| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365495 | A. Building<br>B. Wing | 04/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Evergreen Healthcare Center | 924 Charlie's Way<br>Montpelier, OH 43543 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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|---|---|
| F 0805<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.<br><br>Based on observation, staff interview, review of recipe, and review of diet and nutrition manual the facility failed to serve pureed foods at a smooth consistency for safe swallowing. This had the potential to affect five (#3, #16, #20, #22, and #34) residents who the facility identified to require a pureed diet. The facility census was 44. Observation on 04/08/26 at 11:48 A.M. of the first pan of preprepared pureed ham revealed the pureed ham appeared chopped and was separated, not a smooth consistency. Observation of a test tray of the pureed ham revealed the pureed ham was not a smooth consistency.Interview on 04/08/26 at 11:50 A.M. with Dietary Manager #302 verified the first pan of pureed ham was not smooth. Observation on 04/08/26 at 11:55 A.M. of the second pan of preprepared pureed ham revealed the pureed ham appeared to be a smoother texture however there were clumps of what appeared to be ham rind. Interview on 04/08/26 at 11:56 A.M. with Dietary Manager #302 reported the two pans of pureed ham were prepared at the same time but heated separately. Dietary Manager #302 verified the second pan of pureed ham had what appeared to be clumps of ham.Interview on 04/08/26 at 12:00 P.M. with Therapy Director #286 verified pureed food is a creamy smooth texture with no clumps or lumps. Therapy Director #286 verified the second pan of pureed ham and verified there were ham clumps. Review of honey glazed ham recipe, no date, verified for pureed ham measure out desired number of servings into a food processor and blend until smooth. Add thin liquid if the product needs thinning. Add commercial thickener if the product needs thickening. Review of facility provided document, Diet and Nutrition Care Manual, dated 2019, verified dysphagia puree diet food must be the consistency of moist mashed potatoes or pudding. |

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 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, resident interview, staff interview, review of self-reported incidents, and review of facility policy the facility failed to report incidents of potential misappropriation. This affected one (#27) of one residents reviewed for misappropriation. The facility census was 44. Review of the medical record revealed Resident #27 was admitted on [DATE]. Diagnoses included Type Two Diabetes Mellitus without complications, essential hypertension, hyperlipidemia, chronic kidney disease, anxiety disorder, and lymphedema. Review of the Minimum Data Set (MDS) assessment, dated on 02/04/26, revealed the resident was cognitively intact.Interview on 04/07/26 at 2:16 P.M. with Resident #27 revealed his smart phone was stolen a few months ago. Resident #27 stated he believed it was stolen, not lost as he always left it on his bedside table. Resident #27 stated it was an iPhone 17. Resident #27 stated the police were not called to take report and he was not asked if he desired to make a report.Observation and interview on 04/07/26 at approximately 3:00 P.M. revealed a box for iPhone 16 plus. Interview with Resident #27 revealed his former partner purchased the phone for him for $1400 and he paid the monthly bill. Resident #27 stated since the phone was missing he had not paid the bill. Interview on 04/07/26 at 3:24 P.M. with Certified Nursing Assistant (CNA) #275 revealed Resident #27 did have a new iphone and had told her that it was either lost or stolen. CNA #275 verified they searched his recliner chair thoroughly and looked in laundry with no success. Interview on 04/07/26 at 3:36 P.M. with Licensed Practical Nurse (LPN) #268 revealed approximately a month ago Resident #27 reported his phone was missing and management was notified. Interview on 04/08/26 at 4:11 P.M. with Resident #27 revealed he did initially believe the iPhone was missing or possibly misplaced but quickly came to believe it was stolen. Resident #27 stated he would leave it on his bedside table when he left the room and anyone could have come in and taken it. Resident #27 reported he told many staff that he thought it was stolen. Interview on 04/09/26 at approximately 9:30 A.M. with the Administrator verified a Self Reported incident (SRI) had not been submitted due to the understanding Resident #27's phone was lost, not stolen. The Administrator revealed there was some conflicting information if it was an orange iPhone with a black case as reported by the resident or a black