STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365506	A. Building B. Wing	03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ohio Living Dorothy Love	3003 West Cisco Road Sidney, OH 45365

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46613 Based on medical record review, observations, staff interviews, and policy review, the facility failed to ensure a resident's fingernails were trimmed and without debris. This affected one (#20) out of two residents reviewed for activities of daily living (ADL's). The facility census was 43. Findings include: Review of the medical record for Resident #20 revealed an admitted [DATE] with medical diagnoses of Alzheimer's disease, dementia with agitation, moderate protein calorie malnutrition, depression, hypertensive heart disease with heart failure. Review of the medical record for Resident #20 revealed a quarterly Minimum Data Set (MDS) assessment, dated 12/31/24, which indicated Resident #20 had severely impaired cognition and was dependent upon staff for all ADL's. The MDS indicated Resident #20 received Hospice services. Review of the medical record for Resident #20 revealed an ADL care plan which stated Resident #20 had limited ability to complete ADL's due to impaired cognition related to the history of cerebrovascular accident and Alzheimer's disease. The ADL care plan stated Resident #20 was dependent upon staff for all ADL's. Observation on 03/17/25 at 11:24 A.M. revealed Resident #20 to be sitting in specialized wheelchair in the common area. Resident #20's fingernails were observed to be long with debris noted under the fingernails. Observation on 03/18/25 at 8:35 A.M. revealed Resident #20 being fed breakfast by facility staff. Resident #20's fingernails were observed to be long with debris noted under the fingernails. Observation on 03/19/25 at 8:24 A.M. revealed Resident #20 being fed breakfast by facility staff. Resident #20's fingernails were observed to be long with debris noted under fingernails. Interview on 03/18/25 at 8:37 A.M. with Licensed Practical Nurse (LPN) #246 confirmed Resident #20's fingernails were long with debris noted underneath fingernails. LPN #246 stated Resident #20 received bed baths from Hospice provider and the Hospice provider was supposed to trim Resident #20's fingernails. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/19/25 at 8:26 A.M. with Certified Nursing Assistant (CNA) #236 confirmed Resident #20's fingernails were long with debris underneath the fingernails. CNA #236 stated Resident #20 received bed bathes from Hospice provider that the Hospice aide was supposed to trim Resident #20's fingernails. Review of the facility policy titled, Activities of Daily Living, effective 01/01/25 stated the facility staff are to assist each resident to the extent necessary for completion of ADL's on a daily basis and as needed.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44076 Based on record review, observation and staff interviews, the facility failed to provide a thorough assessment following a skin tear. This affected one (#94) of three residents reviewed for wound care. The facility census was 43. Findings include: Review of medical record for Resident #94 revealed admitted [DATE]. The resident was admitted with diagnoses including stroke, hemiplegia affecting the left non-dominant hand, chronic obstructive pulmonary disease (COPD), and nausea. The resident remained at the facility. The admission Minimum Data Set (MDS) dated [DATE] revealed she had a Brief Interview Mental Status (BIMS) score of a 12, indicating intact cognition. She required substantial assistance with meals, was dependent for toileting hygiene, bed mobility and transfers. Review of Resident #94's physician orders revealed on order for four percent (%) Lidocaine (pain) patch apply to the area of pain. On for 12 hours and off for 12 hours with a start date of 03/04/25. Review of Resident #94's medical record revealed the Lidocaine patch was to be applied at 5:00 A.M. and removed at 5:00 P.M. Review of the progress note dated 03/15/25 revealed a Certified Nursing Assistant (CNA) had removed a Lidocaine (pain) patch off of Resident #94's neck which caused a small skin tear. Review of the electronic charting did not provide documentation a skin assessment had been completed on 03/15/24 for Resident #94's skin tear. Review of the progress notes did not reveal the physician or family notification of a skin tear. No treatment interventions had