STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365279	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/31/2024
NAME OF PROVIDER OR SUPPLIER: Merit House LLC		STREET ADDRESS, CITY, STATE, ZIP CODE: 4645 Lewis Ave Toledo, OH 43612	

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 47057 Based on observation, staff interview and review of facility policy, the facility failed to maintain a dignified dining experience for the residents by serving meals on disposable dishware. This had the potential to affect 79 of 81 residents who received meals from the kitchen. The facility identified two residents (#2 and #34) who received no food from the kitchen. The facility census was 81. Findings include: Observation on 12/26/24 at 1:15 P.M. of lunch trays being picked up by Certified Nursing Assistant (CNA) #502 revealed desserts for all of the trays were served in a Styrofoam bowl. Interview at the time of the observation with CNA #502 verified the desserts were served in a Styrofoam bowl. Further interview with CNA #501 revealed meals were sometimes served in Styrofoam containers. Observation on 12/26/24 at 4:54 P.M. of the dinner meal service revealed the meal was served to residents in a disposable, clear and green, carryout container. Interview on 12/26/24 at 4:55 P.M. with [NAME] #425 verified dinner was served in disposable carryout containers and further stated she decided to serve the meals in disposable containers as she did not want to dirty the dishes. Interview on 12/26/24 at 5:00 P.M. with Resident #10 revealed it bothered her when meals were served on disposable dishware instead of on regular plates. Interview on 12/30/24 at 4:50 P.M. with the Administrator revealed two (#2 and #34) residents were identified as NPO and did not receive meals from the kitchen. Interview on 12/31/24 at 12:10 P.M. with Dietary Technician (DT) #501 revealed she had observed residents being served meals on disposable dishware. Review of the facility policy titled Dignity, revised February 2021, revealed each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. This deficiency represents non-compliance investigated under Complaint Number OH00160314.

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: 365279	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/31/2024
NAME OF PROVIDER OR SUPPLIER Merit House LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 4645 Lewis Ave Toledo, OH 43612	

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47057 Based on resident interview, observation, medical record review, staff interview and review of facility policy, the facility failed to complete dressing changes according to physician orders. This affected one (#30) of three residents reviewed for wound care. The facility census was 81. Findings include: Review of the medical record for Resident #30 revealed an admitted [DATE]. Diagnoses included status post cardiac arrest, respiratory arrest, chronic obstructive pulmonary disease (COPD), diabetes mellitus type two, and congestive heart failure. Review of the admission Minimum Data Set (MDS) assessment, dated 12/12/24, revealed Resident #30 was cognitively intact and was admitted with no unhealed pressure or vascular ulcers. Review of a nursing progress note dated 12/27/24 revealed Resident #30 had an intact purple area noted to the right heel during her shower. A physician order was obtained to apply skin prep to the right heel, cover with abdominal (ABD) pad and wrap with kerlix for protection, to be done twice daily and as needed, and apply offloading heel boot. Review of the physician order dated 12/27/24 revealed Resident #30 had an order to apply skin prep to the right heel, let dry, cover with ABD pad and wrap with kerlix twice daily and as needed. Interview on 12/30/24 at 4:32 P.M. with Resident #30 revealed had a spot on her right heel and no dressing change had been completed for about a week. Resident #30 further stated she was not aware how she got the spot, it just showed up. Resident #30 stated she had been involved in therapy services and ambulating, with a goal to discharge home. Concurrent observation of Resident #30's right heel wound dressing revealed the dressing was dated 12/27/24. Interview on 12/30/24 at 4:36 P.M. with Registered Nurse (RN) #308 verified Resident #30's right heel dressing was dated 12/27/24. RN #308 further stated she placed that dressing on 12/27/24. Coinciding review of the Treatment Administration Record (TAR) for December 2024 revealed Resident #30's right heel wound treatment was documented as completed twice daily, per physician order, including 12/28/24 and 12/29/24. Further interview with RN #308 verified the physician order written for Resident #30's right heel was for twice daily dressing changes and further confirmed the TAR reflected the treatment had been signed off as being completed by the weekend nurse; however, the treatment had not been completed since 12/27/24. Interview on 12/31/24 at 10:20 A.M. with wound care RN #321 confirmed Resident #30's original physician order was for twice daily dressing changes for a suspected right heel deep tissue injury. RN #321 stated on 12/30/24, the order was changed to once daily as the usual treatment for this type of wound was daily, not twice daily. RN #321 stated she was made aware Resident #30's right heel dressing changes were not completed as ordered on 12/28/24 and 12/29/24. Review of the facility policy titled Wound Care, revised October 2010, revealed the purpose of the procedure was to provide guidelines for the care of wounds to promote healing. (continued on next page)

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	365279	A. Building B. Wing	12/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Merit House LLC	4645 Lewis Ave Toledo, OH 43612

