STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365455	A. Building B. Wing	01/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ivy Woods Healthcare Center.	2025 Wyoming Avenue Cincinnati, OH 45205

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and review of the Long Term Care Facility Resident Assessment Instrument 3.0 User's Manual (RAI manual), the facility failed to ensure the Minimum Data Set (MDS) assessments were accurate. This affected four (#52, #103, #46, and #92) of 19 residents reviewed for accuracy of the MDS assessment. The facility census was 89.Findings included:1. Review of the medical record revealed the facility admitted Resident #52 on 08/22/2025. Diagnosis included essential hypertension (high blood pressure). Review of Resident #52's Smoking assessment dated [DATE] revealed the resident used three to five cigarettes daily, was aware of the risks, and was independent for smoking. Review of the admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/29/2025, revealed Resident #52 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Section J1300 of the admission MDS revealed code 0 and indicated Resident #52 currently used no tobacco. During an interview on 01/15/2026 at 1:30 P.M., the Executive Director (ED) reported the facility followed the RAI manual. During an interview on 01/16/2026 at 10:13 A.M., the MDS Licensed Practical Nurse (LPN) #10 revealed her process for completing the MDS was to review the admission paperwork, hospital paperwork, health history, and the in-house provider's documentation. The MDS LPN #10 stated she then completed and reviewed the MDS prior to a registered nurse signing the assessment as complete. The MDS LPN #10 stated she had missed Resident #52's smoking assessment and question J1300 was incorrectly coded. During an interview on 01/16/2026 at 1:37 P.M., the Director of Nursing (DON) said she was not familiar with all steps of the MDS completion process, but she would expect the MDS to be coded accurately and the RAI manual to be followed. Review of the RAI manual dated 10/2025 section J1300 Current Tobacco Use revealed Steps for Assessment l. Ask the resident if they used tobacco in any form during the 7-day look-back period. 2. If the resident states that they used tobacco in some form during the 7-day look-back period, code 1, yes. 3. If the resident is unable to answer or indicates that they did not use tobacco of any kind during the look-back period, review the medical record and interview staff for any indication of tobacco use by the resident during the look-back period. Coding Instructions - Code 0, no: if there are no indications the resident used any form or tobacco. - Code 1, yes: if the resident or any other source indicates the resident used tobacco in some form during the look-back period. 2. Review of the medical record revealed the facility admitted Resident #103 on 10/28/2025. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Diagnoses included severe protein-calorie malnutrition and pressure ulcer of unspecified site and unspecified stage. Review of Resident #103's Wound Assessment Report dated 10/30/2025 revealed the resident admitted to the facility with partial thickness abrasions to the mid back, left shoulder, right inner knee, and left lower back; a Stage 1 (intact skin, with non-blanchable redness) pressure ulcer injury to the left lateral foot; a Stage 2 (shallow open wound) pressure ulcer injury to the left great toe; a Stage 4 (full-thickness tissue loss with exposed muscle, tendon, or bone) pressure ulcer injury to the left buttocks; and a deep tissue injury (DTI, injury to deep tissues under intact skin often at the bone-muscle interface) pressure ulcer injury to the left heel, the left ankle, and the right posterior ankle. Review of the admission MDS, with an Assessment Reference Date (ARD) of 11/05/2025, revealed Resident #103 had a Brief Interview for Mental Status (BIMS) score of five, which indicated the resident had severe cognitive impairment. Section M0300B1 indicated Resident #103 had one Stage 2 pressure ulcer, and Section M0300B2 indicated the Stage 2 pressure ulcer was not present on admission. The MDS also indicated one Stage 4 and three Unstageable Deep Tissue Injuries were present on admission/entry or reentry. During an interview on 01/16/2026 at 10:13 A.M., MDS LPN #10 revealed her process for completing the MDS was to review the admission paperwork, hospital paperwork, health history, and the in-house provider's documentation. The MDS LPN #10 stated she then completed and reviewed the MDS prior to a registered nurse signing the assessment as complete. The MDS LPN #10 reviewed section M of Resident 103's MDS and stated that the coding for the number of Stage 2 pressure ulcers present upon admission was coded incorrectly. During an interview on 01/16/2026 at 1:37 P.M., the Director of Nursing (DON) stated that she was not familiar with all steps of the MDS completion process, but she expected the MDS to be coded accurately and the RAI manual to be followed. Review of the RAI manual, dated 10/2025, Section M0300B2: Stage 2 Pressure Ulcers, revealed Coding Instructions for M0300B2- M0300B1- Enter the number of pressure ulcers that are currently present and whose deepest anatomical stage is 2. – Enter 0 if no Stage 2 pressure ulcers are present and skip to M0300C, Stage 3. M0300B2 – Enter the number of these Stage 2 pressure ulcers that were first noted at the time of admission/entry AND—for residents who are reentering the facility after a hospital stay, enter the number of Stage 2 pressure ulcers that were acquired during the hospitalization (i.e.[id est, that is], the Stage 2 pressure ulcer was not acquired in the nursing facility prior to admission to the hospital). Enter 0 if no Stage 2 pressure ulcers were first noted at the time of admission/entry or reentry. 