

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365566	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER Carecore at Minster		STREET ADDRESS, CITY, STATE, ZIP CODE 24 North Hamilton Street Minster, OH 45865	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview, review of manufacturer instructions, and policy review, the facility failed to store, prepare, and distribute food in a safe and sanitary manner. This had the potential to affect all residents who receive food from the kitchen. The facility identified one (#10) resident that did not receive food from the kitchen. The facility census was 56. Findings include: 1. Observation of the kitchen on 09/15/25 at 7:49 A.M. revealed one of the two hand washing sinks did not have paper towels to dry hands, the two storage shelves under the preparation tables were covered in a greasy debris. Additional observation revealed greasy debris in the cabinet shelf above the preparation table. The findings were confirmed by Dietary [NAME] (DC) #310 at the time of the observation. 2. Observation on 09/15/25 at 7:55 A.M. of the of the four flavor cold beverage juice dispenser revealed a sticky dried on substance on all four nozzles. Further observation revealed a sticky dried substance on top of and under the shelf that holds the bottles of concentrate in the refrigerated section. Interview on 09/15/25 at 7:55 A.M. with Dietary Aide (DA) #355 revealed the four flavor cold beverage juice dispenser was cleaned once a week. Further interview revealed the machine was cleaned about one week ago and was not listed on the daily or weekly cleaning list. DA #355 confirmed the appearance of the juice dispenser at that time. Review of the undated manufacture instructions for the four flavor cold beverage juice dispenser revealed daily cleaning and parts washing instructions included to remove and wash the dispense nozzles, drip tray, and drip tray cover in a mild detergent solution and rinse thoroughly. Further review revealed additional cleaning included wiping the splash panel, areas around dispense nozzle, and refrigerated compartment with a clean, damp cloth. Users are to use a brush and a mild detergent solution to clean inside dispense area where dispense nozzles are removed and rinse clean. 3. Observation of the walk-in refrigerator on 09/15/25 at 8:15 A.M. revealed three bags of wilted brown lettuce with a best by date of 09/08/25, three bags of lettuce with the best by date of 09/07/25, and two bags of lettuce with a best by date of 09/09/25. Additional observation revealed three heads of lettuce on a tray that were wilted and uncovered. Interview on 09/15/25 at 8:31 A.M. with the Dietary Manager (DM) #354 stated all products are checked for expiration by one dietary aide every day they work and stated the dietary aide's last day of work was on 09/12/25. Further interview verified the presence of the expired bags of lettuce and the uncovered and wilted lettuce heads. DM #354 stated the lettuce heads are only used for garnish and the best by date was not the same as the expiration date. Review of policy titled, Food Receiving and Storage, revised November 2022, revealed all foods stored in the refrigerator or freezer are to be covered, labeled, and dated with use by date. Additional review revealed refrigerated foods are labeled, dated, and monitored so they are used by their use-by date, frozen, or discarded. 4. Observation of the preparation area on 09/15/25 at 8:22 A.M. revealed DC #310 using a bucket of sanitizer to clean the preparation table. DA #355 tested the sanitizer and revealed concentration sanitizer between 100 and 200 parts per million (PPM). Interview on 09/15/25 at 8:23 A.M. with DA #355 stated the sanitizer concentration must be a minimum of 200 PPM. Further interview stated the bucket between 100 and 200 PPM should be dumped out and a new one should be filled. 5. Observation on 09/15/25 at 10:17 A.M. with DC #310 revealed DC #310 completed preparation of a new puree of (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	meat for lunch. DC #310 removed gloves, took the food processor to the dish washing area, washed the food processor, brought it back to the preparation area, put gloves on, then proceeded to handle the meat portions with their gloved hand. Interview on 09/15/25 at 10:41 A.M. with DC #310 verified she did not wash her hands, and stated the dish area was sanitary, so she did not have to wash hands after removing gloves and cleaning the food processor. Review of policy titled, Preventing Foodborne Illness - Employee Hygiene and Sanitary Practices, dated November of 2022, revealed employees must wash their hands after handling soiled equipment or utensils and whenever entering or reentering the kitchen.