been entered for a skin tear. Interview with observation on 03/19/25 at 10:10 A.M. with Registered Nurse (RN) #275 revealed she had not been notified of a skin tear on the neck of Resident #94. RN #275 proceeded to remove the Lidocaine (pain) patch from the back of the neck of Resident #94 which revealed a small, scabbed area. The area measured approximately one centimeter (cm) by (x) one cm. Phone interview on 03/19/25 at 1:43 P.M. with Licensed Practical Nurse (LPN) #210 revealed on 03/15/25 he had been informed by CNA #292 during evening care he had removed Resident #94's lidocaine patch and inadvertently caused a skin tear. LPN #210 stated he assessed the area and noted a small skin tear. LPN #210 decided to leave the area open to air. LPN #210 verified he did not fill out a skin assessment, notify the family or physician but simply passed it along in report. Phone interview on 03/20/25 at 3:17 P.M. with CNA #292 revealed on 03/15/25, he was getting ready to get Resident #94 washed up for the night when he observed she still had a Lidocaine patch on her neck. CNA #292 shared sometimes the patches were falling off and he was able to easily remove them. CNA #292 stated that the patch that evening had a lot of adhesive on it. CNA #292 stated when he pealed the Lidocaine patch off, a piece of Resident #94's skin came off with it. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/20/25 at 6:59 A.M. with LPN Supervisor #234 revealed she was made aware when she came into work on 03/15/25 by LPN #210 about a skin tear on the neck of Resident #94 which had been caused by CNA #292 removing her Lidocaine patch. LPN Supervisor #234 stated she did not assess the area. LPN Supervisor #234 verified CNA's cannot remove Lidocaine patches. LPN Supervisor #234 shared she did not address the incident with CNA #292 nor did she report the incident to management because LPN #210 had informed her he spoke to CNA #292 and informed him he could not remove the patches. LPN Supervisor #234 confirmed Resident #94's Lidocaine patch was to be on at 5:00 A.M. and off at 5:00 P.M. and it had not been removed as scheduled on 03/15/25.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44076 Based on record review, observation, staff interview and review of the facility policy, the facility failed to timely assess a wound to determine if it was a pressure ulcer and to identify a stage of the wound. Additionally, the facility failed to properly wrap a pressure ulcer as instructed. This affected one (#97) of three residents reviewed for wound care. The facility census was 43. Findings include: Review of medical record for Resident #97 revealed admitted [DATE]. The resident was admitted with diagnoses including lymphedema, hypertension, atherosclerotic heart disease, moderate protein calorie malnutrition. The resident remained at the facility. The quarterly Minimum Data Set (MDS) dated [DATE] revealed she had a Brief Interview Mental Status (BIMS) score of 13 indicating intact cognition. She required set up for meals, was dependent with toileting hygiene, and required substantial assistance for bed mobility and transfers. A care plan for lymphedema revealed edema extending into thighs and abdomen, with several fluid filled blisters to bilateral lower extremities. Review of Resident #97's physician orders dated 03/06/25 revealed an order to the right lower extremity to apply A&D (vaseline preferably) to left after washing. Apply Adaptic with Medihoney to open areas, cover with ABD's (abdominal pad), wrap with 2-flex, change three times a week (Tuesday, Thursday and Saturday). Change on day shift, check placement and change as needed on nights. Review of Resident #97's wound note dated 03/13/25 documented right lower leg wound just below the knee which was nearly circumferential, worse on the medial and posterior aspect. Measurements were 3.9 centimeters (cm) by (x) 29 cm x 0.2 cm. The ulcer bed was documented as 60 percent (%) red/purple and blistered in areas, 40 % brown/yellow necrotic tissue and moderate amount of serosanguineous drainage. Review of the wound note revealed the wound was not classified as to the type of wound (i.e. pressure ulcer or non-pressure ulcer) and there was no staging of the wound if the wound was a pressure ulcer. Interview on 03/19/25 at 10:41 A.M. with Registered Nurse (RN) #316 revealed she rounds with the Wound Care Nurse Practitioner (WCNP) #328. RN #316 stated Resident #97's new right leg wound had been labeled as a venous ulcer, but she was unable to provide an explanation. RN #316 stated she would call WCNP #328 for clarification. A second interview on 03/19/25 at 11:12 A.M. revealed WCNP #328 had stated she was waiting until her weekly visit (next on 03/20/25) to determine the type of wound. Observation on 03/20/25 at 7:43 A.M. of the dressing change for Resident #97 with WCNP #328 revealed the wraps to her bilateral legs were started at her ankles and ended below her knees. WCNP #328 stated to Resident #97 they did not wrap your feet this time. The dressing to the right leg was removed and revealed a linear, wound which measured 0.4 cm x 4.4 cm x 0 cm. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/20/25 at 10:10 A.M. with WCNP #328 revealed during her last visit to the facility she had been made aware by staff the right dressing for Resident #97 had rolled down and caused fluid filled blisters to form, causing a deep tissue injury. The treatment was the same as the other venous ulcers of applying Vaseline, Adaptic with Medihoney, covered with ABD pad, wrap with 2-flex. WCNP #328 mentioned the area had much improved. WCNP #329 stated education had been provided to the facility staff on the proper dressing technique and verified her feet had not been wrapped as educated. WCNP #328 confirmed Resident #97's right lower leg wound was a pressure ulcer and should have been staged. Interview on 03/20/25 at 11:17 A.M. with RN #316 acknowledged staff had been educated to wrap the bilateral legs of Resident #97 and was unsure why the treatment was not completed as instructed. Review of the facility policy Prevention, Detection and Treatment of Pressure Ulcers revised 09/14/25 revealed the assessment of the pressure ulcer would include the type of ulcer (pressure versus non pressure) and the ulcer stage.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44076 Based on medical record review and staff interviews, the facility failed to ensure a transdermal patch was removed by a qualified staff member and as physician ordered. This affected one (#94) of 12 residents reviewed for medication administration. The facility census was 43. Findings include: Review of medical record for Resident #94 revealed admitted [DATE]. The resident was admitted with diagnoses including stroke, hemiplegia affecting the left non-dominant hand, Chronic Obstructive Pulmonary Disease (COPD), and nausea. The resident remained at the facility. The admission Minimum Data Set (MDS) dated [DATE] revealed he had a Brief Interview Mental Status (BIMS) score of 12 indicating intact cognition. She required substantial assistance with meals, dependent for toileting hygiene, bed mobility and transfers. Review of Resident #94's physician orders revealed on order for four percent (%) Lidocaine (pain) patch apply to the area of pain. On for 12 hours and off for 12 hours with a start date of 03/04/25. Review of Resident #94's medical record revealed the Lidocaine patch was to be applied at 5:00 A.M. and removed at 5:00 P.M. Review of the progress note dated 03/15/25 revealed a Certified Nursing Assistant (CNA) had removed a Lidocaine (pain) patch off of Resident #94's neck which caused a small skin tear. Phone interview on 03/19/25 at 1:43 P.M. with Licensed Practical Nurse (LPN) #210 revealed on 03/15/25 he had been informed by the CNA #292 during evening care he had removed the lidocaine patch and inadvertently caused a skin tear. LPN #210 confirmed CNA #292 is not trained in medication administration including removing transdermal patches. Phone interview on 03/20/25 at 3:17 P.M. with CNA #292 revealed on 03/15/25, he was getting ready to get Resident #94 washed up for the night when he observed she still had a Lidocaine patch on her neck. CNA #292 shared sometimes the patches were falling off and he was able to easily remove them. CNA #292 stated that the patch that evening had a lot of adhesive on it. CNA #292 stated when he pealed the Lidocaine patch off, a piece of Resident #94's skin came off with it. CNA #292 confirmed he is not trained in medication administration including removing transdermal patches. Interview on 03/20/25 at 6:59 A.M. with LPN Supervisor #234 revealed she was made aware when she came into work on 03/15/25 by LPN #210 about a skin tear on the neck of Resident #94 which had been caused by CNA #292 removing her Lidocaine patch. LPN Supervisor #234 stated she did not assess the area. LPN Supervisor #234 verified CNA's cannot remove Lidocaine patches. LPN Supervisor #234 shared she did not address the incident with CNA #292 nor did she report the incident to management because LPN #210 had informed her he spoke to CNA #292 and informed him he could not remove the patches. LPN Supervisor #234 confirmed Resident #94's Lidocaine patch was to be on at 5:00 A.M. and off at 5:00 P.M. and it had not been removed as scheduled on 03/15/25.