

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365322	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2025
NAME OF PROVIDER OR SUPPLIER Maria Joseph Living Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4830 Salem Avenue Dayton, OH 45416	

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)
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to ensure accurate documentation of medication administration. This affected one (#10) out of three residents reviewed for medication administration. The facility census was 245. Findings include: Review of medical record for Resident #10 revealed admission date of 05/22/25. The resident was admitted with diagnoses including end stage renal disease, type two diabetes mellitus, depression and hypertension. The resident was hospitalized on [DATE] and did not return. The admission Minimum Data Set (MDS) dated [DATE] revealed he had a Brief Interview Mental Status (BIMS) score of 15 indicating intact cognition. He required supervision for eating, extensive two-person assistance for bed mobility, toileting and dependence for transfers. Review of the physician orders revealed an order for Coreg (blood pressure) 6.25 milligrams (mg) one tablet twice daily. Hold for Systolic Blood Pressure (SBP) less than 110 millimeters of mercury (mm Hg). Review of the June Medication Administration Record (MAR) revealed on 06/28/25 at 9:00 the blood pressure was SBP was documented as 96 mm HG. The medication was signed as given. Review of the July MAR revealed on 07/06/25 the 9:00 A.M. SBP was 100 mm Hg and on 07/12/25 the 9:00 A.M. SBP was 96. Each day the medication was documented as given. Interview on 09/11/25 at 12:30 P.M. with Registered Nurse (RN) #22 revealed she was Resident #10's nurse on 06/28/25, 07/06/25 and 07/12/25. RN #22 stated she did not give the Coreg as the MAR indicated. RN #22 explained she believed because she documented the blood pressure was outside of the parameters, it meant she did not give it. RN #22 denied knowledge electronic charting offered a code to indicate a medication was outside of parameters, or to see the nurses' notes. Interview on 09/11/25 at 1:17 P.M. with the Director of Nursing acknowledged Resident #10's MAR documentation on 06/28/25, 07/06/25 and 07/12/25 did not reflect the medication had been held per parameters. This deficiency is based on incidental findings discovered during the course of this complaint investigation.</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation and staff interview, the facility failed to ensure infection control measures were followed during incontinence care. This affected (#11) out of three residents reviewed for infection control. The facility census was 245. Findings include: Review of medical record for Resident #11 revealed admission date of 04/08/25. The resident was admitted with diagnoses including end stage renal disease, diabetes mellitus, depression, gout, and anxiety. The significant change Minimum Data Set (MDS) dated [DATE] revealed he had a Brief Interview Mental Status (BIMS) score of 13 indicating intact cognition. He required supervision with eating, maximum assistance with dependent for toileting hygiene, bed mobility and transfers. Observation on 09/08/25 at 3:52 P.M. revealed Certified Nursing Assistant (CNA) #31 was assisted by CNA #10 in providing incontinence care for Resident #11. Both CNA's donned Personal Protective Equipment (PPE) for enhanced barrier precautions without concern. CNA #31 was observed to perform thorough peri care using two washcloths, one soapy to cleanse and the other wet to rinse. When peri care was completed, CNA #31 placed both soiled wash clothes on the bedside table and used a towel to pat dry and place it on the bed. CNA #10 assisted CNA #31 to place a clean incontinent product, redress and reposition Resident #11. CNA #31 removed the soiled washcloths and entered Resident #11's restroom without disinfecting Resident #11's bedside table. CNA #31 returned with soiled items in a clear plastic bag having doffed her PPE and washed her hands. Interview on 09/08/25 at 4:09 P.M. directly following observed incontinence care for Resident #11, CNA #31 verified she place soiled wash clothes on the bedside table and stated she should have brought a bag with her to place the soiled items at bedside. CNA #31 acknowledged placing the soiled washcloths on the bedside table presented an infection control concern. This deficiency is based on incidental findings discovered during the course of this complaint investigation.</p>