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, observations, staff interviews, and review of the Long- Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, the facility failed to ensure accurate coding on Minimum Data Set (MDS) assessments. This affected one (#50) of five residents reviewed for accidents. The facility census was 56. Findings include: Review of the medical record for Resident #50 revealed an admission date of 09/01/24 with medical diagnoses including convulsions, diabetes mellitus, morbid obesity, and Down syndrome. Review of the medical diagnoses revealed on 08/04/25 Resident #50 was given a diagnosis of a pathological fracture of the right humerus. Review of the medical record for Resident #50 revealed no documentation to support a diagnosis of osteoporosis prior to 08/03/25. Review of the medical record for Resident #50 revealed a discharge Minimum Data Set (MDS) assessment, with Assessment Reference Date (ARD) of 08/16/25, which indicated Resident #50 had moderate cognitive impairment and was independent with bed mobility, transfers, and ambulation up to 10 feet. The MDS assessment indicated Resident #50 required supervision only with ambulation up to 50 and 150 feet and did not use a wheelchair. The MDS assessment also indicated Resident #50 had two or more falls with no injury noted since last assessment on 07/16/25. Review of the annual MDS assessment, with ARD of 08/27/25, indicated Resident #50 had moderately impaired cognition, was independent with bed mobility, transfers, and ambulation up to 10 feet and required supervision with ambulation up to 50 and 150 feet. The MDS assessment indicated Resident #50 did not use a wheelchair. The MDS assessment indicated Resident #50 had two or more falls with no injury since readmission on [DATE]. Review of the medical record for Resident #50 revealed a nurse's note dated 08/03/25 at 3:22 A.M. which revealed Resident #50 was found on the floor in his room. The note revealed Resident #50 complained of right shoulder pain and was only able to move his right arm from the elbow down. The note continued Resident #50 had ice applied to the right shoulder and pain medication was administered. Resident #50 was sent to the hospital for evaluation and treatment of increased right shoulder pain. Review of the medical record for Resident #50 revealed hospital documentation dated 08/03/25 which indicated Resident #50 was seen for a fall with right shoulder pain. The hospital x-ray indicated Resident #50 sustained an impacted right humeral neck fracture and had mild degenerative changes. The x-ray did not have any documentation to support Resident #50 had osteoporosis. Review of the medical record for Resident #50 revealed the activities of daily living (ADLs) documentation from 08/10/25 to 08/16/25 did not have documentation to support Resident #50 was independent with transfers or ambulation but indicated Resident #50 required supervision to substantial/maximum staff assistance. Further review of ADLs documentation from 08/21/25 to 08/27/25 did not have documentation to support Resident #50 was independent with transfers or ambulation but indicated Resident #50 required supervision to partial/moderate staff assistance with ambulation and partial/moderate to substantial/maximum assistance with transfers. Review of the facility ADLs documentation revealed the facility does not document on resident's wheelchair mobility. Review of the medical record for Resident #50 revealed a care plan for ADLs self-care performance deficit related to abnormalities of gait and mobility. The care plan stated fluctuations in ADLs self-performance and support provided are anticipated related to diagnoses and impaired cognition. Review of the interventions revealed staff are to assist with ADLs as needed and Resident #50 was independent with transfers, bed mobility, and required supervision with ambulation. Observations on 09/16/25 at 2:43 P.M. and on 09/17/25 at 9:45 A.M. revealed Resident #50 wheeled himself in a wheelchair around the facility. Resident #50 was observed to have a sling on his right arm with each observation. Interview on 09/17/25 at 9:46 A.M. with Licensed Practical Nurse (LPN) #392 stated she provided care for Resident #50 routinely. LPN #392 stated since Resident #50's fall on 08/03/25 he required staff assistance with ambulation in his room and with transfers. LPN #392 stated Resident #50 no longer (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	walked in the hallways since his fall on 08/03/25, but would propel himself around the facility in a wheelchair independently. Interview on 09/16/25 at 3:11 P.M. with the Director of Nursing (DON) confirmed Resident #50 was given a diagnosis of pathological fracture to the right humerus on 08/03/25 because the Medical Director stated the x-ray did not indicate if the fracture was acute. The DON confirmed Resident #50's medical record did not contain any