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	03/26/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview, and policy review, the facility failed to store food in a safe manner. This had the potential to affect all residents who received food from the kitchen. The facility identified four (#12, #38, #85, and #98) residents who received nothing by mouth. The census was 87.Findings include: Observation of the kitchen on 03/23/26 at 7:55 A.M., during the initial tour with Nutrition Services Assistant (NSA) #48, revealed three storage refrigerators not in temperature range to prevent food-borne illnesses. Further observation revealed refrigerator #1 registered 50 degrees Fahrenheit (F) on the internal thermometer, refrigerator #2 registered 46 degrees F on the internal thermometer, and refrigerator #3 registered 50 degrees F on the internal thermometer.Observation and interview on 03/23/26 at 7:57 A.M. revealed NSA #48 obtained pudding from refrigerator #1 and revealed a temperature of 45 degrees F and the temperature of milk from refrigerator #3 was 45 degrees F. NSA #48 confirmed the refrigerator and food temperatures. Review of a policy titled, Infection Control/Food Safety Storage of Perishable Foods, dated 01/2026, revealed a reliable thermometer shall be provided in a clearly visible position placed inside each refrigerator and freezer, close to the door. Refrigerator temps should be 41 degrees or below.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, resident interview, and staff interview, the facility failed to ensure a reasonable accommodations were made for a resident related to placement and use of a urinal in the resident's room. This affected one (#71) of one residents reviewed for accommodation of needs. The census was 87.Findings include:Observation on 03/23/26 at 9:28 A.M. revealed a urinal with 1000 milliliters (mls) of urine inside was placed on a bedside tray table in Resident #71's room, the same surface utilized for meals and personal items. Resident #71's medication and personal items were sitting on bedside tray at the time of the observation.Interview on 03/23/26 at 9:28 A.M. with Resident #71 revealed the resident did not like the urinal being placed on the bedside table, reporting there was no other place to put urinal. Observation at the time of the interview revealed no alternative storage or designated area available for the urinal within Resident #71's reach.Interview on 03/23/26 at 9:30 A.M. with Certified Nurse Aide (CNA) #75 verified Resident #71's urinal was routinely placed on the bedside tray for accessibility and acknowledged the resident had expressed concerns but no changes were made.Interview on 03/23/26 at 9:40 A.M. with Registered Nurse (RN) #15 verified Resident #71's urinal was routinely placed on the bedside tray for accessibility. RN #15 discussed with Resident #71 to place snacks in a basket on bedside tray and place urinal on bedside table with no other items.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on paper and electronic medical record review, staff interview, and policy review, the facility failed to ensure the resident's code status was consistent throughout the entire medical record. This affected one (#103) of one residents reviewed for advanced directives. The census was 87. Findings include: Review of Resident #103's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including urinary tract infection, hypertensive chronic kidney disease, type II diabetes, unspecified dementia, atrial fibrillation, and peripheral vascular disease. Review of Resident #103's Minimum Data Set (MDS) assessment dated [DATE] revealed the resident's cognitive status was assessed as moderately impaired.Review of Resident #103's physician's orders in the electronic health record (EHR) revealed an order dated [DATE] for a code status of Do Not Resuscitate Comfort Care - Arrest (DNRCC-A; the resident would be receive cardiopulmonary resuscitation (CPR) until the heart or breathing stops the comfort care measured would be implemented).Review of Resident #103's physical (paper) medical record revealed a document dated [DATE] indicating the resident was a full code (CPR is initiated for heart or respiratory arrest). There was no state DNR form found in the paper record.Review of Resident #103's plan of care dated [DATE] revealed the resident was identified with a code status of DNRCC-A.Interview with Licensed Practical Nurse (LPN) #45 on [DATE] at 3:49 P.M. confirmed Resident #103's code status order in the paper medical record did not match the code status order in the resident's EHR. LPN #45 stated she would confirm with physician and family which code status was correct.Review of the facility advanced directives policy, dated [DATE], revealed advance directives will be reviewed with the resident and/or the responsible party upon admission.