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	09/23/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44454 Based on medical record review, observation, resident interview, and staff interview, the facility failed to ensure residents received the necessary services to maintain a dignified appearance. This affected one (Resident #62) of three residents reviewed for dignity. The facility census was 85. Findings include: Review of the medical record revealed Resident #62 was admitted to the facility on [DATE]. Diagnoses included chronic obstructive pulmonary disease, chronic kidney disease, heart failure, gout, hypertension, and type II diabetes mellitus. Review of the quarterly Minimum Data Set assessment dated [DATE] revealed Resident #62 had a moderate cognitive impairment. The resident was dependent on staff assistance for dressing and personal hygiene. Review of the physician progress notes dated 01/17/24 and 03/12/24 revealed Resident #62's right breast was surgically absent and an order for a prosthetic bra per patient request. Review of the social service progress notes dated 03/14/24 revealed Resident #62 mentioned her insurance previously covered two bras on a yearly basis and social services would check to see if the resident would qualify for two free bras. Review of the physician progress notes dated 04/03/24, 05/28/24 07/10/24, and 07/30/24 revealed Resident #62's right breast was surgically absent and an order for a prosthetic bra per patient request. Further review of the medical record revealed no evidence Resident #62's request for a prosthetic bra was followed up on. An interview on 09/16/24 at 9:30 A.M. with Resident #62 revealed the resident had a breast removed and needed a special bra. The resident reported the facility was aware she needed a bra but that she had not heard anything regarding this. Resident #62 reported she sometimes felt ashamed to go out due to not having an appropriate bra. An observation at the time of interview verified Resident #62 did not have a prosthetic bra. (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
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 09/17/24 at 4:01 P.M. with Licensed Social Worker #478 verified Resident #62's request for a prosthetic bra had not been followed up on.

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35033 Based on review of the medical record, observation, staff interview, and policy review, the facility failed to ensure a call light was within reach and bed side rails were in place per physician orders. This affected two (Residents #182 and #128) of two reviewed for accommodation of needs. The facility census was 85. Findings include 1. Review of the medical record for Resident #128 revealed an admitted [DATE]. Diagnoses included type two diabetes mellitus, hypothyroidism, depressive disorder, and gangrene of the right leg. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition. The resident required substantial/maximal assistance for toileting and transfers. Observation on 09/16/24 at 9:56 A.M. revealed the resident had no call light within reach. On the floor near the wall there was a rectangular box no longer attached to the wall with a pull cord attached. Interview on 09/16/24 at 9:56 A.M., Resident #128 asked if someone could get him a call light. Resident #128 revealed he had not had a working call light for a couple of weeks. Interview on 09/16/24 at 9:57 A.M., the Director of Nursing (DON) verified the resident had no call light within reach. The DON revealed she would go and find the resident a pendant call light. Review of the policy, Answering the Call Light, last revised 03/2021, revealed when the resident is in bed or confined to a chair be sure the call light was within each reach of the resident. 44454 2. Review of the medical record revealed Resident #182 was admitted to the facility on [DATE]. Diagnoses included chronic destructive pulmonary disease, asthma, and heart failure. Review of the admission MDS assessment dated [DATE] revealed Resident #182 was cognitively intact. The resident required partial to moderate assistance from staff for bed mobility. Review of the physician orders for September 2024 identified an active order dated 09/05/24 for top bilateral siderails to aide in bed mobility and promote independence. Review of the plan of care dated 09/07/24 identified Resident #182 was at risk for an activities of daily living self-care performance deficit related to limited mobility. Interventions included half rails up as per physician orders for safety during care provision, to assist with bed mobility, and to observe for injury or entrapment related to siderail use. During an interview on 09/18/24, Resident #182's family member reported the resident was admitted to the facility weeks ago and was supposed to have siderails in place and still did not have them. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation at the time of interview revealed Resident #182 was in their room, lying in bed. The resident's bed did not contain any siderails. An interview on 09/18/24 at 12:08 P.M. with Agency Licensed Practical Nurse #558 verified Resident #182 did not have any siderails on their bed.