iPhone 16 which was the empty iPhone box in his possession. The Administrator stated he was offered assistance with calling someone and offered a free phone through Medicaid and the resident declined. The resident had reportedly stated he would work on getting a replacement. Review of the facilities SRI's, since 02/15/26, revealed no SRI had been submitted for Resident #27's missing iPhone.Review of policy, Abuse, Neglect, and Misappropriation of property, dated 01/07/14, verified a suspected abuse, neglect, or misappropriation investigation report will be initiated by the Director of Nursing (DON) or designee. The Administrator, DON, or designee will report within 24 hours to the appropriate agencies, and document the time and date of that report on the investigation form. |

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|---|---|
| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, resident interview, staff interview, and review of facility policy the facility failed to thoroughly investigate an allegation of misappropriation. This affected one (#27) of one resident reviewed for misappropriation. The facility census was 44. Review of the medical record revealed Resident #27 was admitted on [DATE]. Diagnoses included Type Two Diabetes Mellitus without complications, essential hypertension, hyperlipidemia, chronic kidney disease, anxiety disorder, and lymphedema. Review of the Minimum Data Set (MDS) assessment, dated 02/04/26, revealed the resident was cognitively intact.Interview on 04/07/26 at 2:16 P.M. with Resident #27 revealed his smart phone was stolen a few months ago. Resident #27 stated he believed it was stolen, not lost as he always left it on his bedside table. Resident #27 stated it was an iPhone 17. Resident #27 stated the police were not called to take report and he was not asked if he desired to make a report.Observation and interview on 04/07/26 at approximately 3:00 P.M. revealed a box for iPhone 16 plus. Interview with Resident #27 revealed his former partner purchased the phone for him for $1400 and he paid the monthly bill. Resident #27 stated since the phone was missing he has not paid the bill. Interview on 04/07/26 at 3:24 P.M. with Certified Nursing Assistant (CNA) #275 revealed Resident #27 did have a new iPhone and had told her that it was either lost or stolen. CNA #275 verified they searched his recliner chair thoroughly and looked in laundry with no success. Interview on 04/07/26 at 3:36 P.M. with Licensed Practical Nurse (LPN) #268 revealed approximately a month ago Resident #27 reported his phone was missing and management was notified. Interview on 04/08/26 at 4:11 P.M. with Resident #27 revealed he did initially believe the iPhone was missing or possibly misplaced but quickly came to believe it was stolen. Resident #27 stated he would leave it on his bedside table when he left the room and anyone could have come in and taken it. Resident #27 reported he told many staff that he thought it was stolen. Interview on 04/09/26 at approximately 9:30 A.M. with the Administrator verified a thorough investigation had not been completed. The Administrator reported it had not been alleged the iPhone was stolen. The facility staff search the resident's room thoroughly and areas of the facility including the laundry room. The Administrator verified the police had not been notified.Review of policy, Abuse, Neglect, and Misappropriation of property, dated 01/07/14, verified a suspected abuse, neglect, or misappropriation investigation report will be initiated by the Director of Nursing (DON) or designee. Statements will be obtained from staff related to the incident, including victim, person reporting the incident, accused perpetrator and witnesses. This statement should be in writing, signed, and dated at the time it was written. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, staff interview, and review of the facility policy, the facility failed to ensure dependent residents received timely facial grooming. This affected one (#3) of three residents reviewed for the provision of activities of daily living in a facility census of 44. Findings include:Resident #3 admitted to the facility on [DATE] with the diagnosis including, dementia, anxiety disorder, pseudobulbar affect, major depressive disorder, hypertension, parkinson's disease, neurocognitive disorder, and schizoaffective disorder. According to the most current minimum data set assessment dated [DATE] Resident #3 was assessed with intact cognition, ability to make needs known, no resistive behavior, range of motion impairment to bilateral upper and lower extremities, required substantial to maximal assistance with activities of daily living, utilized a wheelchair for mobility. On 03/24/26 a nursing plan of care was revised to address Resident #3 