STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365306	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madison Health Care	7600 S Ridge Rd Madison, OH 44057

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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** 42730 Based on resident record review, staff interviews, and facility policy review, the facility failed to report injuries of unknown origin to the state agency for Resident #69. This affected one resident (#69) of one reviewed for abuse. The facility census was 102. Findings include: Review of the hospital paperwork for discharge date d 07/30/24 revealed Resident #69 was admitted to the hospital prior to her admission to the facility, not limited to, for risk for self-harm, suicidal behavior with attempted self-injury and dementia with other behavioral disturbance. Resident #69 was admitted due to cutting her left wrist. Review of the medical record for Resident #69 revealed she was admitted to the facility on [DATE] with diagnoses that included generalized anxiety, asthma, and dementia. Review of the progress note dated 07/31/24 at 2:45 P.M. revealed Resident #69 arrived at the facility via stretcher, oriented to room, hall, and call light. Review of the progress note dated 08/01/24 at 2:00 A.M. revealed Resident #69's gait was steady. Review of the progress note dated 08/01/24 at 2:26 A.M. revealed Resident #69 made several trips to the nurse's station concerned about her husband and starting a new life. Review of the progress note dated 08/03/24 at 11:12 A.M. revealed Resident #69 was very anxious, did not sleep, and her gait was unsteady. Review of the progress note dated 08/03/24 at 1:31 P.M. revealed Resident #69 daughter reported Resident #69 was complaining of soreness to right hip. Resident #69 daughter requested x-ray of right hip, and Resident #69 received new orders for x-ray to right hip. Review of the right hip x-ray results completed by a local portable x-ray service dated 08/03/24 revealed Resident #69 had a mildly displaced fracture of the right femoral neck. Review of the progress note dated 08/03/24 at 7:08 P.M. revealed Resident #69 daughter notified of x-ray results and sending Resident #69 to the local emergency room for further evaluation. (continued on next page)

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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(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 Note: The nursing home is disputing this citation.	Review of the progress note dated 08/04/24 at 12:15 A.M. revealed Resident #69 returned to the facility ambulating ad-lib. Resident #69 had no hip fracture, and a nondisplaced superior ramus fracture on the right side. Review of the progress note revealed previous x-ray results showed possible mildly displaced fracture of right femoral neck. There were no gross lytic or blastic lesions (lytic lesions, caused by bone destruction, appear as holes or areas of bone loss, while blastic lesions, characterized by new bone formation, appear as areas of increased bone density) in bones, no abnormal radiopaque foreign body, no dislocation, joint spaces are remarkable with osteopenia (lower than normal bone mineral density). Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #69 had a Brief Interview for Mental Status (BIMS) score of seven, indicating she had short and long-term cognition impairment. Resident #69 had verbal behaviors toward others, behaviors not towards others, and wandering behaviors one to three days of the assessment reference period. She required supervision or set-up with eating, oral hygiene, chair-to-bed transfer, walking ten feet, toileting hygiene, and upper body dressing. She required moderate assistance with showers/bathing, toileting transfers, lower body dressing and walking 50 feet. She required maximum assistance walking 150 feet. She was always continent of bowels and bladder. Review of the progress note dated 08/06/24 at 9:33 A.M. revealed Resident #69 complained of right hip pain, and acetaminophen (analgesic) was given for pain. Review of the progress note dated 08/06/24 at 6:15 P.M. revealed Resident #69 complained of right hip pain and had a slow steady gait. Review of the physician orders dated 08/06/24 revealed Resident #69 had an order in place to follow-up with orthopedic surgeon within three to five days and an orthopedic appointment on 08/08/24 at 1:30 P.M. Review of the physician orders dated 08/08/24 revealed Resident #69 had an order in place for weight-bearing as tolerated to the right hip. Review of the progress note dated 08/08/24 at 11:57 A.M. revealed Resident #69 had a right superior ramus fracture with pain managed effectively with pain regimen. Review of the progress note dated 08/08/24 at 5:10 P.M. revealed Resident #69 was to continue physical therapy with a walker and weight bearing as tolerated to right hip. Review of the physician progress note dated 08/13/24 at 5:31 P.M. revealed Resident #69 had a right superior ramus fracture that was confirmed with a computed tomography (CT) scan. Review of the progress note dated 08/18/24 at 6:10 P.M. revealed Resident #69 revealed she felt a bruise on the top of her left foot. Resident #69 left foot observed to have swelling on the top of foot. Resident #69 received new orders for an x-ray to left foot for pain and swelling. Review of the physician orders dated 08/18/24 revealed Resident #69 had an order in place for an x-ray of her left foot due to pain and swelling. (continued on next page)