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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** 44454 Based on medical record review, staff interview and facility policy review, the facility failed to notify the physician of resident weight loss. This affected one (Resident #48) of three residents reviewed for nutrition. The facility census was 85. Findings include: Review of the medical record revealed Resident #48 was initially admitted to the facility on [DATE]. Diagnoses included severe protein-calorie malnutrition, nutritional deficiency, heart disease, heart failure, weakness, anxiety, depression, and bipolar disorder. Review of the quarterly Minimum Data Set assessment dated [DATE] revealed Resident #48 was cognitively intact. The resident was noted as having weight gain. Review of the plan of care revised 08/15/24 revealed Resident #48 was at risk for decline in nutrition/hydration status related to diagnoses, weight loss, and inadequate nutrition. The resident had weight gain over the past month, likely related to fluid retention, and also reported increased intakes while at the hospital. Interventions included providing supplements as ordered and reporting significant weight changes to the physician. Review of Resident #48's weight record revealed the resident weighed 143.7 pounds on 08/31/24 and 130.2 pounds on 09/01/24, which was a 13.5 pound loss. Review of Resident #48's medical record revealed no documentation the physician or dietitian were notified of the aforementioned weight loss. An interview on 09/18/24 at 4:41 P.M. with the Director of Nursing and the Assistant Director of Nursing verified there was no evidence the physician or dietitian were notified of Resident #48's weight loss prior to 09/18/24. Review of the facility policy titled, Weight Assessment and Intervention, revised September 2008, revealed any weight change of five-percent or more since the last weight assessment would be retaken. If the weight was verified, nursing staff would immediately notify the dietitian in writing.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 49742 Based on observation, resident interview, and staff interview, the facility failed to provide a clean, comfortable, and homelike environment. This affected one (Resident #19) of one resident observed for room cleanliness. The facility census was 85. Findings include: Review of the medical record for Resident #19 revealed an admitted [DATE], with diagnoses that include cerebral infarction, hyperlipidemia, type two diabetes (DM2), bipolar disorder, nutritional deficiency, hypertension (HTN), seborrheic dermatitis, unspecified intellectual disabilities, personal history of COVID-19, tinea unguium. Review of the most recent quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of eight, indicating the resident was moderately cognitively impaired. Observation on 09/16/24 at 3:14 P.M. of the restroom sink in Resident #19's restroom revealed it contained a brown liquid that filled to approximately four inches from the top of the sink, and was not draining. Interview on 09/16/24 at 3:14 P.M. with Resident #19 revealed the sink in her restroom had contained the brown liquid approximately four inches from the top for approximately four days. Interview on 09/16/24 at 3:14 with Medication Aide #434 verified the sink in Resident #19's restroom contained the brown liquid approximately four inches from the top and it was not draining. Observation on 09/17/24 at 1:13 P.M. revealed the sink in Resident #19's restroom still contained the brown liquid approximately four inches from the top and it was not draining. Interview on 09/17/24 at 1:13 P.M. with Housekeeping Aide #505 verified the sink in Resident #19's room contained the brown liquid approximately four inches from the top and it was not draining. Observation on 09/18/24 at 9:13 A.M. revealed the sink in Resident #19's restroom still contained the brown liquid approximately four inches from the top and it was not draining. Interview on 09/18/24 at 9:13 A.M. with Housekeeper #448 verified the sink in Resident #19's restroom contained the brown liquid approximately four inches from the top and it was not draining. Concurrent interview with Housekeeper #448 revealed she had noticed the sink was in this condition the week prior, but was unsure of the date, and reported to the nurse, but was unsure of the nurse. Observation on 09/18/24 at 11:56 A.M. revealed the sink in the restroom of Resident #19's room was free of the brown liquid, clean, and draining appropriately.