activity of daily living (ADL) self-care deficit related to muscle weakness, balance problem, dementia, mood issues, potential medication side effects, Parkinsonism, tremors, presence of neuro-stimulator, muscle wasting/atrophy, and difficulty ambulating. Interventions included; Shower/bath dependent-Helper does all of the effort or two (2) or more helpers assist. Upper body dressing- substantial to maximal assist- helper does more than half the effort. Lower body dressing- Dependent-Helper does all of the effort or 2 or more helpers assist. Personal hygiene- substantial to maximal assist-Helper does more than half the effort. Provide assistive devices as needed. Observation on 04/07/26 at 8:16 A.M. revealed Resident #3 propelling himself in the common corridor. Resident #3 was dressed and noted with heavy facial hair growth. Interview with Resident #3 revealed he prefers to be clean shaven daily with his own electric razor. Staff do not shave him as frequent as he would like. Resident #3 indicated he was last shaven approximately two days ago. On 04/07/26 at 8:21 A.M. interview with Registered Nurse (RN) #273 verified Resident #3 with heavy beard growth greater than two days. RN #273 confirmed Resident #3 had an electric razor in his night stand. According to Resident #3 medical record task documentation scheduled showers/bathing are provided every Wednesday and Saturday. Review of Certified Nurse Assistant (CNA) skin care alert (shower sheets) between 03/04/26 and 04/04/26 revealed 10 opportunities to be shaven during scheduled shower/bathing activities for Resident #3. Of the 10 opportunities four documented times Resident #3 was shaven and six when shaving was not provided. According to the shower sheets Resident #3 was last shaven on 04/01/26. Review of facility Resident Routine Care Policy undated. Routine daily care by certified nursing assistant with specialized training in rehabilitation/restorative care under the supervision of a licensed nurse including but not limited to: maintaining proper body position and alignment for all residents. Maintain adequate fluid and nutritional intake. Implementing and maintaining program for skin care. Maintaining a bladder and bowel training program. Assisting and teaching activities of daily living. Toileting, providing care for incontinence with dignity and maintaining skin integrity. providing therapeutic interventions for cognitively impaired residents. Providing an environment that contributes to a positive self-image preserves dignity and promotes privacy. Observing and document all aspects of care. |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**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 pressure relief interventions were provided to promote wound healing and prevent further deterioration. This affected one (#31) of two residents reviewed with pressure ulcers in a facility. The census of 44. Findings include:Resident #31 admitted to the facility on [DATE] with the diagnosis including, congestive heart failure, chronic obstructive pulmonary disease, Type II Diabetes Mellitus, morbid obesity, chronic respiratory failure, anxiety disorder, hypertension, dementia, chronic peripheral venous insufficiency, osteoarthritis, transient ischemic attack, and dependence on supplemental oxygen. According to the most current minimum data set assessment dated [DATE] Resident #31 was assessed with severe cognitive impairment, no resistive behaviors, range of motion impairment to upper and lower bilateral extremities, utilized a wheelchair propelled by staff, was dependent on staff for all activities of daily living including transfer and repositioning, was always incontinent of bowel and bladder, had no identified weight loss, received a regular diet, was at risk for pressure ulcer development, and was admitted with a stage II pressure ulcer (Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough or bruising. May also present as an intact or open/ruptured blister.). Review of wound care specialist evaluation documentation dated 02/16/26 noted a stage II pressure ulcer injury to the right buttock to be healed. On 02/20/26 a nursing plan of care was revised to address Resident #31's impaired skin integrity, or at risk for altered skin integrity related to weakness, impaired mobility, history of wounds. Interventions included; administer treatments as ordered by medical provider. Complete skin at risk assessment upon admission/readmission, quarterly, and as needed. Complete Weekly Skin checks. Encourage resident to turn and reposition or assist as needed as resident allows. Ensure residents are turned and repositioned. Provide appropriate off-loading mattress & off-loading cushion, if applicable. Provide diet as ordered. On 03/16/26 Resident #31 was assessed a low risk for pressure ulcer