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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 Note: The nursing home is disputing this citation.	Review of the progress note dated 08/18/24 at 7:48 P.M. revealed Resident #69 received an x-ray of left foot by a local portable x-ray service. Resident #69 left foot remained swollen and painful when ambulating. Review of the progress note dated 08/19/24 at 1:45 A.M. revealed Resident #69's x-ray results revealed no acute fracture or dislocation to the left foot. Review of the physician orders dated 08/27/24 revealed Resident #69 had an order in place for physical therapy to evaluate due to left foot pain and swelling and to ice the left foot every two hours for 15 minutes as needed for pain and/or swelling. Review of the physician orders dated 08/30/24 revealed Resident #69 had an order in place for an x-ray to the left foot due to pain and swelling. Review of the physician orders dated 08/31/24 revealed Resident #69 had an order in place for an x-ray of the right hip due to pain. Interview on 03/11/25 at 2:42 P.M. with Licensed Practical Nurse (LPN) #304 revealed Resident #69 had a fracture a couple days after she first arrived at the facility. LPN #304 revealed she had not been aware of any falls and no investigation had been completed to rule out how the fracture occurred. LPN #304 revealed Resident #69 received x-rays that were negative and were treated with pain medications. LPN #304 revealed if a resident had an injury of unknown origin, she would report it right away to the Administrator or Director of Nursing (DON). LPN #304 revealed Resident #69 had a history of self-injury behaviors and could not rule out if the fracture occurred from self-injury or not. Interview on 03/11/25 at 3:24 P.M. with the DON revealed she had no knowledge of what occurred regarding Resident #69 due to not being employed at the facility during that time. Interview on 03/12/25 at 4:25 P.M. with the Administrator revealed she was the abuse coordinator, and any injury of unknown origins were investigated, reported to the state agency-Ohio Department of Health (ODH), and reviewed with the facility's regional team. The Administrator revealed Resident #69 did not admit to the facility with a fracture and the fracture was deemed pathological due to a diagnosis of osteopenia. The Administrator revealed she was unable to verify the cause of the fracture, did not have clinical knowledge to determine if the fracture was a definite result of a diagnosis of osteopenia, and did not report to ODH. Interview on 03/13/25 at 10:30 A.M. with the DON revealed she located a soft file regarding Resident #69 fracture of the right superior pubic ramus. The DON confirmed and verified the information located in the soft file was true and accurate to her knowledge. Review of the soft file revealed Resident #69 was seen in the facility on 08/04/24, approximately four days after admission and three days after report of right hip pain, for initial encounter for a recent fall and pelvic fracture. Review of the soft file revealed, approximately seven months later during the week of the annual survey, an addendum was entered to reflect Resident #69 did not have a fall and the fracture was considered pathological secondary to severe osteoporosis verified after reviewing the nursing home chart with no evidence of fall or foul play. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 Note: The nursing home is disputing this citation.	Interview on 03/13/25 at 11:15 A.M. with the Administrator, DON, and Assistant Director of Nursing (ADON) #411 revealed Resident #69 did not admit to the facility with a fracture; however, after returning from the hospital it was acknowledged she had a history of osteoporosis; therefore, it was assumed the injury was a result of osteoporosis. Interview revealed initial knowledge of her diagnoses was not known and the facility did not complete a self-reported incident (SRI) to investigate the cause of the fracture for Resident #69 who was known to have self-injurious behaviors or if abuse had occurred. Interview confirmed and verified the facility did not investigate an injury of unknow origin, did not rule out an unwitnessed fall or self-injurious behaviors, and did not implement their abuse policy and protocols as it relates to reporting to ODH. The Administrator confirmed and verified the soft file was updated as of 03/12/25, seven months after the incident, and was based on facility information, which did not include an investigation into the result of a hip fracture. The Administrator also confirmed no investigation into the need for the left foot x-ray. Interview on 03/13/25 at 11:52 A.M. with previous DON #850 revealed she was the interim DON at the time of Resident #69's fracture and floated between multiple buildings. DON #850 revealed Resident #69 did not admit to the facility with a pelvic fracture, and the facility ordered an x-ray at the request of the Resident #69's daughter due to Resident #69 complaint of pain. DON #850 revealed the facility did not initiate an SRI to investigate the cause of the injury or rule-out abuse, fall, or self-injurious behaviors. DON #850 revealed Resident #69 was up ambulating throughout the facility with soreness and based on her activity levels, she did not feel like it required further investigating. Interview on 03/13/25 at 2:37 P.M. with Attending Physician (AP) #900 revealed Resident #69 was diagnosed with a pelvic fracture after reporting pain in the right hip area. AP #900 revealed Resident #69, per the facility, did not sustain any trauma. AP #900 revealed Resident #69 could have sustained the fracture from anywhere in between a fall, sitting down too hard or changing posture and/or positions while in bed. AP #900 revealed there were many good guesses that could not be ruled out. AP #900 revealed Resident #69 did not have any investigations or documented falls or trauma that could rule out a specific reason for the fracture. Review of the incident log dated 07/31/24 to 03/10/25 revealed no documented incidents regarding Resident #69. Review of the facility policy titled Abuse, Neglect and Exploitation, reviewed 01/01/24, revealed the facility had a policy in place to develop and implement written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property including but not limited to serious bodily injury that requires medical interventions such as hospitalization . Review of the policy revealed the facility would investigate, protect the residents, and report allegations to the Administrator and state agency. Review of the document revealed the facility did not implement the policy. This deficiency represents non-compliance investigated under Master Complaint Numbers OH00162411.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42730 Based on resident record review, staff interviews, and facility policy review, the facility failed to thoroughly investigate injuries of unknown origin to the state agency for Resident #69. This affected one resident (#69) of one reviewed for abuse. The facility census was 102. Findings include: Review of the hospital paperwork for discharge date d 07/30/24 revealed Resident #69 was admitted to the hospital prior to her admission to the facility, not limited to, for risk for self-harm, suicidal behavior with attempted self-injury and dementia with other behavioral disturbance. Resident #69 was admitted due to cutting her left wrist. Review of the medical record for Resident #69 revealed she was admitted to the facility on [DATE] with diagnoses that included generalized anxiety, asthma, and dementia. Review of the progress note dated 07/31/24 at 2:45 P.M. revealed Resident #69 arrived at the facility via stretcher, oriented to room, hall, and call light. Review of the progress note dated 08/01/24 at 2:00 A.M. revealed Resident #69's gait was steady. Review of the progress note dated 08/01/24 at 2:26 A.M. revealed Resident #69 made several trips to the nurse's station concerned about her husband and starting a new life. Review of the progress note dated 08/03/24 at 11:12 A.M. revealed Resident #69 was very anxious, did not sleep, and her gait was unsteady. Review of the progress note dated 08/03/24 at 1:31 P.M. revealed Resident #69 daughter reported Resident #69 was complaining of soreness to right hip. Resident #69 daughter requested x-ray of right hip, and Resident #69 received new orders for x-ray to right hip. Review of the right hip x-ray results completed by a local portable x-ray service dated 08/03/24 revealed Resident #69 had a mildly displaced fracture of the right femoral neck. Review of the progress note dated 08/03/24 at 7:08 P.M. revealed Resident #69 daughter notified of x-ray results and sending Resident #69 to the local emergency room for further evaluation. Review of the progress note dated 08/04/24 at 12:15 A.M. revealed Resident #69 returned to the facility ambulating ad-lib. Resident #69 had no hip fracture, and a nondisplaced superior ramus fracture on the right side. Review of the progress note revealed previous x-ray results showed possible mildly displaced fracture of right femoral neck. There were no gross lytic or blastic lesions (lytic lesions, caused by bone destruction, appear as holes or areas of bone loss, while blastic lesions, characterized by new bone formation, appear as areas of increased bone density) in bones, no abnormal radiopaque foreign body, no dislocation, joint spaces are remarkable with osteopenia (lower than normal bone mineral density). (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #69 had a Brief Interview for Mental Status (BIMS) score of seven, indicating she had short and long-term cognition impairment. Resident #69 had verbal behaviors toward others, behaviors not towards others, and wandering behaviors one to three days of the assessment reference period. She required supervision or set-up with eating, oral hygiene, chair-to-bed transfer, walking ten feet, toileting hygiene, and upper body dressing. She required moderate assistance with showers/bathing, toileting transfers, lower body dressing and walking 50 feet. She required maximum assistance walking 150 feet. She was always continent of bowels and bladder. Review of the progress note dated 08/06/24 at 9:33 A.M. revealed Resident #69 complained of right hip pain, and acetaminophen (analgesic) was given for pain. Review of the progress note dated 08/06/24 at 6:15 P.M. revealed Resident #69 complained of right hip pain and had a slow steady gait. Review of the physician orders dated 08/06/24 revealed Resident #69 had an order in place to follow-up with orthopedic surgeon within three to five days and an orthopedic appointment on 08/08/24 at 1:30 P.M. Review of the physician orders dated 08/08/24 revealed Resident #69 had an order in place for weight-bearing as tolerated to the right hip. Review of the progress note dated 08/08/24 at 11:57 A.M. revealed Resident #69 had a right superior ramus fracture with pain managed effectively with pain regimen. Review of the progress note dated 08/08/24 at 5:10 P.M. revealed Resident #69 was to continue physical therapy with a walker and weight bearing as tolerated to right hip. Review of the physician progress note dated 08/13/24 at 5:31 P.M. revealed Resident #69 had a right superior ramus fracture that was confirmed with a computed tomography (CT) scan. Review of the progress note dated 08/18/24 at 6:10 P.M. revealed Resident #69 revealed she felt a bruise on the top of her left foot. Resident #69 left foot observed to have swelling on the top of foot. Resident #69 received new orders for an x-ray to left foot for pain and swelling. Review of the physician orders dated 08/18/24 revealed Resident #69 had an order in place for an x-ray of her left foot due to pain and swelling. Review of the progress note dated 08/18/24 at 7:48 P.M. revealed Resident #69 received an x-ray of left foot by a local portable x-ray service. Resident #69 left foot remained swollen and painful when ambulating. Review of the progress note dated 08/19/24 at 1:45 A.M. revealed Resident #69's x-ray results revealed no acute fracture or dislocation to the left foot. Review of the physician orders dated 08/27/24 revealed Resident #69 had an order in place for physical therapy to evaluate due to left foot pain and swelling and to ice the left foot every two hours for 15 minutes as needed for pain and/or swelling. (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the physician orders dated 08/30/24 revealed Resident #69 had an order in place for an x-ray to the left foot due to pain and swelling. Review of the physician orders dated 08/31/24 revealed Resident #69 had an order in place for an x-ray of the right hip due to pain. Interview on 03/11/25 at 2:42 P.M. with Licensed Practical Nurse (LPN) #304 revealed Resident #69 had a fracture a couple days after she first arrived at the facility. LPN #304 revealed she had not been aware of any falls and no investigation had been completed to rule out how the fracture occurred. LPN #304 revealed Resident #69 received x-rays that were negative and were treated with pain medications. LPN #304 revealed if a resident had an injury of unknown origin, she would report it right away to the Administrator or Director of Nursing (DON). LPN #304 revealed Resident #69 had a history of self-injury behaviors and could not rule out if the fracture occurred from self-injury or not. Interview on 03/11/25 at 3:24 P.M. with the DON revealed she had no knowledge of what occurred regarding Resident #69 due to not being employed at the facility during that time. Interview on 03/13/25 at 11:15 A.M. with the Administrator, DON, and Assistant Director of Nursing (ADON) #411 revealed Resident #69 did not admit to the facility with a fracture; however, after returning from the hospital it was acknowledged she had a history of osteoporosis; therefore, it was assumed the injury was a result of osteoporosis. Interview revealed initial knowledge of her diagnoses was not known and the facility did not investigate the cause of the fracture for Resident #69 who was known to have self-injurious behaviors or if abuse had occurred. Interview confirmed and verified the facility did not investigate an injury of unknow origin, did not rule out an unwitnessed fall or self-injurious behaviors, and did not implement their abuse policy and protocols as it relates to reporting to ODH. The Administrator confirmed and verified the soft file was updated as of 03/12/25, seven months after the incident, and was based on facility information, which did not include an investigation into the result of a hip fracture. The Administrator also confirmed no investigation into the need for the left foot x-ray. Interview on 03/13/25 at 10:30 A.M. with the DON revealed she located a soft file regarding Resident #69 fracture of the right superior pubic ramus. The DON confirmed and verified the information located in the soft file was true and accurate to her knowledge. Review of the soft file revealed Resident #69 was seen in the facility on 08/04/24, approximately four days after admission and three days after report of right hip pain, for initial encounter for a recent fall and pelvic fracture. Review of the soft file revealed, approximately seven months later during the week of the annual survey, an addendum was entered to reflect Resident #69 did not have a fall and the fracture was considered pathological secondary to severe osteoporosis verified after reviewing the nursing home chart with no evidence of fall or foul play. (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Interview on 03/13/25 at 11:15 A.M. with the Administrator, DON, and Assistant Director of Nursing (ADON) #411 revealed Resident #69 did not admit to the facility with a fracture; however, after returning from the hospital it was acknowledged she had a history of osteoporosis; therefore, it was assumed the injury was a result of osteoporosis. Interview revealed initial knowledge of her diagnoses was not known and the facility did not complete a self-reported incident (SRI) to investigate the cause of the fracture for Resident #69 who was known to have self-injurious behaviors or if abuse had occurred. Interview confirmed and verified the facility did not investigate an injury of unknow origin, did not rule out an unwitnessed fall or self-injurious behaviors, and did not implement their abuse policy and protocols as it relates to reporting to ODH. The Administrator confirmed and verified the soft file was updated as of 03/12/25, seven months after the incident, and was based on facility information, which did not include an investigation into the result of a hip fracture. The Administrator also confirmed no investigation into the need for the left foot x-ray. Interview on 03/13/25 at 11:52 A.M. with previous DON #850 revealed she was the interim DON at the time of Resident #69's fracture and floated between multiple buildings. DON #850 revealed Resident #69 did not admit to the facility with a pelvic fracture, and the facility ordered an x-ray at the request of the Resident #69's daughter due to Resident #69 complaint of pain. DON #850 revealed the facility did not initiate an SRI to investigate the cause of the injury or rule-out abuse, fall, or self-injurious behaviors. DON #850 revealed Resident #69 was up ambulating throughout the facility with soreness and based on her activity levels, she did not feel like it required further investigating. Interview on 03/13/25 at 2:37 P.M. with Attending Physician (AP) #900 revealed Resident #69 was diagnosed with a pelvic fracture after reporting pain in the right hip area. AP #900 revealed Resident #69, per the facility, did not sustain any trauma. AP #900 revealed Resident #69 could have sustained the fracture from anywhere in between a fall, sitting down too hard or changing posture and/or positions while in bed. AP #900 revealed there were many good guesses that could not be ruled out. AP #900 revealed Resident #69 did not have any investigations or documented falls or trauma that could rule out a specific reason for the fracture. Review of the incident log dated 07/31/24 to 03/10/25 revealed no documented incidents regarding Resident #69. Review of the facility policy titled Abuse, Neglect and Exploitation, reviewed 01/01/24, revealed the facility had a policy in place to develop and implement written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property including but not limited to serious bodily injury that requires medical interventions such as hospitalization . Review of the policy revealed the facility would investigate, protect the residents, and report allegations to the Administrator and state agency. Review of the document revealed the facility did not implement the policy. This deficiency represents non-compliance investigated under Master Complaint Numbers OH00162411.