documentation to support Resident #50 had any bone density disorder or osteoporosis. The DON also confirmed Resident #50's x-ray on 08/03/25 showed an impacted right humeral fracture and mild degenerative changes. Interview on 09/17/25 at 10:46 A.M. with Medical Director #410 confirmed Resident #50's medical record did not have any documentation to support a bone density disorder or osteoporosis which could be the cause of a pathological fracture. Medical Director #410 stated Resident #50's x-ray on 08/03/25 did not indicate the fracture was acute and that was why he diagnosed the right impacted humeral fracture as pathological. Interview on 09/17/25 at 9:50 A.M. with Certified Nurse Aide (CNA) #383 stated Resident #50 was independent with transfers and ambulation prior to his fall on 08/03/25, but since then Resident #50 required staff assistance with transfers and ambulation. CNA #383 also stated Resident #50 used a wheelchair to propel self around facility and no longer ambulated in the fall since fall on 08/03/25. Interview on 09/17/25 at 1:54 P.M. LPN #325 confirmed Resident #50's discharge MDS assessment, with ARD of 08/16/25, and annual MDS assessment, with ARD of 08/27/25, indicated Resident #50 was independent with transfers and ambulation and that Resident #50 did not use a wheelchair for mobility. LPN #325 confirmed both MDS assessments had incorrect coding for Resident #50's ambulation, transfers, and wheelchair mobility. LPN #325 stated the facility utilized the Resident Assessment Instrument (RAI) manual for policies and procedures on accurate completion of MDS assessment. Review of the Long-Term Care Facility RAI 3.0 User's Manual, dated October 2024, on page GG-1 through GG-73 revealed the MDS assessment was to be coded with the usual performance for each activity for the day of the ARD and two previous days. Review of the RAI manual on page J-32 revealed to code a fall with fracture if the resident or family or medical records document a fracture related to a fall in the last six months.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and policy review, the facility failed to develop a plan of care to address resident's with a diagnosis of post-traumatic stress disorder. This affected two (#7 and #43) of two residents review for PTSD. The facility census was 56. Findings include: 1. Review of medical record for Resident #7 revealed an admission date of 05/30/25 with diagnoses including but not limited to post-traumatic stress disorder (PTSD), major depressive disorder, anxiety disorder, and dementia. Review of Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #7 had moderate cognitive impairment. Resident #7 was assessed with PTSD. Review of Resident #7's care plan dated 05/30/25 revealed no care plan addressing the resident's PTSD. Review of a psychiatric note dated 08/19/25 revealed Resident #7's PTSD listed as a diagnosis but was not addressed. Interview on 09/17/25 at 11:26 A.M. with Certified Nurse Aide (CNA) #345 revealed the CNA did not know what Resident #7's PTSD was related to. CNA #345 stated she was unaware of what the resident's triggers were or interventions to assist the resident if he had an exacerbation. CNA #345 stated she would ask the Director of Nursing (DON) for assistance. Interview on 09/17/25 at 11:31 A.M. with the DON revealed she did not know what Resident #7's triggers were or what caused the resident's PTSD. The DON stated Social Services completed a trauma screen for the resident in June 2025, and the DON verified Resident #7's care plan did not specify PTSD as a focus regarding what the trauma was or how to address any triggers. 2. Review of medical record for Resident #43 revealed an admission date of 09/19/23 with diagnoses including but not limited to bipolar disorder, major depressive disorder, PTSD, suicidal ideations, and anxiety disorder. Review of the MDS assessment dated [DATE] revealed Resident #43 was cognitively intact. Resident #43 had a diagnosis of PTSD. Review of Resident #43's care plan dated 09/12/25 revealed no care plan for PTSD to include trauma and what triggers were present. Review of a Social Service trauma screen document dated 06/17/25 revealed Resident #43 was asked if she experienced anything that was so frightening, horrible, or upsetting that, the past month they have felt they were constantly on guard, watchful, or easily startled. The resident answered, Yes, with a comment by the resident that two of her husbands were violent. One husband was verbally and physically abusive to everyone and one husband was physically abusive to her baby. Resident #43 divorced both men. Resident #43 indicated since being at the facility she had not had any issues, but one resident residing in the facility she was watchful of due to that resident's behavior. Interview on 09/17/25 at 11:29 A.M. with CNA #345 revealed she did not know what Resident #43's trauma was or if she had any triggers. Interview on 09/17/25 at 11:31 A.M. with the DON revealed she did not know what Resident #43's triggers were or why she had PTSD. The DON stated Social Services completed a trauma screen for the resident in June 2025. The DON verified Resident #43's care plan did not specify PTSD as a focus regarding what the trauma was or how to address any triggers. Review of policy titled, Care Planning-Interdisciplinary Team, revised March 2022, revealed comprehensive, person-centered care plans are based on resident assessments and developed by an interdisciplinary team (IDT).		