STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365363	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkside Nursing and Rehabilitation Center	908 Symmes Road Fairfield, OH 45014

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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on medical record review, resident interview, staff interview, resident representative interview, review of Self-Reported Incidents (SRIs), and review of the facility policy, the facility failed to honor a resident's right to refuse a haircut. This affected one (Resident #71) of four residents reviewed for resident rights. The facility census was 67 residents.Findings include:Review of the medical record for Resident #71 revealed an admission date of 09/15/22 with diagnoses including traumatic subarachnoid hemorrhage, hydrocephalus, anoxic brain damage and epilepsy. Review of the shower sheet for Resident #71 dated 05/09/25 revealed the resident had a haircut. Interview on 07/21/25 at 1:19 P.M. with Resident #71 confirmed on 05/09/25 the facility staff cut her hair without her permission. Resident #71 stated the staff put her in a chair and held her down. Resident #71 stated she did not want the haircut, but they did it anyway. Interview on 07/22/2025 at 2:50 P.M. with Resident #71's power of attorney (POA) confirmed he felt the resident needed a haircut and he gave the facility permission to cut the resident's hair. Interview on 07/23/2025 at 8:20 A.M. with Certified Nursing Assistant (CNA) #24 confirmed Resident #71's brother asked the facility to cut the resident's hair because it was matted. CNA #24 confirmed the next day she brought Resident #71 to the nurses' station and began cutting the resident' hair using clippers beginning on the right side of the resident's head. Residents #71 asked the CNA to stop half-way through the haircut. CNA #24 stated she did not stop when the resident requested her to stop. CNA #24 stated Licensed Practical Nurse (LPN) #76 and Registered Nurse (RN) #90 were present and encouraged Resident #71 to allow her to continue with the haircut since half of it was already completed. Interview on 07/23/25 at 10:33 A.M. with LPN #76 confirmed she was working the day Resident #71's haircut. LPN #76 confirmed CNA #19 began the haircut and then CNA #24 took over. LPN #76 denied talking to Resident #71 regarding the haircut. Interview on 07/28/25 10:40 A.M. with RN #90 confirmed she observed CNA #24 cutting Resident #71's hair a couple months ago. RN #90 confirmed she was not present when Resident #71 asked for the aide to stop the haircut. She denied speaking to Resident #71 and encouraging CNA #24 to continue the haircut. Interview on 07/28/25 at 10:58 A.M. with CNA #19 confirmed she was assigned to Resident #71 on the day of the haircut. She reports she assisted Resident #71 to a reclining chair and brought her to the nurses' station. She then prepared for the haircut gathering a basin, shampoo, towels and clippers. Resident #71 refused to allow CNA #19 to cut her hair stating because she was white and the resident felt the aide didn't know how to cut her kind of hair. CNA#19 then went to CNA#24 and asked her to cut Resident #71's hair. Interview on 07/28/2025 at 11:55 A.M. with CNA#24 confirmed her signature on Resident #71' shower sheet dated 05/09/25 which indicated the resident had a haircut. Review of the facility SRI for Resident #71 dated 06/09/25 revealed the facility investigated an allegation of neglect/mistreatment abuse when CNA #24 cut Resident #71's hair on 05/09/25 without the resident's permission. The outside psychiatric services provider reported the incident to the facility on 6/9/25, but the hair cut occurred on 5/9/25. Approximately halfway through the haircut, the resident did tell the staff to stop. CNA #24 stopped temporarily, but then told the resident she needed to finish the other side of her head and then completed the haircut. The facility did not substantiate abuse. Record review of facility policy titled Resident Rights revealed the resident had the right to request, refuse and/or discontinue treatment and the resident had the right to make choices about aspects of her life that are significant to the resident. This deficiency represents noncompliance investigated under Complaint Number OH00164105 (iQIES 1308587) and Complaint Number OH00163312 (iQIES 1308685)Complaint Number OH00163016 (iQIES 1308585) and Complaint Number OH00162770 (iQIES 1308590.)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on medical record review, staff interview, resident representative interview, and review of the facility policy, the facility failed to notify residents in writing of room moves and failed to notify resident representatives of room moves. This affected one (Resident #5) of one resident reviewed for room moves. The facility census was 67 residents. Findings include: Review of the medical record for Resident #5 revealed an admission date of 12/20/24 with diagnoses including hypoxic ischemic encephalopathy, cerebral infarction, congestive heart failure (CHF), hypertension, and schizoaffective disorder. Review of the Minimum Data Set (MDS) assessment for Resident #5 dated 04/15/25 revealed the resident had impaired cognition and was dependent on staff for assistance with medication administration, transfers, eating, and personal care. Review of the progress notes for Resident #5 dated 06/17/25 60 06/19/25 revealed the notes did not include information regarding a room change on 06/17/25 through 06/19/25. Interview on 07/22/2025 at 10:22 A.M. with Resident #5's representative confirmed the facility failed to notify her of the resident's room move. Interview on 07/22/25 at 2:41 P.M with Admissions Director (AD) #55 confirmed Resident #5 had a room move on 06/17/25 and the facility failed to notify the resident's representative of the move until after it had already occurred.Review of the facility policy titled Change of Room or Roommate dated 03/01/25 revealed the facility would notify residents and resident representatives of changes in room or roommate in writing in a language and manner the resident and resident representative would understand. The notification should include the reason (s) why the move or change was required.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on medical record review, observation, staff interview, and review of the facility policy, the facility failed to maintain privacy of the resident electronic medical record (EMR). This affected one (Resident #53) of three residents reviewed for privacy. The facility census was 67 residents.Findings include: Review of the medical record for Resident #53 revealed an admission date of 06/03/25 with diagnoses including chronic respiratory failure with hypoxia, cerebrovascular accident, and diabetes mellitus type two. Review of the Minimum Data Set (MDS) assessment for Resident #53 06/10/25 revealed the resident had severe cognitive impairment and was dependent on staff assistance with activities of daily living (ADLs.) Observation on 07/21/25 at 11:18 A.M. revealed the respiratory therapy treatment cart on the 400-nursing unit was unattended with an open computer monitor that displayed private health information from Resident #53's EMR. Interview on 07/21/25 at 11:18 A.M. with Assistant Director of Nursing (ADON) #56 verified the facility staff had failed to protect the privacy medical information for Resident #53. Review of the policy titled Health Insurance Portability and Accountability Act (HIPAA) Security Measures dated 01/01/25 revealed it was the facility's policy to implement reasonable and appropriate measures to protect and maintain the confidentiality, integrity, and availability of the resident's identifiable information and/or records that are in electronic format. Only appropriate employees would have access to electronic protected health information.