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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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973 Based on interview, observation, record review and review of facility policy, the facility did not ensure Resident #71 had an order for the application and maintenance of his brace/splint to his left hand. This affected one resident (#71) out of one resident reviewed for use of a brace and/or splint. This had the potential to affect five additional residents (#24, #33, #39, #76, and #92) identified by the facility as having a brace and/or splint. The facility census was 102. Findings include: Review of the medical record revealed Resident #71 had an admitted [DATE] with diagnoses including paranoid schizophrenia, unspecified fracture of navicular scaphoid bone of left wrist, displaced fracture of triquetrum bone in left wrist, nondisplaced fracture of left radial process of left wrist, and diabetes. Review of Orthopedic #980's progress note (prior to admission) dated 06/17/24 revealed he was seen post op due to left scaphoid fracture that required hardware and pin placement. It was recommended that Resident #71 receive occupational therapy (OT) and a splint, but Resident #71 refused OT but agreed to a splint. There were no identified orders regarding duration of splint and/or guidelines of wearing the splint. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #71 had impaired cognition. He was independent with dressing and required set-up help for personal hygiene. Review of the nursing note dated 12/16/24 at 11:51 P.M. and completed by Licensed Practical Nurse (LPN) #390 revealed Resident #71 continued to wear a splint on the left wrist which he had on since admission and refused to remove. The physician and unit manager were notified. There was no other documentation in the nurses' notes regarding the brace/splint. Review of the care plan dated 12/24/24 revealed Resident #71 required assistance with activities of daily living (ADL) related to co-mobilities and fluctuations. Interventions included inspecting skin condition daily during personal care, report any impaired areas to nurse, assist as needed with daily hygiene, and assist with showering. There was nothing in his care plan regarding his brace/splint to his left wrist/hand and/or refusal of removal. Review of the March 2025 Physician's Orders for Resident #71 revealed there was no order for Resident #71 to have a brace/splint to his left wrist/hand. Observation on 03/10/25 at 9:21 A.M. revealed Resident #71 was wearing a brace splint on his left hand. Interview on 03/10/25 at 9:21 A.M. with Resident #71 revealed he wore the brace/splint all the time as he broke his hand. Observation on 03/11/25 at 11:35 A.M. revealed Resident #71 was lying in his bed with a brace/splint on his left hand. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365306	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madison Health Care	7600 S Ridge Rd Madison, OH 44057