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and policy review, the facility failed to notify the physician of a change in condition in a timely manner. This affected two (#106 and #96) of two residents reviewed for change in condition. The facility census was 87.Findings include:1. Review of the medical record for Resident #106 revealed an admission date of 07/19/24 with diagnoses including centrilobular emphysema, chronic obstructive pulmonary disease (COPD), and essential hypertension.Review of the Discharge Return Anticipated Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #106 was cognitively intact. Resident required set-up assistance with eating, oral hygiene, bathing, personal hygiene, and required partial assistance with toileting hygiene, dressing, bed mobility, transfers, and ambulation. The resident was dependent on staff assistance with wheelchair mobility.Review of the physician order dated 07/19/24 revealed Resident #106 wore oxygen via nasal canula at three liters continuously.Review of the care plan dated 07/19/24 revealed Resident #106 used oxygen therapy relate to COPD with interventions to monitor for signs or symptoms of respiratory distress and report to the physician, such as respiration rate increase, increased heart rate, restlessness, lethargy, and accessory muscle usage.Review of the notification note dated 01/02/26 at 9:39 A.M. revealed Resident #106 was sent to hospital per family request. Further review of the medical record revealed no documentation of vital signs, assessments, or notification to the physician of a change in condition or hospitalization.Interview on 03/25/26 at 3:04 P.M. with the Director of Nursing (DON) confirmed she remembered on 01/02/26 Resident #106 was having trouble breathing in the middle of the night but refused to go to the hospital. The DON stated the resident's daughter came in to visit that morning, she convinced the resident to go to the hospital. The DON confirmed the staff nurse (Licensed Practical Nurse (LPN) #160) working the night of the change in condition did not document the resident's change in respiratory status. The DON confirmed there was no documentation of the physician being notified of the change in condition or of the physician being notified of the transfer to the hospital. The DON stated it was the expectation of the nurse to document all changes in condition, and to notify the physician and family when the change occurs. 2. Record review for Resident #96 revealed the resident was admitted to the facility on [DATE] with diagnoses including disruption of external operation surgical wound, infection following a procedure, acute and chronic combined systolic congestive and diastolic congestive heart failure, and type two diabetes mellitus with diabetic polyneuropathy.Review of the MDS assessment dated [DATE] revealed Resident #96 had intact cognition evidenced by a Brief Interview for Mental Status (BIMS) score of 14. The resident was assessed to be taking antidepressant, hypnotic, diuretic, antiplatelet, insulin, and anticonvulsant medications, and received a therapeutic diet including low salt, diabetic, and low cholesterol.Review of the care plan dated 02/09/26 revealed Resident #96 was at risk for alteration in nutrition/hydration status related to a surgical wound, infection, respiratory failure, type two diabetes, congestive heart failure, heart disease, and chronic kidney disease. Resident #96 was on a therapeutic diet, which may impact weight and/or fluid balance. Interventions included to monitor weight per facility protocol and as needed per order; notify the physician of any significant weight change; and monitor, document, and report to the physician changes in lung sounds on auscultation, edema, shortness of breath, vital signs, and changes in weight.Review of the medical record for Resident #96 revealed a physician order dated 11/12/25 directing staff to notify the physician of a weight gain of two or more pounds in one day or five pounds in one week.Review of weight records revealed Resident #96 was noted to have a weight increase from 219.2 pounds (lbs.) on 03/20/26 to 223.2 lbs. on 03/21/26, totaling a gain of 4.0 lbs. Further review revealed Resident #96 also experienced a weight increase from 220.4 lbs. on 03/24/26 to 223.8 lbs. on 03/25/26, totaling a gain of 3.4 lbs. There was no documentation of the physician being notified of the weight gain in the (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medical record.Interview on 03/25/26 at 2:30 P.M. with Regional Clinical Nurse (RCN) #1 verified the physician was not notified on 03/21/26 or 03/25/26 regarding Resident #96's weight gain per physician order.Review of facility policy titled, Notification of Changes Policy, dated 11/02/16, revealed the facility will inform the resident, the attending physician, and the resident's representative or interested family member of changes which affect the resident.This deficiency represents non-compliance related to Complaint Number 2708212.