3. Review of the medical record revealed the facility admitted Resident #46 on 09/01/2025. Diagnosis included chronic kidney disease, Stage 4 (severe). Review of Resident #46's Care Plan Report included a focus statement initiated 09/18/2025, indicated the resident was on dialysis therapy. Interventions included Day/time: Tuesday Thursday Saturday 6:00 AM along with the dialysis center's address, phone number, transportation details, and Resident #46's dialysis access site on the right upper chest. Review of a 5-day MDS, with an Assessment Reference Date (ARD) of 09/21/2025, revealed Resident #46 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	intact cognition. Section O0110J1 Dialysis and O0110J2 Hemodialysis revealed no check marks and indicated Resident #46 did not have dialysis or hemodialysis on admission, while a resident, or at discharge. Review of a nurse practitioner's Progress Note dated 09/22/2025 revealed diagnoses included dependence of renal dialysis. During an interview on 01/16/2026 at 10:13 A.M., the MDS LPN #10 stated she reviewed information and diagnoses when a resident was admitted , set up the entry in the system, initiated the admission assessment, reviewed the payer source, built a profile, and entered information for the care plan based on verified records. The MDS LPN #10 stated she checked her information and, because she was an LPN, the regional resident assessment coordinator signed off on the MDS, indicating that the MDS was complete. The MDS LPN #10 stated Resident #46 was not on dialysis initially but went to the hospital and returned to the facility on dialysis. The MDS LPN #10 stated the hospital set up dialysis and transportation, and the facility followed the hospital's instructions. The MDS LPN #10 stated dialysis was not captured on the MDS because she did not have dialysis run sheets to verify treatment. During an interview on 01/16/2026 at 1:37 P.M., the Director of Nursing (DON) stated she did not know much about MDSs but expected the assessments to be accurate and the RAI manual to be followed. Review of the RAI manual, dated 10/2025, section O0110J1, Dialysis revealed, Code peritoneal [uses the lining of the abdominal cavity as a natural filter blood] or renal dialysis [uses a dialyzer machine to filter blood] which occurs at the nursing home or at another facility, record treatments of hemofiltration [removal of wastes by filtration of blood across a membrane], Slow Continuous Ultrafiltration (SCUF) [filtration through a semipermeable membrane allowing only the passage of small molecules], Continuous Arteriovenous Hemofiltration (CAVH) [filtration powered by the patient's arterial pressure], and Continuous Ambulatory Peritoneal Dialysis (CAPD) [dialysis through the abdomen] in this item. The manual also indicated, O0110J2, Hemodialysis – Check when the dialysis was hemodialysis. 4. Review of the medical record revealed the facility admitted Resident #92 on 07/04/2025. Diagnoses included depression, bipolar disorder, and anxiety disorder. Review of Resident #92's Notice of Preadmission Screening and Resident Review (PASRR) Level II Outcome dated 07/07/2025 revealed the resident had serious mental illness and recommended specialized services. Review of a modified admission MDS, with an Assessment Reference Date (ARD) of 07/11/2025, revealed Resident #92 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. Section A1500. Preadmission Screening and Resident Review (PASRR) revealed the question Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? was answered, 0. No. On 01/14/2026 at 1:55 P.M., the Executive Director (ED) stated the facility did not have a policy for completing the MDS and followed the RAI manual. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/16/2026 at 10:13 A.M., the MDS LPN #10 stated she reviewed information and diagnoses when a resident was admitted , set up the entry in the system, initiated the admission assessment, reviewed the payer source, built a profile, and entered information for the care plan based on verified records. The MDS LPN #10 stated she checked her information and because she was an LPN, the regional resident assessment coordinator signed off on the MDS, indicating the MDS was complete. The MDS LPN #10 stated that the Social Services Department was responsible for completing the PASRR section of the MDS. During an interview on 01/16/2026 at 10:44 A.M., the Social Services Designee (SSD) #11 stated she completed the PASRR section of the MDS. The SSD #11 stated Resident #92 had a Level II PASRR, and it should have been captured on the MDS. The SSD #11 stated Resident #92's MDS was not accurate because she checked the wrong box and needed to re-submit the MDS. During an interview on 01/16/2026 at 2:03 PM, the ED stated she expected the MDS assessments to be accurate and the RAI manual to be followed. Review of the RAI manual dated 10/2025 section A1500 Preadmission Screening and Resident Review (PASRR) and Steps for Assessment revealed, 3. Review the PASRR report provided by the State if Level II screening was required. Coding Instructions – Code 0, no: and skip to A1550, Conditions Related to ID/DD [Intellectual and Developmental Disability] Status, if any of the following apply: - PASRR Level I screening did not result in a referral for Level II screening, or – Level II screening determined that the resident does not have a serious MI [Mental Illness] and/or ID/DD or related conditions, or – PASRR screening is not required because the resident was admitted from a hospital after requiring acute inpatient care, is receiving services for the condition for which they received care in the hospital, and the attending physician has certified before admission that the resident likely to require less than 30 days of nursing home care. – Code 1, yes: if PASRR Level II screening determined that the resident has a serious mental illness and/or ID/DD or related condition.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on medical record review and staff and resident interview, the facility failed to provide documentation of informed consent prior to the administration of psychotropic medications. This affected one (#17) of five residents reviewed for unnecessary medications. The facility census was 89.Findings included:Review of the medical record indicated the facility admitted Resident #17 on 06/07/2025. Diagnosis included major depressive disorder (recurrent, mild).Review of the quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/18/2025, revealed Resident #17 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated the resident received an antidepressant during the seven-day look-back period. Review of Resident #17's Care Plan included a focus area, initiated 06/07/2025, that indicated the resident was at risk for altered mood and behavior related to depression and anxiety. Interventions directed staff to monitor mood and behavior changes, administer medications as ordered, and provide emotional support and reassurance.Review of the Resident #17's physician order recap report dated for the timeframe from 06/01/2025 through 01/31/2026 included the following medication:- sertraline (an antidepressant) 25 milligrams (mg) one tablet by mouth one time a day, ordered 06/08/2025 and ended 06/24/2025;- sertraline 25 mg two tablets one time a day, started 06/25/2025 with no end date; and - trazodone (an antidepressant) 50 mg one-half tablet at night as needed, ordered 12/12/2025. Review of Resident #17's Medication Administration Record (MAR) dated 01/2026 revealed staff documented the resident was receiving sertraline and trazodone according