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on medical record review, observation, staff interview, and review of the facility policy, the facility failed to maintain a clean, safe, and sanitary environment. This affected two (Residents #3 and #62) and had the potential to affect all of the residents in the facility with the exception of seven facility-identified residents (#6, #18, #41, #45, #51, #67, #68) who did not utilize the shower rooms. The facility census was 67 residents. Findings include:1.Review of the medical record for Resident #3 revealed an admission date of 04/30/24 with diagnoses including atherosclerotic heart disease and osteoarthritis. Review of the Minimum Data Set (MDS) assessment for Resident #3 dated 6/14/25 revealed the resident had impaired cognition and required staff assistance with activities of daily living (ADLs.) Review of the medical record for Resident #62 revealed an admission date of 5/29/25 with diagnoses including traumatic subdural hemorrhage, cerebral infarction, hypertension, heart failure, and spinal stenosis. Review of the MDS assessment for Resident #62 dated 7/09/25 revealed the resident was cognitively intact and required supervision with ADLs. Observation on 07/24/25 at 11:20 A.M. of the room shared by Resident #3 and #62 revealed the room had a strong urine odor and the floor was dirty and sticky. Interview on 07/24/25 at 11:20 A.M with Resident #62 confirmed he was unhappy with staff because his roommate would use the urinal, and the staff did not empty it. The urinal would become full and spill out on the floor and then would run under the curtain toward his side of the room. Interview on 11/24/25 at 11:30 A.M. with Licensed Practical Nurse (LPN) #66 on 11/24/25 at 11:30 A.M. confirmed the room shared by Residents #3 and #62 had a very strong urine odor especially in the area near Resident #3’s urinal. LPN #66 confirmed the floor was soiled and extremely sticky. Review of the facility policy titled Safe and Homelike Environment dated 06/01/24 revealed the facility would create and maintain to the extent possible a homelike environment. Housekeeping and maintenance services would be provided as necessary to maintain a sanitary, orderly, and comfortable environment. The facility would minimize odors by disposing of soiled linens promptly and reporting lingering odors. 2. Observation on 07/28/25 at 11:14 A.M. of the shower room on the 300 hall revealed the toilet was missing and the pipe had been covered, and there were missing pieces of tile around the pipe. Interview on 07/28 25 with Floor Tech (FT) #117 confirmed there were missing tiles from where the broken toilet had been removed. 3.Observation on 07/28/25 at 12:20 P.M. of the shower room on the 100 hall revealed there was dark discoloration between the shower tiles. The toilet bowl was elongated, but the seat was round which left a gap between the edge of the seat and the toilet bowl. The entrance to the shower room was missing pieces of tile, which exposed rough and jagged flooring under the tile. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 07/28/25 at 12:25 P.M. with Registered Nurse (RN) #90 verified the findings in the shower room. This deficiency represents noncompliance investigated under Master Complaint Number OH00167100 (IQIES 1308589) and Complaint Number OH00162770 (iQIES 1308590.)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition Based on medical record review and staff interview, the facility failed to ensure comprehensive assessments were conducted within 14 days of a significant change in resident status. This affected one (Resident # 41) of three residents reviewed for comprehensive assessments. The facility census was 67 residents. Findings include:Review of the medical record for Resident #41 revealed an admission date of 08/23/24 with diagnoses including acute respiratory failure with hypoxia, dependence on mechanical ventilation, tracheostomy, and cerebral infarction. Review of the quarterly Minimum Data Set (MDS) for Resident #41 dated 06/28/25 revealed the resident had intact cognition and was dependent on staff for activities of daily living (ADLs). Review of the pulmonary progress note for Resident #41 dated 07/09/25 revealed the physician gave an order to decannulate (remove the breathing tube) for the resident. Review of the progress note for Resident #41 dated 07/09/25 revealed Respiratory Therapist (RT) #108 decannulated the resident. Review of the medical record for Resident #41 revealed it did not include a comprehensive MDS assessment for the resident following the significant change of being decannulated. Interview on 07/24/25 at 3:35 PM with Regional MDS Nurse (RMN) #142 confirmed the facility had not completed a comprehensive MDS assessment within 14 days of a significant change for the resident.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on medical record review, staff interview, and review of the facility policy, the facility failed to ensure baseline care plans were completed upon admission and a summary was provided to the resident and/or resident's representative within 48 hours of admission. This affected one (Resident #83) of three residents reviewed for admission rights. The facility census was 67 residents.Findings include:Review of the medical record for Resident #83 revealed an admission date of 12/27/24 with diagnoses including anoxic brain damage, and post-traumatic seizures and a discharge date of 06/03/25.Review of the initial/admission care conference report for Resident #83 dated 12/27/24 revealed the facility did not provide a summary of the baseline care plan to the resident.Review of the Minimum Data Set (MDS) assessment for Resident #83 dated 06/03/25 revealed the resident had intact cognition and required staff assistance with activities of daily living (ADLs.)Phone interview on 07/24/25 at 9:16 A.M. with Resident #83 confirmed he could not remember a time when the facility ever met with him about his care.Interview on 07/24/25 at 4:19 P.M. with Social Services Director (SSD) #60 verified the facility had not provided a summary of the baseline care plan to Resident #83 within 48 hours of admission as required.Review of the facility policy titled Care Planning-Resident Participation dated 06/01/24 revealed the facility supported the resident's right to be informed of, and participate in, his or her care planning and treatment (implementation of care). The facility will discuss the care plan with the resident and/or representative at regularly scheduled care plan conferences, and allow them to see the care plan, initially, at routine intervals, and after significant changes. The facility would obtain a signature from the resident and/or resident representative after discussion or viewing of the care plan.