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44454 Based on medical record review, staff interview, review of facility Self-Reported Incidents (SRIs), and review of the facility policy, the facility failed to report an allegation of verbal abuse to the state agency in a timely manner. This affected three (Resident #9, #42, and #54) of three residents reviewed for abuse. The facility census was 85. Findings include: 1. Review of the medical record revealed Resident #9 was admitted to the facility on [DATE]. Diagnoses included schizophrenia, depression, anxiety, bipolar disorder, and muscle weakness. Review of the quarterly Minimum Data Set assessment dated [DATE] revealed the resident was cognitively impaired. The resident required substantial/maximal assistance from staff for a majority of the activities of daily living. Review of the medical record revealed no evidence regarding an allegation of abuse. 2. Review of the medical record revealed Resident #42 was admitted to the facility on [DATE]. Diagnoses included cardiomyopathy, depression, hypertension, and facial weakness. Review of the quarterly Minimum Data Set assessment dated [DATE] identified the resident as cognitively impaired. The resident was dependent on staff for a majority of the activities of daily living. Review of the medical record revealed no evidence regarding an allegation of abuse. 3. Review of the medical record revealed Resident #54 was admitted to the facility on [DATE]. Diagnoses included dementia, hypertension, unsteadiness on feet, heart failure, anxiety, and depression. Review of the significant change Minimum Data Set assessment dated [DATE] identified Resident #54 was cognitively impaired. The resident received hospice services and was dependent on staff for a majority of the activities of daily living. Review of the medical record revealed no evidence regarding an allegation of abuse. Interview on 09/18/24 at 3:54 P.M. with State tested Nurse Aide (STNA) #474 revealed that approximately 10 days prior, STNA #464 had threatened to hit Resident #42 and #54. STNA #474 stated the allegation was reported to management. Interview on 09/18/24 at 4:41 P.M. with the Director of Nursing (DON) revealed it was reported to her that STNA #464 had threatened to hit Resident #9 and #54. The DON reported completing an investigation and providing the investigative documentation to the previous Administrator. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/19/24 at 11:33 A.M. with Administrator #2 revealed the facility was unable to find any investigative documentation related to the allegation. Administrator #2 also verified the allegation should have been reported to the state agency and was not. Review of the facility SRIs revealed there were no reports filed for the allegation of verbal abuse. Review of the facility policy titled, Abuse, Neglect, Exploitation & Misappropriation of Resident Property, revised June 2017, revealed staff should report all incidents/allegations immediately to the Administrator or designee. The policy also stated documentation in the nursing notes should include the results of the resident's assessment, notification of the physician and the resident representative, and any treatment provided. The policy further stated if the event that caused the allegation involves an allegation of abuse or serious bodily injury, it should be reported to the state agency immediately, but no later than two hours after the allegation was made.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44454 Based on medical record review, staff interview, review of facility Self-Reported Incidents (SRIs), review of staff schedules, and review of the facility policy, the facility failed to thoroughly investigate an allegation of verbal abuse and failed to protect residents from potential abuse. This affected three (Resident #9, #42, and #54) of three residents reviewed for abuse. The facility census was 85. Findings include: 1. Review of the medical record revealed Resident #9 was admitted to the facility on [DATE]. Diagnoses included schizophrenia, depression, anxiety, bipolar disorder, and muscle weakness. Review of the quarterly Minimum Data Set assessment dated [DATE] identified the resident as cognitively impaired. The resident required substantial/maximal assistance from staff for a majority of the activities of daily living. Review of the medical record revealed no evidence regarding an allegation of abuse. 2. Review of the medical record revealed Resident #42 was admitted to the facility on [DATE]. Diagnoses included cardiomyopathy, depression, hypertension, and facial weakness. Review of the quarterly Minimum Data Set assessment dated [DATE] identified the resident as cognitively impaired. The resident was dependent on staff for a majority of the activities of daily living. Review of the medical record revealed no evidence regarding an allegation of abuse. 