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/11/25 at 12:24 P.M. with Certified Nursing Assistant (CNA) #344 revealed Resident #71 was admitted with the brace/splint to his left hand. He wore the brace all the time as he would not allow staff to remove it. She had never seen his skin integrity under his brace as he showered independently and was unsure if he took off the brace during his shower. She was not aware of what his orders were regarding the brace/splint including the duration he was to wear it. Interview on 03/11/25 at 2:09 P.M. and 03/12/25 at 7:44 A.M. with Unit Manager/LPN #315 verified Resident #71 was wearing the brace/splint to his left hand, and the facility did not have an order for the brace/splint and/or there was nothing in his care plan regarding the brace, including the refusal to remove it. She verified there was no documentation that staff were monitoring for skin breakdown, monitoring his circulation and/or any documentation regarding refusal to remove the brace except the one nursing note dated 12/16/24 at 11:51 P.M. She also verified there was no documentation the physician was aware of the brace and/or refusal to remove it, except for the one nursing note dated 12/16/24 at 11:51 P.M. She verified she did not know how the left hand appeared under the brace/splint. Observation on 03/11/25 at 4:30 P.M. revealed Resident #71 was in his room with brace/splint on his left hand. Review of the facility policy labeled, Prevention of Decline in Range of Motion, dated 10/01/22, revealed residents who enter the facility without limited range of motion would not experience a reduction of motion unless the resident's clinical conditions demonstrated that a reduction in range of motion was unavoidable. The facility would provide treatment and care in accordance with professional standards including appropriate equipment such as braces or splints. The policy revealed care plan interventions would be developed, delivered and interventions documented in the care plan including type of treatments, frequency of treatment, and measurable objectives. There was no documentation in the policy regarding ensuring a physician order was obtain for the splint and/or brace.

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	365306	A. Building B. Wing	03/13/2025

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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** 42730 Based on observations, resident record review, resident interview, staff interviews and facility policy review, the facility failed to ensure Resident #27, identified as a fall risk, had preventative measures in place to decrease the risk of a fall. This affected one resident (#27) of three residents reviewed for falls. The facility census was 102. Findings include: Review of the medical record for Resident #27 revealed she was admitted to the facility on [DATE] with diagnoses including gastroesophageal reflux disease, personality disorder, chronic obstructive pulmonary disease, and a history of repeated falls. Review of the physician order dated 07/14/24 revealed an order for Resident #27's wheelchair to have the brakes locked at all times when placed next to the bed and resident was in bed to prevent falls. Review of the physician order dated 10/20/24 revealed an order for a sign to remind Resident #27 to ring for assistance. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #27 had a Brief Interview for Mental Status (BIMS) score of four, indicating severe cognitive impairment. Resident #27 had inattention and disorganized thinking that fluctuated. Resident #27 was dependent on staff for activities of daily living (ADL). Review of resident #27's physician order dated 12/27/24 revealed an order for the left side of the bed to be against the wall with the head of the bed towards the door, and Dycem (non-slip material) applied to the chair at all times. Review of the physician order dated 01/03/25 revealed an order for Resident #27 to be placed on the secured memory care unit related to poor judgement secondary to dementia and schizoaffective disorder. Review of the care plan dated 02/14/25 revealed Resident #27 was at risk for falls and required assistance from staff for ADL with interventions that included assisting with bed mobility and transfers, keeping the call light within reach while in bed, nonskid socks when shoes were not worn, and the wheelchair was to be at the bedside with the brakes locked while in bed. Review of the physician order dated 02/24/25 revealed an order to not leave Resident #27 in her room unattended while in the wheelchair. Observation and interview on 03/10/25 at 9:53 A.M. located on the secured memory care unit, Resident #27 was lying in bed yelling out for help. Resident #27 revealed she wanted to get out of bed and needed something to drink. Resident #27's call light was observed at the end of the bed and out of reach. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365306	A. Building B. Wing	03/13/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 03/10/25 at 9:55 A.M. with Certified Nurse Assistant (CNA) #349 verified Resident #27's wheelchair was not in the room, and her call light was out of reach. Interview on 03/11/25 at 2:42 P.M. with Licensed Practical Nurse (LPN) #304 revealed Resident #27 was a fall risk due to her history of falls. LPN #304 revealed Resident #27 had fall interventions in place that included bolster mattress, Dycem applied to her wheelchair, call light within reach at all times, non-skid socks on when not wearing shoes, and wheelchair with the brakes locked at the bedside while the resident was in bed. LPN #304 stated that Resident #27 had falls on 04/28/24, 05/22/24, 09/25/24, and 02/21/25. LPN #304 revealed Resident #27 was at a high risk for falls. Observation and interview on 03/11/25 at 3:00 P.M. revealed Resident #27 lying in bed yelling out for help. Resident #27's wheelchair was not in the room, her call light was not in reach, and she was not wearing non-skid socks while in bed. Resident #27 revealed she wanted to get out of bed and needed something to drink. Interview and observation on 03/11/25 at 3:03 P.M. with LPN #304 verified Resident #27 was lying in bed, yelling out for staff with the call light out of reach, the wheelchair not at the bedside and non-skid socks not in place. LPN #304 stated that she did not know where Resident #27's wheelchair was. Observation on 03/11/25 from 3:03 P.M. to 3:06 P.M. revealed LPN #304, and CNAs #350 and #421 walking up and down the unit hallway looking into other residents' rooms and alternative spaces attempting to locate Resident #27's wheelchair. Observation revealed Resident #27's wheelchair was found located inside the shower room. Review of the facility document titled Fall Prevention and Management Policy, revised 01/08/25, revealed the facility had a policy in place that each resident would be assessed for fall risk and if risk were identified preventive measures would be put in place. Review of the of the document revealed the facility did not implement the policy.

