STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365398	A. Building B. Wing	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Best Care Health and Rehabilitation	2159 Dogwood Ridge Road Wheelersburg, OH 45694

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 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, interview, and facility policy review, the facility failed to notify the Ombudsman of discharge. This affected three Residents (23, #68 and #120) of four reviewed for discharge. The facility census was 79.Findings include:1.Review of the medical record for Resident #23 revealed an admission date of 08/21/25, discharged to the hospital on [DATE] and readmitted to the facility on [DATE] with diagnoses including chronic lymphocytic leukemia of B cell type in remission, chronic kidney disease stage four, cirrhosis of the liver, diabetes mellitus type two, fibromyalgia and mood disorder. Review of the discharge return not anticipated Minimum Data Set (MDS) dated [DATE] revealed Resident #23 was cognitively intact with verbal behaviors towards others. Resident #23 required assistance from the staff to complete activities of daily living. Review of the nursing progress notes revealed no documentation the facility notified the Ombudsman of Resident #23 discharge on [DATE]. 2.Review of the medical record for Resident #68 revealed an admission date of 08/21/25, discharged to hospital on [DATE] and readmitted to the facility on [DATE] with diagnoses including atrial fibrillation, congestive heart failure, liver cirrhosis, diabetes mellitus type two, chronic kidney disease with dialysis. Review of the discharge return not anticipated Minimum Data Set (MDS) most recent completed, dated 08/28/25 revealed Resident #68 was cognitively intact with no behaviors. Review of the nursing progress notes for Resident #68 revealed no documentation the Ombudsman was notified of resident's discharge on [DATE].3.Review of the closed medical record for Resident #120 revealed an initial admission date of 08/12/25, discharged to the hospital on [DATE], readmitted to the facility on [DATE] and discharged to hospital on [DATE] with diagnoses including pleural effusion, chronic kidney disease stage three, cirrhosis of the liver, atrial fibrillation diabetes mellitus type two and Clostridium difficile (C-diff). Review of the Minimum Data Set (MDS) revealed Resident #120 had two admission assessments (limited information) and two discharge return not anticipated assessments. Review of the nursing progress notes revealed no documentation the Ombudsman was notified of Resident #120 discharges to the hospital.Review of the 48 hour plan of care revealed no concerns. Interview on 09/17/25 at 2:55 P.M. with the Director of Nursing confirmed the facility had not notified or had been notifying the Ombudsman of discharges from the facility. Interview on 09/17/25 at 3:20 P. M. with Social Services Director #40 revealed it was a new position and did not know of the notification of the Ombudsman regarding discharge. The Social Services Director #40 stated she called the Ombudsman and received information related to notification of resident discharge.Review of the facility policy titled Bed Hold and Return to Center policy dated 04/20/18 revealed if the facility determined that it can no longer provide the needed services for the resident and was unable to accept the resident in return after transfer, then refer to the Notice of Transfer Discharge policy. That policy was not provided by the facility.This deficiency represents non-compliance investigated under Complaint Number 1382712.

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 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. Based on observation, staff interview and medical record review the facility failed to ensure physician orders were in place for Resident #68 foley catheter. This affected one (Resident #68) of one resident resident reviewed for foley catheters. The facility census was 79.Findings include: Review of the medical record for Resident #68 revealed an admission date of 08/21/25 with diagnoses including atrial fibrillation, congestive heart failure, liver cirrhosis, diabetes mellitus type two, chronic kidney disease with dialysis. Review of the physician orders dated 09/25 revealed no orders in place for Resident #68 indwelling foley catheter.Review of the discharge return not anticipated Minimum Data Set (MDS) most recent completed, dated 08/28/25 revealed Resident #68 was cognitively intact with no behaviors. Resident #68 was dependent on staff for toileting hygiene, bed mobility, and transfers and required substantial assistance with bathing. Resident #68 had an indwelling catheter.Review of the nursing progress notes for Resident #68 revealed no documentation of physician orders for Resident #68 indwelling foley catheter.Review of the Certified Nursing Assistant documentation revealed care was provided for Resident #68 indwelling foley catheter. Review of the plan of care revealed no plan of care for Resident #68 indwelling foley catheter.Interview on 09/17/25 at 2:55 P.M. with the Director of Nursing confirmed Resident #68 had no physician orders for indwelling foley catheter.Observations made during the survey revealed Resident #68 had an indwelling foley catheter to bedside drainage bag with privacy cover.The facility did not have a policy related to physician orders for indwelling foley catheter.This was an incidental finding discovered during investigation of Master Complaint Number 2603203 and Complaint Number 1382712.