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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Celina Manor	1001 Myers Road Celina, OH 45822

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and policy review, the facility failed to issue a resident the Notice of Medicare Non-Coverage (NOMNC) and Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNF ABN) after the facility initiated a discharge from Medicare part A services. This affected one (#32) of three residents reviewed for beneficiary notices. The facility census was 72.Findings include:Review of the medical record for Resident #32 revealed an admission date of 05/29/25. Diagnoses included aftercare following surgery on the circulatory system, diabetes mellitus, and dementia. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #32 was cognitively intact.Resident #32 received skilled services under Medicare part A from 05/29/25 through 07/18/25. Resident #32 had skilled days left on 07/18/25 and remained in the facility. There was no documentation to support the facility issued Resident #32 a NOMNC or SNF ABN. Interview on 03/26/26 at 10:41 A.M. with the Director of Nursing (DON) confirmed the facility initiated Resident #32's discharge from Medicare part A services because skilled services were ending. The DON confirmed the medical record did not have documentation to support the facility issued Resident #32 a NOMNC or SNF ABN prior to services ending 07/19/25. Review of the facility policy titled Skilled Nursing Facility (SNF)- Beneficiary Notice Requirements, revised November 2022, revealed the facility would issue the Notice of Medicare Provider Non-Coverage (Form CMS-10123) when there is a termination of all Medicare Part A or Part B therapy services for coverage reasons. The Notice of Medicare Provider Non-Coverage informs the beneficiary of his/her right to an expedited review of a service termination by the Quality Improvement Organization (QIO). The facility must issue the notice, no later than two days before the services are terminated, but far enough in advance that the beneficiary/representative can man an informed decision. The Advanced Beneficiary Notice (ABN) of Non-Coverage is only issued if the beneficiary intends to continue services and the SNF believes the services may not be covered under Medicare. It is the facility's responsibility to inform the beneficiary about potential non-coverage and the option to continue services with the beneficiary accepting financial liability for those services if billed and denied.

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident and staff interviews, and policy review, the facility failed to address a resident's concern regarding staff in a timely manner. This affected one (#31) of four residents reviewed for dignity and respect.Findings include:Review of the medical record for Resident #31 revealed an admission date of 07/09/21.Diagnoses included anoxic brain damage, diabetes mellitus type two, and depression.The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #31 had intact cognition.Interview on 03/24/26 at 12:08 P.M. with Resident #31 revealed he did have a concern a staff member had not treated him with dignity and respect. He shared Certified Nursing Assistant (CNA) #268 had told him he was too old to be wearing a diaper. Resident #31 denied he believed CNA #268 had not been verbally abusive but felt she had disrespected him by the comment. Resident #31 acknowledged he had not spoken to management regarding the issue and was agreeable of notification to the Director of Nursing (DON) of the concern.Interview on 03/24/26 at 12:42 P.M. with the DON acknowledged she had not been aware of a dignity concern by Resident #31 and stated she would follow up with him.Follow- up interview on 03/26/26 at 8:39 A.M. with the DON regarding the dignity and respect concern from Resident #31 revealed she had not spoken to Resident #31 herself, but instead had the Resident Services Coordinator (RSC) #201 interview him.Interview on 03/26/26 at 8:58 A.M. with RSC #201 revealed she had spoken to Resident #31 and he had voiced a general concern with CNA #268. RSC #201 explained Resident #31 had informed her he and CNA #268 have friendly back and forth banter and he sometimes feels she goes too far. RSC #201 verified she had not been informed of Resident #31's concern by the DON until that morning (03/26/26).Interview on 03/26/26 at 3:33 P.M. with the Administrator revealed it would be her expectation that staff would follow up with a resident's concern for dignity and respect within 24 hours.Review of the facility policy titled Resident Rights, revised 11/2016, revealed a facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his pr her quality of life, recognizing each individual's individuality.

