| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365510 | A. Building<br>B. Wing | 09/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Bethesda Care Center | 600 N Brush St<br>Fremont, OH 43420 |

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 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to ensure resident care plans accurately documented their code status. This affected one resident (#40) of three residents (#33, #40, and #68) reviewed for care planning. The facility census was 75.Findings Include:Review of the medical record for Resident #40 revealed an admission date of [DATE]. Diagnoses included local infection of the skin and subcutaneous tissue, sepsis, bloodstream infection due to central venous catheter, cellulitis of left lower limb, morbid obesity, type two diabetes mellitus (DM2), disorder of vein, hypertension, tubulointerstitial nephritis, thrombocytopenia, streptococcus, non-pressure chronic ulcer of skin, disorder of arteries and arterioles, nonrheumatic mitral valve insufficiency, chronic lymphocytic leukemia of b-cell type, disorder of brain, chronic ischemic heart disease, pneumonia, viral hepatitis, stage three chronic kidney disease, dependence on renal dialysis, heart disease, glomerular disorders, anemia, lymphedema, acute kidney failure, peripheral vascular disease (PVD), cardiac murmur, hypoxemia, unspecified kidney failure, unspecified hearing loss, unspecified open would of lower leg, anemia, and other disorders of phosphorus metabolism.Review of the most recent Medicare Five-Day Minimum Data Set (MDS) assessment, dated [DATE], revealed a Brief Interview of Mental Status (BIMS) score of 15, indicating Resident #40 was cognitively intact. Further review of this MDS assessment revealed Resident #40 required at least some assistance for all functional abilities. Review of the medical record for Resident #40 revealed a signed Advanced Directives Form (a form that indicated the persons wishes should they have a catastrophic cardiac or pulmonary event that would require life sustaining measures), dated [DATE], that indicated Resident #40 wished to be Do Not Resuscitate Comfort Care-Arrest (DNR CC-A), meaning that providers will treat Resident #40 as any other without a DNR order, until the point of cardiac or respiratory arrest (the sudden loss of cardiac function or cessation of breathing) at which point all interventions will cease and the DNR Comfort care (DNR-CC) protocol will be implemented. Review of an physician order for dated [DATE] revealed Resident #40 ' s code status was DNR CC-A. Review of the most recent Care Plan for Resident #40 dated [DATE] revealed care planned interventions reflecting that the resident/responsible party have chosen that CPR (cardio-pulmonary recusation) will be attempted during cardiac/pulmonary arrest. Listing goals of if cardio/pulmonary arrest occurs, resident will receive artificial resuscitation. Full CPR will be performed by staff. Listed interventions included provide full resuscitative measures and initiate 911. Interview on [DATE] at 7:28 A.M. with the Director of Nursing (DON) verified Resident #40 had a signed Advanced Directives form, dated [DATE]. She further verified Resident #40 had an order in place to be to DNR CC-A on [DATE]. She also verified that Resident #40 was care planned to be a full-code, not a DNR CC-A. Review of the facility policy titled, Advance Directives, dated [DATE], revealed advance directives will be respected in accordance with state law and facility policy and that the plan of care of reach resident will be consistent with his or her documented treatment preferences and/or advance directives.This deficiency represents non-compliance investigated under Complaint Number 2607054. |

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 0678<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.<br><br>Based on medical record review and staff interview, the facility failed to ensure resident code status orders accurately reflected their wishes as documented in their Advance Directives Form. This affected one resident (#40) of three residents (#33, #40, and #68) reviewed for code status. The facility census was 75.Findings Include:Review of the medical record for Resident #40 revealed an admission date of 07/23/25. Diagnoses included local infection of the skin and subcutaneous tissue, sepsis, bloodstream infection due to central venous catheter, cellulitis of left lower limb, morbid obesity, type two diabetes mellitus (DM2), disorder of vein, hypertension, tubulointerstitial nephritis, thrombocytopenia, streptococcus, non-pressure chronic ulcer of skin, disorder of arteries and arterioles, nonrheumatic mitral valve insufficiency, chronic lymphocytic leukemia of b-cell type, disorder of brain, chronic ischemic heart disease, pneumonia, viral hepatitis, stage three chronic kidney disease, dependence on renal dialysis, heart disease, glomerular disorders, anemia, lymphedema, acute kidney failure, peripheral vascular disease (PVD), cardiac murmur, hypoxemia, unspecified kidney failure, unspecified hearing loss, unspecified open would of lower leg, anemia, and other disorders of phosphorus metabolism. Review of the most recent Medicare Five-Day Minimum Data Set (MDS) assessment, dated 08/28/25, revealed a Brief Interview of Mental Status (BIMS) score of 15, indicating Resident #40 was cognitively intact. Further review of this MDS assessment revealed Resident #40 required at least some assistance for all functional abilities. Review of the medical record for Resident #40 revealed a signed Advanced Directives Form (a form that indicated the persons wishes should the have a catastrophic cardiac or pulmonary event that would require life sustaining measures), dated 06/20/25, that indicated Resident #40 wished to be Do Not Resuscitate (DNR) Comfort Care-Arrest (DNR CC-A), meaning that providers will treat Resident #40 as any other without a DNR order, until the point of cardiac or respiratory arrest (the sudden loss of cardiac function or cessation of breathing) at which point all interventions will cease and the DNR Comfort care (DNR-CC) protocol will be implemented. Review of the physician order for Resident #40 dated 07/23/25 revealed Resident #40's code status was full code (all resuscitation procedures will be provided in the event of a catastrophic cardiac or pulmonary event that would require life-sustaining measures). Review of the physician order for Resident #40 revealed an order dated 09/23/25 that Resident #40's code status was changed to DNR CC-A from full code. Interview on 09/24/25 at 7:28 A.M., with the Director of Nursing (DON) verified Resident #40 had a signed Advanced Directives form, dated 06/20/25. She further verified Resident #40 had an order in place to be a full code from 07/23/25 through 09/23/25 and the order was changed to DNR CC-A on 09/23/25. Review of the facility policy titled, Advance Directives, dated December 206, revealed advance directives will be respected in accordance with state law and facility policy and that the plan of care of reach resident will be consistent with his or her documented treatment preferences and/or advance directives. This deficiency represents non-compliance investigated under Complaint Number 2607054. |