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F 0689 Level of Harm - Minimal harm or potential for 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** Based on observation, medical record review, staff interview, and policy review, the facility failed to investigate a resident skin condition obtained from trauma. This affected one (#38) of six residents reviewed for skin care. The census was 87.Findings include:Review of Resident #38's medical record revealed an admission date of 12/10/24. Diagnoses included malnutrition, psychotic disturbance, hearing loss, and dementia.Review of an annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #38 had severely impaired cognition, had no pressure sores, and had open skin lesions.Review of progress notes revealed on 11/22/25 an open area to Resident #38's right hip was noted as being 1.0 centimeter (cm) long by 2.8 cm wide. On 11/25/25 Resident #38 was added to the nurse practitioner's (NP) weekly wound rounds. Further review of progress notes revealed no documentation of any incident related to Resident #38's right hip wound.Review of NP wound notes dated 11/25/25 revealed Resident #38 had a right hip full-thickness wound related to trauma measuring 0.5 cm long by 1.0 cm wide by 0.1 cm deep. The wound was documented as in-house acquired and was reportedly obtained while staff were getting Resident #38 up for a shower.Review of NP wound notes dated 03/17/26 revealed Resident #38 continued to have a right hip full-thickness wound related to trauma measuring 2.8 cm long by 1.5 wide by 0.8 cm deep. The wound was documented as in-house acquired and was reportedly obtained while staff were getting Resident #38 up for a shower.Interview with the Director of Nursing (DON) and Regional Clinical Nurse (RCN) #1 on 03/24/26 at 1:10 P.M. confirmed Resident #38's right hip wound was documented as the result of trauma. Both the DON and RCN #1 confirmed there was not an investigation completed or any documentation of the origin of Resident #38's right hip wound.Observation on 03/25/26 at 11:45 A.M. revealed Resident #38 had right hip wound.Review of the facility's policy titled, Accident and Incidents, dated revised April 2016, revealed the facility will ensure the resident's environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistive devices to reduce accidents. All accidents and/or incidents occurring on the facility premises or involving a resident and staff off the premises must be investigated and reported to the Administrator or his designee.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, medical record review, and staff interview, the facility failed to ensure medications were maintained in a safe and secure manner. This affected one (#71) of one residents observed for medication storage. The census was 87.Findings include: Review of the medical record for Resident #71 revealed an order for chlorhexidine gluconate mouth/throat solution 0.12 percent (%), give 0.5 ounces by mouth two times a day for prophylactic with instructions to spit the medication out and do not swallow. Further review of Resident #71's medical record revealed no assessment for self-administration was completed.Observation on 03/23/26 at 9:36 A.M. revealed a medication cup with a light blue liquid substance on the bedside tray out of reach for Resident #71. The medication was not secured and was readily accessible to others.Interview on 03/23/26 at 10:06 A.M. with Resident #71 revealed medication was typically brought in and left on the bedside tray for him to take. Resident #71 stated he had already taken his pills but had not completed the mouthwash.Interview on 03/23/26 at 10:06 A.M. with Registered Nurse (RN) #15 verified the medication at Resident #71's bedside was chlorhexidine gluconate mouth/throat solution 0.12% and the medication should have been administered instead of left on table.Interview on 03/24/25 at 5:05 P.M. with Regional Clinical Nurse (RCN) #1 confirmed no self-administration assessment was completed for Resident #71 because the resident was not able to be self-administering medication. RCN #1 stated the facility completes medical self-assessments only if residents are capable to complete the task.