3. Review of the medical record revealed Resident #54 was admitted to the facility on [DATE]. Diagnoses included dementia, hypertension, unsteadiness on feet, heart failure, anxiety, and depression. Review of the significant change Minimum Data Set assessment dated [DATE] identified Resident #54 was cognitively impaired. The resident received hospice services and was dependent on staff for a majority of the activities of daily living. Review of the medical record revealed no evidence regarding an allegation of abuse. Interview on 09/18/24 at 3:54 P.M. with State tested Nurse Aide (STNA) #474 revealed that approximately 10 days prior, STNA #464 had threatened to hit Resident #42 and #54. STNA #474 stated the allegation was reported to management. Interview on 09/18/24 at 4:41 P.M. with the Director of Nursing (DON) revealed it was reported to them that STNA #464 had threatened to hit Resident #9 and #54. The DON reported completing an investigation and providing the investigative documentation to the previous Administrator. The DON reported having no evidence regarding investigative documentation. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 09/19/24 at 11:33 A.M. with Administrator #2 revealed the facility was unable to provide any investigative documentation related to the allegation. Review of the facility SRIs revealed there were no reports filed for the allegation of verbal abuse. Review of nursing staff schedules for 09/05/24 to 09/19/24 revealed STNA #464 worked at the facility on 09/05/24, 09/06/24, 09/07/24, 09/08/24, 09/10/24, 09/13/24, 09/16/24, 09/17/24, and 09/19/24. A follow-up interview on 09/19/24 at 12:45 P.M. with Administrator #2 revealed STNA #464 was sent home on 09/19/24 and was not allowed to return until the investigation was complete. Review of the facility policy titled, Abuse, Neglect, Exploitation & Misappropriation of Resident Property, revised June 2017, revealed staff should report all incidents/allegations immediately to the Administrator or designee. The policy also stated documentation in the nursing notes should include the results of the resident's assessment, notification of the physician and the resident representative, and any treatment provided. The policy also stated if a staff member was accused or suspected, the facility should immediately remove the staff member from the facility and the schedule pending the outcome of the investigation. The policy further stated once the Administrator and state agency were notified of the allegation, and investigation would be conducted and would include: interviewing the resident, the accused and all witnesses; obtaining statements from the resident, if possible, the accused, and each witness; reviewing the resident's record; if the accused was an employee, reviewing their employment records.

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44454 Based on medical record review, observation, resident interview, and staff interview, the facility failed to ensure admission orders were obtained to provide care and treatment to a resident with a surgical incision. This affected one (#178) of one resident identified with a surgical incision. The facility census was 85. Findings include: Review of the medical record revealed Resident #178 was admitted to the facility on [DATE]. Diagnoses included occlusion and stenosis of left carotid artery, anesthesia of skin, paresthesia of skin, polyneuropathy, hyperlipidemia, and depression. Review of the hospital record dated 09/13/24 revealed Resident #178 was discharged with the recommendation to wash the surgical incision twice daily with soap and water. Review of the admission assessment dated [DATE] revealed Resident #178 was cognitively intact and utilized a walker for ambulation. The resident had a 6.5 centimeter surgical incision on his neck. Observation on 09/16/24 at 10:01 A.M. revealed Resident #178 had several pieces of clear tape covering an incision located on the right side of their neck. Interview at the time of observation revealed Resident #178 reported the incision was from a recent surgery and the facility did not perform any type of treatments on it. Review of the physician orders for September 2024 revealed there were no orders in place to wash Resident #178's neck incision until an order was initiated on 09/16/24 at 6:00 P.M. to wash the resident's neck incision with soap and water every shift for wound care. Review of the treatment administration record for September 2024 revealed Resident #178's neck incision was not washed until the evening/night shift on 09/16/24. An interview on 09/19/24 at 1:53 P.M. with the Assistant Director of Nursing (ADON) verified Resident #178 should have and an order in place to cleanse his surgical incision upon admission and did not.