to the physician orders.Review of Resident #17's record revealed no evidence of informed consent or documentation of discussion of risks, benefits, and alternatives with the resident or their representative prior to initiation or continuation of those medications.During an interview on 01/15/2026 at 10:58 AM, the Medical Records Coordinator (MRC) #14 stated she was unsure where the original consent for Resident #17's psychotropic medications was located and would have to get back with the surveyor.During an interview on 01/15/2026 at 1:20 P.M., the Regional Director of Clinical Operations (RDCO) #12 stated she was unsure where the original consent for Resident #17's psychotropic medication was located and would have to get back with the surveyor.During an interview on 01/15/2026 at 3:48 P.M., Licensed Practical Nurse (LPN) #03 stated she did not know about the consents for psychotropic medications and was unsure who was responsible but thought the provider obtained them. During an interview on 01/16/2026 at 11:45 A.M., Resident #17 stated they did not recall staff reviewing the resident's medications last month and was unsure what medications the resident took.During an interview on 01/16/2026 at 12:12 P.M., the Medical Director (MD) stated the psychiatric nurse practitioner (NP) typically reviewed psychotropic medications and discussed risks and benefits with the resident or responsible party prior to administration. The MD stated it should be documented in psychiatric NP's notes, and they were not sure why it was not there.During an interview on 01/16/2026 at 12:55 P.M., the Clinical Manager Registered Nurse (CMRN) #13 stated the psychiatric NP reviewed the medications and did the risk/benefit discussion with the resident prior to ordering the medication. The CMRN #13 stated she was unsure who would obtain consent if not the psychiatric NP. During an interview on 01/16/2026 at 1:32 P.M., the Director of Nursing (DON) stated the consent could be obtained by the nurse or admission staff, but she was unsure where it was documented. The DON confirmed psychotropic medications such as trazodone required consent and stated the psychiatric NP usually ordered all psychotropic medications. The DON stated the nurse who received the order should have obtained consent prior to ordering the medication from the pharmacy and administering the medication. During an interview on 01/16/2026 at 11:04 AM, the Executive Director (ED) stated the facility did not have a policy specific to psychotropic medications.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on medical record review, observation, staff interview, and facility policy review, the facility failed to ensure the comprehensive care plans included the use of bed rails. This affected two (#20 and #43) of two sampled residents reviewed for bed rail use. The facility census was 89. Findings included:1. Review of the medical record revealed the facility admitted Resident #43 on 01/29/2022. Diagnoses included unspecified convulsions, acute respiratory failure with hypoxia, and unspecified dementia without behavioral disturbance.Review of the annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/09/2025, revealed Resident #43 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated the resident required setup or clean-up assistance with rolling left and right in bed, sitting on the side of the bed and lying back down, standing, and transfers. The MDS also specified that bed rails were not used as a restraint.Review of Resident #43's physician order summary report with active orders as of 01/13/2026, included an order, dated 10/12/2021, for bilateral grab bars to the bed to enhance mobility and transfers, every shift.Review of Resident #43's Informed Consent Installation of Bed Rail or Assist Bar Not Used as a Restraint, dated 12/15/2023, recommended both right and left bedrails (position bars) were requested by the resident and recommended to promote independence with bed mobility and transfers. The document was signed by Resident #43 on 12/15/2023 but was not signed by a nurse.Review of Resident #43's January 2026 Treatment Administration Record (TAR) revealed grab bars to bed to enhance mobility and transfers every shift. Review of Resident #43's Care Plan Report, revised 09/03/2025, did not include the use of side rails or assistive grab bars.Observations on 01/12/2026 at 10:03 A.M., on 01/13/2026 at 9:45 A.M., on 01/14/2026 at 2:15 P.M., and on 01/15/2026 at 8:55 A.M. revealed Resident #43's bed with two bed canes (assistive bars to provide support) attached at the top of the bed. During an interview on 01/15/2026 at 9:25 A.M., the MDS Licensed Practical Nurse (LPN) #10 stated that if a resident had bed rails, it should be included on the resident's care plan and should include the reason for the bed rails. The MDS LPN #10 stated she must have missed the bed rails when she updated the care plan with the last assessment. During an interview on 01/15/2026 at 10:14 AM, the Divisional Director of Clinical Operations (DDCO)#15 stated use of bed rails should be included on the care plan. During an interview on 01/15/2026 at 3:48 P.M., LPN #03 stated the use of bed rails should be included on the care plan.During an interview on 01/16/2026 at 11:30 A.M., LPN #04 stated she thought bed rails should be care planned.During an interview on 01/16/2026 at 12:55 P.M., the Clinical Manager Registered Nurse (CMRN) #13 verified Resident #43 had orders for grab bars. The CMRN #13 stated the use of grab bars should be included on the care plan.During an interview on 01/16/2026 at 1:32 P.M., the Director of Nursing (DON) stated that the use of bed rails should be included on the care plan. 2. Review of the medical record revealed the facility admitted Resident #20 on 09/12/2008 and readmitted the resident on 11/23/2018. Diagnoses included hypertensive heart disease with heart failure, hemiplegia and hemiparesis following cerebral infarction (a stroke) affecting the left non-dominant side, chronic obstructive pulmonary disease (COPD), vascular dementia, and epilepsy.Review of the MDS, with an Assessment Reference Date (ARD) of 11/20/2025, revealed Resident #20 had a Brief Interview for Mental Status (BIMS) score of three, which indicated the resident had severe cognitive impairment. The MDS indicated the resident required substantial/maximal assistance with rolling left to right in bed, partial/moderate assistance with standing and transferring, and supervision or touching assistance with sitting on the side of the bed and lying on the bed. The MDS also specified that bed rails were not used as a restraint.Review of Resident #20's physician order summary report with active orders as of 01/13/2026, revealed an order dated 