STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365336	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Locust Ridge Healthcare LLC	12745 Elm Corner Road Williamsburg, OH 45176

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on medical record review, staff interview, and facility policy review, the facility failed to issue a Skilled Nursing Facility Advance Beneficiary Notice (SNF ABN) when Medicare Part A services were discontinued and the resident had benefits days remaining. This affected one (Resident #34) of three residents reviewed for beneficiary notices. The facility census was 59 residents. Findings include:Review of the medical record for Resident #34 revealed an admission date of 10/04/25 with diagnosis of metabolic encephalopathy. Review of the Minimum Data Set (MDS) assessment for Resident #34 dated 03/11/26 revealed the resident had intact cognition. Review of the SNF Beneficiary Notification Review for Resident #34 revealed the resident's Medicare Part A skilled services started on 02/11/26 and the last covered day of Part A service was 03/11/26. Per the SNF Beneficiary Notification Review, the facility initiated the discharge from Medicare Part A services when benefits days were not exhausted, and the resident was not issued a SNF ABN. During an interview on 05/13/2026 at 12:28 PM, the Social Services Director (SSD) stated the SNF ABN was issued hours prior to the last covered day. The SSD reviewed her files and confirmed a SNF ABN was not issued to Resident #34 or the resident's representative. The SSD stated she thought the SNF ABN was only to be issued if one skilled service remained, and if all skilled services were being cut then only the Notice of Medicare Non-Coverage (NOMNC) would be issued. During an interview on 05/13/2026 at 3:00 PM, the Administrator stated a resident should always receive a SNF ABN and NOMNC when Medicare Part A services were discontinued and the resident still had benefits days remaining. Review of the facility policy titled Medicare Advance Beneficiary and Medicare Non-Coverage Notices dated 03/28/23 revealed the facility would issue SNF ABN notices for the following triggering events: a. Initiation - In the situation in which the direct of admissions or benefits coordinator believes Medicare will not pay for extended care items or services that a physician has ordered, a SNF ABN is issued to the beneficiary before those non-covered extended care items or services are furnished to the beneficiary. b. Reduction - In the situation in which the facility proposed to reduce a beneficiary's extended care items or services because it expects that Medicare will not pay for a subset of extended care items or services, or for any items or services at the current level and/or frequency of care that a physician has ordered, the SNF ABN is issued to the beneficiary before items or services to the beneficiary are reduced. c. Termination - In the situation in which the facility proposed to stop furnishing all extended care items or services to a beneficiary because it expects that Medicare will not continue to pay for the items or services that a physician has ordered and the beneficiary would like to continue receiving services.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on medical record review, observation, staff interview, review of manufacturer information, and facility policy review, the facility failed to ensure the medication error rate was five percent (%) or less. The facility had three medication errors of 28 opportunities which resulted in a medication error rate of 10.71 percent (%.) This affected two (Residents #21 and #22) of three residents observed for medication administration. The facility census was 59 residents. Findings include:1.Review of the medical record for Resident #21 revealed an admission date of 02/13/26 with a diagnosis of diabetes mellitus type two. Review of the Minimum Data Set (MDS) assessment for Resident #21 dated 02/18/26 revealed the resident had moderate cognitive impairment and received insulin injections seven of the last seven days of the assessment period. Review of the physician's orders for Resident #21 revealed an order dated 05/11/26 for Novolog insulin 10 units per subcutaneous pen-injector before meals. Observation of medication administration for Resident #21 on 05/13/26 at 8:24 A.M. per Licensed Practical Nurse (LPN) #2 revealed the nurse administered 10 units of Novolog insulin to the resident but did not prime the pen prior to the injection. LPN #2 administered the insulin after Resident #21 had consumed approximately 50 % of his breakfast meal at the time of administration. Interview on 05/13/26 at 10:10 A.M. with LPN #2 confirmed she did not prime the pen prior to insulin administration for Resident #21. LPN #2 stated Resident #21's insulin was ordered to be administered prior to meals, but the resident had already consumed 50% of the breakfast meal when she administered the dose of insulin. Review of the manufacturer information for the Novolog FlexPen dated 2009 revealed the nurse should do an air shot to prime the needle prior to each administration using the following steps: dial two units, hold the syringe with needle pointing up and tap reservoir gently to move air bubbles to top of needle, press the push button on the syringe as far as it will go until a drop of insulin appears. 2. Review of the medical record for Resident #22 revealed an admission date of 05/01/22 with a diagnosis of type two diabetes mellitus. Review of the physician's orders for Resident #22 revealed an order dated 06/04/24, for insulin glargine 35 units per subcutaneous pen injection twice per day and an order dated 03/20/26 for insulin lispro 20 units per subcutaneous injection before meals and an order dated 03/20/26 for insulin lispro 12 units per subcutaneous injection if the resident's blood glucose level was between 251 milligrams per deciliter (mg/dL) and 300 mg/dL. Review of the MDS assessment for Resident #22 dated 04/27/26 revealed the resident had intact cognition and received insulin injections seven of the last seven days of the assessment period.Observation of medication administration for Resident #22 on 05/12/26 at 8:27 A.M. per LPN #1 revealed the nures administered 35 units of insulin glargine and 32 units of insulin lispro but did not prime the pens prior to the injections. LPN #1 administered the insulin after Resident #22 had consumed approximately 90% of his breakfast meal at the time of administration. Interview on 05/13/26 at 2:06 P.M. with LPN #1 confirmed she could not remember if she had primed the pen prior to insulin administration for Resident #22. LPN #1 stated Resident #22's insulin was ordered to be administered prior to meals, but the resident had already consumed 90% of the breakfast meal when she administered the dose of insulin. Review of the manufacturer information for insulin lispro revised 05/02/25 revealed the insulin pen must be primed before each injection to make sure the pen is ready to dose. Performing the priming step is important to confirm that insulin comes out when you push the injection button and to remove air that may collect in the insulin cartridge during normal use. If you do not prime, you may get too much or too little insulin. Interview on 05/14/26 at 8:29 A.M. with the Director of Nursing (DON) confirmed she expected insulin to be administered as ordered without errors, and each insulin pen should be primed with two units of insulin prior to dialing the prescribed dosage of insulin to administer to the resident to ensure the resident received the prescribed dosage. Review of the facility policy titled Administering Medications dated 02/14/24 revealed medications are administered in a safe and timely manner, and as prescribed. The policy specified medications, including insulin and any oral or subcutaneous hypoglycemic, are administered in accordance with prescriber orders, including any required time frame.