| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365330 | A. Building<br>B. Wing | 05/28/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Ayden Healthcare of Wauseon | 303 W Leggett St<br>Wauseon, OH 43567 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>Based on observation, staff interview, and review of facility policy the facility failed to ensure residents were treated with dignity and respect when a facility staff used profanity. This affected six (#7, #14, #16, #26, #41, and #43) of six residents identified to be in the common area. The facility census was 47.Findings include:Observation on 05/27/26 at 6:28 A.M. revealed Certified Nursing Assistant (CNA) #335 at the nurses' station visually reviewing a piece of paper. CNA #335 stated in a loud tone, I get that she is new, but you are not going to [explicative] me over. Further observation revealed Residents #7, #14, #16, #26, #41, and #43 were in the common area located approximately 10 feet from the nurses' station and within hearing distance. Interview on 05/27/26 at 6:30 A.M. with CNA #335 verified using profanity in front of the residents. Review of the facility provided document titled, Resident Rights, dated 10/03/23, revealed resident's had the right to be treated at all times with courtesy, respect, and full recognition of dignity and individuality. This was an incidental finding discovered during the complaint investigation. |

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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|---|---|
| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Allow residents to self-administer drugs if determined clinically appropriate.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, resident interview, staff interview and review of facility policy, the facility failed to ensure medication self-administration evaluations were completed. This affected one (#19) of one resident reviewed for medication self-administration. The facility census was 47. Findings include:Review of the medical record revealed Resident #19 was admitted on [DATE]. Diagnoses included hypocalcemia, Type II diabetes mellitus, anxiety disorder, depression, hypothyroidism, adjustment disorder with mixed anxiety and depressed mood, paranoid personality disorder, malignant neoplasm of thyroid gland, and mild neurocognitive disorder due to known physiological condition without behavioral disturbance. Review of the Minimum Data Set (MDS) assessment, dated 05/08/26, revealed the resident was cognitively intact. Further review of Resident #19's medical record revealed no evidence a self-administration assessment was completed for the resident to safely self-administer medications or a physician's order was in place for the self-administration of medications.Review of the Medication Administration Review (MAR) for May 2026 revealed Resident #19 received the following morning medications on 05/27/26: cranberry (herbal) oral tablet; cyanocobalamin (vitamin) tablet 500 microgram (mcg); desvenlafaxine succinate ER (antidepressant) oral tablet extended release 24 hour 100 milligram (mg); folic acid (vitamin) tablet one mg; Jardiance (antidiabetic) 25 mg; levothyroxine sodium (thyroid product) oral tablet 200 mcg; levothyroxine sodium oral tablet 50 mcg; montelukast sodium oral tablet 10 mg; prempro (estrogen) oral tablet 0.3-1.5 mg; rosuvastatin calcium (lipid lowering agent) oral tablet 10 mg; vitamin A (supplement) oral tablet 3000 mcg; zinc (supplement) 50 mg; buspirone (anti-anxiety) tablet five mg; calcitriol capsule (supplement) 0.5 mcg two tablets; doxycycline hyclate (tetracycline) 100 mg; calcium acetate tablet 667 mg give three tablets; calcium citrate 1200 mg; renvela 800 mg; Tylenol 325 mg give two tablets; and magnesium oxide (supplement) 400 mg. Observation on 05/27/26 at 9:45 A.M. revealed a medication cup, approximately half full of medications, was on Resident #19's bedside table. Nursing staff were not present in the room. Interview on 05/27/26 at 9:49 A.M. with Therapy #365 verified Resident #19 had unattended medications at bedside. Interview on 05/27/26 at 9:50 A.M. with Resident #19 revealed the nurses left her medications at bedside because she liked to spread them out. Interview on 05/27/26 at 10:06 A.M. with Licensed Practical Nurse (LPN) #360 verified leaving Resident #19's medications unattended at the bedside. Interview on 05/27/26 10:51 A.M. with the Director of Nursing (DON) verified Resident #19 was not assessed to self-administer medications and did not have a physician's order in place to self-administer mediations. The DON stated Resident #19 would be appropriate to self-administer medication. Review of the facility policy titled, Administering Medication, revised December 2012, revealed resident may self-administer their own medications only if the attending physician, in conjunction with the Interdisciplinary Care Planning Team, determined that they had the decision-making capacity to do so safely. This deficiency was an incidental finding discovered during the complaint investigation. |

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| | 365330 | A. Building<br>B. Wing | 05/28/2026 |

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| Ayden Healthcare of Wauseon | 303 W Leggett St<br>Wauseon, OH 43567 |

