STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365265	A. Building B. Wing	08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Piqua Manor	1840 West High Street Piqua, OH 45356

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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
	365265	A. Building B. Wing	08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Piqua Manor	1840 West High Street Piqua, OH 45356

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on medical record review, staff interviews, review of the facility investigation information and policy review, the facility failed to report an allegation of abuse. This affected one (#85) resident out of three reviewed for abuse. The facility census was 90.Findings include:Review of the medical record for Resident #85 revealed an admission date of 08/26/22 with medical diagnoses of senile degeneration of brain, hypertension, diabetes mellitus, and unspecified psychosis. Review of an annual Minimum Data Set (MDS) assessment, dated 06/02/25, indicated Resident #85 had severe cognitive impairment and required partial/moderate staff assistance with bathing/showers, supervision with bed mobility and transfers, and set-up assistance with eating. Interviews on 08/22/25 between 9:30 A.M and 10:26 A.M. with Licensed Practical Nurse (LPN) #207 and #205 and Certified Nursing Assistant (CNA) #202, #217, and #227 all stated they were aware of an allegation that CNA #220 took a photo of Resident #85 when the resident was walking in her room topless. They all confirmed they had not been working on 06/13/25, the day of the allegation, but confirmed they received education on the facility policy for phone use at work. Interview on 08/22/25 at 11:00 A.M. with Housekeeper #231 stated on 06/13/25 she was at the nurses' station across from Resident #85's room and observed Resident #85 walking toward the closet in her room. Housekeeper #231 stated Resident #85 had pants on but was topless. Housekeeper #231 stated she observed CNA #220 state Oh, look at Resident #85. I need to take a picture and sent to Resident #85's daughter. Housekeeper #231 stated she observed STNA #220 take her phone out of her pocket, and appeared she take a picture of Resident #85. Housekeeper #231 stated she immediately reported the incident to the facility Administrator. Interview on 08/22/25 at 11:32 A.M. with Director of Nursing (DON) confirmed an allegation of abuse had been made that CNA #220 took a photo of Resident #85 while she was in her room and topless. DON stated the Administrator had been made aware of the allegation of abuse and interviewed witnesses CNA #211 and Housekeeper #231 and took their statements. DON also stated the Administrator interviewed CNA #220 who denied taking a picture of Resident #85. DON confirmed Administrator did not interview the two CNAs in training who were also present at the time of the incident per witness statements. DON confirmed the facility had not completed a Self-Reported Incident or notified Ohio Department of Health as per regulations. DON confirmed CNA #220 had been terminated on 06/13/25. Review of the facility policy titled, Abuse, Neglect, Injuries of Unknown Source, and/or Misappropriation of Resident Property, stated the facility would investigate all alleged violations involving Abuse, Neglect, Exploitation, Mistreatment of a resident or Misappropriation of Resident Property, including injury of unknown source, in accordance with the policy. Mistreatment was defined as inappropriate treatment or exploitation of a resident. The policy stated all allegations of abuse, neglect, exploitation, mistreatment of a resident, or misappropriation of resident property, and all injuries of unknown source must be immediately reported to Administrator. The policy stated allegations of abuse or serious bodily injury must be reported to Ohio Department of Health (ODH) immediately, but no later than two hours after the allegation was made. The policy continued to state the Administrator, or his/her designee would notify ODH all alleged violations involving abuse, neglect, exploitation, mistreatment of a resident, or misappropriation of resident property, and all injuries of unknown source as soon as possible but in no event later than 24 hours from the time the incident/allegation was made known to the staff member. The policy stated the investigation protocol included interviewing the resident, the accused and any witnesses.This deficiency represents non-compliance investigated under Complaint Number 1385924.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365265	A. Building B. Wing	08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Piqua Manor	1840 West High Street Piqua, OH 45356

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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365265	A. Building B. Wing	08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Piqua Manor	1840 West High Street Piqua, OH 45356