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on medical record review, resident interview, staff interview, and review of the facility policy, the facility failed to hold resident care conferences on a regular basis. This affected five (Residents #4, #83, #20, #34, and #41) of five residents reviewed for care planning. The facility census was 67 residents. Findings include:1.Review of the medical record for Resident #4 revealed an admission date of 04/21/23 with diagnoses including chronic respiratory failure with hypoxia, morbid obesity, and diabetes mellitus. Review of the Minimum Data Set (MDS) assessment for Resident #4 revealed the resident had intact cognition and was dependent on staff with activities of daily living (ADLs.) Interview on 07/21/25 at 10:18 A.M. with Resident #4 confirmed no knowledge of when he or his wife last attended a care conference. Review of the care conference summary reports for Resident #4 revealed the facility did not conduct care conferences for the resident for the third quarter of 2024, the first quarter of 2025, and the second quarter of 2025. Interview on 07/23/25 at 3:39 P.M. with Social Services Director (SSD) #60 and Regional Social Services Director (RSSD) #250 verified the facility had not held care conferences with Resident #4 for the third quarter of 2024, the first quarter of 2025, and the second quarter of 2025. 2. Review of the medical record for Resident #80 revealed an admission date of 06/21/24 with diagnoses including diabetes mellitus type one, morbid obesity, chronic right heart failure, peripheral vascular disease, and obstructive sleep apnea. The resident transferred to another nursing facility on 05/15/25. Review of the MDS assessment for Resident #80 dated 04/03/25 revealed the resident had intact cognition and required staff assistance with ADLs. Review of the care conference summary reports for Resident #80 revealed the facility did not conduct care conferences in the third quarter of 2024, the fourth quarter of 2024, and the first quarter of 2025. Interview on 07/23/25 at 3:40 P.M. with SSD #60 and RSSD #250 verified care conferences were not held with Resident #80 in the third quarter of 2024, the fourth quarter of 2024, and the first quarter of 2025. 3. Review of the medical record for Resident #20 revealed an admission date of o1/12/24 with diagnoses including chronic respiratory failure and quadriplegia. Review of the MDS assessment for Resident #20 dated 06/24/25 revealed the resident had intact cognition and was dependent on staff for ADLs. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the care conference summary reports for Resident #20 revealed the facility did not conduct care conferences in the first quarter of 2024, the second quarter of 2024, the fourth quarter of 2024, and the first quarter of 2025. Interview on 07/23/25 at 3:41 P.M. with SSD #60 and RSSD #250 verified the facility had not held care conferences with Resident #20 for the first quarter of 2024, the second quarter of 2024, and the first quarter of 2025. 4. Review of the medical record for Resident #34 revealed an admission date of 04/25/24 with diagnoses including chronic respiratory failure, encephalopathy, and epilepsy. Review of the MDS assessment for Resident #34 dated 04/30/25 revealed the resident had impaired cognition and was dependent on staff for ADLs. Review of the care conference summary reports for Resident #34 revealed the facility did not conduct care conferences in the third quarter of 2024, the fourth quarter of 2024, the first quarter of 2025, and the second quarter of 2025. Interview on 07/23/25 at 3:42 P.M. with SSD #60 and RSSD #250 verified the facility did not hold care conferences for Resident #34 in the third quarter of 2024, the fourth quarter of 2024, the first quarter of 2025, and the second quarter of 2025. 5. Review of the medical records for Resident #41 revealed an admission date of 08/23/24 with diagnoses including acute respiratory failure with hypoxia, dependence on mechanical ventilation, and cerebral infarction. Review of the MDS assessment for Resident #41 dated 06/28/25 revealed the resident had intact cognition and was dependent on staff for ADLs. Review of the care conference summary reports for Resident #41 revealed the facility did not conduct care conferences in the fourth quarter of 2024, the first quarter of 2025, and the second quarter of 2025. Interview on 07/23/25 at 3:43 P.M. with SSD #60 and RSSD #250 verified the facility had not held care conferences for Resident #41 in the fourth quarter of 2024, the first quarter of 2025, and the second quarter of 2025. Review of the policy titled Care Planning-Resident Participation dated 06/01/24 revealed the facility supported the resident’s right to be informed of, and participate in, his or her care planning and treatment (implementation of care). The facility would discuss the care plan with the resident and/or representative at regularly scheduled care plan conferences, and allow them to see the care plan, initially, at routine intervals, and after significant changes. The facility would obtain a signature from the resident and/or resident representative after discussion or viewing of the care plan. This deficiency represents noncompliance investigated under Complaint Number OH00164605 (iQIES 1308587)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. Based on medical record review, observation, and staff interview, the facility failed to identify and initiate prompt treatment for non-pressure wounds. This affected one (Resident #5) of one resident reviewed for skin conditions. The facility census was 67 residents. Findings include:Review of the medical record for Resident #5 revealed an admission date of 12/20/24 with diagnoses including hypoxic ischemic encephalopathy, cerebral infarction, congestive heart failure (CHF), schizoaffective disorder, and hidradenitis suppurativa. Review of the Minimum Data Set (MDS) assessment for Resident #5 dated 04/15/25 revealed the resident had impaired cognition and was dependent on staff assistance with activities of daily living (ADLs.) Review of the progress note for Resident #5 dated 07/14/25 at 1:50 P.M. revealed the nurse identified blood on the resident pillow and an open wound behind the resident's right ear. The nurse applied A&D ointment to the area.Review of the progress notes for Resident #5 dated 07/23/25 at 11:39 A.M. revealed there was an open area behind the resident's right ear that measured 1.2 centimeter (cm) in width by 0.4 cm in length by 0.1 cm in depth with a scant serosanguineous drainage. There was no treatment ordered.Review of Treatment Administration Record (TAR) for Resident #5 dated July 2025 revealed there were no treatments ordered for the open area to the resident's right ear.Observation on 07/21/25 at 9:49 A.M. revealed Resident #5's pillow had an unknown reddish rust stain smeared all over the right side of the pillow.Interview on 07/21/25 at 11:50 A.M. with Housekeeper (HK) #118 confirmed there was a dried rust-colored stain all over the right side of Resident #5's pillow. HK #118 stated he believed the unknown substance was dried blood.Interview on 07/22/25 at 10:21 A.M. with