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	03/19/2026

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, staff interview, and review of facility policy, the facility failed to ensure interventions and wound treatments were implemented as physician ordered and with appropriate technique. This affected two (#1 and #2) of three residents reviewed for wound care. The facility census was 88. Findings include:1. Review of Resident #1's medical record revealed an admission date of 04/04/25, with diagnoses including dementia, acute respiratory failure, Type II diabetes mellitus with diabetic neuropathy, dysphagia, history of aspiration pneumonia, gastrostomy (G-tube), and hypertension.Review of the Minimum Data Set (MDS) assessment, dated 02/04/26, revealed Resident #1 was in a persistent vegetative state, was unable to make needs known, was severely cognitively impaired, was dependent on staff for all activities of daily living (ADLs), was incontinent of bowel and bladder, had no known weight loss, received all nutrition via feeding tube, was at risk for pressure ulcer development with no skin breakdown, and received anticoagulant and antidepressant medications. Review of the plan of care, dated 02/06/26, revealed Resident #1 was at risk for impaired skin integrity related to history of ulcers, diabetes, poor circulation, decreased mobility, side effects of medication use, chronic itching, malnutrition and occasional incontinence. Interventions included skin to be free of breakdown, barrier cream/ointment after each incontinent episode as needed, inspect skin during routine daily care and pressure reducing mattress. Review of the return from hospital assessment dated [DATE] revealed Resident #1 was re-admitted to the facility with skin alterations. Review of the pressure ulcer development risk assessment (Braden) dated 03/11/26 revealed Resident #1 scored an 11, indicating the resident was at high risk for pressure ulcer development. Review of the skin alteration assessment dated [DATE] revealed Resident #1 had a stage II pressure injury to the coccyx, measuring 0.8 centimeters (cm) long by (x) 0.7 cm wide x 0.1 cm deep with serosangous (blood tinged) drainage. A second area of skin alteration, described as excoriation, was documented to the groin and thighs with measurements undetermined and bright red blood drainage. Review of the physician orders revealed an order dated 03/11/26 to cleanse the coccyx with soap and water, pat dry, apply foam dressing, and change daily and as needed (PRN). On 03/12/26, the order was changed to cleanse the coccyx with wound wash, apply zinc cream to foam cover and apply over wounds, and apply zinc cream to rest of buttocks every shift and PRN. Further review revealed an order dated 03/11/26 to cleanse the sacrum and medial thigh/groin area twice daily and apply house barrier cream. Review of a Wound Specialist evaluation dated 03/17/26 revealed Resident #1 admitted with a stage II pressure ulcer measuring 2.0 cm x 1.7 cm x 0.1 with small amount of sero-sanguiuneous drainage. The wound was noted to be improving. Treatment orders to the sacral wound were continued to cleanse with wound cleanser or normal saline, pat dry, apply house barrier cream with zinc to wound bed, cover with dry dressing, and change every shift and PRN if soiled or dislodged. Pressure relief and off-loading. The wound specialist evaluated the resident's right superior buttock to have moisture associated skin damage (MASD), measuring 1.8 cm x 1.7 cm x 0.1 cm with a small amount of sero-sanguineous drainage. Treatment orders were to cleanse with wound cleanser or normal saline, pat dry, apply house barrier cream with zinc to the wound bed, cover with dry dressing, and change every shift and PRN if soiled (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
	365453	A. Building B. Wing	03/19/2026