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	365306	A. Building B. Wing	03/13/2025

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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** 51526 Based on record review, observations, staff interviews and facility policy review, the facility failed to assess Resident #89 for oxygen titration and failed to ensure oxygen was administered with high flow oxygen tubing. Also, the facility did not ensure Residents #7 and #81 had proper signage indicating oxygen in use on the entrance to their rooms. This affected three residents (#7, #81, and #89) out of four residents reviewed for oxygen use. This had the potential to affect 22 additional residents (#24, #30, #36, #39, #46, #47, #50, #51, #52, #53, #56, #59, #60, #76, #80, #82, #88, #91, #93, #95, #156, and #254) identified by the facility with oxygen. The facility census was 102. Findings include: 1. Review of the medical record revealed Resident #89 was admitted to the facility on [DATE] with diagnoses including dementia with behavioral disturbances, acute respiratory failure with hypoxia (low oxygen levels), amnesia (loss of memory), and aphasia (disorder which affects the ability to communicate). The resident was receiving Hospice care. Review of the medical record revealed Resident #89 had a physician's order dated 10/09/24 for oxygen (O2) to be administered at two to ten liters/minute per nasal cannula (NC) every shift to maintain pulse oximetry. There were no parameters in the order for titration of flow rate or the percentage of oxygenation to be maintained. Record review of vital signs in the O2 Sats Summary Report show the last entered value was on 02/24/25 at 10:49 P.M. with a 96.0% value. No documentation of what the oxygen flow rate was at the time. Review of the treatment administration records (TAR) and nursing progress notes for Resident #89 indicated no evidence the facility assessed the resident's O2 saturation from 02/27/25 through 03/12/25 to determine the resident's O2 saturation percentage and need for the administration of O2 or its effectiveness. On 03/11/25 at 9:11 A.M. Resident #89 was observed in bed in his room sleeping. The oxygen concentrator was on and set to a flow rate of nine liters/minute with humidity, but the nasal cannula (oxygen tubing) was not a high flow nasal cannula and was tucked underneath the resident and not positioned in his nose. On 03/11/25 at 9:12 A.M. Resident #89 was observed in bed and turned slightly to the left side. The resident was still not wearing the nasal cannula in his nose as the cannula was tucked to the side. The observation was verified by Licensed Practical Nurse (LPN) #384 at 9:15 A.M. Interview with LPN #384 on 03/11/25 at 9:12 A.M. stated the resident typically removes his oxygen and will refuse it at times. LPN #384 verified the oxygen tubing was not dated but was unsure if the tubing was a high flow nasal cannula (high flow nasal cannula allows a reduction of airway resistance, improved breathing and oxygenation when flow rates are greater than five liters/minute). Higher oxygen flow rates require humidity and a larger delivery system. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365306	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madison Health Care	7600 S Ridge Rd Madison, OH 44057

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/11/25 at 9:20 A.M. with Nurse Manager #391 verified the oxygen delivery system was not high flow but a regular nasal cannula. Nurse Manager #391 proceeded to procure a green high flow nasal cannula system and switched it out. The oxygen was then placed on Resident #89 for use. Review of the undated facility policy: Oxygen Administration stated staff shall document the initial and ongoing assessment of the resident's condition warranting oxygen and the response to oxygen therapy. Additionally, the resident's care plan shall identify the interventions for oxygen therapy, based upon the resident's assessment and orders, such as, but not limited to: The type of oxygen delivery system When to administer, such as continuous or intermittent and/or when to discontinue Equipment setting for the prescribed flow rates Monitoring of SpO2 (oxygen saturation) levels and/or vitals as ordered Monitoring for complications associated with the use of oxygen 39973 2. Review of the medical record for Resident #7 revealed an admitted [DATE] with diagnoses including morbid obesity, intellectual disability, heart failure, and respiratory failure. Review of the care plan dated 09/04/24 revealed Resident #7 had potential for complications related to obstructive sleep apnea and asthma. Intervention included assessment for difficulty in breathing, elevating head of bed, and assistance in transferring the resident to ensure oxygen concentrator was brought to the room. There was nothing regarding signage to be maintained on the outside of the door indicating oxygen in use. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #7 had intact cognition and was on oxygen. Review of the March 2025 Physician Orders revealed Resident #7 had an order for continuous oxygen at two to three liters per minute to maintain oxygen saturation of 89 percent. Observation on 03/10/25 at 9:34 A.M. revealed Resident #7 had an oxygen concentrator with oxygen at two liters per minute per nasal cannula. There was no oxygen signage on the outside of his room indicating oxygen was in use. Observation and interview on 03/10/25 at 10:04 A.M. with the Administrator and Unit Manager/LPN #315 verified there was no oxygen signage on the outside of Resident #7's room indicating that the resident had oxygen in use. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365306	A. Building B. Wing	03/13/2025

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the undated facility policy labeled, Oxygen Administration revealed oxygen was to be administered in consistent professional standard including oxygen warning signs placed on the door of the resident's room where oxygen was in use. 3. Review of the medical record for Resident #81 revealed an admitted [DATE] with diagnoses including chronic obstructive pulmonary disease, diabetes, heart failure, and chronic respiratory failure with hypoxia. Review of the Medicare five-day MDS assessment dated [DATE] revealed Resident #81 had impaired cognition and was on oxygen. Review of the care plan dated 02/06/25 revealed Resident #81 had an alteration in cardiac output related to heart failure and hypertension. Interventions included administering oxygen as ordered by the physician. There was nothing regarding signage to be maintained on the outside of the door indicating oxygen in use. Review of the March 2025 Physician Orders revealed Resident #81 had an order for oxygen at two liters per minute continuously per nasal cannula to maintain oxygen saturation level of 93 percent or above. Observation on 03/10/25 at 9:06 A.M. revealed Resident #81 had an oxygen concentrator with oxygen at two liters per minute per nasal cannula. There was no oxygen signage on the outside of his room indicating oxygen was in use. Observation and interview on 03/10/25 at 10:04 A.M. with the Administrator and Unit Manager/LPN #315 verified there was no oxygen signage on the outside of Resident #81's room indicating that the resident had oxygen in use. Review of the undated facility policy labeled, Oxygen Administration revealed oxygen was to be administered in consistent professional standard including oxygen warning signs placed on the door of the resident's room where oxygen was in use.

