 was dependent on staff for activities of daily living. (continued on next page)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of care plan dated 09/09/24 revealed infection control/Enhanced Barrier Precautions (EBP)/tracheostomy related to tracheostomy and oxygen dependence secondary to respiratory failure and occlusion in his throat from cancer on his vocal cords; the resident was at risk for further decline and sudden respiratory distress to failure going forward; hospice services in place. Interventions included educate resident, family, and frequent visitors on use of EBP; including how and when to use Personal Protective Equipment (PPE) provided outside the residents room, ensure proper PPE is maintained outside residents room and that the signage identifying that EBP are in use is posted on the residents door. Further review of the care plan revealed no respiratory care plan noted. Interview on 09/25/24 at approximately 1:45 P.M. with the Director of Nursing (DON) verified Resident #41 did not have a respiratory care plan. 4. Review of medical record for Resident #57 revealed an admitted [DATE] with diagnoses including but not limited to cerebral infarction, type two diabetes, congestive heart failure, difficulty walking, anxiety, and hypertension. Review of the MDS assessment dated [DATE] revealed the resident had moderate cognitive impairment. Resident #57 was dependent for bed mobility and transfers. Resident #57 was substantial/maximal assistance for activities of daily living. Review of care plan dated 07/11/24 revealed no care plan for activities of daily living (ADLs). Interview on 09/25/24 at 1:28 P.M. with the DON verified Resident #57 did not have an ADLs care plan. 5. Review of medical record for Resident #71 revealed an admitted [DATE] with diagnoses including but not limited to type two diabetes, sepsis, bipolar disorder, cutaneous abscess of the buttock, and cutaneous abscess. Review of the MDS assessment dated [DATE] revealed the resident was cognitively intact. The resident required supervision/touching assistance for ADLs and bed mobility, transfers, and ambulation. Review of physician orders revealed keep area with drains on right buttock clean and cover with ABD pad daily until follow up appointment. Review of care plan dated 07/11/24 revealed a care plan for at risk for skin impairment but no care plan regarding the actual skin impairment to the resident's right buttock with interventions. Interview on 09/25/24 at 10:33 A.M. with the DON verified no care plan was initiated for the actual skin issue. DON verified the resident had the skin issue since admission. Review of the policy, Care Plan, Comprehensive Person-Centered, dated 2001, revealed the comprehensive person-centered care plan describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45751 Based on observation, interview, and policy review. the facility failed to ensure weekly skin assessments were being completed thoroughly. This affected one resident (#71) of three residents reviewed for skin issues. Additionally, the facility failed to ensure treatments were completed as ordered and an order for suture removal was completed. This affected two residents (#23 and #29) of three residents reviewed for skin. The facility census was 80. Findings include: 1. Review of medical record for Resident #71 revealed an admitted [DATE] with diagnoses including but not limited to type two diabetes, sepsis, bipolar disorder, cutaneous abscess of the buttock, and cutaneous abscess. Review of Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact. The resident required supervision/touching assistance for Activities of Daily Living (ADLs) and bed mobility, transfers, and ambulation. Review of physician orders revealed keep area with drains on right buttock clean and cover with ABD pad daily until follow up appointment. Review of Skin Review Weekly dated 09/23/24 revealed the form was blank. No description, measurements, location, type of wound, and treatment that was ordered was listed on the form. Interview on 09/25/24 at 10:33 A.M. with the Director of Nursing (DON) verified the weekly skin note dated 09/23/24 did not contain the information requested such as surgical wound, location, measurements, and treatment ordered. The DON verified the skin assessments should be completed thoroughly. 2. Review of medical record for Resident #29 revealed an admitted [DATE] with diagnoses including but not limited to myoneural disorder, spondylosis, congestive heart failure, anxiety, major depressive disorder, and unspecified convulsions. Review of the MDS assessment dated [DATE] revealed the resident was cognitively intact. Resident #29 required supervision or touching assistance for ADLs. Review of current physician orders revealed apply compression stockings in the A.M. and remove at bedtime (tubi-grips or ace wraps), and unna boots to bilateral extremities then wrap with coban as needed. Review of the Treatment Administration Record (TAR) for September 2024 revealed the treatment for compression stockings/ace wraps was signed off as completed on 09/23/24. Observation on 09/23/24 at 2:02 P.M. revealed the residents legs were not wrapped and the lower legs appeared to have abrasions/scratches with seeping fluid. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 09/24/24 at 10:31 A.M. of Resident #29's legs revealed his legs were not wrapped. Resident #29's legs were observed to be seeping fluid at this time. Interview on 09/23/24 at 2:02 P.M. with Resident #29 revealed the resident stated the nurses do not wrap his legs like they should. Resident #29 stated the nurses do not wrap his legs some days. Interview on 09/24/24 at 10:33 A.M. with Licensed Practical Nurse (LPN) #174 revealed the nurse verified she worked on 09/23/24 and stated Resident #29 refused to let her wrap his legs on 09/23/24 after several attempts. LPN #174 verified she did not place wraps on Resident #29's legs on 09/24/24. Interview on 09/24/24 at 1:55 P.M. with Resident #29 revealed the resident denied ever refusing for his legs to be wrapped. Observation at the time of the interview revealed the residents legs were wrapped. 44815 3. Review of the medical record for Resident #23 revealed an admitted [DATE] with diagnoses of cerebral infarction, dementia, and epilepsy. Review of the quarterly MDS assessment dated [DATE] revealed Resident #23's cognition was assessed via staff, and Resident #23 had impaired cognition. Resident #23 required supervision or touching assistance for chair to bed transfers and walking. Review of a progress note dated 09/05/24 at 2:00 A.M. revealed Resident #23 fell in the hallway near the nurses' station. Resident #23 was walking with aides to get a soda and tripped on the legs of a parked mechanical lift and hit his head resulting in a 2-3 centimeter laceration near the corner of his left eye. The fall was witnessed by staff. The physician was notified via voicemail. Review of a progress note dated 09/05/24 at 2:30 A.M. revealed Resident #23 was sent to the Emergency Department (ED) via ambulance. Review of a progress note dated 09/05/24 at 5:48 A.M. revealed Resident #23 received stitches and a CT (computed tomography) scan was negative. Review of a progress note dated 09/05/24 at 6:44 A.M. revealed Resident #23 returned to the facility with no new orders. Review of the hospital discharge paperwork dated 09/05/24 revealed Resident #23's stitches should be removed in five to six days either by the facility physician or at the hospital. Review of a current physician order dated 09/07/24 revealed Resident #23's left outer eye sutures should be cleaned with soap and water every day, and left open to air; apply dressing as needed for drainage. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 09/26/24 at 1:35 P.M. with Registered Nurse (RN) #182 confirmed Resident #23's stitches were still in place. RN #182 stated she just cleaned them today. Further observation revealed the stitches and surrounding tissue showed no signs or symptoms of infection. Further interview with RN #182 revealed she was the nurse on duty when Resident #23 returned from the hospital with stitches on 09/05/24 and no accompanying paperwork or orders were received from the hospital. RN #182 was unaware Resident #23's stitches should have been removed.