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49742 Based on observation, medical record review, review of facility policy, staff interview, and resident interview, the facility failed to provide grooming services for a resident. This affected one resident (Resident #20) of three residents observed for ADLs. The facility census was 85. Findings include: Review of the medical record for Resident #20 revealed an admitted [DATE] with diagnoses of polyosteoarthritis, acute respiratory failure, type two diabetes, asthma, pulmonary embolism, metabolic encephalopathy, schizoaffective disorder, stage four chronic kidney disease, major depressive disorder, nutritional deficiency, anxiety, bipolar disorder, hypothyroidism, restless osteoarthritis, and hypertension. Review of the most recent annual Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of seven, indicating Resident #20 was severely cognitively impaired. Review of the MDS revealed that Resident #20 required substantial or maximal assistance with personal hygiene. Observation on 09/16/24 at 9:33 A.M. revealed the nails on both of Resident #20's hands were long and dirty. Concurrent observation revealed Resident #20 had multiple long, coarse hairs present on both sides of her chin. Interview on 09/16/24 at 9:34 A.M. with Resident #20 revealed she does not like her nails long or dirty and would like them to be shorter and clean. Concurrent interview with Resident #20 revealed she also does not like the multiple long, coarse chin hairs that are present on her chin and would like them to be removed. Interview on 09/16/24 at 9:43 A.M. with State tested Nursing Assistant (STNA) #467 verified Resident #20's long and dirty nails and facial hair. Review of the facility policy titled, Activities of Daily Living (ADLs), Supporting, with a revision date of March 2018, revealed residents who are unable to carry out ADLs independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35033 Based on medical record review, staff interview and policy review, the facility failed to assist with vision services in a timely manner. This affected two (#32, #46) of two residents reviewed for vision services. The facility census was 85. Findings include: 1. Review of the medical record for Resident #32 revealed an admitted [DATE]. Diagnoses included dementia, epilepsy, anxiety and atrial fibrillation. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had adequate vision with no corrective lenses. Review of the medical record revealed no documentation Resident #32 had seen the provider for vision services. Review of a Request for Service form dated 06/13/24 revealed the resident had requested dental, eye care, and podiatry services. Review of facility documentation revealed the eye physician was last in the facility on 09/16/24. Interview on 09/16/24 at 10:55 A.M., Resident #32 stated since his admission, he had told many staff members he needed to see an eye doctor. Interview on 09/17/24 at 1:56 P.M., Licensed Social Worker (LSW) #478 revealed residents were added to the provider visit list when they signed up for services. LSW #478 verified Resident #32 was not added to the list to be seen by the vision provider on 09/16/24. Review of the policy, Care of the Visually Impaired Resident, last revised 03/2021, revealed it was the responsibility of the facility to assist residents in locating available resources to obtain needed services. 49742 2. Review of the medical record for Resident #46 revealed an admitted [DATE] and diagnoses of cerebral infarction, congestive heart failure, heart disease, spinal stenosis, atrial fibrillation, hydronephrosis, sacral and sacrococcygeal stenosis, gastroesophageal reflux disease, anxiety, depressive disorder, colostomy, nutritional deficiency, and hyperlipidemia. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] for Resident #46 revealed a Brief Interview of Mental Status (BIMS) score of 15, indicating Resident #46 was cognitively intact. Interview on 09/16/24 at 11:10 A.M. with Resident #46 revealed she would like to see an eye doctor but has not been provided with his opportunity since her admission. (continued on next page)

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

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility supplied list of dates the optometrist has been at the facility revealed that since Resident #46's admission to the facility on [DATE], the optometrist had been to the facility on [DATE]. Review of facility records revealed Resident #46 signed a request for service to see an optometrist on 03/08/24. Interview on 09/17/24 at 1:10 P.M. with Resident #46 revealed she was evaluated by the optometrist on 09/16/24. Interview on 09/19/24 at 11:49 A.M. with Licensed Social Worker (LSW) #478 revealed Resident #46 was admitted on [DATE] and signed her request for service to see an optometrist on 03/08/24. LSW #478 revealed the optometrist was in the facility to examine residents on 04/03/24, however Resident #46 was not evaluated at this time.