Resident #5's representative confirmed the resident had an open wound on his right ear.Interview on 07/23/2025 at 9:15 A.M. with Certified Nurse Aide (CNA) #44 confirmed Resident #5 had an open area behind his right ear that was identified a couple of weeks ago. Observation on 07/23/25 at 11:05 P.M. of the area behind Resident #5's ear with Licensed Practical Nurse (LPN) #66 revealed there was an area which measured 1.0 cm in length by 2.0 cm in width with a small amount of bloody drainage to the area behind the area and to the resident's pillow. Interview on 07/23/25 at 11:10 A.M. with LPN #66 confirmed the facility identified the open area to Resident #5's right ear on 07/14/25 and the facility had not initiated a treatment.Interview on 07/23/25 at 12:50 P.M. with Nurse Practitioner (NP) #251 stated Resident #5 had a treatment order to apply ointment to resident's dry skin but there was no order specific to the area behind the residents' right ear. NP #251 stated she believed the area behind the right ear was a non-pressure wound related to the resident's diagnosis of hidradenitis suppurativa (a chronic skin condition featuring lumps under the skin that can be painful and tend to enlarge and drain pus.) Interview on 07/30/25 at 10:54 A.M. with Assistant Director of Nursing (ADON) #56 confirmed the facility failed to put a treatment in place for Resident #05's ear after the nurse identified the open area behind the right ear on 07/14/25. This deficiency represents noncompliance investigated under Complaint Number OH00163016 (iQIES 1308585.)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on medical record review, observation, staff interview, review of the facility policy, and review of online guidelines per the National Pressure Ulcer Advisory Panel (NPUAP), the facility failed to implement treatment once the pressure ulcers were identified. This resulted in Actual Harm for Resident #34, who was admitted to the facility without pressure ulcers and developed pressure ulcers to her right antecubital and left antecubital space (inside of the elbows), which were not identified and treated until they had developed into stage IV ulcers with exposed tendon. This affected one (Resident #34) of five residents reviewed for pressure ulcers. The facility census was 67 residents. Findings include:Review of the medical record for Resident #34 revealed an admission date of 04/25/24 with diagnoses including chronic respiratory failure, encephalopathy, and epilepsy. Review of the pressure ulcer risk assessment for Resident #34 dated 04/25/24 revealed the resident was at high risk for the development of pressure ulcers. Review of the physician’s orders for Resident #34 revealed an order dated 04/25/24 for the resident to have weekly skin checks per a licensed nurse. Review of the care plan for Resident #34, dated 04/26/24 revealed the resident had the potential for alteration in skin integrity and required protective/preventative skin care maintenance related to bladder incontinence, bowel incontinence, decreased mobility, history of previous skin breakdown, Impaired cognition. Interventions included the following: encourage the resident to float heels as tolerated, encourage to turn and reposition every two hours and as needed as tolerated, inspect for any reddened areas during daily care, pressure reducing cushion to chair to promote comfort and prevent skin breakdown, pressure reducing mattress on bed to promote comfort and prevent skin breakdown, monitor skin prior to and after placing bilateral hand splints. Review of the care plan for Resident #34, dated 04/26/24, revealed the resident needed assistance with activities of daily living (ADL) related to cognitive impairment, hemiparesis, immobility, and due to the resident being in a persistent vegetative state. Interventions included the following: inspect skin condition daily during personal care and report any impaired areas to the charge nurse, staff to anticipate needs, staff to perform ADL as the resident was totally dependent and did not participate in any aspect of the care task Review of the progress note for Resident #34 dated 03/06/25 revealed the facility met with the resident’s family to discuss the resident’s appropriateness for palliative care services, and the family was in agreement. The resident’s provider gave an order to admit the resident to palliative care services for acute respiratory failure. Review of the Minimum Data Set (MDS) assessment for Resident #34, dated 04/30/25, revealed the resident had impaired cognition and was dependent on staff for assistance with all ADL and received 100 percent of her nutrition via tube feeding. Review of the pressure ulcer risk assessment for Resident #34 dated 05/08/25 revealed the resident was at high risk for the development of pressure ulcers. Review of the weekly skin checks for Resident #34 dated 05/06/25, 05/13/25, 05/20/25, and 05/27/25, revealed the resident had no open areas. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the shower sheet for Resident #34 dated 05/23/25 completed by Certified Nursing Assistant (CNA) #48 and signed by Registered Nurse (RN) #89, revealed the aide noted two open areas to the inside of the resident’s right and left elbows. Review of the medical record for Resident #34 dated 05/23/25 to 05/28/25 revealed the record did not include documentation of open areas to the resident’s right and left inner elbows. Review of the skin assessment for Resident #34 dated 05/29/25, revealed there was a pressure ulcer to the resident’s right antecubital space which measured 1.0 centimeter (cm) in length by 2.0 cm in width by 0.5 cm in depth. The wound bed had full tendon exposure with 100 percent granulation tissue (new connective tissue). The resident also had a pressure ulcer to the left antecubital space which measured 1.0 cm in length by 1.0 cm in width by 0.3 cm in depth. The wound bed had full tendon exposure with 100 percent granulation tissue. Review of the physician’s order for Resident #34, dated 05/29/25, was to cleanse bilateral inner elbows with normal saline (NS), pat dry, apply calcium alginate to the wound beds, cover with an abdominal dressing (ABD), and loosely wrap with Kerlix (gauze roll), complete every night shift. Review of the care plan for Resident #34, dated 05/29/25, revealed the resident had an actual area of skin impairment of pressure related to contractures to the bilateral arms. Interventions included the following: initiate wound treatment, continue treatment as ordered by the physician, nursing to observe the wound dressing daily to ensure that the dressing remained intact and that there were no signs or symptoms of infection or increased drainage, observe and document character of wound weekly, observe for clinical changes, such as infection and/or worsening of wound, skin observation and document on bath/shower days, charge nurse to notify the wound nurse, physician and family of any new areas Review of the wound visit note for Resident #34 dated 06/04/25, per Wound Doctor (WD) #150 revealed the resident had a stage IV pressure area to the right antecubital space which measured 0.8 cm in length by 1.3 cm in width by 0.6 cm in depth. There was a moderate amount of exudate (drainage) from the wound with exposed underlying structure and 100 percent granulation tissue within the wound bed. The resident had a stage IV pressure area to the left antecubital space which measured 0.7 cm in length by 1.1 cm in width by 0. 