development. The assessment interventions listed turn and reposition every two hours and bed check every two hours. Review of nursing progress notes on 03/16/26 at 2:59 P.M. New area assessed on resident's right buttocks this morning during cares. Pressure ulcer Stage II per wound care nurse, that was in today to assess. Measurements were documented as 2.2 centimeters (cm) long x 1.5 cm wide x 0.2 deep. On 03/16/26 wound care specialist evaluation identified the right buttock wound as end of life skin failure, measuring 2.2 cm x 1.2 cm x 0.2 cm, with moderate serosanguineous drainage. Review of physician orders noted on 03/30/26 right buttock treatment: Cleanse area with wound wash, pat dry, apply Calcium Alginate to wound base, and cover with border gauze dressing daily and as needed (prn),in the evening for wound management and as needed for dressing soilage/dislodgement. Review of wound care specialist wound evaluation dated 04/06/ revealed the right buttock wound noted measurement at 2.6 cm x 1.4 cm x 0.2 cm with moderate serosanguineous drainage. Partial thickness and stable condition. Observation on 04/08/26 at 6:48 A.M. noted Resident #31 seated in a wheelchair positioned at 45 degrees, placed inside the east unit lounge. Interview with Licensed Practical Nurse (LPN) #206 at the time of observation revealed Resident #31 was placed to the wheelchair from her bed approximately 30 minutes prior as a fall prevention intervention. Continuous observation noted Resident #31 to be taken to the dining room in the wheelchair at 8:17 A.M. At 8:33 A.M. Resident #31 was returned to the east unit lounge in the wheelchair. No attempts to reposition the resident or check the resident for incontinence were provided. Resident #31 remained in the east unit lounge in the wheelchair positioned at 45 degrees until 12:09 P.M. when Certified Nurse Assistant (CNA) #217 and Licensed Practical Nurse (LPN) #228 propelled Resident #31 to the dining room. CNA #217 provided Resident #31 with the lunch meal while the resident remained positioned at 45 degrees in the wheelchair. At 12:41 P.M. noted Resident #31 was returned to lounge in the wheelchair by CNA #217. No observation noted Resident #31 to be<br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | provided with repositioning or incontinence care throughout the continuous observations. Observation at 1:12 P.M. revealed Resident #31 to be propelled in the wheelchair to her room by CNA #272, CNA #217 and Director of Nursing (DON). Resident #31 was placed to bed using a mechanical lift. Observation noted Resident #31 soiled with a moderate amount of urine per adult incontinence brief. The DON removed the brief and soiled wound dressing to Resident #31 right buttock. The DON verified Resident #31 tissue to the buttock was reddened. Pericare was provided by the DON. The existing dressing was removed with moderate serosanguineous drainage, and moderate amount of urine per brief. DON cleansed the wound and measured the wound with 2.5 cm x 1.0 cm x 0.2 cm. Resident #31 was observed wincing and pulling away when the wound was manipulated. DON applied a new dressing and brief. The DON asked the resident if she had pain and responded pain to buttocks. CNA #272 and the DON proceeded to position Resident #31 in bed. Interview on 04/08/26 at 1:37 P.M. with CNA #272 stated she assumed care of the residents on the east unit with CNA #217 at 6:00 A.M. CNA #272 verified she did not provide Resident #31 with incontinence checks, care or repositioning throughout the day and was unaware if CNA #217 had provided any. Interview on 04/08/26 at 1:45 P.M. with CNA #217 stated she assumed care of the residents on the east unit with CNA #272 at 6:00 A.M. CNA #217 verified she provided no incontinence checks, care or repositioning to Resident #31 throughout the day. CNA #217 was unaware if CNA #272 had attempted to provide any care to Resident #31. Review of facility Skin Care and Wound Management Policy undated. The interdisciplinary team evaluates, and documents identified skin impairments and pre-existing signs to determine the type of impairment, underlying condition(s) contributing to it and description of impairment to determine appropriate treatment. Skin care and wound management program includes, but is not limited to: Analysis of facility pressure ulcer data for quality improvement opportunities. Application of treatment protocols based on clinical best practice standards for promoting wound healing. Daily monitoring of existing wounds. Identification of residents/patients at risk for development of pressure ulcers. Implementation of prevention strategies to decrease the potential for developing pressure ulcers. Prevention included complete the Braden Scale on admission, weekly for three weeks, quarterly and with change