STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365453	A. Building B. Wing	02/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ayden Healthcare of Oregon	3953 Navarre Ave Oregon, OH 43616

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, and staff interview, the facility failed to maintain a safe and sanitary environment by containing cigarettes in approved extinguishment receptacles. This affected 17 residents (#1, #3, #22, #23, #29, #34, #38, #40, #41, #51, #52, #53, #55, #56, #57, #66, #70) identified as independent of unsupervised smokers and an additional 32 residents (#2, #6, #5, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #47, #48, #49, #50, #54, #57, #58, #59, #60, #61, #62, #63, #64, #65, #67, #68, #69, #71, #72) residing on the south end of the building. Facility census 79. Findings include:Observation of the south 300 resident community room on 02/23/26 at 8:54 A.M. revealed four extinguished cigarette butts on the carpeted floor. A plastic trash can was identified inside the building near the outside exit door to the designated independent smoking area. The trash can had multiple paper and styrofoam items inside with multiple extinguished cigarettes inside. Continued observation located outside the community room exit door discovered greater than 17 extinguished cigarettes were observed on the ground and in vicinity of the combustible wood building exterior. On 02/23/26 at 8:58 A.M. observation with Unit Manager Licensed Practical Nurse (LPN) #301 verified the discarded cigarettes located in the community room, plastic trash can and outside designated independent resident smoking area. On 02/23/26 at 1:10 P.M. the facility Administrator provided a list of residents whom smoke. The facility identified 17 residents (#1, #3, #22, #23, #29, #34, #38, #40, #41, #51, #52, #53, #55, #56, #57, #66, #70) as independent of unsupervised smokers. In addition 32 residents (#2, #6, #5, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #47, #48, #49, #50, #54, #57, #58, #59, #60, #61, #62, #63, #64, #65, #67, #68, #69, #71, #72) were identified to reside on the south end of the building.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview, and review of facility policy, the facility failed to ensure proper hand sanitation was maintained during meal preparation and dining service. This affected 78 current residents identified to receive meals from the facility kitchen excluding one resident (#18) receiving nutrition via feeding tube. Findings include: On 02/23/26 at 12:09 P.M. observation during the lunch meal service noted Dietary Aide (DA) #201 wearing single use plastic gloves while handling empty individual meal trays. DA #201 proceeded to handle soiled meal trays and handled the commercial dishwasher while placing the soiled trays inside. DA #201 removed the clean trays and returned to the serving line without changing gloves or washing hands. DA #201 began handling clean utensils and placing meal tickets to the clean meal trays without changing the gloves. At 12:14 P.M. DA #201 handled tray meal tickets with gloves and the tickets fell to the floor. DA #201 proceeded to pick the tickets off the floor and placed them to the clean meal trays on the meal service line. DA #201 changed gloves. However, no hand washing was observed. On 02/23/26 at 12:39 P.M. interview with DA #201 verified when gloves are cross contaminated. Staff are to removed the soiled gloves and wash hands before donning a new pair. On 02/23/26 observation during the lunch meal service noted at 11:55 A.M. [NAME] #200 exited the kitchen wearing plastic single use gloves. [NAME] #200 placed hands on the kitchen entry door, placed hands on the walk-in cooler and obtained various food items. [NAME] #200 used the gloved hand to close the cooler door and reentered the kitchen using the door handle. [NAME] #200 proceeded to handle food and clean plates without changing gloves or washing hands. At 12:00 P.M. [NAME] #200 exited the kitchen wearing single use plastic gloves and placed hands on the door handle exiting the kitchen and door handle to walk-in cooler. [NAME] #200 proceeded to close the walk-in cooler with the gloved hand while carrying a tray of tuna fish sandwiches and re-entered the kitchen handling the door knob with the gloved hand. [NAME] #200 then proceeded to handle the sandwiches with the soiled gloves placing them to plates. At 12:03 P.M. [NAME] #200 exited the kitchen with single use plastic gloved hands and handled the door knob to the kitchen entry door and walk-in cooler door. [NAME] #200 returned to the kitchen with food items while placing the gloved hands on the door knobs. At 12:30 P.M. [NAME] #200 exited the kitchen through the front kitchen entry door. [NAME] #200 