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	or dislodged. Pressure relief and off-loading. Observation on 03/18/26 at 7:45 A.M. revealed Certified Nursing Assistant (CNA) #200 and CNA #201 entered Resident #1's room. CNA #200 and CNA #201 proceeded to perform incontinence care and repositioned the resident on his back. Continued observation between 8:00 A.M. and 11:13 A.M. revealed Resident #1 remained positioned on his back. Staff were not observed to check on Resident #1 for incontinence care or reposition the resident between 8:00 A.M. and 11:13 A.M. Continued observation on 03/18/26 at 11:13 A.M. revealed Licensed Practical Nurse (LPN) #300 entered Resident #1's room. LPN #300 exposed Resident #1's G-tube site and discovered Resident #1 was heavily soiled with urine contained in an adult incontinence brief. LPN #300 continued to provide care and treatment to the G-tube and related tube feeding. LPN #300 did not address Resident #1's incontinence care needs. Observation on 03/18/26 at 11:58 A.M. revealed CNA #201 and CNA #202 entered Resident #1's room. CNA #201 and CNA #202 removed Resident #1's incontinence brief and noted the resident was heavily soiled with urine. CNA #201 and CNA #202 proceeded to cleanse the resident using disposable incontinence wipes and incontinence spray cleanser. CNA #201 and CNA #202 positioned Resident #1 to the left side and noted Resident #1 with an area of MASD and a wound to the sacrum. No dressing was applied to the wounds. Concurrent interview with CNA #201 revealed they had assumed care of Resident #1 at 11:00 A.M. and was unaware of when Resident #1 was last checked for incontinence care or repositioned. Both CNA #201 and CNA #202 stated Resident #1 was to be checked, changed for incontinence, and repositioned every two hours. Observation on 03/18/26 at 12:12 P.M., during interview with LPN #300, verified a current physician order was in place for a dressing to be applied to Resident #1's MASD and sacral wound and no dressing was in place as physician ordered. Review of the facility policy titled, Skin Management Program, revised April 2023, revealed, upon completion of the Braden Scale, the nurse would initiate/review the resident's skin alteration plan of care and verify plan of care recognized interventions to assist in reducing the resident's risk of skin breakdown. 2. Review of the medical record revealed Resident #2 admitted to the facility on [DATE], with diagnoses including paraplegia, chronic osteomyelitis, pressure ulcer stage IV to the right buttock and sacral region, anemia, polyneuropathy, hypertension, depression, history of venous thrombosis and embolism, and mild intellectual disabilities.Review of the MDS assessment, dated 12/18/25, revealed Resident #2 had intact cognition, had no behaviors, had bilateral lower extremity range of motion impairment, was dependent on staff for completion of ADLs, required partial to moderate assistance with bed mobility, was incontinent of bowel and bladder, and was at risk for pressure ulcer development. Resident #2 admitted with two stage IV pressure ulcers. Review of the physician orders revealed on 11/19/25, an order was initiated for a open area to Resident #2's right posterior thigh to cleanse the area with liquid antibacterial soap and water, pat dry, and apply Prisma and silicone Border Zetuvit once daily and PRN. Review of the plan of care, revised 02/06/26, revealed Resident #2 was at risk for infection related to communal living and current osteomyelitis. Interventions included administer antibiotics as ordered, complete treatments as ordered, Enhanced Barrier Precautions (EBP), and evaluate for signs and symptoms of infection and report to physician (MD), including redness, swelling, increased pain, purulent drainage, elevated temperature, change in color of sections, cough, congestion, abnormal lungs sounds, diarrhea, and/or vomiting. In addition, on 02/06/26, the nursing plan of care was revised to address the resident being at risk for impaired skin integrity related to incontinence, decreased mobility, current wounds, and chronic osteomyelitis. Goals were noted as skin would be free of breakdown, wound to coccyx would improve by review date, and wound to the right thigh would improve by review date. Interventions included barrier cream/ointment after each incontinent episode as needed, dietary evaluation as needed, explain all procedures prior to care, inspect skin during routine daily care, and pressure reducing mattress. Lastly, on 02/06/26, a nursing plan of care was implemented to address Resident #2's long-term use of antibiotic therapy related to chronic osteomyelitis. Interventions included administer medication as ordered, antibiotics were non-selective and could result in the eradication of beneficial microorganisms and the emergence of undesired ones, (continued on next page)