06/04/2025 for bilateral grab bars to the bed to enhance resident mobility and repositioning every shift for safety.Review of Resident #20's Informed Consent Installation of Bed Rail (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	or Assist Bar Not Used as a Restraint dated 12/15/2023 recommended both right and left bed rail position bars to promote independence with bed mobility and transfers. The consent was signed by the resident representative and two nurses on 12/15/2023.Review of Resident #20's Care Plan Report revised 11/26/2025 did not include the use of side rails or assistive grab bars.Observations on 01/12/2026 at 10:19 A.M., on 01/13/2026 at 2:12 P.M., on 01/14/2026 at 9:43 A.M., and on 01/15/2026 at 11:55 A.M. revealed Resident #20's bed with two bed canes positioned at the top of the bed. During an interview on 01/15/2026 at 9:25 A.M., the MDS LPN #10 stated that if a resident had bed rails, it should be included on the resident's care plan and should include the reason for the bed rails. The MDS LPN #10 stated she must have missed the bed rails when she updated the care plan with the last assessment. During an interview on 01/15/2026 at 10:14 AM, the DDCO#15 stated use of bed rails should be included on the care plan. During an interview on 01/15/2026 at 3:48 PM, LPN #03 stated that the use of bed rails should be included on the care plan.During an interview on 01/16/2026 at 11:30 AM, LPN #04 stated she thought bed rails should be care planned.During an interview on 01/16/2026 at 12:55 PM, the CMRN #13 verified Resident #20 had orders for grab bars. The CMRN stated that the use of grab bars should be included on the care plan.During an interview on 01/16/2026 at 1:32 PM, the Director of Nursing (DON) stated that the use of bed rails should be included on the care plan.Review of a facility policy titled, Plan of Care Overview, undated indicated The purpose of the policy is to provide guidance to the facility to support the inclusion of the resident or resident representative in all aspects of person-centered care planning and that this planning includes the provision of services to enable the resident to live with dignity and supports the resident's goals, choices, and preferences including, but not limited to, goals related to the [sic] their daily routines and goals to potentially return to a community setting.Review of a facility policy titled, Safe Use of Bed Rails, dated 02/27/2023, indicated Definitions: Bed rails: are adjustable metal or rigid plastic bars that attach to the bed. The policy also indicated, Examples of bed rails include but are not limited to: side rails, bed side rails, and safety rails; grab bars and assist bars. The policy also indicated, Documentation: a. Physician order is required b. Completion of Bed Safety Evaluation c. Consent obtained for bed rail use d. Education provided to the resident or, if applicable, resident representative and e. Care Plan for the use/need for bed rails.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. Based on medical record review, observation, staff and resident interview, and facility policy review, the facility failed to assess the use of bed rails for two (#20 and #43) of two residents sampled for use of bed rails. In addition, the facility failed to ensure bed rails were maintained. This affected one (#43) of two residents sampled for bed rails. The facility census was 89.Findings included:1. Review of the medical record revealed the facility admitted Resident #43 on 01/29/2022. Diagnoses included unspecified convulsions, acute respiratory failure with hypoxia, and unspecified dementia without behavioral disturbance.Review of the annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/09/2025, revealed Resident #43 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated the resident required setup or clean-up assistance with rolling left and right in bed, sitting on the side of the bed and lying back down, standing, and transfers. The MDS also specified that bed rails were not used as a restraint.Review of Resident #43's physician order summary report with active orders as of 01/13/2026, included an order, dated 10/12/2021, for bilateral grab bars to the bed to enhance mobility and transfers, every shift.An observation on 01/12/2026 at 10:03 A.M. revealed Resident #43 lying in bed with two bed canes attached at the top of the bed. The observation revealed the left bed cane was loose and leaning outward away from the mattress.An observation on 01/13/2026 at 9:45 A.M. revealed Resident #43's bed canes remained in place, and the left cane continued to be loose and leaned outward. An observation on 01/14/2026 at 2:15 P.M. revealed the left bed cane continued to be loose and leaned outward, creating a gap between the cane and the mattress.An observation and interview on 01/15/2026 at 8:55 A.M. revealed the left bed cane remained loose and leaned outward. Resident #43 was observed lying in bed and stated they did not use the bars and tried not to use the loose one.Review of Resident #43's Bed Safety Evaluation dated 12/06/2025 indicated the resident was capable of decision-making; was capable of using their call light; had not demonstrated poor bed mobility or difficulty sitting on the side of the bed; was able to transfer independently from bed; was not receiving medication that would require increased safety precautions; had no current medical symptoms that would require use of a bed mobility device; and no device was currently in use. The Bed Safety Evaluation did not mention any type of side rails.Review of Resident #43's Informed Consent Installation of Bed Rail or Assist Bar Not Used as a Restraint dated 12/15/2023 recommended both right and left bedrails (position bars) were requested by the resident and recommended to promote independence with bed mobility and transfers. The document was signed Resident #43 but was not signed by a nurse.Review of Resident #43's Treatment Administration Record (TAR) dated 01/2026 revealed grab bars to bed to enhance mobility and transfers every shift. Resident #43's record did not include an assessment for the use of side rails, positioning/grab bars, or canes; the risk to the resident of side rail use; or side rail alternatives that were attempted and the reasons for their failure. During an interview on 01/15/2026 at 10:00 A.M., Certified Nursing Assistant (CNA) #01 stated Resident #43 used their bed cane when standing and transferring, and she thought it was beneficial. CNA #01 stated she did not realize the bed cane was loose, and, if she had, she would have submitted a work order and notified the maintenance department. During a concurrent observation and interview on 01/15/2026 at 2:10 P.M. upon entering Resident #43's room, the Director of Plant Maintenance (DPM) #16 noted the loose bed cane and stated a work order needed to be done to tighten the rail, but he had not received one. During an interview on 01/15/2026 at 3:48 P.M., Licensed Practical Nurse (LPN) #03 stated they completed bed safety evaluations every quarter but did not realize the form did not address bed rails. LPN #03 stated Resident #43 used their bars for standing and positioning, LPN #03 stated they were not aware Resident #43's bar was loose and a work order should have been submitted. During an interview on 01/16/2026 at 1:32 P.M., the Director (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of Nursing (DON) stated that therapy usually did the assessment for bedrails and then therapy staff would bring the assessment to her. The DON verified the Bed Safety Evaluation did not include an assessment for the use of positioning bars. The DON stated Resident #43's positioning bars were used for repositioning. 