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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 medical record review, staff interview, and policy review, the facility failed to ensure the medical record was complete and accurate related to a resident's change in condition. This affected one (#106) of two residents reviewed for change in condition. The facility census was 87.Findings include:Review of the medical record for Resident #106 revealed an admission date of 07/19/24 with diagnoses including centrilobular emphysema, chronic obstructive pulmonary disease (COPD), and essential hypertension.Review of the Discharge Return Anticipated Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #106 was cognitively intact. Resident #106 required set-up assistance with eating, oral hygiene, bathing, personal hygiene, and required partial assistance with toileting hygiene, dressing, bed mobility, transfers, and ambulation. Resident #106 was dependent on staff assistance with wheelchair mobility.Review of the care plan dated 07/19/24 revealed Resident #106 used oxygen therapy relate to COPD with interventions to monitor for signs or symptoms of respiratory distress and report to the physician, such as respiration rate increase, increased heart rate, restlessness, lethargy, and accessory muscle usage.Review of the notification note dated 01/02/26 at 9:39 A.M. revealed Resident #196 was sent to the hospital per family request. Further review revealed there were no specifics about the reason for the hospitalization including no documented vital signs or resident assessments. Interview on 03/25/26 at 3:04 P.M. with the Director of Nursing (DON) confirmed she remembered on 01/02/26 Resident #106 was having trouble breathing in the middle of the night but refused to go to the hospital. The DON confirmed when the resident's daughter came in to visit that morning, she convinced the resident to go to the hospital. The DON stated the staff nurse (Licensed Practical Nurse (LPN) #160) working the night of the change in condition did not document Resident #106's change in respiratory status, including no documentation of vitals signs and assessments of the resident. The DON stated it was the expectation of the nurse to document all changes in condition, and to notify the physician and family when the change occurred. Interview on 03/25/26 at 3:18 P.M. with LPN #160 confirmed on 01/02/26 when she arrived to work on day shift at 7:00 A.M., the start of the shift, she received report from the night shift nurse that Resident #106 was struggling to breath throughout the night. LPN #160 confirmed she took Resident #106's vital signs, but did not document the resident's condition or the vital signs in the medical record. Interview on 03/25/26 at 3:22 P.M. with the DON confirmed LPN #160 should have completed a Situation, Background, Assessment, and Recommendation (SBAR) assessment for Resident #106 when there was a change in condition or when the resident was transferred to the hospital.Review of the facility documentation policy, dated 10/2005, revealed the facility will document a complete account of resident's care including signs, symptoms, response to care, and episodic charting.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, staff interview, and policy review, the facility failed to ensure staff wore appropriate personal protective equipment during high contact care interactions with residents in enhanced barrier precautions. This affected two (#12 and #38) of 11 residents reviewed for EBP. The census was 87.Findings include: 1. Review of Resident #38's medical record revealed an admission date of 12/10/24. Diagnoses included malnutrition, psychotic disturbance, hearing loss, and dementia.Review of an annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #38 had severely impaired cognition, had no pressure sores, and had open skin lesions.Observation on 03/25/26 at 11:48 A.M. revealed Assistant Director of Nursing (ADON) #1 did not put on a gown before performing Resident #38's right hip wound treatment. Further observation revealed a sign posted above the head of Resident #38's bed informed staff to use enhanced barrier precautions (EBP) when performing high contact activities of which wound care was listed.Interview with ADON #1 on 03/25/26 at 11:55 A.M. confirmed she did not put on a gown when performing Resident #38's right hip wound treatment and confirmed Resident #38 was in EBP.2. Review of Resident #12's medical record revealed and admission date of 02/17/26. Diagnoses included muscle weakness, chronic hepatitis, malnutrition, and mechanical ventilator dependence.Review of an admission MDS assessment dated [DATE] revealed Resident #12 had severely impaired cognition, required tracheostomy care, and an invasive mechanical ventilator.Observation on 03/25/26 at 1:52 P.M. revealed Respiratory Therapist (RT) #67 did not put on a gown before performing Resident #12's tracheostomy care. Further observation revealed a sign posted above the head of Resident #12's bed informed staff to use EBP when performing