in clinical condition to identify risk indicators. Develop a care plan with individualized interventions to address risk factors. Communicate risk factors and interventions to the care giving team. On 04/08/26 at 1:10 P.M. interview with the Director of Nursing (DON) verified Resident #31 is dependent for all care. Resident #31 is to be reposition, checked and changed for incontinence every two hours. |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, staff interview, and review of the facility policy, the facility failed to ensure timely incontinence care was provided to a dependent resident. This affected one, (#31) of two residents reviewed for incontinence care services in a facility census of 44. Findings include:Resident #31 admitted to the facility on [DATE] with the diagnosis including, congestive heart failure, chronic obstructive pulmonary disease, Type II Diabetes Mellitus, morbid obesity, chronic respiratory failure, anxiety disorder, hypertension, dementia, chronic peripheral venous insufficiency, osteoarthritis, transient ischemic attack, and dependence on supplemental oxygen. According to the most current minimum data set assessment dated [DATE] Resident #31 was assesed with severe cognitive impairment, no resistive behaviors, range of motion impairment to upper and lower bilateral extremities, utilized a wheelchair propelled by staff, was dependent on staff for all activities of daily living including transfer and repositioning, was always incontinent of bowel and bladder, had no identified weight loss, received a regular diet, was at risk for pressure ulcer development, was admitted with a stage II pressure ulcer (Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough or bruising. May also present as an intact or open/ruptured blister.) . On 02/20/26 a nursing plan of care was revised to address Resident #31's incontinent of bowel and bladder related to weakness, impaired mobility, assistance needed with activities of daily living (ADL), and obesity. Goal included Resident will remain free of skin break down due to incontinence. Interventions were listed as follows; Apply barrier creams as ordered. Check resident for incontinence. Wash, rinse and dry perineum. Change clothing as needed (PRN) after incontinence episodes. Observe for signs and symptoms of urinary tract infection (UTI) (pain, burning, urine cloudiness, fever, altered mental status, foul smelling urine, etc.). Observe/report to medical provider if identified. Resident uses disposable briefs. Change as needed. On 03/16/26 Resident #31 was assessed a low risk for pressure ulcer development. The assessment interventions listed turn and reposition every two hours and bed check every two hours. Observation on 04/08/26 at 6:48 A.M. noted Resident #31 seated in a wheelchair positioned at 45 degrees, placed inside the east unit lounge. Interview with Licensed Practical Nurse (LPN) #206 at the time of observation revealed Resident #31 was placed to the wheelchair from her bed approximately 30 minutes prior as a fall prevention intervention. Continuous observation noted Resident #31 to be taken to the dining room in the wheelchair at 8:17 A.M. At 8:33 A.M. Resident #31 was returned to the east unit lounge in the wheelchair. No attempts to reposition the resident or check the resident for incontinence were provided. Resident #31 remained in the east unit lounge in the wheelchair positioned at 45 degrees until 12:09 P.M. when Certified Nurse Assistant (CNA) #217 and Licensed Practical Nurse (LPN) #228 propelled Resident #31 to the dining room. CNA #217 provided Resident #31 with the lunch meal while the resident remained positioned at 45 degrees in the wheelchair. At 12:41 P.M. noted Resident #31 was returned to lounge in the wheelchair by CNA #217. No observation noted Resident #31 to be provided with repositioning or incontinence care throughout the continuous observations. On 04/08/26 at 1:10 P.M. interview with the Director of Nursing (DON) verified Resident #31 is dependent for all care. Resident #31 is to be reposition, checked and changed for incontinence every two hours. Observation at 1:12 P.M. noted Resident #31 to be propelled in the wheelchair to her room by CNA #272, CNA #217 and Director of Nursing. Resident #31 was placed to bed using a mechanical lift. Observation noted Resident #31 soiled with a moderate amount of urine per adult incontinence brief. The DON removed the brief and soiled wound dressing to Resident #31 right buttock. The DON verified Resident #31's tissue to the buttock was reddened. The DON provided incontinence care and replaced the soiled dressing with a clean dressing. CNA #272 and the DON proceeded to position Resident #31 in bed. Interview on 04/08/26 at 1:37 P.M. with CNA #272 stated she assumed care of the