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of fall investigation reports, and staff interview, the facility failed to ensure care plans were updated with current fall interventions. This affected one (#50) of five reviewed for accidents. The facility census was 56. Findings include: Review of the medical record for Resident #50 revealed an admission date of 09/01/24 with medical diagnoses including convulsions, diabetes mellitus, morbid obesity, and Down syndrome. Review of the medical record for Resident #50 revealed an annual Minimum Data Set (MDS) assessment dated [DATE] which indicated Resident #50 had moderately impaired cognition, was independent with bed mobility, transfers, and ambulation up to 10 feet, and required supervision with ambulation up to 50 and 150 feet. The MDS assessment indicated Resident #50 did not use a wheelchair. The MDS assessment indicated Resident #50 had two or more falls with no injury since readmission on [DATE]. Review of the fall care plan, dated 09/23/24, revealed Resident #50 was at risk for falls related to impulsive, medication side effects, and abnormalities of gait and mobility. The fall interventions included on 07/15/25 to offer activity upon rising, on 07/16/25 to ensure staff to use two staff members during transfers when behaviors are noted, on 07/17/25 to use night light during nighttime hours, and on 08/04/25 for non-skid strips to bedside. Review of the medical record for Resident #50 revealed documentation to support Resident #50 sustained falls on 07/10/25, 07/17/25, 07/18/25, and 08/03/25. Review of the fall investigation reports for Resident #50 revealed the resident had a fall on 07/10/25 with a new intervention to encourage two staff members to assist Resident #50 with ambulation when having behaviors, a fall on 07/17/25 with a new intervention to use a night light, a fall on 07/18/25 with a new intervention for staff to ambulate behind Resident #50 in the doorway, and a fall on 08/03/25 with a new intervention for non-skid strips to bedside. Interview on 09/17/25 at 12:10 P.M. with the Director of Nursing (DON) confirmed Resident #50's fall care plan did not contain documentation to support the 07/18/25 fall intervention to have staff to ambulate behind Resident #50 in the doorway.		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident representative interview, staff interview, medical record review, and policy review, the facility failed to assist residents in attending scheduled activities of their preference and on a consistent basis. This affected two (#10 and #9) of three residents sampled for activities. The facility census was 56. Findings include: 1. Review of the medical record revealed Resident #10 was admitted on [DATE] with diagnoses of spastic quadriplegic cerebral palsy and aphasia. Review of the Minimum Data Set (MDS) assessment dated [DATE] for Resident #10 revealed the resident was completely dependent for all care and exhibited no rejection of care or behavioral issues. Review of the care plan dated 09/16/25 for Resident #10 revealed the resident was dependent on staff for all activities with interventions to bring the resident to the activity room to be around other residents during activities and to escort the resident to activities they may be interested in. Review of an order dated 05/30/25 revealed Resident #10 may go out on a leave of absence (LOA) with supervision. The order had no end date. Further review revealed an order dated 06/19/24 that Resident #10 was to be up once a day on the 7:00 A.M. to 3:00 P.M. shift for two hours for therapeutic wheelchair positioning. The order had no end date. Interview on 09/17/25 at 11:40 A.M. with Resident #10's family revealed they participated in the resident's care planning and had an expectation Resident #10 would be brought down to activities such as BINGO. Observation on 09/15/25 at 12:44 P.M. revealed Resident #10 lying in bed with the television (TV) on. Observation on 09/16/25 at 9:24 A.M., 11:44 A.M., 12:03 P.M., 1:28 P.M., 2:18 P.M., and 3:00 P.M. revealed Resident #10 laying in bed with the TV on. Further observation 09/16/25 at 2:18 P.M. revealed BINGO was being played in the