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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on medical record review, staff interviews, review of the facility investigation information and facility policy review, the facility failed to thoroughly investigate an allegation of abuse. This affected one resident (#85) out of three reviewed for abuse. The facility census was 90.Findings include:Review of the medical record for Resident #85 revealed an admission date of 08/26/22 with medical diagnoses of senile degeneration of brain, hypertension, diabetes mellitus, and unspecified psychosis. Review of an annual Minimum Data Set (MDS) assessment, dated 06/02/25, indicated Resident #85 had severe cognitive impairment and required partial/moderate staff assistance with bathing/showers, supervision with bed mobility and transfers, and set-up assistance with eating. Interviews on 08/22/25 between 9:30 A.M and 10:26 A.M. with Licensed Practical Nurse (LPN) #207 and #205 and Certified Nursing Assistant (CNA) #202, #217, and #227 all stated they were aware of an allegation that CNA #220 took a photo of Resident #85 when the resident was walking in her room topless. They all confirmed that they had not been working on 06/13/25, the day of the allegation, but confirmed they received education on the facility policy for phone use at work. Interview on 08/22/25 at 11:00 A.M. with Housekeeper #231 stated on 06/13/25 she was at the nurses' station across from Resident #85's room and observed Resident #85 walking toward the closet in her room. Housekeeper #231 stated Resident #85 had pants on but was topless. Housekeeper #231 stated she observed CNA #220 state Oh, look at Resident #85. I need to take a picture and sent to Resident #85's daughter. Housekeeper #231 stated she observed CNA #220 take her phone out of her pocket, and appeared she take a picture of Resident #85. Housekeeper #231 stated she immediately reported the incident to the facility Administrator. Interview on 08/22/25 at 11:32 A.M. with Director of Nursing (DON) confirmed an allegation of abuse had been made that CNA #220 took a photo of Resident #85 while she was in her room and topless. DON stated the Administrator had been made aware of the allegation of abuse and interviewed witnesses CNA #211 and Housekeeper #231 and took their statements. DON also stated the Administrator interviewed CNA #220 who denied taking a picture of Resident #85. DON confirmed Administrator did not interview the two CNAs in training who were also present at the time of the incident per witness statements. DON confirmed the facility had not completed a Self-Reported Incident or notified Ohio Department of Health as per regulations. DON confirmed CNA #220 had been terminated on 06/13/25. Review of the facility investigation documentation revealed on 06/13/25 Administrator obtained witness statements from Housekeeper #231, CNA #211 and CNA #220. Review of witness statement from CNA #211 revealed documentation to support two CNAs in training were also present at the time of the incident. Review of the facility investigation information did not contain documentation to support the two CNAs in training were interviewed. Further review of the investigation revealed no documentation to support any residents on the hall were interviewed for concerns of abuse. Review of the facility policy titled, Abuse, Neglect, Injuries of Unknown Source, and/or Misappropriation of Resident Property, stated the facility would investigate all alleged violations involving Abuse, Neglect, Exploitation, Mistreatment of a resident or Misappropriation of Resident Property, including injury of unknown source, in accordance with the policy. Mistreatment was defined as inappropriate treatment or exploitation of a resident. The policy stated all allegations of abuse, neglect, exploitation, mistreatment of a resident, or misappropriation of resident property, and all injuries of unknown source must be immediately reported to Administrator. The policy stated allegations of abuse or serious bodily injury must be reported to Ohio Department of Health (ODH) immediately, but no later than two hours after the allegation was made. The policy continued to state the Administrator, or his/her designee would notify ODH all alleged violations involving abuse, neglect, exploitation, mistreatment of a resident, or misappropriation of resident property, and all injuries of unknown source as soon as possible but in no event later than 24 hours from the time the incident/allegation was made known to the staff member. The policy stated the investigation protocol included interviewing the resident, the accused and any witnesses.This deficiency represents non-compliance investigated under Complaint Number 1385924.