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	03/19/2026

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	causing secondary infections such as oral thrush, colitis, and vaginitis, any antibiotic may cause diarrhea, nausea, vomiting, anorexia, and hypersensitivity /allergic reactions, monitor every shift for adverse reaction, ask physician to review medication for possible dose reduction every three months, observe for possible side effects every shift, and report pertinent laboratory test results to the MD. Review of the weekly wound rounds documentation dated 03/18/26 revealed the right gluteal fold wound was discovered on admission. The wound measured 1.5 cm x 0.3 cm x 1.6 cm with a small amount or serous drainage and unchanged wound status. Observation on 03/18/26 at 7:27 A.M. revealed LPN #300 obtained dressing treatment supplies and placed them next to Resident #2 in bed. LPN #300 applied gloves and a gown. LPN #300 positioned Resident #2 on the left side and exposed the right posterior gluteal fold wound, with the dressing dislodged. LPN #300 removed the cover dressing and packing from inside the wound, and disposed of the soiled dressings into a trash bag. LPN #300 then opened the gauze packaging with the soiled gloves and cleansed the wound with wound cleanser spray. No liquid antibacterial soap was used. LPN #300, with the same soiled gloves, proceeded to pat dry the wound with four x four gauze pads. LPN #300 opened a dressing treatment identified as collagen purcol pad with the soiled gloves and packed the pad to the wound. No Prizma wound treatment was applied. LPN #300 then opened a silicone border dressing package with the same gloves and covered the wound. Concurrent interview with LPN #300 verified gloves were not changed between clean and soiled dressings and further confirmed the dressing supplies used to complete the treatment. Interview on 03/18/26 at 1:50 P.M. with the Director of Nursing (DON) verified Resident #2's wound treatment was not administered as ordered by the physician. Review of the facility policy titled, Dressings, Dry/Clean, revised September 2013, revealed the procedure was to clean bedside stand, establish a clean field, place clean equipment on the clean field, arrange supplies so they could be easily reached, wash and dry hands thoroughly, put on gloves, loosen tape and remove soiled dressing, wash and dry hands thoroughly, open dry/clean dressing(s) by pulling corners of the exterior wrapping outward (touching only the exterior surface), using clean technique, open other products (prescribed dressing; dry, clean gauze), wash and dry hands thoroughly, put on clean gloves, assess the wound and surrounding skin for edema/redness/drainage/ tissue healing progress and wound stage, cleanse the wound with ordered cleanser, use clean gauze for each cleansing stroke, clean from the least contaminated area to most contaminated area, use dry gauze to pat the wound dry, apply the ordered dressing and secure with tape or bordered dressing per order, discard disposable items into designated container, remove disposable gloves and discard into container, and wash and dry hands thoroughly. This deficiency represents non-compliance investigated under Master Complaint Number 2803908 and Complaint Number 2800644.