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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 44815

Based on observations, medical record review, review of fall investigations, staff and resident interviews, review of hospital records, and review of the facility policies, the facility failed to ensure a safe environment to prevent falls, resulting in actual harm when Resident #23 tripped over the legs of an improperly stored mechanical lift resulting in a facial laceration requiring stitches and a fractured left olecranon (elbow) fracture. Further, the facility failed to ensure neurological checks were completed after falls for Resident #22, failed to ensure fall incidents were thoroughly investigated for Resident #22 and Resident #63, and failed to ensure fall preventions were in place for Resident #22. Lastly, the facility failed to ensure a safe environment to prevent falls for Resident #52. This affected four residents (#23, #22, #63, #52) of five residents reviewed for falls. The facility census was 80.

Findings include:

1. Review of the medical record for Resident #23 revealed an admitted [DATE] with diagnoses of cerebral infarction, dementia, and epilepsy.

Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #23's cognition was assessed via staff, and Resident #23 had impaired cognition. Resident #23 required supervision or touching assistance for chair to bed transfers and walking.

Review of the Fall Risk Evaluation dated 06/27/24 revealed Resident #23 had a score of 9.0 and was not at high risk for falls.

Review of the current care plan revealed Resident #23 was at risk for falls due to decreased safety awareness, impaired balance and unpredictable seizures. Interventions in place prior to the fall on 09/05/24 included having his bed against the wall, staff to report adverse effects of medications, and therapy to screen if indicated.

Review of a progress note dated 09/05/24 at 2:00 A.M. revealed Resident #23 fell in the hallway near the nurses' station. Resident #23 was walking with aides to get a soda and tripped on the legs of a parked mechanical lift and hit his head resulting in a 2-3 centimeter laceration near the corner of his left eye. The fall was witnessed by staff. The physician was notified via voicemail.

Review of a progress note dated 09/05/24 at 2:30 A.M. revealed Resident #23 was sent to the Emergency Department (ED) via ambulance.

Review of a progress note dated 09/05/24 at 5:48 A.M. revealed Resident #23 received stitches and a CT (computed tomography) scan was negative.