5 cm in depth. There was a moderate amount of exudate from the wound with exposed underlying structure and100 percent granulation tissue within the wound bed. The resident was at high risk for development of wounds due to encephalopathy, generalize muscle weakness, epilepsy, persistent vegetative state, and respiratory failure with tracheostomy status. During an observation of Resident #34’s skin on 07/24/25 at 11:09 A.M., Licensed Practical Nurse (LPN) #92 revealed the resident had a nickel sized open area to the right and left antecubital spaces which appeared to be approximately 0.5 cm in depth. Both areas had red wound beds, with the peri wound area intact, and no signs of infection. The wounds were healing. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 07/24/25 at 2:31 P.M., LPN #92 stated she functioned as the unit manager and the wound nurse for the facility, and she expected staff to notify her of any changes to the resident’s skin integrity and initiate treatment for new impaired skin areas immediately. LPN #92 said she did not recall how or when she was notified of the open areas for Resident #34. LPN #92 stated CNA #48 first identified open areas to Resident #34’s bilateral antecubital spaces on 05/23/25, but the facility did not initiate treatment until 05/29/25 when the areas were assessed to be stage IV pressure ulcers. During an interview on 07/24/25 at 2:35 P.M., the Director of Nursing (DON) stated Resident #34’s clinical condition was compromised due to acute respiratory failure and worsening bilateral arm contractures. Resident #34 had recently been ordered to receive palliative care services, the facility did not obtain timely treatment for the pressure ulcers. During an interview on 07/24/25 at 2:59 P.M., CNA #48 stated she observed small red open areas to the inside of Resident #34’s right and left elbows on 05/23/25 during a shower and she notified the nurse on duty immediately. Multiple attempts to reach RN #89 for a phone interview on 07/24/25 were unsuccessful. Review of the facility policy titled “Pressure Injury Prevention and Management”, dated 03/05/25, revealed that licensed nurses would conduct a full body skin assessment on all residents upon admission/readmission, weekly, and after any newly identified pressure injury. Findings will be documented in the medical record. Assessments of pressure injuries would be performed by a licensed nurse and documented in the resident’s medical record. The staging of pressure injuries would be clearly identified to ensure correct coding on the MDS. Nursing assistants would inspect the resident’s skin during bathing and would report any concerns to the resident’s nurse immediately after the task. Review of online guidelines per the NPUAP, dated 2014 pages 70-71 at https://npiap.com/general/custom.asp?page=2014Guidelines, revealed facilities should educate health professionals on how to undertake a comprehensive skin assessment that included the techniques for identifying blanching response, localized heat, edema, and induration. Further review of the guidelines revealed ongoing assessment of the skin was necessary in order to detect early signs of pressure damage. Visual assessment for erythema (redness of the skin) was the first component of every skin inspection. Skin redness and tissue edema resulting from capillary occlusion was a response to pressure, especially over bony prominences. Staff should conduct a head-to-toe assessment with particular focus on skin overlying bony prominences including the sacrum, ischial tuberosities, greater trochanters and heels and each time the patient was repositioned was an opportunity to conduct a brief skin assessment. This deficiency represents noncompliance investigated under Complaint Number OH00165854 (iQIES 1308588) and Complaint Number OH00163312 (iQIES 1308586) and Complaint Number OH163016 (iQIES 1308585.)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, resident interview, staff interview, and review the facility policy, the failed to appropriately assess and treat resident pain. This affected one (Resident #62) of three residents reviewed for pain management. The facility census was 67 residents Findings include:Review of the medical record for Resident #62 revealed an admission date of on 5/29/25 with diagnoses including traumatic subdural hemorrhage, cerebral infarction, heart failure, and spinal stenosis. Resident #62 was transferred to the hospital on [DATE] and was readmitted to the facility on [DATE].Review of the Minimum Data Set (MDS) assessment for Resident #62 dated 7/09/25 revealed the resident was cognitively intact and required staff assistance with activities of daily living (ADLs.)Review of the Medication Administration Record (MAR) for Resident #62 dated July 2025 for Resident #62 revealed there was an order for oxycodone 5 milligrams (mg) every six hours with a start date of 07/02/25 and a stop date of 07/23/25.Review of the hospital order form for Resident #62 dated 07/22/25 at the time of discharge from the hospital revealed there was no order for oxycodone.Review of the facility-controlled drug receipt disposition form for Resident #62 for Oxycodone IR Tablet 5 mg confirmed he received a dose on 07/22/25 at 7:40 P.M.Review of the readmission nursing assessment for Resident #62 dated 07/22/25 revealed the resident voiced complaints of pain and rated the pain as a three on a scale of 1 to 10 with 10 being the worst pain. Review of the facility-controlled drug receipt disposition form for Resident #62 revealed the resident received a dose of oxycodone 5 mg on 07/22/25 at 7:40 P.M.Review of the physician order summary for Resident #62 revealed an order dated 07/24/25 for oxycodone 5mg one tablet every six hours as needed for pain. Interview on 07/24/25 at 11:20 A.M with Resident #62 confirmed he returned from the hospital on [DATE] in the evening and asked for his pain medication and the nurse gave him a pain pill. Resident #62 confirmed the nurse later told him he would not be able to have any more doses of pain medications because the facility did not have an order. Resident #62 stated he did not understand, and he was in pain. Resident #62 stated he had told the nurses numerous time that he had pain and nothing was done. Interview on 07/24/24 at 11:30 A.M. with Licensed Practical Nurse (LPN) #66 confirmed the evening staff gave Resident #62 an oxycodone 5 mg tablet on 07/22/25 at 7:40 P.M. LPN #66 stated Resident #62 had an order for oxycodone as needed prior to discharge to the hospital. LPN #66 stated she assumed the evening nurse thought Resident #62 had readmitted with the same oxycodone order and administered it to him. LPN #66 confirmed Resident #66 had voiced complaints of pain, but the facility did not have an order on file for the pain medication, and she was not able to administer the medication. LPN #66 confirmed Resident #62 had not been given his as needed pain medication since the one dose he received after his return from the hospital on [DATE]. Review of the facility policy titled Pain Management dated 08/22/22 revealed the facility must ensure that pain management was provided to residents consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goal and preferences. The facility would recognize when the resident was experiencing pain and evaluate the resident for pain upon admission, during ongoing scheduled assessments, and when a significant change in condition or status occurred and should manage or prevent pain consistent with the comprehensive assessment and plan of care.