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	03/19/2026

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, and staff interview the facility failed to ensure timely and effective incontinence care was provided. This affected two (#1 and #2) of three residents reviewed for incontinence care. The facility census was 88. Findings include:1. Review of the medical record revealed Resident #2 admitted to the facility on [DATE], with diagnoses including paraplegia, chronic osteomyelitis, pressure ulcer stage IV to the right buttock and sacral region, anemia, polyneuropathy, hypertension, depression, history of venous thrombosis and embolism, and mild intellectual disabilities.Review of the MDS assessment, dated 12/18/25, revealed Resident #2 had intact cognition, had no behaviors, had bilateral lower extremity range of motion impairment, was dependent on staff for completion of ADLs, required partial to moderate assistance with bed mobility, was incontinent of bowel and bladder, and was at risk for pressure ulcer development. Resident #2 admitted with two stage IV pressure ulcers. Review of the plan of care, revised on 02/06/26, revealed Resident #2 was at risk for alteration in elimination related to urinary retention, paraplegia, weakness, and decreased mobility. Interventions included administer medications as ordered, monitor for signs and symptoms (s/x) of urinary tract infection (UTI), elevated temperature, dysuria, flank pain, hematuria, foul smelling urine/report to physician (MD)/seek diagnosis and promptly treat, and provide incontinence care as needed. Observation on 03/18/26 at 7:10 A.M. revealed Certified Nursing Assistant (CNA) #202 entered Resident #2's room. CNA #202 proceeded to removed Resident #2's urine and bowel movement (BM) soiled incontinence brief and positioned the resident on the left side. CNA #202 cleansed the BM and placed a new adult incontinence brief. However, CNA #202 did not cleanse the Resident's anterior perinium of the soiled urine. CNA #202 discarded the soiled brief in the trash receptacle. Interview on 03/18/26 at 7:20 A.M. with CNA #202 confirmed they did not cleanse the urine from Resident #2's anterior perinium during incontinence care. 2. Review of Resident #1's medical record revealed an admission date of 04/04/25, with diagnoses including dementia, acute respiratory failure, Type II diabetes mellitus with diabetic neuropathy, dysphagia, history of aspiration pneumonia, gastrostomy (G-tube), and hypertension.Review of the Minimum Data Set (MDS) assessment, dated 02/04/26, revealed Resident #1 was in a persistent vegetative state, was unable to make needs known, was severely cognitively impaired, was dependent on staff for all activities of daily living (ADLs), was incontinent of bowel and bladder, had no known weight loss, received all nutrition via feeding tube, was at risk for pressure ulcer development with no skin breakdown, and received anticoagulant and antidepressant medications. Review of the plan of care, revised 02/06/26, revealed Resident #1 was at risk for alteration in elimination related to cognitive deficit, weakness, decreased mobility, lack of core muscles, muscle wasting and atrophy, side effects of medications, and constipation. Intervention included to provide incontinence care as needed. Observation on 03/18/26 at 7:45 A.M. revealed CNA #200 and CNA #201 entered Resident #1's room. CNA #200 and CNA #201 proceeded to perform incontinence care and repositioned the resident. Continued observation between 8:00 A.M. and 11:13 A.M. revealed Resident #1 remained positioned on his back. No staff were observed to check on Resident #1 for incontinence care needs between 8:00 A.M. and 11:13 A.M. Observation on 03/18/26 at 11:13 A.M. revealed Licensed Practical Nurse (LPN) #300 was observed to enter Resident #1's room. LPN #300 exposed Resident #1's G-tube site and discovered the resident was heavily soiled with urine contained in an adult incontinence brief. LPN #300 continued to provide care and treatment to the G-tube and related tube feeding. LPN #300 made no attempt to address Resident #1's incontinence care needs. Observation on 03/18/26 at 11:58 A.M. revealed CNA #201 and CNA #202 entered Resident #1's room. CNA #201 and CNA #202 removed Resident #1's brief and noted the resident was heavily soiled with urine. CNA #201 and CNA #202 proceeded to cleanse the area using disposable incontinence wipes and incontinence spray cleanser. (continued on next page)

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	03/19/2026

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA #201 and CNA #202 positioned Resident #1 to the left side. Concurrent interview with CNA #201 revealed they had assumed care of Resident #1 at 11:00 A.M. and was unaware of when the resident was last checked for incontinence care. Both CNA #201 and CNA #202 stated Resident #1 was to be checked and changed for incontinence every two hours. Interview on 03/19/26 at 5:55 A.M. with the Director of Nursing (DON) revealed the facility did not have a policy or procedure in place regarding the provision of incontinence care. The procedure was determined to be a standard of practice task and residents were to be checked, changed, and repositioned every two hours.This deficiency represents non-compliance investigated under Master Complaint Number 2803908 and Complaint Number 2800644.

