STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365279	A. Building B. Wing	01/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Merit House LLC	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 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. Based on medical record review, staff interview, and review of facility policy, the facility failed to ensure narcotic pain medications were administered as ordered. This affected one (#11) of three residents reviewed for narcotic pain medication use. The facility census was 84. Findings include:Review of Resident #11's medical record revealed an admission date of 01/16/26. Diagnoses included nondisplaced fracture of right humerus subsequent encounter, morbid obesity, fall subsequent encounter, fracture of first and second lumbar vertebra, anxiety disorder, and alcohol use.Review of Resident #11's Minimum Data Set (MDS) revealed an admission MDS was in progress.Review of Resident #11's Baseline Care Plan dated 01/17/26 revealed was alert and aware. Resident #11 plan was to complete physical and occupational therapy to increase strength and stamina and discharge home. While at the facility the nursing staff would provide nursing care as ordered to reach optimal health status. Resident #11 had indicators of pain and a goal was in place for adequate pain control. Review of Resident #11's physician orders revealed an order dated 01/16/26 and discontinued 01/19/26 for acetaminophen 500 milligrams (mg) every six hours as needed for mild to moderate pain. The acetaminophen 500 mg was reordered 01/19/26 and still active for every six hours as needed for mild to moderate pain with no more than four tablets per day. Further review of Resident #11's physician orders revealed an order dated 01/16/26 and discontinued 01/22/26 for Roxicodone oral tablet 5 milligrams (mg) (Oxycodone HCl) give one tablet by mouth every six hours as needed for severe pain for seven days. Severe pain was noted to be a pain level of eight to ten on a scale of one to ten. On 01/17/26 Resident #11 was administered his as needed (PRN) Roxicodone for a pain level of seven, on 01/18/26 he was administered his PRN pain medication twice for pain levels of seven. On 01/20/26 Resident #11 received his pain medication for a documented pain level of zero and again on 01/20/26 for a pain level of seven. On 01/21/26 Resident #11 was administered his PRN pain medications for pain levels of seven and six. Eight administrations were provided when Resident #11's pain was below ordered parameters.Additionally, Resident #11's order was refilled on 01/22/26 for Roxicodone oral Tablet 5 milligrams (mg) (Oxycodone HCl) give one tablet by mouth every six hours as needed for severe pain. On 01/27/26 Resident #11 was administered his PRN pain medication for a pain level of seven which also was a pain level below the required parameters for administration. Interview on 01/27/26 at 1:33 P.M. with Licensed Practical Nurse (LPN) #130 and Registered Nurse (RN) #180 verified Resident #11's PRN pain medications were administered outside of parameters, when Resident #11 pain level was below eight. RN #180 verified there were eight administrations with the first order when Resident #11's pain level was below eight and administered once under the second order with a pain level of seven. Follow up interview on 01/27/26 at 2:32 P.M. with LPN #130 verified Resident #11 had an order for acetaminophen 500 mg for mild or moderate pain every six hours as needed which should have been administered when Resident #11's pain levels were below eight. Review of the facility policy titled Administering Medications, revised 10/03/24 revealed medications were to be administered in a safe and timely manner and as prescribed. This (continued on next page)

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

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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	deficiency represents non-compliance investigated under Complaint Number 2695906.