Review of a progress note dated 09/05/24 at 6:44 A.M. revealed Resident #23 returned to the facility with no new orders.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of a progress note dated 09/05/24 at 12:53 P.M. revealed Resident #23's left forearm and elbow appeared swollen and bruised and Resident #23 was guarding. An order was received for an x-ray of the left arm. Review of a progress note dated 09/05/24 revealed Resident #23 was sent to the ED for evaluation of his left arm. Review of a progress note dated 09/05/24 at 7:00 P.M. revealed Resident #23 returned to the facility via stretcher with no new orders. Review of the Interdisciplinary Team progress note dated 09/05/24 at 9:48 A.M. revealed the cause of the fall was equipment in the hallway and the intervention was to educate staff regarding appropriate storage of equipment. Review of the hospital discharge paperwork dated 09/05/24 at 4:41 A.M. revealed Resident #23 received stitches. Review of the hospital discharge paperwork dated 09/05/24 at 3:33 P.M. revealed Resident #23 presented to the ED for evaluation of a fall. Resident #23 was diagnosed via x-ray with a fractured left olecranon (elbow). Resident #23 received fentanyl (pain medication) at the ED. Resident #23's left arm was placed in a long-arm splint and sling. Review of the undated staff education titled, Proper Storage of Equipment, revealed housekeeping, State tested Nurse Aides (STNAs) and nurses were educated. Interview on 09/24/24 at 4:51 P.M. with Registered Nurse (RN) #182 revealed she worked 09/05/24 and was the nurse for Resident #23 when he returned from the hospital with stitches on 09/05/24 at approximately 6:40 A.M. RN #182 stated Resident #23 began to eat breakfast in the dining room, then had a seizure. After the seizure resolved, the staff assisted Resident #23 to his room to rest. RN #182 stated she was familiar with his seizure activity and was not concerned it was related to his head injury. Further interview revealed the staff began to change Resident #23's clothes before lunch and found his left arm swollen. RN #182 contacted the physician who ordered an x-ray, but the mobile x-ray service was unable to get a good view of Resident #23's arm, so Resident #23 was sent back to the ED. Interview on 09/25/24 at 2:39 P.M. with the Director of Nursing (DON) and concurrent review of the facility's fall investigation into Resident #23's fall on 09/05/24 revealed Resident #22 did not require assistance while walking, and was accompanied by staff while walking down the hall to get a soda. Concurrent observation occurred when the DON and surveyor entered the secured unit where the DON demonstrated the physical condition of the fall. The DON stated a mechanical lift was backed against the wall along the 600 hall across from the MDS Coordinator's office. A floor heater was also noted to be along the wall opposite the office. The DON stated the legs were sticking into the walkway. Interview on 09/26/24 at 11:37 A.M. with the DON confirmed the staff education was not dated. The DON stated she did not review a policy; she explained to staff where to store mechanical lifts, such as in the beauty shop or near the shower when the shower was not in use. The DON stated she did not have any formal audits to ensure equipment was stored properly. The DON did not provide a date the education was provided before the conclusion of the survey. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365202	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carecore at Lima LLC	599 South Shawnee Street Lima, OH 45804

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Observation and interview on 09/26/24 at approximately 4:00 P.M. with Maintenance Director #104 revealed the 600 hall where the DON indicated the mechanical lift was placed was 93.5 wide. Further observation revealed the mechanical lift base, at floor level, from back wheel to front wheel was 42.5 while the part of the mechanical lift at eye level was more narrow than the legs. The usable width of the hallway floorspace was reduced to approximately 51 (four feet, 3 inches) for Resident #23 and the STNA to walk together down the hall. Review of the policy Fall Risk Assessment, dated 2001, revealed the staff will seek to identify environmental factors that may contribute to falling, such as lighting and room layout. 2. Review of the medical record for Resident #22 revealed an admitted [DATE] with diagnoses of hemiplegia and hemiparesis, and need for assistance with personal care. Review of the comprehensive admission MDS assessment dated [DATE] revealed Resident #22 had impaired cognition, mobilized with a wheelchair, was dependent for shower/bathing, chair to bed transfers, and tub/shower transfers. Review of the Fall Risk Evaluation dated 07/16/24 revealed Resident #22 was at risk for falls. Review of the current care plan revealed Resident #22 was at risk for falls related to hemiplegia, hemiparesis and weakness. Interventions included keeping a fall mat at bedside (added 09/17/24), encouraging call light use, and keeping the bed in the lowest position. Review of a nursing progress note dated 08/18/24 at 4:25 A.M. revealed Resident #22 was found sitting on the floor in front of her bed with legs outstretched in front of her. Resident #22 was assessed and found to have no injuries. Review of the fall investigation dated 08/20/24 revealed Resident #22 was found on 08/18/24 at 4:20 A.M. sitting on the floor in front of her bed with her legs outstretched. Resident #22 was assessed and no injuries were found. Review of the Interdisciplinary Team's (IDT) review revealed no root cause related to the fall and determined the appropriate intervention was a mat to the floor at the outside of the bed and the other side of the bed placed against to the wall to ensure adequate floor space in the room for mobility equipment. Review of a nursing progress note dated 09/14/24 at 5:56 A.M. revealed Resident #22 was found on the floor. Resident #22 was assessed and found to have no injuries. Review of the fall investigation dated 09/14/24 revealed Resident #22 was found on the floor on 09/14/24 at 5:50 A.M. next to her bed. Resident #22 stated she was reaching for a television remote. A nursing assessment was completed and no injuries were identified. The IDT review revealed the root cause was Resident #22 reaching for personal items; therefore, the intervention was to keep personal items within reach. Review of a nursing progress note dated 09/17/24 at 4:25 A.M. revealed Resident #22 was observed lying on her right side on the floor beside her bed. Resident #22 was assessed and found to have no injuries. (continued on next page)

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	365202	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carecore at Lima LLC	599 South Shawnee Street Lima, OH 45804