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	03/19/2026

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, medical record review, and staff interview, the facility failed to ensure gastrostomy tube (G-tube) care and maintenance were provided as ordered. This affected one (#1) of three residents reviewed for G-tube care. The facility identified two (#24 and #33) additional residents who had a G-tube. The facility census was 88. Findings include:Review of Resident #1's medical record revealed an admission date of 04/04/25, with diagnoses including dementia, acute respiratory failure, Type II diabetes mellitus with diabetic neuropathy, dysphagia, history of aspiration pneumonia, gastrostomy (G-tube), and hypertension.Review of the Minimum Data Set (MDS) assessment, dated 02/04/26, revealed Resident #1 was in a persistent vegetative state, was unable to make needs known, was severely cognitively impaired, was dependent on staff for all activities of daily living (ADLs), was incontinent of bowel and bladder, had no known weight loss, received all nutrition via feeding tube, was at risk for pressure ulcer development with no skin breakdown, and received anticoagulant and antidepressant medications.Review of the plan of care, revised 01/30/26, revealed Resident #1 had potential for alteration in nutrition/hydration related to diagnoses of dementia, diabetes mellitus Type II, and hypertension. Resident #1 received nothing by mouth (NPO) and was dependent on tube feeding (TF)/flushes to meet nutrition/hydration needs. Interventions included administer medications as ordered, elevate head of bed (HOB) as ordered, and evaluate tube feed tolerance. Review of the physician orders revealed an order dated 03/11/26 for Resident #1 to receive NPO and tube feeding (Glucerna 1.2) via G-tube every shift off at 12:00 A.M. and on at 4:00 A.M. for 20 hours or until 1500 milliliters (ml) had been infused at a infusion rate of 75 ml per (/) hour (hr) for 20 hours with a 175 ml water flush every six hours. In addition, a physician treatment order was implemented to cleanse area around G-tube with soap and water, then apply new sponge daily and as needed (PRN). Observation on 03/18/26 at 11:13 A.M. revealed Licensed Practical Nurse (LPN) #300 entered Resident #1's room. LPN #300 exposed Resident #1's G-tube site. No dressing (sponge) was in place. LPN #300 proceeded to cleanse a small amount of brown/red dried drainage from the G-tube insertion site. Concurrent interview with LPN #300 verified a dressing should have been applied to Resident #1's G-tube site. Interview on 03/19/26 at 5:55 A.M. with the Director of Nursing (DON) revealed the facility did not have a policy or procedure in place regarding the provision of G-tube care and maintenance. The procedure was determined to be a standard of practice task. This deficiency was an incidental finding discovered during the complaint investigation.