residents<br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | on the east unit with CNA #217 at 6:00 A.M. CNA #272 verified she did not provide Resident #31 with incontinence checks, care or repositioning throughout the day and was unaware if CNA #217 had provided any. Interview on 04/08/26 at 1:45 P.M. with CNA #217 stated she assumed care of the residents on the east unit with CNA #272 at 6:00 A.M. CNA #217 verified she provided no incontinence checks, care or repositioning to Resident #31 throughout the day. CNA #217 was unaware if CNA #272 had attempted to provide any care to Resident #31. Review of facility Resident Routine Care Policy undated. Routine daily care by certified nursing assistant with specialized training in rehabilitation/restorative care under the supervision of a licensed nurse including but not limited to: maintaining proper body position and alignment for all residents. Maintain adequate fluid and nutritional intake. Implementing and maintaining program for skin care. Maintaining a bladder and bowel training program. Assisting and teaching activities of daily living. Toileting, providing care for incontinence with dignity and maintaining skin integrity. providing therapeutic interventions for cognitively impaired residents. Providing an environment that contributes to a positive self-image preserves dignity and promotes privacy. Observing and document all aspects of care. |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, staff interview and facility policy the facility failed to ensure adequate fluid was provided to dependent resident. This affected one of one residents (#31) reviewed for hydration in a facility census of 44. Findings include:Resident #31 admitted to the facility on [DATE] with the diagnosis including, congestive heart failure, chronic obstructive pulmonary disease, type 2 diabetes mellitus, morbid obesity, chronic respiratory failure, anxiety disorder, hypertension, dementia, chronic peripheral venous insufficiency, osteoarthritis, transient ischemic attack, and dependence on supplemental oxygen. According to the most current minimum data set assessment dated [DATE] assessed Resident #31 with severe cognitive impairment, no resistive behaviors, range of motion impairment to upper and lower bilateral extremities, utilized a wheelchair propelled by staff, dependent on staff for all activities of daily living including transfer and repositioning, always incontinent of bowel and bladder, no identified weight loss, received a regular diet, at risk for pressure ulcer development, admitted with a stage 2 pressure ulcer. On 02/06/26 a physician order included the provision of a regular diet with regular texture and consistency. Review of dietary nutritional assessment dated [DATE] noted Resident #31 estimated fluid needs to be between 1496 and 1700 milliliters or cubic centimeters (cc) per day (ml/day) and at risk for malnutrition. Average meal intake was between 26-100%. On 02/20/26 a nursing plan of care was implemented to address Resident #31 risk for dehydration, or potential fluid deficit related to diuretic use. Interventions included the following; Administer medications, per orders. Notify medical provider with signs or symptoms of dehydration. Provide diet as ordered. Provide oral care as needed. Review of task documentation daily fluid intake in cubic centimeters (cc) between 04/01/26 and 04/07/26 were as follows. 04/01/26= 600 cc, 04/02/26= 800 cc, 04/03/26= 1100 cc, 04/04/26= 710 cc, 04/05/26= 720 cc, 04/06/26= 600 cc, 04/07/26= 680 cc. Observation on 04/08/26 at 6:48 A.M. noted Resident #31 seated in a wheelchair placed inside the east unit lounge. Continuous observation noted Resident #31 to be taken to the dining room at 8:17 A.M. and provided with 240 cc of fluid. At 8:33 A.M. Resident #31 was returned to the east unit lounge in the wheelchair. Resident #31 remained in the east unit lounge until 12:09 P.M. when Certified Nurse Assistant (CNA) #217 and Licensed Practical Nurse (LPN) #228 propelled Resident #31 to the dining room. CNA #217 provided Resident #31 with 240 cc of fluid during the meal. At 12:41 P.M. noted Resident #31 was returned to lounge in the wheelchair by CNA #217. No observation noted Resident #31 to be offered fluids/hydration beside the meal throughout the continuous observations. Observation at 1:12 P.M. Resident #31 was taken to her room by CNA #272, CNA #217 and Director of Nursing. Resident #31 was placed to bed. Interview on 04/08/26 at 1:37 P.M. with CNA #272 stated she assumed care of the residents on the east unit with CNA #217 at 6:00 A.M. CNA #272 verified she provided no beverages to Resident #31 throughout the day and was unaware if CNA #217 had provided any. Interview on 04/08/26 at 1:45 P.M. with CNA #217 stated she assumed care of the residents on the east unit