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the fall investigation dated 09/17/24 revealed Resident #22 was found lying on her right side on the floor next to her bed on 09/17/24 at 4:25 A.M The IDT review revealed the cause of the fall was confusion and attempting to ambulate when not capable of ambulating independently. The IDT developed an intervention of putting a fall mat next to the bed. Review of a nursing progress note dated 09/19/24 at 6:42 P.M. revealed Resident #22 was on the floor next to the dresser. Resident #22 stated she hit her head. Further review of the medical record revealed no evidence neurological checks were completed after Resident #22's unwitnessed falls on 08/18/24, 09/14/24, and 09/19/24. Interview and observation on 09/24/24 at 7:30 A.M. with STNA #162 confirmed Resident #22 was lying in bed with her knees hanging over the edge of the bed and no fall mat was in place. STNA #162 further confirmed, upon review of the electronic medical record, Resident #22's care plan indicated she should have a fall mat beside the bed while in bed. STNA #162 stated Resident #22 often tried to get out of bed. Subsequent interview with STNA #162 and LPN #174 on 09/24/24 at approximately 7:35 A.M. revealed neither staff were aware Resident #22 should have a fall mat. Interview on 09/25/24 at 2:46 P.M. with concurrent review of the facility's fall investigations for Resident #22 revealed the facility reviewed the falls for Resident #22 and determined the trend for her falling in the early morning hours was attributed to her having a urinary tract infection (UTI). However, the fall on 08/18/24 was prior to Resident #22's diagnosis with a UTI on 09/14/24. Additionally, the DON stated the IDT team decided not to implement the fall mat on 08/18/24 and instead decided to only do one intervention at a time, selecting the intervention to move the bed against the wall. The DON confirmed Resident #22 was found on the floor next to her bed after the falls on 09/14/24 and 09/17/24. Interview on 09/26/24 at 11:33 A.M. with the DON confirmed she could not provide neurological assessments for Resident #22's unwitnessed falls on 08/18/24, 09/14/24, and 09/19/24. Further interview with the DON revealed the reason Resident #22's fall mat was not in place during the observation on 09/24/24 was because housekeeping was washing it. The DON stated the fall mats get dirty and need to be washed. Review of the policy Falls and Fall Risk, Managing, dated 2001, revealed the staff will identify and implement relevant interventions to try to minimize serious consequences of falling. 3. Review of the medical record for Resident #63 revealed an admitted [DATE] with diagnoses of encephalopathy, repeated falls and unsteadiness on feet. Review of the quarterly MDS assessment dated [DATE] revealed Resident #63 had impaired cognition, mobilized with a walker, required supervision or touching assistance for chair to bed transfer, substantial/maximal assistance for tub/shower transfer, and for shower/bathing self. Further review revealed she had one fall without injury since the previous assessment. Review of the Fall Risk Evaluation dated 12/14/23 revealed a score of zero. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Carecore at Lima LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 599 South Shawnee Street Lima, OH 45804	