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on medical record review, observation, staff interview, review of manufacturer's guidelines, and review of the facility policy, the facility failed to ensure insulin pens were properly labeled and stored. This affected two (Residents #15 and #65) of four residents who received insulin stored in the 200-medication cart. The facility census was 67 residents. Findings include:1. Review of the medical record for Resident #15 revealed an admission date of 1/07/24 with diagnoses of diabetes mellitus type and acute and chronic respiratory failure with hypoxia. Review of the Minimum Data Set (MDS) assessment for Resident #15 dated 05/16/25 revealed the resident had severe cognitive impairment and was dependent on staff for assistance with activities of daily living (ADLs.) Review of the physician's orders for Resident #15 revealed an order dated 07/02/25 for insulin Glargine inject seven units subcutaneously at bedtime for diabetes mellitus. Observation on 07/23/25 at 9:21 A.M. of the 200-hall medication cart with Licensed Practical Nurse #66 revealed Resident #15's insulin Glargine pen was not dated. Interview on 07/23/25 at 9:22 A.M. with LPN #66 confirmed Resident #15's insulin Glargine pen was not dated when removed from refrigerated storage and placed in the 200-hall medication cart. 2. Review of the medical record for Resident #65 revealed an admission date of 05/16/24 with diagnoses of diverticulitis, atherosclerotic heart disease, diabetes mellitus type two, and chronic obstructive pulmonary disease. Review of the MDS assessment for Resident #65 dated 05/23/25 for revealed the resident had intact cognition and required set up assistance with ADLs. Review of physician's orders for Resident #65 revealed an order dated 07/14/25 for Lantus SoloStar insulin pen inject eight unit subcutaneously at bedtime. Observation on 07/23/25 at 9:23 A.M. of the 200-hall medication cart with LPN #66 revealed Resident #65's Lantus SoloStar insulin pen was not dated. Interview on 07/23/25 at 9:24 A.M. with LPN #66 confirmed Resident #65's Lantus SoloStar insulin pen was not dated when removed from refrigerated storage and placed in the 200-hall medication cart Interview on 07/23/25 at 5:15 P.M. with the Director of Nursing and Assistant Director of Nursing #56 verified insulin is to be dated when removed from refrigerated storage and placed in the medication cart. Review of the manufacturer's guidelines for insulin products undated revealed staff should label insulin with the date when taken from refrigeration or put into the cart. Review of the facility policy titled Medication Storage reviewed/revised 03/03/25 revealed it was the policy of the facility to ensure all medications housed on the premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on medical record review, observation, resident interview, and staff interview, the facility failed to provide residents with food that was appealing and palatable. This affected Resident #26 and#62 and had the potential to affect all residents at the facility. The facility identified ten (Residents #1, #5, #15, #16, #35, #38, #46, #53, #64, #84) who did not receive food from the kitchen. The facility census was 67 residents. Findings include: 1.Review of the medical record for Resident #26 revealed an admission date of 12/18/24 with diagnoses including chronic atrial fibrillation, major depressive disorder, hypothyroidism, vascular dementia, heart failure, anorexia. Review of the Minimum Data Set (MDS) assessment for Resident #26 dated 06/27/25 revealed the resident had impaired cognition and required set up assistance from staff with her meals. Review of the physician's orders for Resident #26 revealed an order dated 01/09/25 for a regular diet, mechanical soft texture.Observation on 07/23/25 at 12:30 P.M. revealed Resident #26 was propped up in her bed and her meal was in a closed container on the bedside table. Resident #26 opened the container and there was a gnat flying around the mechanical soft meal which consisted of fish, broccoli and rice. Interview 07/23/25 at 12:31 P.M. with Resident #26 confirmed she could not eat the meal because it tasted terrible and the food was always served cold and tasted terrible.Interview on 07/23/25 at 12:33 P.M. with Licensed Practical Nurse (LPN) 66 confirmed Resident #26's meal tray did not look appealing and contained a gnat flying inside the container of the resident's lunch. 2. Review of the medical record for Resident #62 revealed an admission date of 5/29/25 with diagnoses including traumatic subdural hemorrhage, cerebral infarction, essential primary hypertension, gastro esophageal reflux disease (GERD), heart failure, and spinal stenosis. Review of the MDS assessment for Resident #62 dated 07/09/25 revealed the resident was cognitively intact and required set up assistance with meals. Interview on 07/24/25 at 11:07 A.M. with Resident #62 confirmed he was not happy with the food at the facility. Resident #62 stated the food was unappealing and never served at the correct temperature. Resident #62 stated he thought this was because the food trays sat on the carts too long before the staff passed them out. 3.Observation on 07/23/25 at 11:00 A.M. with Dietary [NAME] (DC)#95 revealed DC #95 prepared mechanical soft fish by mixing water with chicken paste and pouring it in with the fish. The fish was mixed into an unappealing white ball and returned to the pan for mechanical soft diets. DC #95 walked over to the food tray line and served the lump of mechanical soft fish and told the staff on the tray line he would not eat that as he referred to the lump of white mechanical soft fish. Interview on 07/23/25 at 11:05 A.M. with DC #95 confirmed he did not utilize a recipe when he mixed the mechanical soft and pureed food. DC #95 stated he had performed his job for so long he did not need a recipe, and he could just eyeball it. Observation on 07/23/25 at 11:20 A.M. revealed DM#102 placed three servings of steamed broccoli and added four cups of hot water. DM #102 continued to add eight heaping scoops of thickener to three servings of steamed broccoli. Interview on 07/23/25 at 11:22 A.M. confirmed he had placed three services of steamed broccoli into the mixer along with the four cups of hot water. DM #102 confirmed he added the food thickener and stated he wanted the broccoli to be the texture of mashed potatoes. Observation of the test tray on 07/23/25 revealed it left the kitchen on a cart at 12:11 P.M. and all meals were served to the residents at 12:31 P.M. The test tray contained two pieces of baked fish, steamed broccoli, broccoli and cheddar casserole, and iced vanilla cake. Observation with Dietary Manager (DM) #102 on 07/23/25 at 12:11 P.M. revealed the lunch test tray was delivered to 100 hallway. The facility delivered all the resident meals on the 100 hallway, and the test tray was obtained at 12:31 P.M. The fish was cold and did not have a pleasant taste. The broccoli was cold and chewy. The rice casserole was cold, chewy and did not have pleasant taste. The cake was very hard to cut and tasted very dry. Interview with DM #102 on 07/23/25 at 12:33 P.M. confirmed the test tray appeared unappealing. DM #102 confirmed the baked breaded fish was an odd white frozen color, he confirmed the steam broccoli and broccoli cheddar casserole were chewy, and the cake was dry and hard to cut.