2. Review of the medical record revealed the facility admitted Resident #20 on 09/12/2008 and readmitted the resident on 11/23/2018. Diagnoses included hypertensive heart disease with heart failure, hemiplegia and hemiparesis following cerebral infarction (a stroke) affecting the left non-dominant side, chronic obstructive pulmonary disease (COPD), vascular dementia, and epilepsy.Review of the MDS, with an Assessment Reference Date (ARD) of 11/20/2025, revealed Resident #20 had a Brief Interview for Mental Status (BIMS) score of three, which indicated the resident had severe cognitive impairment. The MDS indicated the resident required substantial/maximal assistance with rolling left to right in bed, partial/moderate assistance with standing and transferring, and supervision or touching assistance with sitting on the side of the bed and lying on the bed. The MDS also specified that bed rails were not used as a restraint.Review of Resident #20's physician order summary report with active orders as of 01/13/2026, revealed an order dated 06/04/2025 for bilateral grab bars to the bed to enhance resident mobility and repositioning every shift for safety.An observation on 01/12/2026 at 10:19 A.M. revealed Resident #20 was not in the room, the resident's bed was positioned at a normal height, and two bed canes were at the top of the bed. An observation on 01/13/2026 at 2:12 P.M. revealed Resident #20 was not in the room, two bed canes were positioned at the top of the bed, and the bed canes were not loose. An observation on 01/14/2026 at 9:43 A.M. revealed Resident #20 was not in the room, two bed canes were positioned at the top of the bed, and the bed canes were not loose.An observation on 01/15/2026 at 11:55 A.M. revealed Resident #20 was not in the room, two bed canes were positioned at the top of the bed, and the bed canes were not loose. Review of Resident #20's Bed Safety Evaluation dated 12/04/2025 indicated the resident was not capable of decision-making; was not capable of using their call light; demonstrated poor bed mobility; was able to transfer independently from bed; was not receiving medication that would require increased safety precautions; had a medical symptom of left-sided weakness that required a bed mobility device; a low bed was currently being used; and the resident had not expressed a desire for an assistive device on their bed. The Bed Safety Evaluation did not mention any type of side rails.Review of Resident #20's Informed Consent Installation of Bed Rail or Assist Bar Not Used as a Restraint dated 12/15/2023 recommended both right and left bed rail position bars to promote independence with bed mobility and transfers. The consent was signed by the resident representative and two nurses on 12/15/2023.Review of Resident #20's nursing progress notes dated from January 2025 through January 2026 revealed no mention of grab bars, bed canes, bed bars, side rails, or similar devices.Resident #20's medical record did not include an assessment for the use of side rails, positioning/grab bars, or canes; the risk to the resident of side rail use; or side rail alternatives that were attempted and the reasons for their failure.During an interview on 01/15/2026 at 9:15 A.M., the Regional Director of Clinical Operations (RDCO) #12 stated they were reviewing the bed safety evaluations and trying to locate specific evaluations for bed rails.During an interview on 01/15/2026 at 10:00 A.M., CNA #01 stated Resident #20 used their bed canes to assist with bed mobility and benefited from the canes being there.During an interview on 01/15/2026 at 3:48 P.M., LPN #03 stated they completed bed safety evaluations every quarter but did not realize the form did not address bed rails. LPN #03 stated Resident #20 used their bars for bed mobility. During an interview on 01/16/2026 at 1:32 P.M., the DON stated therapy usually did the assessment for bed rails and then therapy staff would bring the assessment to her. The DON verified the Bed Safety Evaluation did not include an assessment for the use of positioning bars. The DON stated Resident #20's positioning bars were used for repositioning. During an interview on 01/17/2026 at 9:54 A.M., the Regional Director of Therapy (RDT) #17 stated nursing staff completed the bed safety evaluation on admission and referred to the therapy department if there were concerns. The RDT #17 stated the therapy department did not do routine reassessments unless (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	there was a change in condition. She was not aware the bed safety evaluation form did not address bed rails.Review of a facility policy titled, Safe Use of Bed Rails, dated 02/27/2023, indicated Bed rails are adjustable metal or rigid plastic bars that attach to the bed. The policy also indicated, Examples of bed rails include but are not limited to: side rails, bed side rails, and safety rails; grab bars and assist bars. The policy also indicated, Policy: It is the policy of this facility to provide resident centered care that meets the safety, psychosocial, physical, and emotional needs, and concerns of the residents. [Corporate Name] prohibits the use of bed rails as a restraint. The facility will assess the residents' cognition and therapeutic need of the bed rail to assist the resident in reaching their highest potential of independence. A physician order is required to implement the use of bed rails. The policy also indicated, Procedure: 1. Assessment of residents with bed rails include: a. Level of independence with bed mobility b. Review of prior interventions and outcomes prior to the initiation of bed rails c. Medical diagnosis, conditions, symptoms, and/or behavioral symptoms should be evaluated prior to initiation. The policy also indicated, 3. Monitoring a. Bed Safety Evaluation is completed upon admission, quarterly, and as needed such as a significant change in condition. The policy also indicated, 6. Documentation a. Physician order is required b. Completion of Bed Safety Evaluation c. Consent obtained for bed rail use d. Education provided to the resident or, if applicable, resident representative e. Care Plan for the use/need for bed rails.