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the current care plan for Resident #63 revealed she was at risk for falls related to dementia. Interventions included assisting in positioning and comfort as needed and observe daily and report any observed unsafe conditions. Review of the facility's incident report dated 03/10/24 revealed a State tested Nurse Aide (STNA) called the nurse to assist with Resident #23 off the floor in the shower. STNA stated Resident #63 slipped out of the shower chair. Review of an IDT progress note dated 03/11/24 revealed Resident #63 was in the shower and slipped out of the chair stating she had soap in her eyes. Resident #63's fall was witnessed by staff. No injuries were noted. Review of the facility's incident report dated 06/08/24 revealed the nurse was notified by the STNA that Resident #23 slipped out of the shower chair to the floor landing on her behind. Review of an IDT progress note dated 06/11/24 revealed Resident #63 was in the shower and slid off the chair onto the floor. STNA was present during the shower. Resident #63 was assessed and no injuries were noted. A floor mat was on the floor. Interview on 09/25/24 at 2:46 P.M. with the DON revealed she did not attempt to interview with STNA who was present during Resident #63's fall on 03/10/24. Further interview revealed the DON attempted to call the agency STNA who was present during the fall on 06/08/24 but did not receive a return call. The DON confirmed no intervention was implemented after Resident #63's first fall from the shower chair on 03/10/24. Additionally, the DON stated the intervention after Resident #63's second fall from the shower chair was to add a larger fall mat to the floor in the shower; however, the DON stated the larger mat did not fit. Further interview with the DON regarding a fall intervention for Resident #63 revealed staff were expected to stand closer to prevent Resident #63 from sliding from the shower chair again. Review of the policy Falls and Fall Risk, Managing, dated 2001, revealed the staff will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls. 35035 4. Record review for Resident #52 revealed the resident was admitted to the facility on [DATE]. Diagnoses for Resident #52 include encephalopathy, diabetes type two, malnutrition, traumatic amputation of bilateral legs below knees, heart disease, gangrene, altered mental status, and thrombosis with use of anticoagulants. Review of Resident #52's Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed the resident had intact cognition and was dependent on a wheelchair for ambulation. Review of Resident #52's care plans dated 04/09/24 revealed a focus for risk of falls. Interventions include Resident #52 will receive care and interventions necessary to ensure that his safety is maintained, ensure that the seatbelt is fastened when resident is up in wheelchair, observe Resident #52 in his daily activity and report unsafe conditions for interventions to assist with maintaining his safety. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #52's progress notes dated 08/11/24 the resident was attempting to propel himself outside and fell out of the wheelchair and rolled into a hole in the concrete. Per the note the resident suffered no injuries and did not hit his head. Review of the facility's investigation dated 08/11/24 revealed the fall was witnessed. No injuries were noted on the investigation. Resident #52 reported his pain level at a 5 out of 10, in the comments stated resident denied pain at this time. Per the immediate action taken the nurse documented the resident will be educated to ask for assistance when going outside to ensure safety due to the deterioration of the driveway. Interview on 09/23/24 at 11:46 A.M. with Resident #52 revealed the resident stated he had a fall out of his wheelchair on 08/11/24 when he was coming back into the facility by the outside door on the 200-hall. Resident #52 showed the surveyor there are several broken pieces of concrete with bars sticking out near the door and the doorway itself has a raised cracked edge. Resident #52 stated he was attempting to get his motorized wheelchair over the cracked edge when the tires got stuck and his chair fell forward causing him to fall out of the wheelchair onto the ground. Resident #62 stated staff responded quickly to him and got him back into his wheelchair. Resident #52 stated he did not report any injuries to staff at the time of the fall. Interview on 09/23/24 at 3:00 P.M. with Resident #33 revealed the resident witnessed Resident #52's fall on 08/11/24. Per Resident #33, Resident #52 was going back into the facility when his wheelchair front wheels got 'caught in the hole at the doorway'. Resident #33 stated he saw Resident #52 fall forward out of his wheelchair and onto the ground. Resident #33 stated he ran to help but staff had already started to help Resident #52. Resident #33 stated he did not see the resident hit his head and heard the resident tell staff he didn't have any injuries. Interview on 09/24/24 at 3:33 P.M. with the DON verified Resident #62 was outside coming inside when the wheels of his wheelchair was stuck in the doorway threshold and the resident fell out of the wheelchair. The DON stated Resident #52 stated he had no injuries from the fall. Observation and interview on 09/25/24 at 4:00 P.M. with Social Worker (SW) #248 observing the area outside of the doorway into the facility on the 200-hall revealed the concrete was notably raised from the sidewalk to the concrete patio slab. A raised area of about 2-3 inches leaving a space from the sidewalk to the patio was observed. Per SW #248, during the fall investigation it was reported to her the resident was attempting to propel his motorized wheelchair back into the facility when the front wheels caught up on the raised portion of the sidewalk leading to the doorway. SW #248 verified the broken pieces of concrete with what appears to be bars sticking out and stated the facility had not completed any repairs to the sidewalk or patio concrete. Review of the facility policy titled, Fall Risk Assessment', dated 03/2018 revealed staff will seek out to identify environmental risk factors that may contribute to falls. Staff will collaborate to identify and address modifiable fall risk factors and interventions to minimize the risk factor.

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35035 Based on observation, review of the facility policy, record review, resident interview, and staff interview, the facility failed to provide appropriate treatments and services for residents with indwelling catheters. This affected one resident (#130) out of three residents reviewed for indwelling catheters. The facility census was 80. Findings include: 1. Record review for Resident #130 revealed the resident was admitted to the facility on [DATE]. Diagnoses for Resident #130 included polyneuropathy, gout, prostate cancer with metastasis to pelvic bone, and clostridium difficile, (c-diff). Review of Resident #130's Minimum Data Set (MDS) dated [DATE] was in progress at the time of survey. Review of Resident #130's hospital documents dated 09/12/24 revealed the resident had an indwelling catheter placed for the diagnosis of obstructive uropathy. Review of Resident #130's baseline care plan dated 09/20/24 revealed for the bladder assessment the resident was noted as having an indwelling catheter upon admission. Review of Resident #130's comprehensive care plans dated 09/20/24 revealed no focus for bladder or the indwelling catheter. Review of Resident #130's physician orders dating from 09/20/24 to 09/26/24 revealed no orders for the care or continuation of the indwelling catheter in the medical records. Review of Resident #130's Treatment Administration Records (TAR) dated 09/2024 revealed no documentation of catheter care being documented as completed. Interview on 09/23/24 at 9:10 A.M. with Resident #130 revealed the resident had the indwelling catheter inserted while he was at the hospital. Resident #130 stated he did not know what the plan was for the catheter or when the facility was going to be removing the catheter. Resident #130 stated he has asked his nurses about the catheter and they inform him, when he no longer needs the catheter it can be removed. Resident #130 denied any pain associated with the indwelling catheter. Interview on 09/25/24 at 1:30 P.M. with State tested Nurse Aide (STNA) #156 revealed she performed catheter care for Resident #130. STNA #130 stated staff chart completion of care in the computer. STNA #156 stated she reported to the nurse she completed the catheter care and verified the aide knew the resident had an indwelling catheter due to the previous STNA's report. STNA #156 stated she did not know if there was any place to document the catheter care for Resident #130 in the medical records. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/25/24 at 1:35 P.M. with Registered Nurse (RN) #333 revealed the nurse works for an agency, not the facility. RN #333 stated she received the information in report from the previous shift nurse stating Resident #130 had an indwelling catheter. RN #333 verified STNA #130 reported to her the catheter care was completed and there were no issues noted with the catheter. RN #333 stated she could not document the catheter care due no orders for the treatment in the records. RN #333 verified the resident had no focus in his care plans or physician orders for the indwelling catheter in the medical records. Interview on 09/25/24 at 1:45 P.M. with the DON and Regional Registered Nurse (RRN) #275 verified Resident #130 had the indwelling catheter upon admission. The DON verified while the indwelling catheter was documented on the baseline care plans, there were no interventions, the catheter was not on the comprehensive care plans. The DON verified there were no orders and no documentation in the medical records regarding the treatment for the indwelling catheter or the plan for removal for Resident #130. Review of the facility policy titled, Catheter Care, dated 08/2022 revealed the facility staff will assess the ongoing need and plan for removal of each indwelling catheter. Per the policy the staff will document all catheter care in the medical records and report any unusual findings.