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and review of the facility policy, the facility failed to store, prepare, and serve food in a sanitary manner and the facility failed to properly store potentially hazardous cleaning agents away from food preparation areas. This had the potential to affect all residents who receive food from the kitchen. The facility identified ten (Residents #1, #5, #15, #16, #35, #38, #46, #53, #64, #84) who do not receive food from the kitchen. The facility census was 67 residents. Findings include: 1.Observation during the initial tour of the kitchen on 07/21/25 at 8:50 A.M. with the Dietary Manager (DM) #102 revealed the refrigerator contained the following unlabeled and undated items: a large open metal container of cooked hamburgers, a large container of what appeared to be cooked sweet potatoes, a large metal container of chicken noodle soup, a large metal container of mashed potatoes, a container of cooked omelets, thirteen individual fruit cups in a paper containers, several pieces of sliced cheese, a large plastic container that appeared to be cooked pot roast. The freezer contained the following unlabeled and undated items: an open bag of curly fries, a bag of fish patties. Interview on 07/21/25 at 8:53 A.M. with DM #102 confirmed the unlabeled and undated items in the facility refrigerator and freezer.Review of the facility policy titled Date Marking for Food Safety dated 03/01/25 revealed the facility would adhere to a date marking system ensure safety of the ready-to-eat temperature control for food safety. The policy stated food would be clearly marked to indicate the date or day by which the food shall be consumed or discarded. The marking system should consist of a color-coded label, the date of opening and the date the item should be discarded. 2. Observation on 07/21/25 at 8:54 A.M. during the initial tour of the kitchen with DM #102 revealed the facility had two gallons of bleach stored under the food preparation table with the steamer and next to the gas stove. Interview on 07/21/25 at 8:54 A.M. with DM #102 confirmed the two gallons of bleach located under the food preparation table next to the gas stove. DM #102 confirmed the two gallons of bleach should be stored in a proper storage area away from the food preparation area. Observation on 07/23/25 at 8:23 A.M. with DM #102 revealed there was a gallon of bleach stored under the food preparation table located next to the gas stove. The counter also contained a spray can of stainless-steel cleaner, and a gallon of de-[NAME]. Interview on 07/23/25 at 8:23 A.M. with DM #102 confirmed the gallon of bleach, the spray can of stainless-steel cleaner, and the gallon of delimer located on the food preparation counter next to the gas stove and confirmed these items should not be stored in food preparation areas.Review of the facility policy titled Chemical Storage dated 06/16/25 revealed chemicals used by the dietary department would be kept in a secure area or in a secure storage area. 3. Observation during the initial tour on 07/21/25 at 9:00 A.M. with DM #102 revealed there was a buildup of crumbs, dirt, and food debris all over the top of the dishwasher and on the kitchen counters. The kitchen ceiling vents in the food preparation areas had a black substance hanging from them. The steamer located next to the stove had a drip pan under it which contained three heavily soiled white towels covered with brown substance that had been shoved under the tray of the steamer. Interview on 07/21/25 at 9:05 A.M. with DM #102 confirmed the dirt and debris on top of the dishwasher and the kitchen counters, the black substance hanging from the ceiling vents, and the dirty towels which had been shoved under the steamer tray because the steamer was broken. Interview on 07/24/25 at 10:45 A.M. with Registered Dietician (RD) #103 confirmed the facility had ongoing issues related to the sanitization in the kitchen. RD #103 stated she had worked with DM #102 to ensure the kitchen was clean and sanitized. RD #103 stated she emailed the facility Administrator outlining identified issues in the kitchen. RD #103 sent an email to the Administrator on 06/05/25 regarding the need for the kitchen steamer to be repaired. RD #103 stated she sent an email to the Administrator on 06/24/25 indicating areas in the kitchen that needed deep cleaning and including the lights, the steam well, and the walls in the kitchen. RD #103 had recommended the kitchen have a routine cleaning schedule.Review of the facility policy titled Sanitary Conditions undated confirmed all food would be properly stored and all food equipment would be cleaned and maintained in a sanitary fashion. 4.Observation of the dishwasher on 07/21/25 at 9:06 A.M. revealed DM #102 ran the dishwasher through two cycles and the thermometer failed to move for the wash cycle or the rinse cycle. Interview on 07/21/25 at 9:16 A.M. with DM #102 confirmed the dishwasher was a low-temperature dishwasher and it should have reached 120 degrees Fahrenheit (F) for the wash cycle and for the rinse cycle to ensure the facility dishes were properly sanitized. DM #102 confirmed the facility dishwasher had been utilized to clean the Resident breakfast dishes on 07/21/25. DM #102 stated the facility would utilize the three

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on record review, review of the facility's Legionella Water Management Plan, observation of hot water tank temperatures, staff interview, and review of the facility legionella mission statement, the facility failed to ensure implementation and maintenance of the legionella water management plan. This had the potential to affect all residents in the facility. The facility census was 67 residents.Findings include: Review of a facility document titled Legionella Water Management Plan undated revealed water entered the facility from the local public water supply and was stored in five holding tanks that were heated by natural gas and/or electricity. There was a tank in a storage room located adjacent to the kitchen that supplied hot water only to the kitchen. There were two tanks located in the dirty utility room of the 100 and 200-nursing units. One tank was designated to supply hot water to the 100-nursing unit, and one tank was designated to supply hot water to the 200-nursing unit. There were two tanks located in the dirty utility room of the 300 and 400-nursing units dirty utility room. One tank was designated to supply hot water to the 300-nursing unit, and one tank was designated to supply hot water to the 400-nursing unit. The four water heaters that supplied hot water to the 100, 200, 300, and 400-nursing units were 120-gallon capacity tanks which were