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44454 Based on medical record review, observation, resident interview, and staff interview, the facility failed to ensure dietary supplements were administered per the physician's order. This affected one (#48) of three residents reviewed for nutrition. The facility census was 85. Findings include: Review of the medical record revealed Resident #48 was initially admitted to the facility on [DATE]. Diagnoses included severe protein-calorie malnutrition, nutritional deficiency, heart disease, heart failure, weakness, anxiety, depression, and bipolar disorder. Review of the quarterly Minimum Data Set assessment dated [DATE] revealed Resident #48 was cognitively intact. Review of the plan of care revised 08/15/24 revealed Resident #48 was at risk for decline in nutrition/hydration status related to diagnoses, weight loss, and inadequate nutrition. The resident had weight gain over the past month, was likely related to fluid retention, and also reported increased intakes while at the hospital. Interventions included providing supplements as ordered. Review of the nutritional assessment dated [DATE] revealed the resident was prescribed a magic cup three times per day. Review of the physician orders for September 2024 identified an order for a magic cup (supplement) with meals. During an interview on 09/16/24 at 10:44 A.M., Resident #48 reported they were supposed to receive a magic cup with meals and it was a throw of the coin on whether they received it. Observation of the lunch meal on 09/16/24 at 12:17 P.M. revealed the resident did not receive a magic cup with their lunch meal. Interview on 09/17/24 at 2:19 P.M. with Resident #48 revealed the resident did not receive a magic cup with the breakfast or lunch meal. Observation and interview on 09/18/24 at 8:28 A.M., revealed Resident #48 did not receive a magic cup with the breakfast meal. Resident #48 reported they never received a magic cup for breakfast, only at times for lunch and dinner. Interview on 09/18/24 at 8:46 A.M. with Licensed Practical Nurse #445 verified Resident #48 was supposed to receive a magic cup with breakfast. Observation and interview on 09/18/24 at 8:47 A.M. with State tested Nurse Aide #474 verified Resident #48 did not receive a magic cup with the breakfast meal.

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F 0730 Level of Harm - Potential for minimal harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. 49742 Based on record review and interview, the facility failed to complete a performance review of every nurse aide at least once every 12 months. This affected two State tested Nursing Assistants (STNAs #402 and #475) of four STNAs reviewed. This had the potential to affect all residents residing in the facility. The facility census was 85. Findings include: 1. Review of facility personnel records for STNA #402 revealed a hire date of 08/24/23. Further review revealed no 90-day or annual employee evaluations were present in her employee file. 2. Review of facility personnel records for STNA #475 revealed a hire date of 03/28/24. Further review revealed no 90-day employee evaluation was present in her employee file. Interview on 09/23/24 at 11:50 A.M. with Administrator #2 verified that there was no 90-day employee evaluation present for STNA #402 and STNA #475.

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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** 35033 Based on review of the medical record, review of physician orders, review of medication administration records, staff interview, and policy review, the facility failed to ensure medications were administered per physician orders. This affected one (#77) of six residents reviewed for medications. The facility census was 85. Findings include Review of the medical record for Resident #77 revealed an admitted [DATE]. Diagnoses included fracture of the left femur, type two diabetes mellitus, bipolar disorder, and epilepsy. Review of a physician order dated 09/10/24 revealed the resident was ordered lactulose oral solution 10 grams/15 milliliters (ml), give 45 ml by mouth three times a day for chronic hepatic failure. Review of the Medication Administration Record (MAR) from 09/09/24 through 09/19/24 revealed the resident had not received two doses of the lactulose per physician orders on 09/12/24 and had not received one dose on 09/13/24. Review of the medication orders administration note dated 09/12/24 at 12:30 P.M. revealed the lactulose medication not available and refused. Review of the medication orders administration note dated 09/12/24 at 3:14 P.M. revealed the lactulose was not available, the pharmacy stated it would be in the next delivery. Review of the medication orders administration note dated 09/13/24 at 9:57 A.M. revealed the lactulose was not available. Interview on 09/17/24 at 3:50 P.M., Licensed Practical Nurse (LPN) #445 revealed Resident #77's lactulose was not available when the resident first arrived because the pharmacy had not delivered the medication. Interview on 09/18/24 at 1:57 P.M., the Director of Nursing (DON) revealed Resident #77's lactulose was available on 09/12/24 and 09/13/24, however, the nurse could not find the medication as she had not looked in the side drawer of the medication cart. Review of the policy, Administering Medications, last revised 04/2019, revealed medications would be administered in a safe and timely manner, and as prescribed. This deficiency represents noncompliance investigated under Complaint Number OH00157910.