activities room. Interview on 09/16/25 at 3:05 P.M. with Licensed Practical Nurse (LPN) #392 verified the order for Resident #10 to be up in wheelchair between 7:00 A.M. and 3:00 P.M., and further verified Resident #10 was not up in the wheelchair before 3:00 P.M. Continued interview with LPN #392 revealed staff get Resident #10 up by 6:00 P.M., but do not take the resident outside or down to activities. Interview on 09/17/25 at 11:30 A.M. with Activities Director (AD) #357 stated Resident #10 was never brought down to activities due to being on continuous tube feeding and needing to be plugged in. Further interview with AD #357 verified the BINGO activity conducted on 09/16/25 and Resident #10 was not brought down. 2. Review of the medical record for Resident #9 revealed an admission date of 04/21/21 with diagnoses including but not limited to displaced fracture of the left humerus, dementia, depression, and restlessness and agitation. Review of the MDS assessment dated [DATE] revealed Resident #9 had severe cognitive impairment with delusions. Review of the MDS assessment dated [DATE] revealed Resident #9 had the the following activity (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	preferences listed as very important including being around animals such as pets, doing things with groups of people, doing favorite activity, and participating in religious services or practices. Review of a care plan dated 07/28/25 revealed Resident #9 engaged in daily independent activities of her choice. Her family was supportive with care and psycho-social well-being. Resident #9 went on outings as permitted with family and enjoyed visits from others. Interventions included Resident #9 enjoyed playing BINGO, trivia, talking, and going outside when it was nice out. Resident #9 attended Rosary and church services. Resident #9 enjoyed sitting in the common area during waking hours and socializing with other ladies. Staff were to assist the resident to and from activities of her desire. Review of Resident #9's activity documentation for August 2025 revealed no documentation for 08/01/25, 08/04/25, and 08/18/25. Further review of one-on-one activity with the codes for conversation (CO), games/cards (GC), music (MU), snacks/hydration (SH), prayers (PR), communication (CM), outside (OU), strolling the unit (SU), nails/hand massage (NH), reading (RE), art/coloring (AC), comfort measures (CM), and activity cart (AC) were charted as not applicable (NA) on 08/06/25, 08/10/25, 08/12/25, 08/14/25, 08/19/25, 08/21/25, 08/22/25, and 08/29/25. Spiritual activity with Catholic communion and/or mass (C), pastoral visit (PV), and any church service (CS) or Bible study was marked as not applicable on 08/06/25, 08/09/25, 08/12/25, 08/16/25, 08/19/25, 08/23/25, and 08/30/25. Review of Resident #9's activity documentation for September 2025 revealed one-on one-activity was marked as not applicable on 09/01/25, 09/02/25, 09/05/25, 09/09/25, 09/10/25, and 09/15/25.; and spiritual activity was marked as not applicable on 09/02/25. Observation on 09/15/25 at 9:26 A.M. of the memory care unit activity calendar revealed activities for the day included at 10:15 A.M., morning stretches in the main lobby, 10:30 A.M., Rosary in the main lobby, 11:00 A.M., daily chronicles, and at 1:30 P.M. watercolors in the main lobby. Further observation revealed the main lobby was located outside of the memory care unit. Observation on 09/15/25 at 10:35 A.M. revealed residents in the main lobby for Rosary. Rosary was observed to be a recording on TV and no residents from the memory care unit are observed in the activity, including Resident #9. Interview on 09/18/25 at 11:19 A.M. with Activity Director (AD #357) revealed the activities staff run the activities in the memory care unit. AD #357 verified the activity staff document the activities. AD #357 stated she will mark an activity as not applicable when it does not pertain to the activity per the key. AD #357 stated there was no option to mark other for an activity. AD #347 verified there was no consistent documentation of staff providing activities for Resident #9 and verified Rosary was held outside the memory care unit. Review of policy titled, Resident Self Determination and Participation, dated August 2025, revealed the administration and staff will include resident preferences on activities in the care planning process. Additional review revealed residents should be provided with assistance as needed to engage in their preferred activities on a routine basis Review of policy titled, Activities, reviewed 09/16/25, revealed the facility provided an ongoing program to support residents in their choices of activities based on their comprehensive assessment, care plan, and preferences. Further review revealed staff will assist residents to and from activities when necessary.		