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review , interview, and facility policy review, the facility failed to ensure medications on admission were received from pharmacy and administered to the residents timely. This affected three Residents (#42, #68 and #120) of five residents reviewed for medication administration. The facility census was 79.Findings include:1.Review of the closed medical record for Resident #120 revealed an initial admission date of 08/12/25 with diagnoses including pleural effusion, chronic kidney disease stage three, cirrhosis of the liver, atrial fibrillation diabetes mellitus type two and Clostridium difficile (C-diff). Review of the Medication Administration Record (MAR) dated 08/25 revealed Resident #120 was ordered on 08/12/25 Vancomycin hydrochloride capsule 125 milligrams (mg) by mouth four times daily for C-diff, Sulcralfate 1 gram by mouth four times daily for gastroesophageal reflux disease (GERD), and Gabapentin 100 mg by mouth three times daily for pain. The MAR indicated Resident #120 did not receive the Sulcralfate and Gabapentin until the morning dose on 08/14/25. The MAR indicated Resident #120 did not receive the Vancomycin 125 mg by mouth up to her discharge back to the hospital on [DATE] for chest pain. Review of the nursing progress notes revealed a note dated 08/13/25 at 9:39 A.M. awaiting pharmacy, a note dated 08/13/25 at 4:29 P.M. awaiting pharmacy, a noted dated 08/13/25 4:29 P.M. Sulcralfate 1 gram by mouth four times day for GERD, awaiting pharmacy, a note dated 08/13/25 at 4:29 P.M. Gabapentin 100 mg by mouth three times day for pain, awaiting pharmacy, a note dated 08/13/25 4:30 P.M. Vancomycin hydrochloride (hcl) oral capsule 125 mg by mouth four times a day for infection for four days, awaiting pharmacy, a note dated 08/14/25 at 6:02 P.M. Vancomycin hcl 25 mg per milliliter (ml) solution reconstituted, give 5 ml by mouth four times day for C-diff for 8 days, awaiting on pharmacy, and no documentation the physician or Nurse Practitioner (NP) was notified for instructions. Review of the Minimum Data Set (MDS) revealed Resident #120 had two admission assessments (limited information) and two discharge return not anticipated assessments. Interview on 09/17/25 at 12:54 P.M. with Licensed Practical Nurse (LPN) #21 confirmed there was a problem getting medications from pharmacy timely especially with admissions. LPN #21 confirmed Resident #120 missed doses of medication for several days after admission. LPN #21 stated if a resident missed a medication the procedure was to call the pharmacy, notify the Nurse Practitioner (NP) or physician, and document. The facility has a Pixus system with medications on hand but does not always have what the resident was ordered. LPN #21 stated the facility was working on a new pharmacy. Interview on 09/17/25 at 1:15 P.M. with NP (on site) revealed Resident #21 had no adverse effects from missing the medications.Interview on 09/17/25 at 2:55 P.M. with the Director of Nursing (DON) confirmed Resident #21 did not receive the medication Vancomycin oral tablets for three days after admission. DON confirmed there was no documentation in nursing progress notes the physician or NP was notified.2.Review of the medical record for Resident #42 revealed an admission date of 09/03/25 with diagnoses including weakness, chronic obstructive pulmonary disorder cirrhosis of liver, chronic viral Hepatitis C, diabetes mellitus type two and congestive heart failure.Review of the MAR dated 09/25 for Resident #42 revealed the following orders dated 09/03/25 on admission: Clopidogrel bisulfate 75 milligrams (mg) by mouth daily not administered until 09/05/25, Lantus insulin Solostar injector pen 100 units/milliliter (ml) inject 8 units subcutaneously daily not administered until 09/05/25, Nicotine patch 21mg/24 hours apply in the morning and remove in the evening not administered until 09/05/25, Sertraline hydrochloride 100 mg by mouth daily not administered until 09/05/25, Trelegy ellipta inhalation powder 100-62.5-25 micrograms one puff daily for 90 days not administered until 09/05/25, Cefazolin intravenous 2.0-0.9 grams/100 ml every 8 hours for 15 days not administered until 09/05/25, and Creon 36000-114000 units give 2 capsules by mouth three times daily not administered until 09/15/25.Review of the nursing progress notes for Resident #42 revealed the following: 09/03/25 at 8:39 P.M. the physician and family was notified of Resident #42 admission to the facility. The resident had no known allergies. Resident #42 tolerated transfer well, oriented to call light, bed controls and television remote. The resident had a midline intravenous site to left upper extremity and a supra pubic catheter. Also noted a wound to coccyx covered with mepilex. The skin assessment was completed. Resident #42 was a full code and was alert and oriented to person, place and time. A note dated 09/04/25 at 4:54 P.M. medications not delivered by pharmacy. A note dated 09/04/25 at 11:46 A.M. Cefazolin in sodium chloride intravenous solution 2.0-0.9 grams/100 ml was not available. A note dated 09/05/25 1:21 P.M. Creon oral capsule delayed release 36000-114000 units give two capsules by mouth three times daily was