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on medical record review, observation, staff interview, and facility policy review, the facility failed to ensure the medication error rate was less than five percent. There were two medication errors out of 26 opportunities for error with a calculated medication error rate of 7.69 percent. This affected one (#01) of five residents reviewed during medication administration. The facility census was 89. Findings included:Review of the medical record indicated the facility admitted Resident #01 on 02/18/2020. Diagnoses included hemiplegia following cerebral infarction, chronic obstructive pulmonary disease (COPD), vascular dementia, and constipation.Review of an annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/08/2025, revealed Resident #01 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated the resident had moderate cognitive impairment.Review of Resident #01's Physician Order Summary Report, with active orders as of 01/13/2026, revealed an order dated 12/23/2025 for ascorbic acid (vitamin C) oral tablet 250 milligrams (mg) give one tablet by mouth two times a day for supplement give with iron tablet and an order dated 04/24/2025 for senna (a laxative) oral capsule 8.6 mg, give one capsule by mouth two times a day for constipation.A medication administration observation on 01/13/2026 at 9:36 A.M., revealed Licensed Practical Nurse (LPN) #06 administered vitamin C 500 mg, one tablet and Senna Plus (docusate, a stool softener, and senna) 50/8.6 mg one tablet to Resident #01 instead of the ordered doses of ascorbic acid 250 mg and senna 8.6 mg.During an interview on 01/13/2026 at 3:17 P.M., LPN #06 stated the medication administration process was to check the resident's name, birthday, and identification band for the right patient, right dose, and right route. LPN #06 stated she compared the medication in the drawer to the computer system, which served as the medication administration record (MAR). LPN #06 stated the medication drawer contained stock supply. LPN #06 stated Resident #01 was administered Vitamin C 500 mg, and the facility had a couple of different senna medications in the medication cart. After reviewing the physician's orders, LPN #06 stated Resident #01 had an order for ascorbic acid 250 mg two times a day and acknowledged 500 mg was not the correct dose. LPN #06 provided the surveyor with the Senna Plus bottle and stated that it was the medication she administered that morning. After checking the physician's order, LPN #06 stated senna 8.6 mg was Resident #01's routine order.During an interview on 01/14/2026 at 7:19 A.M., the Director of Nursing (DON) stated the nurse should look at the MAR, check the resident, and check the medication to ensure it was correct. The DON stated she expected nurses to administer medications as the physician ordered because nurses did not have a license to prescribe medications. The DON stated she expected the medication error rate to be less than 5 percent and would prefer zero percent.Review of a facility policy titled, Medication Administration, undated indicated a. Administer medication only as prescribed by the provider. The policy also indicated f. Observe the five rights in giving each medication: i. the right resident ii. the right time iii. the right medicine iv. the right dose v. the right route.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on medical record review, staff interview, review of the Long Term Care Pharmacist Recommendation, and policy review, the facility failed to ensure discontinuation of physician orders were transcribed in the medical record. This affected one (#32) of five residents reviewed for Medication Regimen Review (MRR). The facility census was 89.Findings included:Review of the medical record revealed the facility admitted Resident #32 on 07/18/2025. Diagnosis included vascular dementia, unspecified severity with other behavioral disturbance.Review of an admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/25/2025, revealed Resident #32 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated the resident had moderate cognitive impairment.Review of Resident #32's Long Term Care Pharmacist Recommendation dated 12/18/2025 revealed under Issues/Concerns: The resident had the following active orders: Folic acid (vitamin B-9) 1 mg daily, a multivitamin, Thiamine (vitamin B1) 100 mg daily, and cholecalciferol (vitamin D3) 1000 units daily. Recommendations: To reduce medication burden and reduce the risk of adverse effects, please evaluate the above medication for discontinuation. The section Physician/Prescriber Response revealed on 01/02/2026 the Medical Director responded to discontinue all medications listed by the pharmacy consultant.Review of Resident #32's Physician Order Summary Report with active orders as of 01/12/2026 revealed an order Thiamine Mononitrate (a synthetic vitamin B1) oral tablet 100 mg give 1 tablet by mouth one time a day for supplement, started 07/19/2025.Review of Resident #32's Medication Administration Record dated 01/2026 revealed the transcription of an order for thiamine mononitrate oral tablet 100 milligram (mg), give one tablet by mouth one time a day for supplement, started 07/19/2025 at 7:00 AM with no end date indicated.During an interview on 01/16/2026 at 11:35 A.M., the Medical Director (MD) stated pharmacy reviews were completed once monthly or more as needed by the pharmacist. The MD stated the pharmacist emailed the MRR and recommendations to the Director of Nursing (DON). The MD stated they reviewed the MRR and any recommendations made. The MD stated it was their expectation for the DON to follow the recommendations and update the resident's orders. The MD verified their signature and date on Resident #32's Long Term Care Pharmacist Recommendation form and stated it was their direction to discontinue all the medications the pharmacist had recommended. The MD stated it was their expectation for the staff to discontinue those medications and contact them if clarification was needed.During an interview on 01/16/2026 at 4:07 P.M., the DON stated pharmacy recommendations were completed monthly, and they received the MRR in an email from the pharmacist. The DON stated they had the MD review the MRRs and recommendations. The DON stated they took the recommendations and changed