with CNA #272 at 6:00 A.M. CNA #217 verified she provided no beverages to Resident #31 throughout the day other than during the breakfast and lunch meals. CNA #217 was unaware if CNA #272 had attempted to provide the resident any beverages. On 04/08/26 at 1:49 P.M. interview with LPN #228 revealed she assumed care of Resident #31 at 7:00 A.M. LPN #228 stated she gave Resident #31 a small amount of water with morning medications. However, no further fluids had been offered or provided to the resident as side from the breakfast and lunch meals. Review of facility General Hydration Services policy undated. The facility offers each resident sufficient fluid, including water and other liquids, consistent with residents needs and preferences to maintain proper hydration and health. Assess the residents nutritional and health status needs for proper amount, type, preference, and proper consistency of fluids. Drinks, which may include water and other beverage choices consistent with resient needs and preferences and that are sufficient to maintain residents hydration, will be served during the three (3) meals provided each day.<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365495 | A. Building<br>B. Wing | 04/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Evergreen Healthcare Center | 924 Charlie's Way<br>Montpelier, OH 43543 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Observe eating and drinking providing modifications as needed. Provide fresh water at bedside in the proper consistency and drinking device, if appropriate. Provide water or other fluids for medication pass. Update care plans and notify family of changes as appropriate. This deficiency represents non-compliance investigated under Complaint 2805637. |

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| F 0791<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide or obtain dental services for each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, resident interview, staff interview, and review of facility policy the facility failed to ensure timely follow-up for dental concerns. This affected one (#27) of one resident reviewed for dental services. The facility census was 44. Review of the medical record revealed Resident #27 was admitted on [DATE]. Diagnoses included Type II Diabetes Mellitus without complications, essential hypertension, hyperlipidemia, chronic kidney disease, anxiety disorder, and lymphedema. Review of the Minimum Data Set (MDS) assessment, dated on 02/04/26, revealed the resident was cognitively intact and required set-up/clean-up assistance for oral hygiene. Resident #27 had obvious or likely cavity or broken natural teeth. The MDS assessment, dated 02/03/25, also identified obvious or likely cavity or broken natural teeth. Review of most recent care plan, verified Resident #27 had oral/dental problems. Interventions include to complete oral assessment upon admission and as needed, observe for signs and symptoms of infection and dental problems, and education the resident in changes in dentition. Review of the dental treatment note, dated 10/29/25, revealed Resident #27 had missing teeth and root tips present. It was identified the resident would benefit from full upper and lower dentures. Review of dental treatment note, dated 02/23/26, revealed Resident #27 met with a new provider for an initial assessment. Review of progress notes, dated 04/05/26, revealed Resident #27 had complaints of left side modular pain. Review of telehealth progress notes, dated 04/06/26, revealed Resident #27 was seen for dental pain. Resident #27 complained of left tooth pain that started last night and slightly worsened tonight. He reported mild left facial swelling and difficulty chewing. Interview on 04/06/26 at 2:10 P.M. with Resident #27 verified he has seen a dentist that recommended extractions and full dentures but there has been no follow-up. Subsequent observation revealed Resident #27 had missing teeth, broken teeth, and black colored teeth. Resident #27 reported he begun having tooth pain last night. Interview on 04/08/26 at 3:40 P.M. with Social Services #271 verified Resident #27 had not been scheduled with an oral surgeon for teeth extraction. Social Services #271 reported the facility switched providers between the two dental visits. Social Services #271 verified it was unknown why the tooth extraction was not completed after the October 2025 visit and does not have a date on the calendar for the dentist to return to the facility. It is unknown whether the dentist can complete an extraction for the resident or if he should be referred to an oral surgeon. Review of policy, Dental Services, no date, verified the facility will assist the resident in obtaining services to meet the needs of residents including making appointments. |

