| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365377 | A. Building<br>B. Wing | 03/30/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Celina Manor | 1001 Myers Road<br>Celina, OH 45822 |

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 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate dialysis care/services for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, dialysis staff interview, staff interview, and review of facility policy, the facility failed to implement pre-admission physician orders for peritoneal dialysis (PD) (treatment for kidney failure that cleans the blood using the body's abdominal lining (peritoneum) as a natural filter) and provide ongoing monitoring of the resident receiving PD. This affected one (#77) of one resident reviewed for dialysis. The facility census was 72.Findings include:Review of the medical record for Resident #77 revealed an admission date of 11/15/25. Diagnoses included chronic kidney disease (CKD) stage five. Resident #77 was hospitalized on [DATE] and did not return to the facility. The discharge Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #77 received dialysis services.Review of the written pre-admission physician order for PD for three daily exchanges at 6:00 A.M., 2:00 P.M. and 10:00 P.M. There was also an order to monitor for signs and symptoms of peritonitis such as fever, abdominal pain and cloudy effluent (waste fluid from peritoneal dialysis consisting of dialysate, excess body water and toxins). The orders was signed 11/14/25.Review of the facilities physician orders for Resident #77 revealed there were no orders to monitor for signs and symptoms of peritonitis.The care plan, dated 11/17/25 revealed Resident #77 required PD related to CKD stage five. Interventions to monitor labs and report to the doctor as needed, monitor and report to physician signs and symptoms of bleeding, bacteremia, septic shock, report significant changes in pulse, respirations and blood pressure immediately.Review of the paper peritoneal flowsheet documentation revealed there were columns to document the time of the peritoneal dialysis and condition/other comments (call nurse immediately for cloudy fluid, abdominal pain fever). The first date completed on this document was 11/15/26 at 2:00 P.M. with a note the PD nurse had completed the exchange. The second documentation was on 11/15/26 at 10:00 P.M. and contained no documentation in the condition/comment section. Further daily documentation on 11/16/25, 11/17/25, and 11/18/25 revealed no correlating condition/comments for each time PD was completed, instead there was one entry for the entire day. There was no documentation PD was completed on 11/18/26 at 6:00 A.M.Review of the dialysis flowsheet for the PD cycler machine (a table-top device used to treat kidney failure, typically used overnight) revealed the start date was 11/19/25. There was no description of the effluent on 11/19/25, 11/20/25, 11/21/25 or 11/22/25.Interview on 03/30/26 at 9:02 A.M. with PD Nurse #355 from Company #1 revealed the facility staff would need to monitor the effluent for cloudiness and/or if the resident developed abdominal pain and fever during the procedure and report these things immediately to her staff. If they did occur, PD Nurse #355 verified the facility staff had been trained on the Peritoneal Dialysis Cycler the facility had used for Resident #77.Interview on 03/30/26 at 1:17 P.M. with the Director of Nursing (DON) verified the paper charting did not allow for an area to provide description of the effluent or signs and symptoms of abdominal pain and or fever for each time PD was performed. The DON confirmed there was no documentation for PD on 11/18/25 at 6:00 A.M. and there was no order to monitor for signs and symptoms of peritonitis as physician ordered. The DON confirmed there was no physician order in the electronic charting for the use of the Peritoneal Dialysis Cycler . The DON explained the cycler was brought in by Resident #77's caregiver and Company #1 was aware she was using it because they provide the<br>(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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| | 365377 | A. Building<br>B. Wing | 03/30/2026 |

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| Celina Manor | 1001 Myers Road<br>Celina, OH 45822 |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | daily orders for the amount of dialysate to use with the cycler.Review of the facility policy titled Dialysis Care revised 04/04/18 revealed the facility would provide an ongoing assessment of the resident's condition and monitoring for complications before, during and after treatments including: monitoring resident condition during the treatment, monitoring for complications, implementing appropriate interventions and using appropriate infection control practices.This deficiency represents non-compliance investigated under Complaint Number 2681777. |

| 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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, staff interview, and policy review, the facility failed to administer medications to a resident utilizing the proper infection control procedure. This affected one (Resident #29) of five residents reviewed for infection control. The facility census was 72.Findings include:Review of the medical record for Resident #29 revealed an admission date of 02/28/14. Diagnoses included depression, traumatic brain injury, and anxiety. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #29 had impaired cognition. Observation on 03/25/26 at 6:58 A.M. revealed Registered Nurse (RN) #281 was preparing Resident #29's medications. RN #282 pulled the medication card containing Amoxicillin-Pot Clavulanate (antibiotic) oral tablet 875-125 milligrams (mg) and pushed the pill out of the medication card directly into the RN's ungloved hand. RN #281 then used her fingers to place the medication into the medication cup. RN #281 followed this same process with Escitalopram Oxalate (antidepressant) oral tablet 20 mg, Furosemide (diuretic) tablet 20 mg, Sennosides (laxative) tablet 8.6 mg Lyrica Oral (nerve pain) capsule 75 mg and Vitamin D (supplement) 1,000 units and placed each pill into her ungloved hand and used her fingers to place them into the medication cup prior to administering them to Resident #29.Interview on 03/25/26 at 7:27 A.M. with RN #281 directly following the administration of medications to Resident #29 verified she placed each medication into her ungloved hands prior to administering the medications. RN #281 acknowledged the proper procedure was to push the pill from the card directly into the medication cup.Review of the facility policy titled Medication Administration-General guidelines revised 10/08/25 revealed medications are administered as prescribed in accordance with good nursing principals and practices and only by persons legally authorized to do so.This deficiency represents non-compliance investigated under Complaint Number 2681777. |