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	365306	A. Building B. Wing	03/13/2025

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973 Based on record review, observation, interview and review of the facility policy, the facility failed to ensure Resident #95 was free of significant medication error. This affected one resident (#95) out of four residents observed for medication administration. The facility census was 102. Findings included: Review of the medical record for Resident #95 revealed an admitted [DATE] with diagnoses including chronic obstructive pulmonary disease, dysphagia, hypertension, and acute respiratory failure with hypoxia. Review of the care plan dated 10/22/24 revealed Resident #95 was at risk for alterations in nutrition as he was to have nothing by mouth. He was receiving all his nutrition through a percutaneous endoscopic gastrostomy (PEG) tube (a tube inserted through the abdominal wall into the stomach to provide nutrition, medications, and hydration). Interventions included medications per physician order and provide tube feeding as ordered to meet nutrition and hydration needs. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #95 had impaired cognition and a PEG tube. Review of the March 2025 physician orders revealed Resident #95 had the following orders: aspirin 81 milligram (mg) tablet (blood thinner) per PEG tube due to atrial fibrillation, guaifenesin 600 mg tablet (cough medicine) per PEG tube for excess mucous, Plavix 75 mg tablet (antiplatelet) per PEG tube for blood clot, Pro-Stat oral liquid 30 milliliter (ml) (liquid protein supplement) per PEG tube as a nutritional supplement, Seroquel 25 mg tablet (antipsychotic) per PEG tube for agitation, sennosides oral tablet 8.6 mg (stimulant laxative) per PEG tube for constipation, thiamine 100 mg oral tablet (water-soluble B vitamin) per PEG tube for supplement, apixaban 5 mg tablet (anticoagulant) per PEG tube for cerebral infarction due to blood clot, and ascorbic acid 1000 mg tablet (vitamin C) per PEG tube as a supplement. There was no order to crush all the medications together and give them all at once (cocktailing). Observation on 03/11/25 at 9:07 A.M. of Licensed Practical Nurse (LPN) #306 administering Resident #95's medications through his PEG tube revealed she placed the following medications inside a cup: aspirin 81 mg, Plavix 75 mg, apixaban 5 mg, sennosides 8.6 mg, Seroquel 25mg, thiamine 100 mg, and ascorbic acid 1000 mg. She proceeded to take 600 mg guaifenesin (25 milliliters) and mixed with Pro-Stat 30 ml in a cup. Then, she took all the tablets and crushed them together and mixed the medications in the same cup that the guaifenesin and Pro-Stat were in. She proceeded into Resident #95's room, flushed the PEG tube with water then administered all the combined medications in the cup at once into the PEG tube and then flushed the PEG tube with water. Interview on 03/11/25 at 9:38 A.M. and 1:15 P.M. with LPN #306 verified that there was no order to cocktail or mix all the medications together and administer all at the same time. She stated that she had thought there was an order and was unaware if it was reviewed with the physician regarding potential side effects/interactions if the medications were administered together. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365306	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madison Health Care	7600 S Ridge Rd Madison, OH 44057

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/11/25 at 3:31 P.M. with the Director of Nursing (DON) verified Resident #95 did not have a physician order to cocktail or to mix all his medications together and administer at the same time. She stated she was not aware the nurses were cocktailing Resident #95's medications when they administered through the PEG tube. She was always taught that medications were never to be crushed and mixed together due to the potential of medications having interactions when combined. She verified the nurses should be giving each medication separately and flushing between each medication to ensure no interactions. The facility did not have a policy regarding medications through a PEG tube including cocktailing and/or mixing of medications together and administering at the same time. Review of the facility policy labeled, Medication Administration, dated 08/22/22, revealed medications were administered by licensed nurses as ordered by the physician in accordance with professional standards of practice. There was nothing in the policy regarding administering medications through a PEG tube. Review of the facility policy labeled, Care and Treatment of Feeding Tubes, dated 06/01/24, extent the facility was to utilize feeding tubes in accordance with current clinical standards with interventions to prevent complications to the extent as possible. The feeding tube would be utilized in accordance with physician orders. There was nothing in the policy regarding the administration of medications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365306	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. 37097 Based on observation and staff interview, the facility failed to maintain its dumpster area in a clean and sanitary manner. This had the potential to affect all 102 residents residing in the facility. Findings include: Observation of the facilities dumpster area on 03/10/25 at 8:35 A.M. revealed two dumpster lids were not closed on one of two dumpsters. The top lid was open, and the side door was open with cardboard boxes hanging out the side. Interview at the time of the observation with Dietary Manager #381 verified the condition of the dumpsters at the time of observation.

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	365306	A. Building B. Wing	03/13/2025

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F 0917 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure each resident has 1) at least one window to the outside in a room; 2) a room at or above ground level; 3) adequate bedding; 4) furniture that meets the resident's needs; or 5) adequate closet space. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973 Based on record review, observation, interview and review of the facility policy, the facility failed to have an individual designated closet space in the resident's bedroom which affected three residents (#17, #18, and #81) out of three residents reviewed for adequate closet space and had the potential to affect three additional residents (#2, #3, and #67) identified by the facility as sharing closet space with Residents #17, #18, and #81. The facility census was 102. Findings include: 1. Review of the medical record for Resident #17 revealed an admitted [DATE] with diagnoses including bipolar disorder, paranoid personality disorder, and schizophrenia. Review of the care plan dated 02/20/20 revealed Resident #17 was independent or required set-up with his activities of daily living (ADL). Interventions included assistance in choosing appropriate clothing as needed, encouraging and allowing the resident to complete self-care as able, and set-up assistance with dressing and personal hygiene. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #17 had impaired cognition. He required set-up assistance with dressing and personal hygiene. Interview on 03/10/25 at 9:16 A.M. with Resident #17 revealed he did not like that his roommate (Resident #18) wore his clothes. He revealed Resident #18 takes them out of the closet and does not even look whose clothing it was. He revealed there was only one closet that all three residents (#2, #17, and #18) shared and that the closet did not have dividers. He revealed the facility just hung all three residents' clothing up in the closet randomly, and they were supposed to go by the label inside the clothing, but Resident #18 never looked at the labels. Observation on 03/10/25 at 9:16 A.M. revealed there was one small closet in Resident #17's room that was shared by three residents (#2, #17, and #18). There was clothing hanging in the closet, but there were no dividers inside the closet indicating which space or clothing was designated for each resident. 2. Review of the medical record for Resident #18 revealed an admitted [DATE] with diagnoses including major depression, anxiety disorder, schizoaffective disorder, and bipolar disorder. Review of the care plan dated 03/10/23 revealed Resident #18 needed assistance with ADL due to cognitive impairment, schizoaffective disorder, and fluctuations were expected. Interventions included supervision and oversight including verbal cues or encouragement with dressing, hygiene, grooming, observing changes in ADL ability, and adjusting assistance as needed. Review of the quarterly MDS assessment dated [DATE] revealed Resident #18 had impaired cognition. He required set-up assistance with personal hygiene and dressing. He was independent with ambulation and transfers. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365306	A. Building B. Wing	03/13/2025