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35033 Based on observation, medical record review, staff interview, and policy review, the facility failed to ensure medications were administered in accordance with physician orders resulting in a medication error rate of five percent. 37 medications were observed with two medication errors, resulting in a medication error rate of five percent. This affected one (#17) of two residents reviewed for medication administration. The facility census was 85. Findings include Review of the medical record for Resident #17 revealed an admitted [DATE]. Diagnoses included malignant neoplasm of breast, type two diabetes mellitus, chronic obstructive pulmonary disease, and chronic kidney disease. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition. Review of the physician order dated 07/18/24 revealed orders for fluticasone propionate suspension 50 micrograms/actuation (mcg/act), one spray in each nostril in the morning for allergic rhinitis. Review of a physician order dated 07/17/24 revealed orders for simethicone oral capsule 125 milligrams (mg), one capsule by mouth four times a day for gas. Review of the Medication Administration Record (MAR) dated 09/17/24 revealed Resident #17 was not administered the fluticasone or simethicone on 09/17/24. Observation on 09/17/24 at 8:24 A.M., Licensed Practical Nurse (LPN) #419 administered 24 medications to Resident #17. The resident was not administered the fluticasone 50 mcg/act or simethicone 125 mg. Interview on 09/17/24 at 8:31 A.M., LPN #419 revealed the fluticasone and simethicone were not available to administer to Resident #17. Review of the policy, Administering Medications, last revised 04/2019, revealed medications would be administered in a safe and timely.

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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** 49742 Based on observation, facility policy review, and staff interview, the facility failed to utilize proper Personal Protective Equipment (PPE) for a resident positive for COVID-19. This affected one (Resident #4) of one resident observed for COVID-19 precautions. The facility census was 85. Findings include: Review of the medical record for Resident #4 revealed an admitted [DATE] with diagnoses that include Alzheimer's disease, chronic obstructive pulmonary disease (COPD), pseudo-bulbar affect (PBA), type two diabetes (DM2), anxiety disorder, rheumatoid arthritis, osteoarthritis, hypertension, atherosclerotic heart disease, major depressive disorder, and hyperlipidemia. Observation on 09/16/24 at 10:41 A.M. revealed a COVID-19 isolation cart present outside of the room of Resident #4. Resident #4 was positive for COVID-19. The door to Resident #4's room was open. Further observation of State tested Nursing Assistant (STNA) #503 revealed she doffed her gown and gloves in Resident #4's room exited the room wearing the surgical mask that she wore while in Resident #4's room. At no time did STNA #503 wear an N95 respirator or eye protection in Resident #4's room. Interview on 09/16/24 at 10:43 A.M. with STNA #503 verified there were no N95 masks or face shields present on the isolation cart outside of the room of Resident #4. Further interview with STNA #503 verified she changed her mask after she left Resident #4's room and she did not wear an N-95 or face shield while in Resident #4's room. Interview on 09/16/24 at 1:36 P.M. with the Director of Nursing (DON) revealed N95 masks and face shields are to be present on isolation carts outside of resident rooms that are COVID-19 positive. Review of the facility policy titled, Policy for Managing Viral Respiratory Pathogens, updated 02/13/24, revealed staff who enter the room of a resident with signs or symptoms of an unknown respiratory viral infection that is consistent with SARS-CoV-2 infection will adhere to Standard Precautions and use an N95 mask or higher, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face). This PPE usage may be adjusted once the cause of the infection is identified.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49742 Based on review of facility electronic medical record, staff interview, and review of facility policy, the facility failed to residents were educated on and received the COVID-19 vaccination. This affected two residents (Resident #332 and Resident #46) of five residents reviewed. The facility census was 85. Findings include: 1. Review of the medical record for Resident #32 revealed an admitted [DATE]. Review of the most recent Minimum Data Set (MDS) assessment revealed a Brief Interview for Mental Status (BIMS) score of 13, indicating Resident #32 was cognitively intact. Further review of the medical record revealed no documentation of education of administration or refusal of the COVID-19 vaccination. Interview on 09/19/24 at 3:09 P.M. with Registered Nurse (RN) #484 revealed the facility had no documented of education of administration or refusal of the COVID-19 vaccine for Resident #32. 