high contact activities of which tracheostomy care was listed.Interview with RT #67 on 03/25/26 at 1:59 P.M. confirmed she did not put on a gown when performing Resident #12's tracheostomy care and confirmed Resident #12 was in EBP.Review of the facility's policy titled, Enhance Barrier Precautions, dated revised August 2022, revealed it is the policy of the facility to use EBP to prevent transmission of multi-drug resistant organisms (MDROs) from an infected or colonized resident through an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. High contact areas included dressing, bathing/showering, transferring, providing hygiene, changing linens, changing attends or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator, and wound care: any skin opening requiring a dressing. An impervious gown should be worn when high-contact resident care activities are being performed.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and facility policy review, the facility failed to ensure influenza and pneumococcal vaccinations were offered and administered to residents. This affected three (#7, #38, and #70) of five residents reviewed for immunizations. The census was 87.Findings include: 1. Review of Resident #7's medical record revealed an admission date of 11/05/25. Diagnoses included multiple sclerosis, sleep apnea, diabetes mellitus type two, depression, and congestive heart failure.Review of a Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #7 was cognitively intact.Further review of Resident #7's medical record revealed a date of birth of [DATE] which represented the resident's age as [AGE] years old.Review of Resident #7's immunization list revealed no documentation of a pneumococcal vaccine being offered or administered and no documentation of Resident #7 previously receiving a pneumococcal vaccine.2. Review of Resident #38's medical record revealed an admission date of 12/10/24. Diagnoses included malnutrition, psychotic disturbance, hearing loss, and dementia.Review of an annual MDS assessment dated [DATE] revealed Resident #38 had severely impaired cognition.Further review of Resident #38's medical record revealed her date of birth was 11/16/49 which represented the resident's age as [AGE] years old.Review of a pneumococcal vaccine consent document dated 12/13/24 revealed Resident #38's son signed that Resident #38 had previously had a pneumococcal vaccine. Review of Resident #38's immunization list revealed no documentation of a pneumococcal vaccine being offered or administered at the facility. There was no documentation of what date Resident #38 previously received a pneumococcal vaccine or what type of vaccine was received.3. Review of Resident #70's medical record revealed an admission date 01/07/26. Diagnoses included atrial fibrillation, liver failure, depressive disorder, anxiety disorder, and kidney failure.Review of a significant change MDS assessment dated [DATE] revealed Resident #70 was cognitively intact.Review of an influenza vaccine consent form revealed Resident #70 signed and consented to the vaccine on 01/09/26.Review of Resident #70's medication administration records (MARs) revealed on 01/13/26 the influenza vaccine was documented as being held and to see nursing notes. Review of the resident's nursing notes revealed no documentation of a reason the influenza vaccine was held.Review of Resident #70's immunization list revealed no documentation of an influenza vaccine being administered at the facility.Interview with Regional Clinical Nurse (RCN) #1 on 03/25/26 at 4:10 P.M. confirmed there was no documentation of Resident #7 being offered or receiving the pneumococcal vaccine while at the facility. RCN #1 confirmed there was no documentation of Resident #70 previously receiving a vaccine. RCN #1 confirmed Resident #38 had not been re-offered the pneumococcal vaccine since 2024. RCN #1 confirmed there was no documentation of when Resident #38 received a pneumococcal vaccine or what type was administered. RCN #1 confirmed both Resident #7 and Resident #38 were eligible to receive the pneumococcal vaccine due to age and health conditions. Review of the facility's policy titled, Resident Pneumococcal Vaccination, revised April 2022, revealed each resident's vaccination status will be determined upon admission and will be documented in the medical record. Current residents will have their medical record reviewed for immunization status yearly and as needed. All residents without documented history of immunizations or with unknown pneumococcal vaccination status will be educated on and offered the vaccine sequence.Review of the facility's policy titled, Resident Influenza (Flu) Vaccination, revised April 2022, revealed current and newly admitted resident's will be offered the influenza vaccine from October of each year through the end of March of the following year. Each resident's immunization status will be determined prior to vaccination and will be documented in the resident's medical record. A resident who received the vaccination prior to admission will not receive the vaccine.