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| | 365510 | A. Building<br>B. Wing | 09/25/2025 |

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| Bethesda Care Center | 600 N Brush St<br>Fremont, OH 43420 |

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|---|---|
| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>Based on observation, staff interview, medical record review, and review of facility policy, the facility failed to ensure routine medications were supplied to residents. This affected one resident (#40) of three residents (#33, #40, and #77) reviewed for pharmacy services. The facility census was 75.Findings Include:Review of the medical record for Resident #40 revealed an admission date of 07/23/25. Diagnoses included local infection of the skin and subcutaneous tissue, sepsis, bloodstream infection due to central venous catheter, cellulitis of left lower limb, morbid obesity, type two diabetes mellitus (DM2), disorder of vein, hypertension, tubulointerstitial nephritis, thrombocytopenia, streptococcus, non-pressure chronic ulcer of skin, disorder of arteries and arterioles, nonrheumatic mitral valve insufficiency, chronic lymphocytic leukemia of b-cell type, disorder of brain, chronic ischemic heart disease, pneumonia, viral hepatitis, stage three chronic kidney disease, dependence on renal dialysis, heart disease, glomerular disorders, anemia, lymphedema, acute kidney failure, peripheral vascular disease (PVD), cardiac murmur, hypoxemia, unspecified kidney failure, unspecified hearing loss, unspecified open would of lower leg, anemia, and other disorders of phosphorus metabolism. Review of the most recent Medicare Five-Day Minimum Data Set (MDS) assessment, dated 08/28/25, revealed a Brief Interview of Mental Status (BIMS) score of 15, indicating Resident #40 was cognitively intact. Further review of this MDS assessment revealed Resident #40 required at least some assistance for all functional abilities. Review of a physician order for Resident #40 dated 07/24/25 revealed one tablet of Magnesium Gluconate Oral Tablet 250 milligrams (mg) to be administered by mouth (PO) in the morning daily for hypomagnesemia. Review of the electronic medication administration record (MAR) dated from 07/24/25 through 08/23/25, revealed Resident #40 was not administered his ordered doses of one tablet of Magnesium Gluconate Oral Tablet 250 mg, on 07/26/25, 08/04/25, and 08/14/25 due to the medication not being available. Review of a physician order for Resident #40 dated 08/24/25 through 09/12/25 revealed one tablet of Magnesium Gluconate Oral Tablet 250 mg to be administered by PO in the morning daily for supplement. Review of the electronic MAR dated from 08/24/25 through 09/12/25, revealed Resident #40 was not administered his ordered doses of one tablet of Magnesium Gluconate Oral Tablet 250 mg, on 08/24/25, 08/25/25, 08/27/25, 08/29/25, 08/31/25, 09/01/25, 09/03/25, 09/05/25, 09/06/25, 09/07/25, 09/08/25, and 09/10/25 due to not being available. Interview on 09/24/25 at 7:38 A.M., the Director of Nursing (DON) verified Resident #40's ordered dose of one tablet of Magnesium Gluconate Oral Tablet 250 mg was not administered on 07/26/25, 08/04/25, 08/14/25, 08/24/25, 08/25/25, 08/27/25, 08/29/25, 08/31/25, 09/01/25, 09/03/25, 09/05/25, 09/06/25, 09/07/25, 09/08/25, and 09/10/25. Review of the facility policy titled, Ordering Receiving Non-Controlled Medications, dated June 2024, revealed medications and related products are received from the pharmacy on a timely basis. The facility maintains accurate records of medication order and receipt. This deficiency represents non-compliance investigated under Complaint Number 2616985 and 2607054. |