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and policy review, the facility failed to complete a discharge recapitulation of stay or discharge summary upon resident discharge to another healthcare setting. This affected one (#75) of one resident reviewed for planned discharge. The facility census was 72. Findings include:Review of the medical record for Resident #75 revealed an admission date of 10/28/25. Diagnoses included pneumonia, pulmonary fibrosis, emphysema, and chronic obstructive pulmonary disease (COPD).The admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #75 was cognitively intact. Review of the Social Service Weekly Baseline and Discharge Planning tool dated 12/22/25 revealed Resident #75 would be transferring to an Assisted Living on 12/26/25. The tool did not contain any other documentation.The medical record for Resident #75 revealed no documentation to support the facility completed a discharge recapitulation of stay or discharge summary.Interview on 03/26/26 at 3:15 P.M. with Director of Nursing (DON) confirmed Resident #75 had a planned discharge to an Assisted Living facility and the medical record for Resident #75 did not have documentation to support the facility completed a discharge recapitulation of stay or discharge summary. Review of the facility policy titled Admission, Transfer, Discharge and Room Change, dated 2025, revealed it was the responsibility of the DON to ensure that resident discharges are made only upon the physician written order unless the resident is leaving against medical advice (AMA) and that transfers and discharges are documented in the resident's clinical record. Written notification would also be provided to be the resident (whether facility or resident initiated) which would include the following information: reason for transfer or discharge, effective date of transfer or discharge, reason the resident was transferred or discharged , stated of the resident's appeal rights, and the name, address, and telephone number for Ombudsman's office.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, observations, and policy review, the facility failed to ensure a resident who was at risk for falls and had a history of falls had their fall care plan interventions in place. This affected one (#5) of two residents reviewed for falls. The facility census was 72.Findings include:Review of the medical record for Resident #5 revealed an admission date of 09/12/25. Diagnoses included chronic obstructive pulmonary disease (COPD), lymphedema, and anxiety. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #5 had impaired cognition and required moderate assistance from staff with toileting hygiene, bed mobility, and transfers.The care plan, last revised on 01/21/26, revealed Resident #5 was at risk for falls related to impaired mobility, weakness, a history of falls, confusion, edema, and COPD. Interventions to provide a safe environment with even floors, free from spills and a small pad sensor to the chair and a larger sensor pad to the bed.Observation on 03/25/26 at 9:25 A.M. revealed Resident #5 was in her recliner chair in the reclined position; her eyes were closed. There did not appear to be a sensor plugged in close to the recliner.Interview and observation on 03/25/26 at 9:37 A.M. with Certified Nursing Assistant (CNAs) #269 and CNA #248 in Resident #5's room confirmed there was a sensor on the bed, however there was no sensor on Resident #5's chair. CNA #269 and CNA #248 stated they were unaware Resident #5 needed a chair alarm in her recliner. CNAs #269 and #248 said Resident #5 needed the bed sensor pad because the resident would get up unattended through the night.Observation and interview on 03/25/26 at 9:49 A.M. with with Licensed Practical Nurse (LPN) #235 in Resident #5's room revealed Resident #5 was awake in her recliner. LPN #235 asked Resident #5 to stand with her walker allowing LPN #5 to verify there was no chair sensor. Following the observation, LPN #235 accessed Resident #5's care plan and verified Resident #5's care plan did list a chair and bed sensor as an intervention for falls. Review of the facility policy titled Fall Reduction, revised 04/2016, revealed based on outcome of the fall assessment, a fall risk reduction plan would be added to the plan of care.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **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 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.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, medical record review and review of facility policy, the facility failed to monitor for potential adverse side effects for residents receiving psychotropic medications. This affected three (#47, #65, and #70) of five residents reviewed for unnecessary medications. The facility census was 72.Findings include: 1. Review of the medical record for Resident #65 revealed an admission on [DATE]. Diagnoses included Alzheimer's disease, depression, and anxiety.Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #65 had impaired cognition. Review of the plan of care dated 02/05/26 revealed Resident #65 was at risk for adverse effects/complications due to psychotropic medication related to Alzheimer's disease and anxiety. Interventions included monitoring behaviors every shift, monitoring resident for side effects of medication use and notifying physician of adverse side effects.Review of the physicians' orders for Resident #65 revealed on 02/14/26, there was an order for Zoloft oral tablet 50 milligrams (mg) give one tablet by mouth one time a day for depression. There was no documentation in Resident #65's medical record for routine monitoring of behaviors and side effects of the psychotropic medication. Interview on 03/26/26 at 11:01 A.M. with Physician Assistant (PA) #201 who was contracted by the facility for psychiatry services stated he speaks to the staff present on the in-person visits regarding any medication side effects. PA #201 verified he had access to residents' medical records and has not reviewed any documentation specifically for monitoring for adverse side effects for psychotropic medications. Interview on 03/26/26 at 11:47 A.M. with the Administrator and the Director of Nursing verified the facility does not document any adverse side effects of the psychoactive medication for Resident #65. 