the orders as needed in the system. The DON verified Resident #32's MRR recommendation to show the physician's response was to discontinue the medications listed. The DON verified on Resident #32's MAR the thiamine was not discontinued and was still being administered to the resident. The DON stated they were responsible for updating the orders from the MD, and they must have been pulled away at the time they updated the resident's orders and did not finish.During an interview on 01/17/2026 at 8:34 A.M., the Executive Director stated the DON was responsible to make sure the MRRs were completed, accurate, and updated in the residents' orders.Review of a facility policy titled, Medication Regimen Review, undated revealed Procedure: a. The consultant Pharmacist shall conduct a monthly medication regimen review for each resident in the facility. The policy also indicated, 3. Irregularity Reports. A. The Director of Nursing (DON) or designee will be responsible for addressing all medication irregularity reports with the medical practitioner in a manner that meets the needs of the resident. The consultant Pharmacist must provide the DON the report of Non-urgent irregularities within 72 hours of their last scheduled consultation visit for the month or sooner. Urgent or Clinically Significant Medication Irregularity is communicated the day it is observed.

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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 medical record review, observation, staff interview, review of staff training transcripts, and facility policy review, the facility failed to ensure appropriate Personal Protective Equipment (PPE) was worn for one (#05) of two residents sampled for Enhanced Barrier Precautions (EBP). In addition the facility failed to clean and store nebulizer equipment after use. This affected two (#17 and #20) of four residents sampled for infection control. The facility census was 89.Findings included:1. Review of the medical record revealed the facility admitted Resident #05 on 11/18/2024. Diagnoses included gastrostomy status, systemic lupus erythematosus, and other paralytic syndrome following cerebral infarction. Review of an annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/26/2025, revealed Resident #05 had a Brief Interview for Mental Status (BIMS) score of six, which indicated the resident had severe cognitive impairment. Review of Resident #05's Care Plan Report included a focus area dated 12/23/2024 indicating the resident required Enhanced Barrier Precautions (EBP) for an indwelling medical device, a gastrostomy tube (G-tube, a tube inserted through the abdomen to the stomach for feeding or drainage). Interventions directed staff to utilize appropriate Personal Protective Equipment (PPE) during high contact care (dressing, bathing/showering, transferring in room or therapy gym, providing hygiene, changing linens, changing briefs, or assisting with toileting), initiated 04/16/2025; to provide education to the resident and resident representative as appropriate, initiated 04/16/2025; and the resident was not isolated to their room and could move about the facility freely, initiated 04/16/2025. Review of Resident #05's Physician Order Summary Report dated 01/2026, contained an order, dated 04/16/2025, for enhanced barrier precautions related to enteral (involving passing through the intestine) When dressing/bathing, showering/transferring in room or therapy gym/personal hygiene, changing linen, providing hygiene, changing briefs or assisting with toileting every shift for EBP. Review of Licensed Practical Nurse (LPN) #06's training transcript dated 01/15/2026 at 2:36 P.M., revealed completed training for EBP with a grade of 100 percent on 12/30/2025, 01/03/2025, 04/15/2024, and 08/23/2023. An observation on 01/12/2026 at 11:44 A.M. revealed an EBP sign on Resident #05's door. The EBP sign read, Stop. Enhanced Barrier Precautions, everyone must clean their hands, including before entering and when leaving the room, providers and staff must also: wear gloves and a gown for the following high contact resident care activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy, wound care: any skin opening requiring a dressing. An observation on 01/13/2026 at 8:20 A.M. revealed LPN #06 wore a mask as they entered Resident #05's room to discontinue the resident's continuous tube feeding. The observation revealed LPN #06 washed their hands, donned gloves, but did not don a gown. The observation revealed LPN #06 flushed the residents' G-tube, stopped the residents' feeding pump, disconnected the feeding tube from the G-tube, checked the placement of the residents' G-tube, and replaced the cap on the G-tube port. The observation revealed LPN #06 removed their gloves and washed their hands. During an interview on 01/13/2026 at 8:34 A.M., LPN #06 stated they only wore a gown if bodily fluids (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	or drainage were present. LPN #06 stated staff did not wear gowns to hook up or disconnect a resident's feeding tube or to give medications through a resident's feeding tube. LPN #06 stated they received training for EBP recently. LPN #06 stated they did not realize a gown should have been worn when G-tube care was performed. During an interview on 01/16/2026 at 11:35 A.M., the Medical Director (MD) stated they expected staff to utilize a mask, gloves, and a gown with any resident on EBP. The MD stated that the importance of EBP was to prevent cross contamination and keep the resident free from unnecessary infection. During an interview on 01/16/2026 at 4:07 P.M., the Director of Nursing (DON) stated residents with a feeding tube required staff to use EBP. The DON stated staff were expected to wear gloves, a gown, and a mask for all residents on EBP. The DON stated residents on EBP were identified by a sign on their door that indicated what should be worn in the resident's room when providing high-contact care. During an interview on 01/17/2026 at 8:34 A.M., the Executive Director (ED) stated staff were expected to utilize all PPE for residents identified as needing EBP, and they expected staff to utilize a gown, gloves, and a mask when in the resident's room. The ED stated it was her expectation that staff utilize EBP when providing any type of care for Resident #05. Review of a facility policy titled, Enhanced Barrier Precautions, undated revealed PPE required - gowns and gloves. The policy also indicated, EBP are indicated for residents with any of the following: Indwelling medical device examples include central lines including PICC [Peripherally Inserted Central Catheter], urinary catheters, feeding tubes, and tracheostomies. A peripheral IV [intravenous] line is not