2. Review of the medical record for Resident #46 revealed an admitted [DATE]. Review of the most recent quarterly MDS assessment dated [DATE] revealed a BIMS score of 15, indicating Resident #46 was cognitively intact. Review of the medical record for Resident #46 revealed the only COVID-19 vaccination she received was dated 05/17/21. There was no documentation showing the resident was educated on or offered the COVID-19 vaccination upon admission or at any time thereafter. Interview on 09/19/24 at 3:09 P.M. with RN #484 verified Resident #46 has only received one COVID-19 vaccination on 05/17/21. Concurrent interview with RN #484 verified the facility has not provided education or offered the COVID-19 vaccination to Resident #46. Interview on 09/23/24 at 1:23 P.M. with RN #484 revealed the facility received the information on 09/20/24 regarding the offered COVID-19 vaccinations and their availability but they are not currently offering them to residents. Concurrent interview with RN #484 revealed she will discuss the COVID-19 vaccination options with the facility physician on 09/24/24 to determine the most appropriate vaccination option for residents. Further interview with RN #484 revealed the facility plans to begin offering COVID-19 vaccinations to residents on 09/25/24. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/23/24 at 2:32 P.M. with Administrator #2 revealed the facility should be offering COVID-19 vaccinations and educating residents on the COVID-19 vaccination. Review of the facility policy titled, Policy for Managing Viral Respiratory Pathogens, with a revision date of 02/13/24, revealed Merit House will provide recommended vaccines to residents and staff and provide information (e.g., posted materials and letters) to families and other visitors encouraging them to be vaccinated. Residents and staff will be encouraged to receive all recommended vaccines. Recommended vaccines help prevent infection and complications such as severe illness and death. Merit House will utilize its contracted institutional pharmacy and medical practitioners to ensure access to indicated vaccines for residents and staff.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 35033 Based on observation, review of a facility investigation, staff interview, and policy review, the facility failed to maintain a safe environment free from an outdoor fire. This had the potential to affect 11 residents (#5, #9, #14, #34, #38, #42, #46, #54, #61, #77, #181) with rooms in proximity to where the fire occurred. The facility census was 85. Findings include Review of an incident summary dated 09/13/24 about 3:50 P.M. by the Administrator revealed a nurse stated there was smoke outside of the 200 Hall lounge exit door on the sidewalk. When the Administrator arrived, there was a small flowerpot under a chair that staff put dirt and water on because it was smoking. There were no residents or staff witnessed sitting in the chair which had a hole. The Administrator reviewed the camera footage but the area was not in view of the camera. Observation on 09/16/24 at 3:15 P.M., with the Director of Maintenance (DM) #416 revealed a red fabric patio chair near the southwest doorway of the interior courtyard with a burn hole in the seat of the chair approximately six inches by four inches. There was black soot staining on the wall behind the chair which extended upward to approximately 18 inches below the vinyl soffit. Also on the wall were small pieces of burnt plastic. On the ground below the chair there was black potting soil intermixed with numerous cigarette butts. Interview on 09/16/24 at 3:15 P.M., DM #416 verified the burn hole in the chair and the black soot staining on the wall and the cigarette butts in the potting soil. During further interview, DM #416 revealed they believed the fire started when staff put out a cigarette in the flower planter. Interview on 09/18/24 at 2:41 P.M., Licensed Practical Nurse (LPN) #445 revealed there was a small fire in a flowerpot in the courtyard. LPN #445 revealed no staff or residents were in the courtyard at the time. LPN #445 revealed herself and another staff member threw potting soil on top of the fire. Review of the policy, Safety and Supervision of Residents, last revised 07/2017, revealed the facility would stive to make the environment as free from accident hazards as possible. Resident safety, supervision, and assistance to prevent accidents were facility-wide priorities. This deficiency represents noncompliance investigated under Complaint Number OH00157910.