

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365461	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2026
NAME OF PROVIDER OR SUPPLIER Muskingum Skilled Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 501 Pinecrest Drive Beverly, OH 45715	
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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. Based on record review, staff interview, and resident interview, the facility failed to ensure residents received the proper treatment to maintain vision and hearing abilities. This affected three residents (#3, #11, and #22) of three residents reviewed for vision and hearing. The facility census was 37. Findings include: 1. Review of the record for Resident #22 revealed an admission date of 04/02/25 and diagnoses including chronic obstructive pulmonary disease, congestive heart failure, personality disorder, and morbid obesity. Review of a vision exam on 04/29/26 revealed the resident's chief complaint was dry eyes overall. Gets crusty and stuck in the mornings. No drops used and no current drops. Would like drops. Exam showed red flaky skin on lashes. The resident was noted to have squamous blepharitis (inflammation of the eyelids) of both eyes and both upper and lower eyelids. The eye physician recommended Erythromycin (antibiotic) ointment to both eyes twice daily for 10 days. Dry eye syndrome was also noted of both lacrimal glands and artificial tears to both eyes twice daily was recommended. There was no evidence the resident received either eye medication recommended by the eye physician. Review of a Minimum Data Set (MDS) assessment completed 07/01/26 revealed a brief interview for mental status (BIMS) score of 15, indicating intact cognition. Interview with the Director of Nursing on 07/29/26 at 8:20 A.M. confirmed there was no evidence the resident received either recommended eye drop. She stated the resident did want the eye drops as the fan she uses in her room makes her eyes dry. Interview with Resident #22 on 07/29/26 at 8:50 A.M. revealed she did want to use eye drops for her eyes. 2. Review of the record for Resident #11 revealed an admission date of 02/14/25 and diagnoses including paranoid schizophrenia, morbid obesity, diabetes, and chronic venous hypertension. Review of onsite audiology consults revealed on 11/06/25 and 02/04/26 otoscopy revealed completely occluding cerumen (wax) in both ears. Cerumen is too hard and impacted to remove safely. Will require an ear drop regimen with subsequent irrigation once daily for three days. This will either completely clear out the patients ears or soften the wax enough to allow for removal by me at the next visit. There was no evidence the resident ever received any ear drops or irrigation to remove the wax that was occluding his ears. Review of a MDS assessment completed 06/12/26 revealed a BIMS score of 13, indicating intact cognition. It further stated his hearing was adequate. Interview with the Director of Nursing on 07/28/26 at 3:45 P.M. confirmed there was no evidence Resident #11 ever received any ear drops or irrigations of his ears. 3. Review of the record for Resident #3 revealed an admission date of 12/23/21 and diagnoses including acute kidney failure, acute respiratory failure, diabetes, and morbid obesity. Review of an onsite vision exam on 04/29/26 revealed the resident reported his eyes feel dry. The note stated the resident had dry eye syndrome of both lacrimal glands. The note stated to continue Restasis drops (used to increase natural tear production) twice daily in both eyes and start artificial tears twice daily in both eyes. Review of the medication administration record revealed Resident #3 received Restasis drops in both eyes twice daily from 09/12/25 until 05/09/26, when they were discontinued. There was no (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
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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documentation in the record to indicate why the drops were discontinued after it was recommended that they continue on 04/29/26. In addition, there was no evidence the resident received the artificial tears drops as recommended. Review of a MDS assessment completed 07/12/26 revealed a BIMS score of 15, indicating intact cognition. Interview with the Director of Nursing on 07/29/26 at 8:20 A.M. revealed there was no evidence the resident received the eye drops as recommended. She stated she did not know why the Restasis drops were discontinued. This deficiency represents non-compliance investigated under Complaint Number 3106020.		

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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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on record review, staff interview, and resident interview, the facility failed to assist a resident in making an appointment and arranging transportation to and from the dental service location to obtain dental care. This affected one resident (#22) of three residents reviewed for dental care. The facility census was 37. Findings include: Review of the record for Resident #22 revealed an admission date of 04/02/25 and diagnoses including chronic obstructive pulmonary disease, congestive heart failure, personality disorder, and morbid obesity. Review of an onsite dental consult on 10/16/25 revealed patient is bedbound and needs to be referred out for sedation and removal of remaining teeth. No pain or discomfort noted by patient. Review of nursing progress notes on 05/04/26 at 2:18 P.M. revealed an appointment had been set up with an outside dental service on 05/18/26. Review of nursing progress notes on 05/18/26 at 10:53 A.M. revealed the nurse was notified that the transportation office had canceled the transportation for the resident's dental appointment today. Contacted scheduler to reschedule appointment. There was no evidence that another outside dental appointment had been scheduled as of 07/29/26. Review of a Minimum Data Set assessment completed 07/01/26 revealed a brief interview for mental status score of 15, indicating intact cognition. Interview with the Director of Nursing on 07/29/26 at 8:20 A.M. confirmed there was no evidence of any attempts to reschedule an outside dental appointment for Resident #22 since 05/18/26. Interview with Resident #22 on 07/29/26 at 8:50 A.M. revealed that her teeth are bad and broken off. She stated that she did not have significant pain from her teeth. However, she stated she did want to see a dentist to have her teeth pulled. This deficiency represents non-compliance investigated under Complaint Number 3106020.		