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	03/19/2026

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 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, review of the medical record, staff interview, and review of facility policy, the facility failed to ensure enhanced barriers precautions (EBP) were implemented. This affected two (#1, #3) of three residents reviewed for infection control. The facility identified 26 (#1, #2, #3, #15, #16, #17, #18, #19, #20, #21, #22, #23, #24, #25, #26, #27, #28, #29, #30, #31, #32, #33, #34, #35, #36, and #37) residents on EBP. The facility census was 88. Findings include:1. Review of the medical record revealed Resident #1 admitted to the facility on [DATE], with diagnoses including dementia, acute respiratory failure, Type II diabetes mellitus with diabetic neuropathy, dysphagia, history of aspiration pneumonia, gastrostomy (G-tube), and hypertension.Review of the Minimum Data Set (MDS) assessment, dated 02/04/26, revealed Resident #1 was in a persistent vegetative state, was unable to make needs known, had severe cognitive impairment, was dependent on staff for all activities of daily living (ADLs), was incontinent of bowel and bladder, had no known weight loss, received all nutrition via feeding tube, was at risk for pressure ulcer development with no skin breakdown, and received anticoagulant and antidepressant medications. Review of the physician orders revealed Resident #1 had an order dated 03/11/26 to receive nothing by mouth (NPO) and tube feeding (Glucerna 1.2) via G-tube every shift, off at 12:00 A.M. and on at 4:00 A.M., for 20 hours or until 1500 milliliters (ml) had been infused at a infusion rate of 75 ml per hour for 20 hours, with a 175 ml water flush every six Hours. In addition, physician wound treatment orders were modified on 03/17/26 as follows: right buttock moisture associated skin damage (MASD) - cleanse with wound cleanser or normal saline, pat dry, apply house barrier cream with zinc to wound bed, cover with dry dressing, and change every shift and as needed (PRN) if soiled or dislodged and sacral wound - cleanse with wound cleanser or normal saline, pat dry, apply house barrier cream with zinc to wound bed, cover with dry dressing, and change every shift and PRN if soiled or dislodged. The medical record lacked a physician order or nursing plan of care for the implementation of EBP. Observation on 03/18/26 at 6:59 A.M. revealed Resident #1 was in bed with the tube feeding infusing. Further observation revealed no signage near the entry of Resident #1's room instructing staff that EBP were in place or personal protective equipment (PPE) located near the resident's room. Observation on 03/18/26 at 7:45 A.M. revealed Certified Nursing Assistant (CNA) #200 and CNA #201 entered Resident #1's room. Neither staff donned PPE. CNA #200 and CNA #201 proceeded to perform incontinence care and repositioned the resident. Interview on 03/18/26 at 8:00 A.M. with CNA #200 confirmed no PPE was applied during care for Resident #1. CNA #200 verified they were unaware Resident #1 was in EBP and PPE was to be applied during direct contact with the resident. Interview on 03/18/26 at 10:40 A.M. with the Director of Nursing (DON) verified there was no signage or PPE at Resident #1's room entry to alert staff that the resident was on EBP. 2. Review of the medical record revealed Resident #3 admitted to the facility on [DATE] with diagnoses including human immunodeficiency virus (HIV), Type II diabetes mellitus with diabetic neuropathy, chronic obstructive pulmonary disease, necrotizing fasciitis, peripheral vascular disease, lymphedema, and nutritional anemia.Review of the MDS assessment, dated 03/11/26, revealed Resident #3 had moderately impaired cognition, no resistive behaviors, range of motion impairment to bilateral lower extremities, was dependent on staff for completion of ADLs, was incontinent of bowel and bladder, and was at risk for pressure ulcer development. Resident #3 admitted with one stage III pressure ulcer and one stage IV pressure ulcer. Review of the physician orders revealed orders dated 03/09/26 to cleanse Resident #3's left hip wound with wound cleanser, pat dry, apply skin prep to periwound, lightly pack wound with collagen rope with silver, apply collagen with silver to the wound bed, cover wound with dry dressing, and change daily and as needed (PRN) and to cleanse the left shoulder wound with wound cleanser, pat dry, apply skin prep to periwound, apply collagen powder to wound bed, cover with calcium alginate and dry dressing, and change daily and PRN. Observation on 03/18/26 at 6:56 A.M. revealed Resident (continued on next page)

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	03/19/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#3's call light was active. Further observation revealed no EBP signage or PPE was located near the entry to Resident #3's room. Continued observation revealed at 6:58 A.M., CNA #200 and CNA #201 entered Resident #3's room. Neither staff donned PPE. CNA #200 and CNA #201 proceeded to perform incontinence care and repositioned the resident. Interview on 03/18/26 at 7:10 A.M. with CNA #202 revealed they assumed care of Resident #3 at 6:00 A.M. CNA #202 verified they were unaware Resident #3 required EBP and confirmed no sign was in place at the resident's room to alert staff to EBP and no PPE was readily accessible. Interview on 03/19/26 at 5:58 A.M. with the DON revealed the facility policy did not contain instructions to include or require a physician order or plan of care to place or maintain a resident in EBP. Review of the facility policy, Enhanced Barrier Precautions (EBP), dated August 2022, revealed EBP were an infection control intervention designed to reduce the transmission of resistant organisms that employed the use of a gown and gloves during high contact resident care activities. Nursing home residents with wounds and indwelling medical devices (for example, G-tube, catheter, et cetera) were at especially high risk for both acquisition and colonization with multi drug resistant organisms (MDRO). The use of a gown and gloves for high contact resident care activities was indicated when contact precautions did not otherwise apply. Examples of high contact activities included: dressing, bathing, transferring, providing personal hygiene, changing briefs, and wound care. This deficiency was an incidental finding discovered during the complaint investigation.