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| Evergreen Healthcare Center | 924 Charlie's Way<br>Montpelier, OH 43543 |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, staff interview, and review of the facility policy, the facility failed to ensure Enhanced Barrier Precautions were followed as ordered by the physician. This affected one of two residents (#2) reviewed for implementation of Enhanced Barrier Precautions. The facility identified 14 current residents(#2, #7, #13, #20, #22, #24, #26, #29, #31, #32, #35, #43, #48, #50) placed in Enhanced Barrier Precautions.Findings include:1. Resident #2 admitted to the facility on [DATE] with the diagnosis including, neoplasm of bone, soft tissue, skin, and endocrine glands, malignant neoplasm of brain, Type II Diabetes Mellitus, neuromuscular dysfunction of bladder, paraplegia, hypertension, coronary artery disease, anxiety disorder, polyneuropathy, cauda equina syndrome and abdominal aortic aneurysm. According to the most current minimum data set assessment dated [DATE] Resident #2 was assessed with intact cognition, range of motion impairment to bilateral lower extremities, utilized an indwelling urinary catheter, was always incontinent of bowel, received a therapeutic diet, was at risk for pressure ulcer development readmitted with one stage III pressure ulcer (Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.), and two stageIV (Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.) pressure ulcers, received antidepressant, anticoagulant, antibiotic, antiplatelet, and anticonvulsant medications. Review of physician orders dated 10/13/25 noted the initiation of Enhanced barrier precautions related to: Foley Catheter when dressing/bathing, showering/transferring in room or therapy gym/personal hygiene, changing linen, providing hygiene, changing briefs or assisting with toileting for indwelling urinary (Foley) Catheter. On 10/30/25 a nursing plan of care was implemented to address Resident #2's indwelling foley catheter. Interventions included Enhanced barrier precautions when dressing/bathing/showering/transferring/personal hygiene, changing linens, toileting and peri-care, providing care to urinary catheter. On 01/27/26 an additional nursing plan of care was revised to address Resident #2's administration of an antibiotic for chemotherapy prophylactic. Intervention noted Enhanced barrier precautions related to:When dressing/bathing/showering/transferring/personal hygiene, changing linens, toileting and peri-care, providing care to resident with history of or colonized multi-drug resistant organism. Observation on 04/08/26 at 6:55 A.M. noted Resident #2's room door closed. Inside Resident #2's room discovered contract Phlebotomist (laboratory technician) #314 at the bedside with no Personal Protective Equipment (PPE) applied and attempting to obtain a blood specimen from Resident #2. Observation outside Resident #2 door noted a sign posted indicating Enhanced Barrier Precautions were required inside the room. Instructions on the sign noted Doctors and staff must wear gloves and a gown for the following high-contact resident care activities; dressing, bathing/showering, transferring, providing hygiene, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheotomy, and wound care. On 04/08/26 at 7:04 A.M.an interview with Phlebotomist #314 revealed they were unaware Resident #2 was in enhanced barrier precautions and verified they did not wear a gown when obtaining laboratory blood specimen. Review of facility Enhanced Barrier Precautions (EBP) policy undated. Personal Protective Equipment (PPE) required included gowns and gloves. Communication to staff and visitors included posting a sign on the resident door indicating enhanced barrier precautions is required. Enhanced barrier precautions refer to infection control intervention designed to reduce transmission of multi-drug resistant organisms that employs hand hygiene, targeted gown and glove use during high contact resident care activities that include; dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube,<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | tracheostomy/ventilatory, wound care: any skin opening requiring a dressing. EBP are indicated for residents with wounds and/or indwelling medical devices. On 04/08/26 at 7:13 A.M. observation during interview with the Director of Nursing (DON) verified Resident #2's room had a EBP sign at the door entry and personal protective equipment (PPE) available inside the door. DON confirmed Phlebotomist #314 was required to wear a gown and gloves when obtaining Resident #2's blood specimen. On 04/09/26 at 10:04 A.M. administrator provided list of 14 current residents(#2, #7, #13, #20, #22, #24, #26, #29, #31, #32, #35, #43, #48, #50) placed in Enhanced Barrier Precautions. |