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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** Based on observation, resident and staff interview, medical record review, and policy review, the facility failed to ensure orders for dressing changes were completed as ordered. This affected one (#44) of two residents sampled for dressing changes. The facility census was 56. Findings include: Review of the medical record revealed Resident #44 was admitted on [DATE] with diagnoses including unspecified atrial fibrillation and diabetes mellitus with neuropathy. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #44 had a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognitive function. Review of the care plan for Resident #44 dated 09/18/25 revealed Resident #44 was at risk for impaired skin integrity due to a left lower extremity contusion and a left posterior ankle blister. Interventions included to provide treatment as ordered. Review of physician orders for Resident #44 revealed an order dated 09/12/25 for a dressing to the left lower leg contusion with directions to cleanse with wound cleanser, pat dry, apply calcium alginate, wrap with kerlix, and wrap with Coban. The treatment was to be changed every day. Review of Resident #44's physician orders revealed an order dated 09/11/25 for a dressing to a left posterior ankle blister with directions to cleanse with wound cleanser, pat dry, apply betadine, wrap with kerlix, and wrap with Coban. The treatment was to be changed every day. Observation on 09/15/25 at 12:31 P.M. revealed the dressing to Resident #44's left lower leg was wrapped with kerlix but had no Coban. Further observation revealed the treatment was undated and falling off. Interview on 09/15/25 at 12:31 P.M. with Resident #44 stated the dressing was last changed two days ago. Observation on 09/16/25 at 11:47 A.M. revealed Resident #44 with a dressing to the lower left leg, dated 09/15/25, and wrapped with kerlix but not wrapped with Coban. Interview on 09/17/25 at 9:51 A.M. with Licensed Practical Nurse (LPN) #392 verified the order for the dressing change to the left lower leg included a Coban wrap. Further interview verified Resident #44 dressing was not wrapped with Coban. Review of policy titled, Wound Care, dated 2001, revealed the wound should be washed, dried with gauze and treatment applied as indicated in the order.		

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NAME OF PROVIDER OR SUPPLIER Carecore at Minster		STREET ADDRESS, CITY, STATE, ZIP CODE 24 North Hamilton Street Minster, OH 45865	
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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on medical record review, review of a dialysis binder, and staff interview, the facility failed to ensure adequate and appropriate clinical information was provided to and received from a dialysis provider to ensure coordination of care. This affected one (#4) of one residents reviewed for dialysis. The facility census was 56. Findings include: Review of the medical record for Resident #4 revealed an admission date of 07/31/25 with diagnoses including but not limited to end stage renal disease, non-compliance with renal dialysis for other reasons, and dependence on renal dialysis. Review of current physician orders revealed Resident #4 was scheduled for dialysis treatments on Mondays, Wednesdays, and Fridays. Review of a care plan dated 07/31/25 revealed Resident #4 had renal failure related to end stage renal disease and dependence on renal dialysis. Interventions included to auscultate heart and lung sounds, check bruit and thrill (a thrill is a palpable, buzzing sensation or vibration felt on the skin overlying a blood vessel due to turbulent blood flow, while a bruit is the audible whooshing sound that results from the same turbulent flow and is detected by listening with a stethoscope), dietary consultation to regulate protein and potassium intake, fluids as ordered, monitor changes in mental status including lethargy, somnolence, fatigue, tremors, and seizures, and monitor for signs and symptoms of hypovolemia or hypervolemia. Further review of a care plan dated 07/31/25 revealed Resident #4 needed hemodialysis related to end stage renal disease. Interventions included to check and change the dressing daily at access site, monitor for dry skin and apply lotion as needed, monitor laboratory values and report to the doctor as needed, monitor/document for peripheral edema, monitor/document and report to the doctor signs and symptoms of depression, monitor/document/report to doctor any signs and symptoms of infection to access site including redness, swelling, warmth, or drainage as needed, monitor/document/report to the doctor any signs and symptoms of renal insufficiency including changes in level of consciousness, changes in skin turgor, oral mucosa, and changes in heart and lung sounds, and obtain weights and vital signs per protocol and report significant changes