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|---|---|
| F 0561<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, resident interview, staff interview and review of facility policy, the facility failed to ensure resident's choices were honored. This affected one (#19) of three residents reviewed for choices. The facility census was 47.Findings include:Review of the medical record revealed Resident #19 was admitted on [DATE]. Diagnoses included hypocalcemia, Type II diabetes mellitus, anxiety disorder, depression, hypothyroidism, adjustment disorder with mixed anxiety and depressed mood, paranoid personality disorder, malignant neoplasm of thyroid gland, and mild neurocognitive disorder due to known physiological condition without behavioral disturbance. Review of the Minimum Data Set (MDS) assessment, dated 05/08/26, revealed the resident was cognitively intact. Review of Resident #19's written documentation, dated 3/30/26, revealed the staff pulled her curtain open and used the roommate's trash can to prop open the door. Resident #19 documented propping the door open let in a great amount of light and the nighttime staff were not not letting her sleep. Review of Resident #19's written documentation, dated 04/08/26, revealed nighttime staff used the trash can to prop the door open, preventing the resident from sleeping. The documentation also revealed Resident #19 wore ear plugs, with no success, to aid in her sleep. Review of Resident #19's written documentation revealed on 4/11/26, the resident reported she did not sleep well and had sleep disorders. The resident asked the facility staff to shut the door tight and they did not respect her by leaving it open. Certified Nursing Assistant (CNA) #355 opened the door using the trash can to prop it open and left the light on. Resident #19 documented her eyes hurt from lack of sleep. Review of Resident #19's written documentation, undated, revealed the nighttime facility staff were noisy and would not shut the door or keep it closed. Interview on 05/26/26 at 8:59 A.M. with Resident #19 revealed she had severe insomnia and slept better when it was dark. Resident #19 stated the aides would not allow the door to stay closed at night and they propped the door with her roommate's trash can. Resident #19 stated she asked for the door to stay closed and closed it herself, only for the door to be opened and propped shortly after. Observation on 05/27/26 at 6:05 A.M. revealed Resident #19's door was propped open with a garbage can. Interview on 05/27/26 at 6:20 A.M. with CNA #355 verified Resident #19 did not like the door to her open. CNA #355 stated for the past week she had propped the door open due to the roommate's condition. Interview on 05/27/26 at 6:23 A.M. with Registered Nurse (RN) #398 verified Resident #19 had complained about not sleeping well due to the room door being propped open. Interview on 05/28/26 at 8:45 A.M. with Resident #19 verified the room door had been propped open for months as indicated in the resident's documentation. Review of the facility provided document titled, Resident Rights, dated 10/03/23, revealed residents had the right upon reasonable request to have room doors closed and to have them not opened without knocking, except in the case of emergency or unless not medically advisable as documented in the resident's medical record by the attending physician. This deficiency represents non-compliance investigated under Complaint Number 2991972. |

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| | 365330 | A. Building<br>B. Wing | 05/28/2026 |

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| Ayden Healthcare of Wauseon | 303 W Leggett St<br>Wauseon, OH 43567 |

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|---|---|
| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>Based on review of written staff statements, staff interviews and review of facility policy, the facility failed to ensure residents were free from abuse. This affected one (#16) of four residents reviewed for abuse. The facility census was 47.Findings include:Review of the medical record for Resident #16 revealed an admission date of 04/03/26 with diagnoses of dementia, adjustment disorder, and fracture of the sacrum.Review of the Brief Interview for Mental Status (BIMS) dated 05/19/26 revealed Resident #16 had significant cognitive impairment.Interview on 05/27/26 10:51 A.M. with the Director of Nursing (DON) and the Administrator revealed a report of an allegation of abuse that occurred in the afternoon of 05/26/26 between Licensed Practical Nurse (LPN) #330 and Resident #16. The Administrator stated LPN #300 and Registered Nurse (RN) #315 had knowledge of the incident on the date of occurrence and did not report it at the time of the incident. LPN #300 reported the allegation this morning. Interview on 05/27/26 at 11:30 A.M. with LPN #300 revealed she walked down the north hall when LPN #330 reported to her that Resident #16 was attempting to hit her (LPN #330) and LPN #330 stated she grabbed the wrists of Resident #16 and told the resident, If you hit me, I will hit you back and call the police.Interview on 05/27/26 at 12:37 P.M. with RN #398 revealed she witnessed the incident between Resident #16 and LPN #330 on 05/26/26. RN #398 stated she was attempting to help redirect Resident #16 and was behind her trying to remove Resident #16 from entering the wrong room by maneuvering the wheelchair backwards. RN #398 stated LPN #330 was also present. Resident #16 hit at LPN #330 and LPN #330 grabbed the resident's wrists, pinned them to the armrests on the wheelchair and stated, If your going to hit, I will hit you back and call the cops.Interview on 05/27/26 at 12:47 P.M. with RN #315 revealed she spoke with LPN #330 and she was informed by the nurse that Resident #16 was on the unit attempting to go into a male resident's room. LPN #330 tried to redirect the resident when Resident #16 became combative and LPN #330 reported to RN #315 that she grabbed Resident #16's hands, pinned them to the wheelchair arms and told the resident, If you hit me, I will hit you back and call the police.A telephone interview on 05/27/26 at 1:32 P.M with LPN #330 revealed Resident #16 was trying to enter a male resident's room and when she tried to redirect her, the resident became combative. LPN #330 further stated she grabbed Resident #16's wrists and pinned them to the wheelchair armrests. LPN #330 denied telling Resident #16 that she would hit her back or call the police. Review of the written statement authored by LPN #300 revealed on 05/26/27 she was told by LPN #330 that Resident #16 had been hitting her and LPN #330 held both hands down and told Resident #16, If you hit me, I will hit you back and call the police.Review of the written statement dated 05/27/26 and authored by RN #315 revealed she spoke with LPN #330 on 05/26/26 and LPN #330 reported Resident #16 was attempting to be redirected form entering a male resident's room and the resident became combative. LPN #330 further reported to RN #315 that she grabbed Resident #16 by both wrists, held her arms on the armrests of the resident's wheelchair and stated to Resident #16, If you hit me, I'll hit you back and call the police. Another staff member was able to redirect Resident #16 at that time.Review of the transcribed telephone interview with LPN #330, dated 05/27/26 and completed by the Administrator and DON, revealed LPN #330 stated Resident #16 tried to hit her on her side so she grabbed both of her arms and held them to the arms of her wheelchair. LPN #330 stated, I told her do not hit me or I will call the cops. Further review revealed LPN #330 stated that .nurses are abused everyday and i do not tolerate that. When attempting to explain how her aggressive response may be perceived, LPN #330 cut the Administrator off.Review of the written statement from Human Resource Director (HRD) #305, dated 05/28/26, revealed she observed LPN #330 holding Resident #16's hands down onto her wheelchair and talking very firmly to the resident.Review of the witness statement from RN #398, obtained via telephone interview on 05/27/26, revealed Resident #16 attempted to hit LPN #330. LPN #330 then grabbed Resident #16's wrists and put them on the armrests and the nurses hands were on the<br>(continued on next page) |