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency represents non-compliance investigated under Complaint Number OH00160314.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47057 Based on observation, resident interview, medical record review, staff interview and review of facility policy, the facility failed to obtain a physician order for administration of oxygen therapy. This affected one (#30) of three residents reviewed for oxygen therapy. The facility identified 18 residents who received oxygen therapy. The facility census was 81. Findings include: Review of the medical record for Resident #30 revealed an admitted [DATE]. Diagnoses included status post cardiac arrest, respiratory arrest, chronic obstructive pulmonary disease (COPD), and congestive heart failure. Review of the admission Minimum Data Set (MDS) assessment, dated 12/12/24, revealed Resident #30 was cognitively intact and received oxygen therapy. Review of the physician orders for December 2024 revealed no order for oxygen therapy. Observation on 12/30/24 at 4:32 P.M. of Resident #30 revealed she was wearing oxygen via nasal cannula, running at two liters per minute (lpm). Concurrent interview with Resident #30 revealed she had been receiving oxygen therapy since admission. Resident #30 further stated she was on oxygen therapy at home, prior to her admission to the facility. Interview on 12/30/24 at 4:36 P.M. with Registered Nurse (RN) #308 confirmed Resident #30 had been on oxygen since her admission. RN #308 verified there was no physician order for Resident #30's oxygen therapy, despite having it since her admission on 12/06/24. RN #308 further verified from the hospital referral records that Resident #30 should have had an order for oxygen therapy, as it was on the referral paperwork, and it must have been missed. Interview on 12/31/24 at 12:32 P.M. with the Administrator verified a physician order was not written until 12/30/24 for Resident #30's oxygen therapy. Review of the facility policy titled Oxygen Administration, revised October 2010, revealed to verify there was a physician order for this procedure and . Review the physician's order or the facility protocol for oxygen administration. This deficiency is an incidental finding discovered during the complaint investigation.

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NAME OF PROVIDER OR SUPPLIER Merit House LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 4645 Lewis Ave Toledo, OH 43612	

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47057 Based on observation, medical record review, staff interview, review of the emergency medication box (E-box) inventory and review of facility policy, the facility failed to administer medications per physician order. This affected one (#100) of three residents reviewed for medication administration. The facility census was 81. Findings include: Review of the medical record for Resident #100 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included chronic obstructive pulmonary disease (COPD), emphysema, and anxiety. Review of the admission Minimum Data Set (MDS) assessment, dated 12/13/24, revealed Resident #100 was cognitively intact. Review of the admission orders for Resident #100 revealed he was ordered Zithromax (antibiotic) 250 milligrams (mg) to give two tablets on day one for acute exacerbation of COPD and prednisone (oral steroid used to decrease inflammation) 20 mg to give one and a half tablets (30 mg total) for acute exacerbation of COPD. Review of the Medication Administration Record (MAR) for December 2024 revealed on 12/07/24 a code five, followed by the nurse's initials, was entered into the MAR for the administration of both Zithromax 250 mg two tablets and prednisone 20 mg one and a half tablets. Further review of the MAR revealed code five indicated a note was made in the nursing progress notes for any infraction of the medication administration. Review of the nursing progress note dated 12/07/24 at 3:37 A.M. for Resident #100 revealed the Zithromax 250 mg two tablets was not administered due to awaiting pharmacy. Review of the nursing progress notes dated 12/07/24 at 12:16 P.M. for Resident #100 revealed the prednisone 20 mg one and a half tablets was not administered due to meds (medication) on order. Interview on 12/26/24 at 4:46 P.M. with Licensed Practical Nurse (LPN) #327 revealed the facility had an E-box that common medications could be pulled from for immediate use. LPN #327 further stated the E-box did not have all medications, but a select variety to get the resident started, such as antibiotics, some insulin and some narcotic medications that would be needed. Further interview with LPN #327 revealed the contracted pharmacy was responsible for maintaining the E-box. Review of the undated E-box inventory sheet provided by the facility revealed Zithromax 250 mg (total of six tablets) and and prednisone (four 20 mg tablets and four five mg tablets) were available in the E-box for administration. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/30/24 at 8:47 A.M. with the Director of Nursing (DON) revealed just because the facility had an E-box that did not mean the medication was in stock in the E-box. The DON declined to verify Resident #100's medications were available and not administered as ordered based on the documentation. The DON further stated she was not working as the floor nurse and could not determine if the medications were available in the E-box for administration. Interview on 12/20/24 at 10:57 A.M. with pharmacy Processing Manager (PM) #500 revealed the pharmacy contract provided an E-box of medications for use for new orders and newly admitted residents. Further interview with PM #500 revealed the pharmacy conducted an in-house audit on 12/04/24 the facility E-box and verified Zithromax 250 mg, prednisone 20 mg and prednisone five mg was fully stocked and available for use. PM #500 further verified there were no requests submitted to the pharmacy from 12/04/24, following the in-house audit, and 12/07/24 for the use of Zithromax 250 mg or prednisone for any resident, so the facility had a full stock available of Zithromax (six tablets) and prednisone (four 20 mg and four five mg tablets). PM #500 further confirmed no submission forms were sent to the pharmacy regarding any medications used from the E-box for Resident #100. Review of facility policy titled Administering Medications, revised April 2019, revealed medications were administered per prescriber orders, including any required time frame. This deficiency represents non-compliance investigated under Complaint Number OH00160314 and continued non-compliance to the surveys dated 09/23/24 and 11/06/24.