2. Review of the medical record for Resident #70 revealed an admission date of 09/02/25. Diagnoses included Alzheimer's disease with late onset, anxiety and severe dementia with agitation. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #70 had severely impaired cognition. During the review period, Resident #70 exhibited physical and verbal behaviors towards others on one to three days, had behaviors that were not directed at others occurring four to six days, and had rejection of care on one to three days and wandering behaviors occurring four to six days. Review of the physicians' orders for Resident #70 for the month of March 2026 revealed Resident #70 was receiving psychotropic medications. These included the following: an order dated 03/05/26 for Celexa oral tablet 20 milligrams (mg) give one tablet by mouth daily related to anxiety; an order dated 03/19/26 for hydroxyzine oral tablet 25 mg give one tablet by mouth as needed for agitation/anxiety three times a day for fourteen days; an order dated 02/28/26 for valproic acid oral solution 250 mg per five milliliter (ml) give 10 ml by mouth two times a day related to dementia with severe agitation; and an order dated 02/04/26 for trazodone oral tablet 50 mg give one tablet by mouth one time a day related to anxiety disorder. There was no documentation in Resident #70's medical record for routine monitoring of behaviors and side effects of the psychotropic medication. Interview on 03/26/26 at 11:01 A.M. with Physician Assistant (PA) #201 who was contracted by the facility for psychiatry services stated he speaks to the staff present on the in-person visits regarding any medication side effects. PA #201 verified he had access to residents' medical records and has not reviewed any documentation specifically for monitoring for adverse side effects for psychotropic medications. Interview on 03/26/26 at 11:47 A.M. with the Administrator and the Director of Nursing verified the facility does not document any adverse side effects of the psychoactive medication for Resident #70. 3. Medical record review for Resident #47 revealed an admission date of 01/06/26 with diagnoses including Alzheimer's disease and dementia with behaviors. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #47 had impaired cognition. During the review period, Resident #47 exhibited verbal and physical behaviors on one to three days and behaviors not directed towards others and wandering four to six days. Resident #47 received medications from the pharmacological class of antidepressants and antianxiety. Review of the plan of (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care dated 01/06/26 revealed Resident #47 had impaired cognitive function and dementia. Interventions included administration of medication as ordered and monitor and document any changes in cognitive function, decision making ability and mental status. Resident #47 was also at risk for adverse side effects or complications related to psychotropic medication use. Interventions included monitoring resident's behaviors and recording every shift, monitoring side effects of medications and notifying physician. Review of the physician's orders for the month of March 2026 revealed Resident #47 was receiving psychotropic medications. These included the following: an order dated 02/18/26 for Ativan oral tablet 0.5 milligrams (mg) give one tablet by mouth three times a day for anxiety; an order dated 02/18/26 for buspirone 7.5 mg one tablet by mouth three times a day for dementia; an order dated 02/18/26 for mirtazapine oral tablet 15 mg one tablet daily for treatment of dementia; and an order dated 02/25/26 for sertraline 100 mg tablet, give one tablet daily for treatment of anxiety. There was no documentation in Resident #47's medical record for routine monitoring of behaviors and side effects of the psychotropic medication. Interview on 03/26/26 at 11:01 A.M. with Physician Assistant (PA) #201 who was contracted by the facility for psychiatry services stated he speaks to the staff present on the in-person visits regarding any medication side effects. PA #201 verified he had access to residents' medical records and has not reviewed any documentation specifically for monitoring for adverse side effects for psychotropic medications. Interview on 03/26/26 at 11:47 A.M. with the Administrator and the Director of Nursing verified the facility does not document any adverse side effects of the psychoactive medication for Resident #47.Review of the facility policy titled Psychotropic Drugs last revised on 03/2017 revealed a physician, nursing or other health care professional will document that the resident is being monitored for adverse consequences or complications of the drug therapy.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **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.

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F 0868 Level of Harm - Potential for minimal harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on record review, staff interview, and policy review, the facility failed to ensure required Quality Assurance and Performance Improvement (QAPI) committee members attended the quarterly meetings as required. This had the potential to affect all 72 residents residing in the facility.Findings include:Review of the facility's QAPI attendance sign in sheets for the third quarter (07/01/25 to 09/30/25) and fourth quarter (10/01/25 to 12/31/25) of 2025 revealed no documentation to support the Infection Control Nurse attended the quarterly meeting.Interview on 03/30/26 at 1:20 P.M. with the Administrator confirmed the Infection Prevention nurse did not attend the quarterly QAPI meetings for the third and fourth quarter of 2025. Review of the facility's policy titled QAPI policy and procedure, dated February 2018, revealed an essential element of the QAPI program was the thoughtful and candid review of the company's provision of care to its residents by the QAPI committee. The full committee would meet quarterly and include the Administrator, Medical Director, Pharmacy Consultant, Social Service Designee, Director of Nursing, Activity Coordinator, Food Service Supervisor, Infection Control Nurse, Environmental Service Supervisor, Restorative Nurse, and Business Office Manager.