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NAME OF PROVIDER OR SUPPLIER Carecore at Lima LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 599 South Shawnee Street Lima, OH 45804	

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35035 Based on record review, resident interview, and staff interview, the facility failed to provide pain medication for a resident per physician orders. This affected one resident (#33) out of five residents reviewed for medications. The facility census was 80. Findings include: Record review for Resident #33 revealed the resident was admitted to the facility on [DATE]. Diagnoses for Resident #33 included hemiplegia, facial weakness, aphasia, asthma, chronic obstructive pulmonary disease, and heart disease. Review of Resident #33's care plans dated 08/08/24 revealed a focus for risk for dental health problems due to missing, broken and carious teeth due to poor oral health and lack of professional dental care. Interventions include administer medications per physician order. Review of Resident #33's physician orders dated 09/19/24 revealed the resident was prescribed Hydrocodone-Acetaminophen 5-325 milligram (mg) every four hours as needed for tooth pain for three days. No other orders for pain medication was noted in the medical records after 09/19/24. Review of Resident #33's hospital paperwork dated 09/18/24 revealed Resident #33 was seen at the hospital for dental pain and infection. Resident #33 was discharged on [DATE] with orders to receive Hydrocodone-Acetaminophen 5-325 mg every four hours as needed for tooth pain for three days and Clindamycin (antibiotic) 300 milligrams (mg) four times a day for 10 for a tooth infection. Review of Resident #33's hospital paperwork dated 09/22/24 revealed the resident was seen at the hospital for dental pain. Resident #33 was discharged on [DATE] with orders to receive Hydrocodone-Acetaminophen 5-325 mg every eight hours as needed for tooth pain for two days. Review of Resident #33's progress notes dated 09/18/24 at 11:23 P.M. revealed the nurse documented Resident #33 complained of severe teeth pain with swollen gums noted. Per the nurse's note the resident requested a narcotic pain medication. Per the note no written script for pain medication was in the records and the nurse was unable to pull the pain medication from the emergency cart. The nurse documented the resident then requesting to go to the hospital, the nurse provided a packet for the resident. Per the note, Resident #33 signed himself out of the facility and went to the hospital. Review of the progress notes dated 09/22/24 at 3:00 A.M. revealed the nurse documented the resident was complaining of dental pain. Per the note the resident was seen on 09/19/24 at the hospital concerning the dental pain and was prescribed the pain medication for the next three days. The nurse documented the prescription was completed and the resident was requesting to go back to the hospital due to increased pain to his gums. The nurse documented she contacted the primary physician of the resident's complaints and the physician stated to inform him of any new orders. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365202	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/26/2024

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Carecore at Lima LLC	599 South Shawnee Street Lima, OH 45804