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|---|---|
| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and facility policy review, the facility failed to ensure injectable medication was dated and labeled. This affected two residents (#23 and #42) identified by the facility as being prescribed injectable medication and residing on the 100-hall. The facility census was 75. Findings Include:Observation on [DATE] at 9:49 A.M. of the medication storage cart for the 100-hall with Licensed Practical Nurse (LPN) #175 revealed a Lantus SoloStar Pen insulin glargine (a type of long-acting insulin), 100 units per milliliter (units/mL), with approximately 60 of 300 units remaining, with a manufacturers date of [DATE], that was unlabeled with the date it was opened or the date it expired.Interview at the time of observation with LPN #175 verified the Lantus SoloStar Pen was unlabeled with the date it was opened or the date it expired. Review of the medication supplier guidelines titled, Medications with Shortened Expiration Dates, dated [DATE], Lantus Insulin glargine SoloStar pens expire 28 days after first use or removal from the refrigerator, whichever comes first.Observation on [DATE] at 9:49 A.M. of the medication storage cart for the 100-hall with LPN #175 revealed an Ozempic (semaglutide) (a medication used to manage DM2) pen, eight milligrams (mg) per three mL, with a manufacture's expiration date of [DATE], with approximately one and one-half mL (two doses) remaining. This Ozempic pen was not labeled with a resident name, date it was open, or date it expired. The pen was labeled for single patient use only by the manufacturer. Observation on [DATE] at 9:49 A.M. of the medication storage cart for the 100-hall with LPN #175 revealed an Ozempic (semaglutide) pen, four mg per three mL, with a manufacturer's expiration date of [DATE], with nearly all medication used. This Ozempic pen was not labeled with a resident name, date it was open, or date it expired. The pen was labeled for single patient use only by the manufacturer. Interview at the time of observation with LPN #175 verified neither of the Ozempic pens were labeled for a specific resident or with a date opened or an expiration date.Review of the medication supplier guidelines titled, Medications with Shortened Expiration Dates, dated [DATE], revealed Ozempic semaglutide injection expires 56 days at controlled room temperatures (59 degrees Fahrenheit (F) to 86 degrees F).Review of the facility policy titled, Storage of Medications, dated [DATE], revealed medications and biologicals are to be stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. Certain medications or package types, such as IV (intravenous) solution, multiple dose injectable vials, ophthalmic, nitroglycerin tablets, and blood sugar testing solutions and strips require an expiration date shorter than the manufacturer's expiration date once opened to ensure medication purity and potency. When the manufacturer has a specified a usable duration after opening the nurse shall place a date opened sticker on the medication and record the date opened and the new date of expiration. No expired medication will be administered to a resident. |

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| | 365510 | A. Building<br>B. Wing | 09/25/2025 |

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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>Based on medical record review, observation, staff interview, and policy review, the facility failed to ensure an effective infection prevention program was followed. This affected one resident (#26) of three reviewed for infection control related to wound care. The facility census was 75.Findings Include:Review of the medical record for Resident #26 revealed and admission date of 04/15/25. Diagnoses included cerebral infarction, benign prostatic hyperplasia (BPH), Barrett's esophagus, diverticulosis of large intestine without perforation, gastric ulcer, gastrointestinal (GI) hemorrhage, diaphragmatic hernia without obstruction or gangrene, hyperlipidemia, atrial fibrillation (a. fib), sick sinus syndrome, vertebra-basilar artery syndrome, neoplasm of uncertain behavior of colon, unspecified dementia, major depressive disorder, atherosclerotic heart disease of native coronary artery, gastroesophageal reflux disease (GERD), hemiplegia and hemiparesis, insomnia, depression, presence of cardiac pacemaker, presence of prosthetic heart valve, other nonspecific abnormal finding of lung field, other abnormalities of gait and mobility, dysphagia, oropharyngeal dysphagia, weakness, personal history of transient ischemic attack (TIA), need for assistance with personal care, and dependence on wheelchair. Review of the most recent quarterly Minimum Data Set (MDS) assessment, dated 08/25/25, revealed a Brief Interview of Mental Status (BIMS) score of 05, indicating Resident #26's cognition was severely impaired. Review of a physician order dated 04/16/25 for Resident #26 revealed enhanced barrier precautions (EBP) due to wounds. Observation on 09/25/25 at 8:40 A.M. of Resident #26's doorway revealed a sign, published by the Centers for Disease Control and Prevention (CDC), indicating he was in EBP and everyone must clean their hands, including before and when leaving room. The sign also indicated 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 lines, urinary catheter, feeding tube, tracheostomy), wound care (any skin opening requiring a dressing). Observation on 09/25/25 at 8:40 A.M., revealed Registered Nurse (RN) #238 entered Resident #26's room and began to perform his dressing change without donning a gown. Interview at the time of observation with RN #238 verified she had not donned a gown prior to beginning the dressing change for Resident #26. Review of the facility policy titled, Isolation - Categories of Transmission-Based Precautions, dated October 2018, revealed the CDC maintains a list of recommended precautions. The signage (placed by the door) informs the staff of the type of CDC precaution(s), instructions for use of PPE (personal protective equipment), and/or instructions to see a nurse before entering the room. This deficiency represents non-compliance investigated under Complaint Number 2626985. |