had gloved hands and handled the entry door knob without changing gloves or washing hands. [NAME] #200 returned to the kitchen with the same gloves applied and handled food items, making grilled sandwiches wearing the same soiled gloves. On 02/23/26 at 12:40 P.M. interview with [NAME] #200 verified the lack of changing gloves and related hand washing when handling food. On 02/23/26 at 1:23 P.M. interview with Dietary Manager (DM) #500 during a review of facility gloving and hand washing policy verified hands are to be washed between glove changes. DM #500 identified one of 79 residents (#18) not receiving food from the facility kitchen. Review of facility single use glove policy updated 11/22/20. Single-use gloves will be worn when handling food directly with hands to assure that bacteria are not transferred from food handlers hands to the food product being served. Gloved hands are considered food contact surface that can get contaminated or soiled. If used, single use gloves shall be used for only one task, used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation. Hands are to be washed when entering the kitchen and before putting on the single use gloves and after removing single use gloves. Anytime a contaminated surface is touched, the gloves must be changed, and hands must be washed: After handling soiled trays or dishes. After handling anything soiled. After handling boxes, crates, packages. After picking up any item from the floor. Any time a contaminated surface is touched. Wash hands after removing gloves. Review of hand washing policy updated (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11/22/20. Hands and exposed portions of arms should be washed immediately before engaging in food preparation. When to wash hands: When entering the kitchen at the start of a shift. After handling soiled equipment or utensils. During food preparation, as often as necessary to remove soil or contamination and prevent cross contamination when changing tasks. Before donning disposable gloves for working with food and after gloves are removed. After engaging in other activities that contaminate the hands. Food preparation and/or pot sinks will not be used for hand washing.

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, and staff interview, the facility failed to ensure resident common showers, and common area corridors were properly cleaned and maintained. This affected 68 current residents excluding 11 residents (#6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16) residing on the medbridge unit. Facility census 79. Findings include:1. Observation on 02/24/26 at 6:09 A.M. noted the north common shower room left stall with a black substance along the edge of the floor and wall. Next to the wall mounted seat on the left revealed an approximate one foot by 8 inch section of missing ceramic tile which exposed the structural backing or [NAME] board, and a one inch diameter hole through the wall ([NAME] board). 2. Observation on 02/24/26 at 6:14 A.M. noted the south common shower room with a soiled brief on the floor in front of the sink. A brown substance with pealing caulk was identified around the base of the toilet. Inside the left shower stall revealed a black substance between the shower stall floor and tile. In addition inside the shower stall noted a black substance between the wall shower tiles, four holes penetrated the wall through the ceramic tile with a black brown substance around the holes, and a broken soap dispenser in the stall leaving jagged edges. 3. On 02/24/26 between 6:15 A.M. and 6:25 A.M. observation of corridor floor tiles revealed a brown/black residue covering various tiles, along corridor walls and at resident room thresholds. These areas were between the following rooms; 101-109, 110-122, 201-210, 301-312, 314-326. 4. On 02/24/26 between 6:15 A.M. and 6:25 A.M. observation located between resident rooms 206-208, 314-327 identified multiple broken floor tiles in the corridor. On 02/24/26 at 6:23 A.M. interview with Licensed Practical Nurse (LPN) #300 revealed the floors had been observed in the same condition since beginning employment at the facility. On 02/24/26 at 6:25 A.M. tour of the facility with Director of Housekeeping Services (DHS) #600 verified the condition of facility flooring, and resident common showers. DHS #600 stated attempts had been implemented to remove the flooring stains which were unsuccessful. DHS #600 verified the tile floors were installed in all facility corridors excluding the Medbridge unit rooms 330-341, which were carpeted and included 11 current residents (#6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16). This deficiency represents non-compliance investigated under Complaint Number 2720626.