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the progress note dated 09/22/24 at 6:04 A.M. revealed the resident returned to the facility from the hospital with new orders for the pain medication every eight hours as needed for two days. Per the note the physician was notified of the new orders from the hospital. Review of the note dated 09/23/24 at 11:22 P.M. revealed the nurse documented she offered Resident #33 Tylenol for pain until the prescribed narcotic pain medication came from pharmacy. Review of Resident #33's vital signs for pain monitoring revealed from 09/01/24 to 9/16/24 the resident stated his pain level was zero out of 10. On 09/17/24 the resident stated his pain level was a eight out of 10. The pain levels was documented as an eight out of 10 on 09/19/24, 09/20/24, and 09/22/24. Interview on 09/23/24 at 2:00 P.M. with Resident #33 revealed the resident complained about not being able to see the dentist. Resident #33 stated the dentist refused to work on his teeth the last time the dentist was in the facility due to Resident #33 not receiving a medication he was supposed to get before the visit. Resident #33 stated around two weeks ago he noticed his teeth were becoming more painful and requested his primary physician to prescribe some pain medication to help the resident through the pain until he can be seen by the dentist again to have the teeth pulled. Resident #33 stated he did not have any pain before 09/17/24. Resident #33 denied any loss of appetite or changes to his daily routine. Resident #33 did state he was in pain mostly at night which was causing him loss of sleep. Interview on 09/24/24 at 1:30 P.M. with the Social Worker (SW) #248 revealed on 09/11/24 Resident #33 was seen by the facility's dentist and was scheduled to receive a procedure of extraction for his teeth on 09/18/24. Per SW #248 stated the resident had not complained about pain until recently when the dentist saw him on 09/11/24 and 09/18/24. Per SW #248, there was a plan to have the resident's teeth extracted when the facility's new dentist will come to the facility. Interview on 09/24/24 at 3:10 P.M. with Resident #33 revealed the resident was sitting outside the facility under the carport. Resident #33 stated after the second visit with the dentist he was told due to him not getting the antibiotics he would have to wait until next month before the dentist could pull his teeth. Resident #33 stated he was in pain and asked for a pain medication after the dentist appointment on 09/18/24 and was refused pain medications. Resident #33 stated he signed himself out of the facility and went to the hospital where he received an order for antibiotics and pain medication. Resident #33 stated he did not request every pain pill when he was allowed to, only when he was in pain, until 09/22/24 when the nurse informed him his pain medication would need a new prescription. Resident #33 stated the pain has not stopped him from doing his daily living tasks but he is upset he cannot have a pain free day. Resident #33 stated he refused Tylenol due to the medication making him sick to his stomach. Resident #33 stated the facility has not offered him any other interventions for pain relief. Interview on 09/24/24 at 3:22 P.M. with Registered Nurse (RN) #344 revealed Resident #33 had requested a pain medication during his morning medication pass and the nurse verified there were no active orders in the records for any pain medication. RN #344 stated she reported it to the DON. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Carecore at Lima LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 599 South Shawnee Street Lima, OH 45804	

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/24/24 at 3:35 P.M. with the Director of Nursing (DON) verified there was an order sent from the hospital on 09/22/24 for Resident #33's pain medication. The DON stated the pharmacy refused to refill the prescription and stated it was never relayed to the facility by the pharmacy the medication would not be supplied. The DON verified Resident #33 had not received any pain medication after he reported pain from 09/22/24 to 09/24/24.