considered an indwelling medical device for the purpose of EBP. 2. Review of the medical record revealed the facility admitted Resident #20 on 09/12/2018 and readmitted on [DATE]. Diagnoses included chronic obstructive pulmonary disease (COPD) and congestive heart failure. Review of an annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/20/2025, revealed Resident #20 had a Brief Interview for Mental Status (BIMS) score of three, which indicated the resident had severe cognitive impairment. Review of Resident #20's Care Plan Report included a focus statement initiated 09/12/2018 for COPD that indicated the resident was at risk for shortness of breath and respiratory complications. Interventions directed staff to administer medications per provider order, initiated 09/12/2018; observe for shortness of breath, initiated 09/12/2018; and elevate the head of the bed as needed, initiated 09/12/2018. Review of Resident #20's Physician Order Summary Report dated 01/13/2026 revealed an active order started 09/22/2024 for albuterol sulfate (a bronchodilator) inhalation nebulization solution 1.25 mg/3 ml (milligrams/milliliter), 1.25 mg inhaled orally by nebulizer every six hours as needed. An observation on 01/12/2026 at 10:19 A.M. revealed Resident #20's nebulizer machine on the nightstand with the mask and medication cannister still connected, not rinsed, or stored in a bag, with dried debris visible on the mask. The observation revealed another used mask was on Resident #20's nightstand, not in a bag. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 01/13/2026 at 2:12 P.M. revealed Resident #20's nebulizer machine remained on the nightstand with the mask and medication cannister on top, not bagged, with dried debris inside the mask. Observations on 01/14/2026 at 9:43 A.M. and 01/15/2026 at 11:55 A.M. revealed Resident #20's same mask in the same condition, on the nightstand, not bagged, with dried debris inside the mask. During an interview on 01/15/2026 at 3:48 P.M., Licensed Practical Nurse (LPN) #03 stated nebulizers should be rinsed and stored in a plastic bag when not in use, and, if no longer needed, the machine should be disinfected and the tubing/mask discarded. During an interview on 01/16/2026 at 11:30 A.M., LPN #04 verified the nebulizer equipment in Resident #20's room was not stored appropriately, and there was no bag to store it in. During an interview on 01/16/2026 at 12:55 P.M., the Clinical Manager Registered Nurse (CMRN) #13 stated nebulizers should be cleaned, dried, and stored in a bag after each use. The CMRN #13 stated that if discontinued, the nebulizer equipment should be removed, cleaned, and stored in the oxygen room. During an interview on 01/16/2026 at 1:32 P.M., the DON stated nebulizers should be cleaned and dried and placed in a bag after each use. The DON stated that the nebulizer machine should be removed and disinfected when the treatment was discontinued. 3. Review of the medical record revealed the facility admitted Resident #17 on 06/07/2025. Diagnoses included COPD and congestive heart failure. Review of a quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/18/2025, revealed Resident #17 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Review of Resident #17's Care Plan Report included a focus area revised 07/02/2025 that indicated the resident had COPD with shortness of breath while lying flat. Interventions directed staff to elevate the head of the bed as needed to prevent shortness of breath while lying flat, revised 07/02/2025; monitor vitals (measurements including body temperature, heart rate, respiratory rate, and blood pressure that indicate the status of the body's vital functions), initiated 06/07/2025; and observe for signs and symptoms of COPD, initiated 06/07/2025. Review of Resident #17's Physician Order Recap Report dated for the timeframe from 06/01/2025 through 01/31/2026, revealed an order for ipratropium-albuterol (bronchodilators) solution 0.5-2.5 (3) mg/3ml (milligrams/milliliter), one vial inhaled orally three times a day for wheezing for five days, started on 12/29/2025 and ended on 01/03/2026. Review of Resident #17's Medication Administration Records (MARs) dated 12/2025 and 01/2026 revealed ipratropium-albuterol was administered from 12/29/2025 through 01/03/2026. An observation on 01/12/2026 at 9:59 A.M. revealed Resident #17's nebulizer machine on the nightstand with the mouthpiece and medication cannister still connected and not stored in a bag. An observation on 01/13/2026 at 2:11 P.M. revealed Resident #17's nebulizer machine remained on (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365455	A. Building B. Wing	01/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ivy Woods Healthcare Center.	2025 Wyoming Avenue Cincinnati, OH 45205

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	the nightstand with the mouthpiece touching the surface and not bagged. An observation on 01/14/2026 at 9:45 A.M. revealed the same condition, Resident #17's nebulizer machine on the nightstand with the mouthpiece touching the surface and not bagged. An observation on 01/15/2026 at 11:55 A.M. revealed the same condition, Resident #17's nebulizer machine on the nightstand with the mouthpiece touching the surface and not bagged. An observation on 01/16/2026 at 9:39 A.M. revealed Resident #17's mouthpiece and cannister were stored in a plastic trash bag. During an interview on 01/15/2026 at 3:48 P.M., LPN #03 stated nebulizers should be rinsed and stored in a plastic bag when not in use, and, if no longer needed, the machine should be disinfected and the tubing/mask discarded. During an interview on 01/16/2026 at 11:30 A.M., LPN #04 stated that if a resident only used the nebulizer for a short time and the order was discontinued, the machine should be removed and cleaned, and the tubing and mask thrown away. During an interview on 01/16/2026 at 12:55 P.M., the CMRN #13 stated nebulizers should be cleaned, dried, and stored in a bag after each use. The CMRN #13 stated that if discontinued, the nebulizer equipment should be removed, cleaned, and stored in the oxygen room. The CMRN #13 stated equipment was changed every seven days. During an interview on 01/16/2026 at 1:32 P.M., the DON stated nebulizers should be cleaned and dried and placed in a bag after each use. The DON stated that the nebulizer machine should be removed and disinfected when the treatment was discontinued. Review of a facility policy titled, Nebulizer [a medical treatment device that converts liquid medication into a mist or aerosol, allowing for direct inhalation into the lungs] Treatments, undated indicated, Rinse the nebulizer with sterile water and allow it to air dry. Alternatively, discard it after therapy if applicable.