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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. 47057 Based on observation, staff interview, review of the facility menu and review of facility policy, the facility failed to follow established menus and further failed to maintain a substitution log. This had the potential to affect 79 of 81 residents who received food from the kitchen. The facility identified two residents (#2 and #34) who received no nutrition from the kitchen. The facility census was 81. Findings include: 1. Review of the facility menu cycle revealed the facility was on a five-week rotation for the winter menu. Further review of the menu revealed for week five, day five (12/26/24), the menu for breakfast was choice of cereal, scrambled eggs, bacon, wheat toast, jelly, butter, juice of choice, milk, and coffee or tea. Observation on 12/26/24 at 7:48 A.M. of the breakfast trayline revealed the meal consisted of two slices of french toast, two sausage links and hot cereal. The cereal was served from a white handled scoop. Concurrent interview with [NAME] #471 verified the breakfast served was french toast, sausage links, cereal of choice and beverage of choice and not the meal identified on the menu. [NAME] #471 was uncertain of the serving size of the white handled scoop used for serving the hot cereal. Further review of the menu for week one, day three (12/31/24), revealed lunch was maple mustard glazed pork tenderloin, baked potato with butter/sour cream/chives, carrots, choice of roll, angel food cake, and coffee/tea. Observation on 12/31/24 at 12:00 P.M. of the lunch trayline revealed the meal consisted of spaghetti, green beans, dinner roll, ice cream and beverage of choice. Coinciding interview with [NAME] # 471 verified the lunch meal served was spaghetti, green beans, dinner roll, and ice cream. [NAME] #471 stated she had to cook the meat that was defrosted and she sometimes made up her own menu. [NAME] #471 verified the lunch meal served was not what was on the menu and was a meal she made up on her own. Continued observation revealed the spaghetti was served using a white handled scoop. Further interview with [NAME] #471 revealed she was not able to identify the portion size of the spaghetti served from the white handled scoop but she stated she knew she needed three ounces of meet and approximately four to six ounces of noodles and, since it was spaghetti, the white handled scoop is what she used. [NAME] #471 confirmed she served four ounces of green beans, one dinner roll and one container of ice cream. Interview on 12/31/24 at 12:05 P.M. with Dietary Manager (DM) #455 confirmed the facility was on week one of the five week menu rotation and further verified the lunch meal served was not the planned menu meal. Interview on 12/31/24 at 12:10 P.M. with Dietary Technician (DT) #501 verified the menu for the day was not followed and, since the meal was not on the menu, she could not verify the serving sizes to be correct. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy titled Menu and Planning, undated, revealed nutritional needs of individuals would be provided in accordance with established national standards, adjusted for age, gender, activity level and disability, through nourishing well balanced diets, unless contraindicated by medical needs. Review of the facility policy titled Standardized Recipes undated, revealed standardized recipes will be used when preparing menu items. 2. Review of the facility menu for week one, day three (12/31/24) revealed the lunch meal was maple mustard glazed pork tenderloin, baked potato with butter/sour cream/chives, carrots, choice of roll, angel food cake, and coffee/tea. Observation on 12/31/24 at 12:00 P.M. of the lunch trayline revealed the meal served consisted of spaghetti, green beans, dinner roll, ice cream and beverage of choice. Concurrent interview with [NAME] # 471 verified the meal served was spaghetti, green beans, roll and ice cream and not the planned lunch menu meal. [NAME] #471 confirmed she made up the meal served on her own as she needed to use the meat that was defrosted. Interview on 12/31/24 at 12:05 P.M. with Dietary Manager #455 confirmed the lunch menu was to be maple mustard glazed pork tenderloin, baked potato with butter/sour cream/chives, carrots, choice of roll, angel food cake, and coffee/tea and verified the meal served was spaghetti, green beans, and ice cream. DM #455 further stated sometimes we have substitutes. When asked by the surveyor for the substitution log, DM #455 stated, I don't know what you're talking about. I have never filled out a log about substitutes. Interview on 12/31/24 at 12:10 P.M. with Dietary Technician (DT) #501 confirmed the menu for the day was not followed and a substitute meal was served. Further interview with DT #501 verified the facility did not maintain a substitution log. Review of the facility policy titled Menu Substitutions, undated, revealed all changes to the menu would be recorded. Records of menu substitutions should be retained for a period of time based on state regulations. This deficiency represents non-compliance investigated under Complaint Number OH00160314.