to be maintained at 140 degrees Fahrenheit (F). The facility was to contact the outside contractor for assistance if unable to maintain the tank temperatures at 140 degrees F. The facility was to check the flow and return temperatures for the water heaters located on the nursing units on a weekly basis. The temperature at the outlet of the hot water tank should not be lower than 140 degrees F and if unable to maintain the desired temperature the program team should develop secondary methods to ensure the system is performing as needed.Observation on 07/28/25 between 11:10 A.M. and 11:30 A.M. of water temperatures with Maintenance Assistant (MA) #117 revealed he used a digital thermometer to measure the temperature of the water output line. The kitchen hot water tank reached 122 degrees F and the hot water tanks for 100, 200, 300 and 400-nursing units reached 118 degrees F. Interview on 07/28/25 at 11:30 A.M. with MA #117 verified the temperature of the kitchen hot water tank was 122 degrees F at the outlet line, and the temperature of the 100, 200, 300, and 400-nursing unit hot water tanks was 118 degrees F at the outlet lines. MA #117 confirmed these temperatures did not meet the 140-degree F threshold and further confirmed the facility had not completed weekly temperature monitoring for the kitchen, 100, 200, 300 and 400-nursing unit hot water tank outlet line temperatures. Interview on 07/28/25 at 11:58 A.M. with the Senior Administrator (SA) #199 verified the kitchen, 100, 200, 300 and 400-nursing unit hot water holding tanks were to be maintained at 140 degrees F or greater.Review of the facility's Legionella Water Management Plan mission statement revealed the facility promoted proactive steps to establish healthy, infection-free environments for residents, staff and visitors. When residents contracted Legionnaires' disease, it was often the result of exposure to inadequately managed building water systems, which could be prevented.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365363	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkside Nursing and Rehabilitation Center	908 Symmes Road Fairfield, OH 45014

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 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide bedrooms that don't allow residents to see each other when privacy is needed. Based on observation, staff interview, and review of the facility policy, the facility failed to provide privacy curtains in resident rooms. This affected four (Residents #26, #28, #59, #62) four residents reviewed for privacy. The facility census was 67 residents.Findings include: Observation on 07/24/25 at 8:42 A.M. with Assistant Director of Nursing (ADON) #56 revealed there were no privacy curtains in the rooms of Residents #26, #28, #59, and #62.Interview 07/24/25 at 8:46 A.M. with ADON #56 confirmed the facility had not provided proper privacy curtains to ensure full visual privacy in the rooms of Residents #26, #28, #59, and #62.Review of the facility policy titled Resident Rights dated 06/01/24 revealed residents had the right to be treated with dignity and respect and had a right to privacy during personal care.

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	365363	A. Building B. Wing	07/31/2025

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on medical record review, observation, staff interview, resident interview, and review of the facility policy, the facility failed to provide an effective pest control program. This affected three (Residents #3, #26, #44) of three residents reviewed for pest control. The facility census was 67 residents.Findings include: 1. Review of the medical record for Resident #3 revealed an 04/30/24 with diagnoses including atherosclerotic heart disease, osteoarthritis, and asthma.Review of the Minimum Data Set (MDS) assessment for Resident #3 dated 6/14/25 revealed the resident had impaired cognition.Observation on 07/21/25 at 11:04 A.M. revealed there were multiple large black flying insects in Resident #3's room. Interview on 07/21/25 at 11:19 A.M. with Unit Manager (UM) #140 confirmed there were multiple large black flying insects in Resident # 3's room.2. Review of the medical record for Resident #26 revealed an admission date of 12/18/24 with diagnoses including chronic atrial fibrillation, major depressive disorder, vascular dementia, and anorexia. Review of the MDS assessment for Resident #26 dated 6/27/25 revealed the resident had impaired cognition and required set up assistance from staff with her meals.Observation on 07/23/25 at 12:30 P.M. revealed Resident #26 was propped up in her bed and her meal was in a closed container on her bedside table. Resident #26 opened the container and there was a gnat flying around inside her meal. Interview on 07/23/25 at 12:31 P.M. with Resident #26 confirmed there was a gnat flying around inside her meal. Interview on 07/23/25 at 12:33 P.M. with Licensed Practical Nurse (LPN) 66 confirmed the meal tray did not look appealing and contained a gnat flying inside the container of Resident #26's lunch.Interview on 07/24/25 at 9:20 A.M. with Maintenance Assistance (MA) #117 confirmed the staff had reported to him that Resident #26 had active gnats in her room. MA #117 reported when staff notified him of a pest issue, he was to contact the pest control company.3. Review of the medical record for Resident #44 revealed an admission date of 02/23/24 with diagnoses including anemia, congestive heart failure, hypertension, and diabetes mellitus. Observation on 07/23/25 at 8:33 A.M. of Resident #44 revealed multiple flies were observed on the resident's motorized wheelchair.Interview on 07/23/25 at 9:02 A.M. with LPN #66 verified the flies in the resident's room.Interview on 07/24/25 at 9:20 A.M. with MA #117 confirmed he was not aware of the issues related to flies in Resident #44's room.Review of the facility policy titled Pest Control dated April 2014 revealed it was the policy of the facility to ensure the facility was free of pest and rodents by maintaining an effective pest control program to eradicate and contain common household pests (example roach, mosquitoes, bees, flies, mice, rats).

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	365363	A. Building B. Wing	07/31/2025

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on review of personnel files, and staff interview, the facility failed to ensure Certified Nursing Assistants (CNAs) completed the required annual number of continuing education hours. This had the potential to affect all residents residing in the facility. The facility census was 67 residents. Findings include: 1.Review of the personnel file for CNA #8 revealed a hire date of 12/07/22 with five hours of continuing education for calendar year 2024.Interview on 07/28/25 at 10:03 A.M. with Human Resources Manager (HRM) #109 verified CNA #8 had only five hours of continuing education completed for calendar year 2024. 2. Review of the personnel file for CNA #15 revealed a hire date of 02/13/23 with five hours of continuing education for calendar year 2024.Interview on 07/28/25 at 10:05 A.M. with HRM #109 verified CNA #15 had only five hours of continuing education completed for calendar year 2024 and the requirement was 12 hours of continuing education annually for CNAs.