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F 0917 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 03/10/25 at 9:20 A.M. with Resident #18 revealed he goes over to the closet and grabs whichever clothing there was in the closet. He verified that sometimes he may have worn his roommate's clothing as he did not know which clothing was his. He verified there were no dividers in the closet indicating which clothing was his. 3. Review of the medical record for Resident #81 revealed an admitted [DATE] with diagnoses including adjustment disorder with mixed anxiety, major depression, and psychosis. Review of the Medicare five-day MDS assessment dated [DATE] revealed Resident #81 had impaired cognition. He required maximum assistance with dressing. Review of the care plan dated 02/06/25 revealed Resident #81 required assistance with ADL due to cognitive impairment, and cerebral infarction with hemiplegia and hemiparesis affecting the left non-dominant side. Interventions included assisting in choosing appropriate clothing as needed, and he wass dependent on staff for personal hygiene and dressing. Interview on 03/10/25 at 9:06 A.M. with Resident #81 revealed there was only one closet for three residents in his room. He stated, look at that small space to put clothes in. He revealed that there was no divider in the closet to identify which portion of the closet was his. He revealed he did not put anything in the closet as it was too small as was on his roommate's side of the room and he did not like to go on that side. Observation and interview on 03/10/25 at 10:04 A.M. with the Administrator and Unit Manager/Licensed Practical Nurse (LPN) #315 verified all three Residents (#2, #17, and #18) shared the closet in their room and all three Residents (#3, #67 and #81) shared the closet in their room. They verified there was no private designated divider for each resident in the closet. Interview on 03/12/25 at 4:50 P.M. with the Administrator verified there was no separate closet and/or divider in the closets, and she could understand how a resident would have a hard time determining which clothing was theirs. Review of the facility policy labeled, Resident Environmental Quality, dated 11/29/22, revealed the facility would maintain a safe, functional and comfortable environment for residents. The facility must provide each resident with functional furniture appropriate to the residents' needs and a private closet space in the resident's bedroom with clothing racks and shelves accessible to the resident.

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	365306	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madison Health Care	7600 S Ridge Rd Madison, OH 44057