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51516 Based on medical record review, observations, staff and resident interviews, and policy review, the facility failed to ensure food was served at an appetizing temperature. This affected one (#97) out of 12 residents review for food concerns. The facility census in the facility was 43. Findings include: Review of medical record for Resident # 97 revealed admitted [DATE] with medical diagnoses of lymphedema, hypertension, atherosclerotic heart disease, and moderate protein calorie malnutrition. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #97 had a Brief Interview Mental Status (BIMS) score of 13 which indicated Resident #97 was cognitively intact. Review of the MDS revealed Resident #97 required set up for meals, was dependent upon staff for toileting hygiene, and required substantial assistance for bed mobility and transfers. Observation on 03/18/25 at 11:56 A.M. revealed [NAME] #239 obtained temperature of food in the steam table on the Rehab Hall. The temperature of the chicken breast was 126 degrees Fahrenheit (F), fish nuggets were 116 degrees F, italian wedding soup with meatballs was 140 degrees F, and zucchini chips were 120 degrees F. Further observation of [NAME] #239 retemped food on test tray and obtained same temperatures. Observation on 03/18/25 at 12:00 P.M. revealed a test tray with fish nuggets, a chicken breast, zucchini chips, and a bowl of Italian wedding soap with meatballs. The test tray looked appealing, and the food had a good flavor. However, the observation revealed the fish nuggets were cold to taste but the soup, chicken breasts, and zucchini chip was slightly warmer to taste. [NAME] #239 confirmed food items should be held/served at or above 135 degrees F to ensure that it is at the appropriate temperature. Interview on 02/17/25 at 10:05 A.M. with Resident #97 regarding food at the facility revealed she had a concern it was not always served hot. Review of undated facility policy titled, Food Temperatures reveals all hot food items must be served at a temperature of at least 135 degrees F.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44076 Based on medical record review, observations, staff, resident and resident representative interviews, the facility failed to ensure residents were served diets as physician ordered. This affected one (#97) of two residents reviewed for dietary orders. The facility census was 43. Findings include: Review of medical record for Resident #97 revealed admitted [DATE]. The resident was admitted with diagnoses including lymphedema, hypertension, atherosclerotic heart disease, moderate protein calorie malnutrition. The resident remained at the facility. The quarterly Minimum Data Set (MDS) dated [DATE] revealed she had a Brief Interview Mental Status (BIMS) score of 13 indicating intact cognition. She required set up for meals, was dependent for toileting hygiene, and required substantial assistance for bed mobility and transfers. A care plan for dysphasia revealed she required and altered diet texture. Interventions revealed she required a mechanically altered diet, thin liquids with extra gravy of condiments. Review of the 03/09/25 progress note revealed Resident #97 had a choking episode during breakfast. She was documented to have been sitting in the recliner, coughing but had stated the item had cleared. Review of the physician orders revealed an order for a mechanical soft foods with extra gravy of condiments on meats and thin liquids with a start date of 03/11/25. Interview on 3/18/26 at 12:33 P.M. with Resident #97's spouse revealed a concern Resident #97 had a hard time eating her lunch, he shared the speech therapist told him she needed her meat ground up. He stated he had told them in the hospital she was having a hard time swallowing and they put it of onto the facility. Observations revealed an uneatened regular texture grilled chicken breast on a bun on Resident #97's lunch plate. Observation and interview on 03/18/25 at 5:52 P.M. directly following tray delivery revealed Resident #97's meal included chopped beef with gravy and mashed potatoes. Resident #97 stated she did not have a concern with this meal. Regarding her lunch she stated the chicken was good, but she was unable to eat it because it had not been cut up like this meal. Observation and interview on 03/19/25 at 8:28 A.M. with Dietary Staff #226 revealed the breakfast tray delivered to Resident #97 included one dark piece of toast, cereal a fried egg. Dietary Staff #226 stated the ticket on Resident #97's plate was for a regular diet. Dietary Staff #226 stated she had been unaware Resident #97 was on a mechanically altered diet. A second interview and observation on 03/19/25 at 8:33 A. M. in the kitchenette revealed a piece of paper taped to the wall and labeled Guest- Diets-Supplement revealed Resident #97 name listed and beside it was mechanically altered, with extra gravy or condiments.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 51516 Based on observations and staff interview, the facility failed to ensure a food thermometer was cleansed/disinfected between checking food temperature on multiple food items to potentially prevent cross contamination. This had the potential to affect 19 residents (#07, #15, #18, #21, #28, #90, #91, #92, #93, #94, #95, #96, #97, #98, #100, #101, #102, #103, and #104) on the Rehab Hall. The facility census was 43. Findings include: Observation on 03/18/25 at 11:20 A.M. on Rehab Hall revealed [NAME] #239 obtained food temperature prior to serving residents on the rehab hall. The observation revealed [NAME] #239 used two different thermometers to check the temperature of the food in the steam table. [NAME] #239 was observed to take the temperature of a chicken breast in the steam table. [NAME] #239 then proceeded to insert the same thermometer into the zucchini chips without cleansing/disinfecting the thermometer prior to checking the temperature of the zucchini chips. Further observation of [NAME] #239 revealed [NAME] #239 used the second thermometer to check the temperature of the Italian wedding soup with meatballs and proceeded to check the temperature of the fish nuggets without cleansing/disinfecting the thermometer prior to checking the temperature of the fish nuggets. Interview on 03/18/25 at 11:23 A.M. with [NAME] #239 verified confirmed she did not cleanse/disinfect either thermometer in between taking the temperature of the food. [NAME] #239 confirmed the food thermometer should be cleansed/disinfected with a alcohol wipe between food items to prevent cross contamination. [NAME] #239 confirmed 19 residents (#07, #15, #18, #21, #28, #90, #91, #92, #93, #94, #95, #96, #97, #98, #100, #101, #102, #103, and #104) reside on the Rehab Hall.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 44076 Based on review of the facilities Legionella Program Plan, staff interview and review of information from the Centers for Disease Control and Prevention (CDC), the facility failed to implement their water management program to reduce the risk of Legionella and/or other pathogens in their water system. This had the potential to affect all 43 residents residing in the facility. The facility census was 43. Findings include: Review of the facilities Legionella Program Plan revealed hot water tank flushing consisted of flushing the bottom drain valve on hot water tanks for five minutes at full flow. This was to be completed quarterly. An additional intervention was hot water tank inspection which included to inspect, clean, disinfect, and descale. This was to be completed annually. Further review of the Legionella documentation and paperwork provided by the facility revealed there was no documented evidence the hot water tank had been flushed or inspected per the Legionella Program Plan. Interview on 03/19/25 at 11:49 A.M. with Maintenance Technician (MT) #245 revealed he was unable to provide documentation the hot water tank had been flushed or inspected per the Legionella Program Plan. MT #245 confirmed there have been no Legionella cases in the facility but failing to complete the water management plan placed all 43 residents residing in the facility at risk for Legionella. Review of information from the CDC at https://www.cdc.gov/control-legionella/php/training/index.html revealed Centers for Medicare and Medicaid Services (CMS) now requires healthcare facilities to have water management policies and procedures to reduce the risk of Legionella and other pathogens in building water systems.