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|---|---|
| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | armrests. RN #398 then stated LPN #330 stated to Resident #16, You are not going to hit or I will hit you back and then call the cops.Review of the facility policy titled, Abuse, Mistreatment, Neglect, Exploitation, and Misappropriation of Resident Property, dated October 2022, revealed residents had the right to be free from abuse, neglect, exploitation, and misappropriation of resident property. Abuse was defined as the willful infliction of injury, unreasonable confinement, intimidations, or punishment resulting in physical harm, pain, or mental anguish. An alleged violation was a situation or occurrence that was observed or reported by staff or resident.This deficiency represents non-compliance investigated under Complaint Number 2807211. |

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|---|---|
| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>Based on review of written staff statements, staff interview and review of the facility policy, the facility failed to ensure staff reported allegations of abuse timely. This affected one (#16) of four residents reviewed for abuse. The facility census was 47. Findings include:Review of the medical record for Resident #16 revealed an admission date of 04/03/26 with diagnoses of dementia, adjustment disorder, and fracture of the sacrum.Interview on 05/27/26 10:51 A.M. with the Director of Nursing (DON) and the Administrator revealed a report of an allegation of abuse that occurred in the afternoon of 05/26/26 between Licensed Practical Nurse (LPN) #330 and Resident #16. The Administrator stated LPN #300 and Registered Nurse (RN) #315 had knowledge of the incident on the date of occurrence and did not report it at the time of the incident. LPN #300 reported the allegation this morning. Interview on 05/27/26 at 11:30 A.M. with LPN #300 revealed she walked down the north hall when LPN #330 reported to her that Resident #16 was attempting to hit her (LPN #330) and LPN #330 stated she grabbed the wrists of Resident #16 and told the resident, If you hit me, I will hit you back and call the police. LPN #300 verified she did not report this to anyone in management following the conversation with LPN #330 on 05/26/26. She stated that following a conversation later in the afternoon with a State Surveyor, she got to thinking and decided to report the incident this morning (05/27/26) when she got to work.Interview on 05/27/26 at 12:47 P.M. with RN #315 revealed she spoke with LPN #330 on 05/26/26 in the afternoon and learned from LPN #330 that she was involved in a situation with Resident #16. LPN #330 reported to RN #315 that Resident #16 became combative. LPN #330 stated to RN #315 that she (LPN #330) grabbed the wrists of Resident #16 and pinned them to the arms of the wheelchair and told the resident, If you hit me, I will hit you back and call the police. RN #315 stated she was enroute to report the incident to the DON and Administrator and got distracted and forgot to follow through.Review of the facility policy titled, Abuse, Mistreatment, Neglect, Exploitation, and Misappropriation of Resident Property, dated October 2022, revealed residents had the right to be free from abuse, neglect, exploitation, and misappropriation of resident property. Facility staff should immediately report all such allegations to the Administrator and to the Ohio Department of Health (ODH) in accordance with this policy. All incidents and allegations of abuse, neglect, exploitation, mistreatment, and misappropriation must be reported immediately to the Administrator or designee. The Administrator/designee should be notified by informing him/her in person, calling via telephone, or sending an email or text message. The Administrator/designee would notify ODH immediately, but not less than two hours after the allegation was made or the serious bodily injury is identified.This was an incidental finding discovered during the complaint investigation. |