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973 Based on observation, interview, review of housekeeping staffing schedules, documentation of room cleanings and facility policy review, the facility did not ensure the environment was maintained in a safe, sanitary and comfortable manner affecting 31 Residents (#1, #2, #3, #5, #7, #8, #11, #17, #18, #20, #21, #22, #23, #24, #27, #34, #37, #38, #40, #46, #56, #58, #60, #64, #66, #67, #71, #73, #81, #92, and #156) out of 102 residents observed for environment. Also, the facility had a dark unlit parking lot that had the potential to affect all 102 residents residing in the facility. Findings include: 1. Observations on the initial tour on 03/10/25 from 9:05 A.M. to 10:04 A.M. of the secured units (400 and 500 units) revealed the following findings: In Residents #1, #7, and #21's room, there were cobwebs in the corners of the ceiling extending down the wall that contained multiple insects inside the webs that were above Resident #1's and Resident #21's beds. The windowsill next to Residents #21's bed appeared to be rotting as it was moist, discolored and falling apart. Under the windowsill, the water appeared to be leaking into the wall as the plaster on the wall was also coming loose and had dark circular water discolorations. This affected Resident #1, #7, and #21 residing in the room. In Residents #60 and #5's room, there were cobwebs in all corners of the room and along the window side of the room extending down the wall that contained multiple insects inside the webs. The windowsill next to Resident #60's bed appeared to be rotting as it was moist, discolored and falling apart. The door tread entering the room had an accumulation of black substance along the tread. There was a brown, yellow dried stained substance that was sticky on the wall alongside of Resident #5's low bed. This affected Residents #5 and #60 residing in the room. In the bathroom that adjoined Residents #1, #5, #7, #21 and #60's rooms, there was a thick, dark brown substance around the toilet, and the bathroom floor had an accumulation of yellow, brown substance covering the floor that was sticky to walk on. This affected Residents #1, #5, #7, #21 and #60 who utilized the bathroom. In Residents #20 and #71's room, there was a fan inside the wall that had a layer of dust covering the vent. This affected Residents #20 and #71. In Residents #2, #17, and #18's room, there was a circular hole in the wall approximately six inches in diameter that was covered with blue strips of thin masking tape. The masking tape also had a hole through the center. The light fixture which covered the length of the room had an accumulation of over 50 dead insects in the light cover. The floor was covered with dirt substances: dried yellow, brown, and dark brown markings, especially the length of the door tread. This affected Residents #2, #17, and #18. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In the bathroom that adjoined Residents #2, #17, #18, #20, and #71's rooms, there was a black substance on the tile surrounding the toilet. There were splatters of yellow, brown substance covering the walls. The floor had a sticky substance with a strong urine odor which also had an accumulation of yellow, brown substances. This affected Residents #2, #17, #18, #20, and#71 who utilized this bathroom. In the bathroom that adjoined Residents #3, #58, #67, and #81's rooms, the door frame was rusted from the bottom of the floor halfway up. This affected Residents #3, #58, #67, and #81 who utilized this bathroom. In Residents #22 and #37's room, there were cobwebs all throughout the ceiling extending down the walls. This affected Residents #22, and #37. Observation and interview on 03/10/25 at 10:04 A.M. the Administrator and Unit Manager/Licensed Practical Nurse (LPN) #315 completed a walk through with the surveyor and verified the above findings. The Administrator revealed the facility had been without a housekeeping supervisor and currently Human Resources Manager (HRM) #325 was overseeing the housekeeping department. Interview on 03/10/25 at 10:28 A.M. and 5:10 P.M. with HRM #325 verified the facility has been without a housekeeping supervisor since 12/12/24 (almost three months). She revealed the facility was short on housekeepers and most likely all the job duties were not getting completed including the deep cleaning of resident's rooms. She revealed there were to be three to four housekeepers per day but for the last few months, they had one to two housekeepers per day. She verified there were three deep cleanings assigned per day as all rooms were to be completed at least once a month. She verified the Housekeeping Staffing Schedule from 12/01/24 to 03/10/25 had 37 days with one to two housekeepers. Observation on 03/11/25 at 11:31 A.M. of Maintenance Assistant #416 revealed he was removing the windowsill from room [ROOM NUMBER]. He verified the windowsill was made of pressed wood that was moist and stated it was dry rotting all the way through as it was falling apart crumbling as he removed it. He revealed yes the leak has most likely been sometime but not sure what it was from. Interview on 03/11/25 at 2:01 P.M. with Director of Maintenance #370 verified in the bathroom that adjoined Residents #2, #17, #18, #20, and #71's rooms had black substances on the tile surrounding the toilet, and the bathroom that adjoined Residents #1, #5, #7, #21 and #60's rooms there was a thick dark brown substance around the toilet. He verified there was rust on the door frame in the bathroom that adjoined Residents #3, #58, #67, and #81's rooms. He revealed it needed to be sanded down and repainted. Interview on 03/11/25 at 4:51 P.M. with Housekeeping #335 revealed lately there were usually three housekeepers, but they did go through a period when they only had two housekeepers per day. He revealed on these days they usually split the 400-500 units, and it was difficult to get the deep cleaning done. He verified there were days that the deep cleanings were not completed. Interview on 03/13/25 at 4:07 P.M. with Director of Maintenance #370 revealed there was no set schedule for cleaning the light fixtures, but if the staff let maintenance know they were dirty, they cleaned them. He had not been notified that Residents #2, #17, and #18's room had multiple dead insects in the light fixture until 03/10/24. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Housekeeping Staffing Schedule from 12/01/24 to 03/10/25 revealed the following days had only one housekeeper: 12/01/24, 12/19/24, 01/13/25, 01/14/25, and 01/27/25. The following days had two housekeepers: 12/03/24, 12/07/24, 12/08/24, 12/12/24, 12/15/24, 12/17/24, 12/20/24, 12/22/24, 12/24/24, 12/26/24, 12/28/24, 12/29/24, 12/31/24, 01/04/25, 01/05/25, 01/09/25, 01/17/25, 01/18/25, 01/20/25, 01/21/25, 01/23/25, 01/24/25, 01/26.25, 01/28/25, 02/09/25, 02/10/25, 02/11/25, 02/13/25, 02/22/25, 02/23/25, 03/08/25, and 03/09/25. Review of the Resident Deep Clean Checkoff List from 01/01/25 to 03/10/25 revealed room [ROOM NUMBER] had a deep clean on 01/06/25 but there was no other documented evidence indicating it had a deep clean for two months. room [ROOM NUMBER] had a deep clean on 01/08/25 but there was no other documented evidence indicating it had a deep cleaning for two months. room [ROOM NUMBER] had a deep clean on 01/15/25 but there was no other documented evidence indicating it had a deep clean for two months. room [ROOM NUMBER] had no documented evidence that a deep clean was completed from 01/01/25 to 03/10/25. Review of the undated Resident Deep Clean Checkoff List revealed the following areas were to be checked off when completed: clean ceilings, vents, and light fixtures, clean windowsills and inside windows, clean and wipe down all walls, clean and wipe down door frames, clean and disinfect the toilet, and clean and wipe down baseboards/ edges (use scrapper to remove dirt in corners). 2. Observation on 03/11/25 at 10:30 A.M. of the main dining room on the first floor revealed one ceiling tile was removed, and the ceiling was actively leaking a watery substance into a brown pale. The surrounding ceiling tiles had circular water stains. Interview on 03/11/25 at 2:01 P.M. with Director of Maintenance #370 verified the main dining room had been leaking for two days or so, and at this time he was unsure where the leak was coming from. Observation on 03/13/25 at 11:20 A.M. of the main dining room on the first floor revealed one ceiling tile removed, and the ceiling continued to actively leak a watery substance into a brown pale. Interview on 03/13/25 at 12:05 P.M. with the Administrator verified the continued leak in the main dining room and revealed she was not sure why it was still leaking. Interview on 03/13/25 at 12:16 P.M. verified with Assistant Director of Nursing (ADON)/LPN #411 that the following 13 Residents (#8, #11, #23, #24, #34, #38, #40, #46, #56, #66, #73, #92, #156) came to the main dining room. She verified that currently the residents were eating in the main dining room with the ceiling actively leaking. Review of the facility policy labeled, Resident Environmental Quality, dated 11/29/22, revealed the facility would be maintained to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. The policy revealed preventative maintenance schedules for the maintenance of the building and equipment should be followed to maintain a safe environment. There was nothing in the policy regarding deep cleans of resident's rooms ensuring cobwebs removed, floors including door threads cleaned, bathroom maintained in clean manner, and cleaning of light fixtures. 42730 (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. Observation on 03/10/25 at 9:14 A.M. of Residents #27 and #64's room revealed a fist-sized hole in the bathroom door and Resident #27's privacy curtain had multiple red-brownish colored stains in various sizes and locations. Residents #27 and #64's bathroom had various unidentified stains on the floor, and the trashcan was overflowing with white and brown paper-like material. Interview and observation on 03/10/25 at 9:16 A.M. with LPN #359 revealed she had never observed residents' privacy curtains being removed and cleaned. LPN #359 revealed she had not noticed the stained privacy curtain, the bathroom condition, or the hole in the bathroom door. LPN #359 verified the above findings at the time of the observation. 4. Observation on 03/12/25 at 7:05 A.M. located in the [NAME] parking lot, revealed the parking lot was poorly lit. Observation revealed no perimeter lighting, light poles or lamp posts to provide illumination. Interview on 03/12/25 at 4:25 P.M. with the Administrator revealed there were no current grievances related to the parking lot lighting. She received a complaint related to the parking lot lighting due to an ambulance knocking down the light pole. The facility was currently still obtaining quotes for repair. The parking lot light pole was broken approximately three months ago. The facility was working with multiple companies to get quotes, and as soon as the facility received a quote, the repairs would be completed. She was unaware of the progress regarding the quotes and parking lot repair timeline. The Administrator verified the condition of the parking lot, a broken light pole and delay in repairs. Interview on 03/13/25 at 1:30 P.M. with Maintenance Director (MD) #370 revealed the lamp post designated for the [NAME] parking lot had been broken for approximately three months. The facility was still waiting for quotes from selected vendors to repair the lamp post. There had not been any quotes completed as of 03/13/25. MD #370 revealed he was not aware of how the lamp post was broken. Follow-up interview on 03/13/25 at 4:10 P.M. with MD #370 also revealed the parking lot had poor lighting due to no lighting around the perimeter of the [NAME] parking lot in addition to the broken lamp post. He was still waiting for a list of approved vendors to contact in order to start the process of repairing the broken lamp post and adding additional lighting to the [NAME] parking lot. All repairs had to be approved through the Regional Maintenance Manager (RMM) #901. MD #370 verified the parking lot did not have any lighting, and repairs had not been completed, approximately three months later. Review of the facility email correspondence dated 03/13/25 at 1:35 P.M. from RMM #901 revealed the facility was still in the process of receiving quotes for the repair of the parking lot lights. Review of the email revealed a commercial vehicle knocked down one of the main light poles causing multiple lights on the [NAME] parking lot to be inoperable. This deficiency represents non-compliance investigated under Master Complaint Number OH00162411. 51526