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NAME OF PROVIDER OR SUPPLIER Carecore at Lima LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 599 South Shawnee Street 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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 44815 Based on observation, staff interview, and review of the menu spreadsheet, the facility failed to provide adequate protein portions to residents on a mechanical soft diet. This affected 14 residents (#2, #3, #4, #6, #16, #17, #28, #32, #37, #43, #53, #63, #68, and #130) identified on a mechanical soft diet. The facility census was 80. Findings include: Observations during meal service on 09/25/24 beginning at 10:46 A.M. revealed [NAME] #206 plating meals using a green handled scoop for the mechanical soft pork loin. Interview and observation on 09/25/24 at approximately 12:00 P.M. with [NAME] #206 revealed the green handled scoop had no measurements, but [NAME] #206's understanding was it was a 3-ounce scoop. Interview and observation of the green handled scoop on 09/25/24 at 12:06 P.M. with Dietary Manager (DM) #198 confirmed the scoop had no measurements on it. Further observation of another green handled scoop, taken from the drawer, revealed it measured 2 and 2/3 ounces. Continued interview and observation of a website with DM #198 revealed the green handled scoop she purchased was 3 and 1/4 ounces. Observation of the two scoops filled with water revealed the unlabeled scoop held less water than the scoop labeled 2 and 2/3 ounces. Interview and observation on 09/25/24 at 12:16 P.M. with Regional Registered Dietitian #500 confirmed the unlabeled scoop was smaller than the one measuring 2 and 2/3 ounces and could not verify what portion of pork loin was provided to residents on a mechanical soft diet. Review of the menu spreadsheet for the noon meal on 09/25/24 revealed the portion of mechanical soft pork loin should be 3 ounces.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 45751 Based on resident interview, staff interview, and test tray, the facility failed to serve palatable meals. This affected two residents (#57 and #60) of two residents reviewed for meals. The facility was 80. Findings include: Review of a test tray on 09/25/24 at 11:55 A.M. with Registered Nurse #178 revealed a plate with roast pork loin, mashed potatoes, and broccoli. Gravy covered the mashed potatoes and pork loin. The broccoli was served in a separate bowl on the plate. The plate presentation was pleasing. The temperature of the food was warm. The pork was seasoned well and tender. The mashed potatoes were bland with very little flavor. Additionally, the gravy had minimal flavor. Further, the broccoli was cooked to an appropriate texture but was bland and unseasoned. RN #178 confirmed the mashed potatoes, gravy, and broccoli tasted bland and lacked seasoning. Interview on 09/25/24 at 12:23 P.M. with Resident #60 revealed she thought the mashed potatoes and gravy tasted bland. Interview on 09/25/24 at 12:26 P.M. with Resident #57 revealed she felt the mashed potatoes were not flavorful.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44815 Based on observation, staff interview, and review of the facility policy, the facility failed to ensure staff used appropriate hand hygiene while preparing meals. Additionally, the facility failed to ensure the dish machine washed dishes at the proper temperature. This had the potential to affect all residents except two (#41 and #42) who were identified as receiving no food from the kitchen. The facility census was 80. Findings include: 1. Observations during meal service on 09/24/24 beginning at approximately 5:05 P.M. revealed [NAME] #202 wearing disposable gloves while plating roast beef sandwiches and cubed potatoes for the evening meal. [NAME] #202 held tongs in her right hand to pick up roast beef and used her left hand to place the beef onto a bun. [NAME] #202 then used her right hand to place cheese and lettuce on the bun, and her right hand to place lettuce on the bun. [NAME] #202 then used her right hand to scoop potatoes onto the plate, and used both hands to close the sandwich. Continued observation revealed [NAME] #202 changing her gloves without washing her hands. [NAME] #202 opened a package of bread, put two slices in a skillet, picked up a squeeze bottle of oil and squeezed it into the pan, then opened a new package of hamburger buns, held the bag with one hand and reached in with the other and placed buns on four plates to begin making more ready-to-eat roast beef sandwiches. Interview with Dietary Manager (DM) #198 on 09/24/24 at 5:38 P.M. revealed she observed [NAME] #202 concurrently with the surveyor and confirmed [NAME] #202 was not practicing appropriate hand hygiene and DM #198 would provide education. DM #198 further confirmed touching bags of bread or rolls was considered a contaminated surface. Observation during meal service on 09/25/24 beginning at 10:46 A.M. revealed [NAME] #206 plating meals. [NAME] #206 wore disposable gloves and used separate serving utensils for pork, broccoli, mashed potatoes, gravy, mechanical soft pork and mechanical soft broccoli. Continued observation at approximately 10:50 A.M. revealed [NAME] #206 changed her gloves, opened a package of bread, removed four slices of bread, scooped mechanical soft pork loin onto the bread and used a knife to cut the two sandwiches into squares while holding the bread with her left hand. Concurrent interview at 10:52 A.M. with [NAME] #206 confirmed she used the same pair of gloves to open a bag of bread, scoop meat, and cut the sandwich for Resident #16 and confirmed she should have changed her gloves before touching ready-to-eat food. Review of the undated policy titled, Bare Hand Contact with Food and Use of Plastic Gloves, revealed gloved hands are considered a food contact surface that can become contaminated or soiled and should be changed anytime a contaminated surface is touched. 2. Observation on 09/24/24 at 4:18 P.M. of the label attached to the dishwasher revealed recommended wash temperatures of 120 degrees Fahrenheit (F) minimum and rinse temperature of 120 degrees F minimum. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Concurrent observation and interview with DM #198 on 09/24/24 beginning at 4:18 P.M., after running three cycles of the dishwasher revealed a wash temperature of 91 degrees F. Continued observation at 4:29 P.M., after additional wash cycles revealed a wash temperature of 108 degrees. DM #198 confirmed the wash temperature of the washing machine did not meet the minimum wash requirements.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 44815 Based on observation, resident and staff interviews, and review of the facility policy, the facility failed to ensure a pest free environment. This had the potential to affect 35 residents (#2, #5, #6, #7, #8, #9, #11, #13, #14, #15, #16, #20, #21, #22, #23, #29, #30, #35, #37, #43, #45, #46, #47, #48, #55, #61, #63, #64, #68, #70, #72, #74, #180, #181, and #182) on the secured unit. The facility census was 80. Findings include: Observation on 09/23/24 at 11:18 A.M. of the secured unit dining room during the noon meal revealed two moths flying around the dining room. Observation on 09/23/24 at 1:21 P.M. during an interview with Resident #37 revealed a moth flying around his room. Observation and interview on 09/23/234 at 3:27 P.M. with a resident who wished to remain anonymous revealed the amount of moths bothered them. One moth was observed in the room at the time of the interview. Interview on 09/23/24 at 3:42 P.M. with Licensed Practical Nurse (LPN #174), who routinely worked the secured unit, confirmed there were lots of moths throughout the building. LPN #174 was told the exterminators said it was because they had bird food inside the building for the outside bird feeders. LPN #174 said a lot of residents complained about the moths. Observation on 09/24/24 at approximately 7:25 A.M. in the secured unit's dining room revealed two moths flying around residents and staff. Observation on 09/25/24 at 7:31 A.M. of the secured unit's dining room revealed Resident #14 swatting away a moth. An interview with Resident #14 at the time was unsuccessful. Concurrent interview with Registered Nurse (RN) #182 confirmed moths were in the dining room and confirmed residents complained about them. Interview on 09/26/24 at 11:55 A.M. with Maintenance Director (MD) #104 revealed he worked at the facility for approximately two months and had no awareness of moths. MD #104 further stated the exterminator company visited routinely and was responsive to facility concerns. Observation on 09/26/24 at 3:30 P.M. revealed a moth flying around the nurses station on the secured unit. Concurrent interview with LPN #174 stated she had not reported the concerns regarding moths to anyone because she felt it was clearly observable to maintenance or any other staff who came onto the secured unit. Review of a receipt from the exterminator company dated 09/06/24 revealed the facility was sprayed for outside insects. Further review of the receipts revealed the exterminator company visited the facility routinely and per request. Receipts listed insects, but no receipts identified moths. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the policy, Homelike Environment, revised 02/2021, revealed the facility would maximize a clean, sanitary, and orderly environment.