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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 0729 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Verify that a nurse aide has been trained; and if they haven't worked as a nurse aide for 2 years, receive retraining. Based on observation, staff interview, personnel file review, and policy review revealed the facility failed to ensure personnel obtained the proper registry. This affected one (#101) of four Certified Nursing Assistant personnel files reviewed. This had the ability to affect all residents. The facility census was 84.Findings include:Observation on 01/27/26 at 11:07 A.M. revealed Certified Nursing Assistant (CNA) #101 was assisting Resident #15 in morning care which involved dressing and positioning in the wheelchair.Review of CNA #101's personnel file revealed a hire date of 08/22/25.Review of CNA #101's Nurse Aide Training and Competency Evaluation Program was completed on 06/13/25. Review of CNA #101's personnel file and the State of Ohio State Tested Nursing Assistant website revealed it was absent of proof of State Registry.Review of the facility staffing schedule revealed CNA #101 worked as a CNA on 01/27/26 and 01/28/26. Interview with CNA #101 on 01/27/26 at 11:52 A.M. revealed she was employed at a CNA and was caring for residents that day.Interview with the Administrator on 01/27/26 at 4:10 P.M. revealed CNA #101 had been employed longer than four months since her completion of a CNA program. The Administrator stated that CNA #101 failed to pass her first registry test and was scheduled to take it again. The Administrator further verified CNA #110 should not be working as a CNA providing resident care without having passed the registry examination and stated CNA #110 was moved to the position of hospitality aide until the registration was completed.In Ohio, an individual can work as a nurse aide for a maximum of four months (approximately 120 days) from their date of hire without being on the state registry. During this grace period, they must complete an approved training program and pass the state competency exam to continue working.Review of the facility policy titled Test Ready CNA undated revealed certain positions within the facility require state mandated certification or licensing. Any employee whose position requires certification or licensing is expected to maintain and fulfill any requirements of the individual certification or license. Failure to maintain a valid license required of a specific position may result in termination of employment and a formal report to the licensing board.This deficiency represents non-compliance investigated under Master Complaint Number 2701102 and Complaint Number 2694213.

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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 0774 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Help the resident with transportation to and from laboratory services outside of the facility. Based on observation, medical record review, resident interview, and staff interview the facility failed to ensure residents were transported to appointments as scheduled. This affected one (#11) of three residents reviewed for transportation to outside appointments. The facility census was 84.Findings include:Review of Resident #11's medical record revealed an admission date of 01/16/26. Diagnoses included nondisplaced fracture of right humerus subsequent encounter, morbid obesity, fall subsequent encounter, fracture of first and second lumbar vertebra, anxiety disorder, and alcohol use.Review of Resident #11's Minimum Data Set (MDS) revealed an admission MDS was in progress.Review of Resident #11's Baseline Care Plan dated 01/17/26 revealed the resident was alert and aware. Resident #11's plan was to complete physical and occupational therapy to increase strength and stamina and discharge home. While at the facility the nursing staff would provide nursing care as ordered to reach optimal health status, therapy would provide therapy services as ordered to reach optimal function, and social services would coordinate services to achieve discharge goals. Resident #11 was non-weight bearing on affected extremity. Staff were to encourage him to participate in his activities of daily living (ADLs) to the fullest extent possible. Resident #11 had a nondisplaced fracture of his right humerus, lumbar spine (L) fractures at L1 and L2 with a traumatic subdural hematoma from subsequent falls. Review of Resident #11's physician orders revealed an order written 01/17/26 for an appointment scheduled 01/27/26 at 8:50 A.M. for an orthopedic follow-up. Further review found an order dated 01/27/26 for an appointment dated 02/03/26 for orthopedic follow-up. Observation on 01/27/26 at 8:39 A.M. of Resident #11 found him standing in the doorway of his room with his right arm in a black sling, the resident was holding papers in his hand. Resident #11 had his shoes on and was looking up and down the hallway.Interview on 01/27/26 at 8:43 A.M. with Resident #11 found him to be alert and aware. Resident #11 reported he was admitted to the facility a week ago Friday and was to have a follow up appointment with his orthopedic doctor today at 8:50 A.M. Resident #11 reported he had a fall before he came to the facility and broke his arm so he had to wear the sling until he was healed. Resident #11 stated his arm and sling were bothering him and he wanted to go today to get it checked out. Resident #11 stated no one had come to get him yet.Observation on 01/27/26 at 10:56 A.M. of Resident #11 found he was still in his room, arm in a sling, shoes on, and his appointment papers were on the bedside table. Coinciding interview with Resident #11 revealed no one ever came and got him and he missed his appointment with his orthopedic doctor. He stated he was told his appointment would be rescheduled. Review of the appointment paperwork on Resident #11's bedside table found on 1/27/26 at 8:50 A.M. Resident #11 was to have had an orthopedic follow-up. The appointment had been scheduled 01/17/26 and required staff accompaniment and the staff needed to be medically trained.Interview on 01/27/25 at 11:03 A.M. with Registered Nurse (RN) #152 verified Resident #11 had not been transported to his orthopedic appointment scheduled for today. RN #152 reported there was some miscommunication with the doctors office and Resident #11 had missed his scheduled appointment. RN #152 stated the appointment was going to be rescheduled. This deficiency represents non-compliance investigated under Complaint Number 2694213.