in pulse, respirations, and blood pressure immediately. Review of the dialysis communication binder provided by the facility, which was a binder Resident #4 took to dialysis treatments, revealed only the time the resident left the facility for dialysis was documented. Further review revealed no documentation was provided to include vital signs, any medications taken, or any incidents (if applicable) that occurred with the resident. Review of Resident #4's medical record revealed no pre- or post-dialysis vital signs or assessments completed by the facility. Review of Resident #4's weights revealed the resident's weights were obtained monthly and there was no pre- or post-dialysis weights recorded. Interview on 09/17/25 at 2:26 P.M. with the Director of Nursing (DON) revealed the facility did not complete any pre- or post-dialysis assessments. The DON stated Resident #4 was skilled, so they do skilled documentation daily, but no other information besides an order sheet and face sheet was sent with the resident to dialysis treatments. The DON verified the facility did not send weights, vital signs, what medications were taken prior to dialysis, or any blood sugars reading with dialysis residents to coordinate care between the facility and the dialysis provider. The DON verified they do not obtain vital signs or complete assessments on Resident #4 when she returns from dialysis, and the facility did not have documentation from the dialysis center upon return.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. Based on medical record review, staff interview, and Medical Director interview, the facility failed to ensure a resident was free from unnecessary medications including duplicate drug therapy. This affected one (#45) of three residents reviewed for antibiotic use. The facility census was 56. Findings include: Review of the medical record for Resident #45 revealed an admission date of 06/13/24 with medical diagnoses including anxiety, anemia, chronic kidney disease stage III, and personal history of urinary tract infection (UTI). Review of the medical record for Resident #45 revealed a quarterly Minimum Data Set (MDS) assessment, dated 09/15/25, that revealed Resident #45 had moderate cognitive impairment and required partial/moderate staff assistance with toilet hygiene, and substantial/maximum staff assistance with bathing, bed mobility, and transfers. The MDS assessment indicated Resident #45 received an antibiotic medication. Review of the medical record for Resident #45 revealed a nurse's notes dated 11/20/24 at 1:20 P.M. which documented the doctor assessed Resident #45, reviewed the chart, and a new order was given for an antibiotic, Bactrim double strength (DS), with instructions to take one tablet by mouth every Monday, Wednesday, and Friday for UTI prevention. Further review revealed Resident #45 was aware and verbalized understanding. Review of Resident #45's orders revealed a physician order dated 11/20/24 for Bactrim DS 800-160 milligrams (mg), one tablet by mouth daily on Monday, Wednesday, and Friday for UTI prevention. Review of a nurse's note on 02/24/25 at 7:43 A.M. revealed Resident #45 was noted to have increased agitation and difficulty urinating. The note also revealed Resident #45's urine was dark in color, had a foul odor, and the physician was notified. Review of a nurse's note dated 02/24/25 at 1:56 P.M. revealed a Certified Nurse Practitioner (CNP) assessed Resident #45 and reviewed the resident's chart. The note revealed Resident #45 was having urinary symptoms and received a new order for Keflex (antibiotic) 500 milligram (mg) two times per day for five days. Review of Resident #45's medical record revealed an order dated 02/24/25 for cephalexin (Keflex) 500 mg one tablet two times per day for five days for a UTI. Review of the medical record for Resident #45 revealed the medication administration record (MAR) for February 2025 had documentation to support Resident #45 was administered cephalexin from 02/24/25 to 02/28/25. Further review of the February 2025 MAR revealed documentation to support Bactrim DS 800-160 mg one tablet was administered on 02/24/25, 02/26/25, and 02/28/25. Review of Resident #45's nurse's note dated 06/22/25 at 7:07 P.M. revealed physician was notified of urine culture results and received a new order for Cipro (antibiotic) two times per day for seven days. Review of Resident #45's physician orders revealed an order dated 06/23/25 for Cipro 500 mg one tablet by mouth two times per day until 06/29/25 for a UTI. Review of Resident #45's June 2025 MAR revealed documentation to support the resident was administered Cipro from 06/24/25 to 06/25/25. Review of the June 2025 MAR revealed Resident #45 refused Cipro from 06/26/25 to 06/29/25. Further review of the June 2025 MAR revealed Resident #45 was administered Bactrim DS on 06/25/25 and refused the medication on 06/23/25 and 06/27/25. Review of the medical record for Resident #45 revealed no documentation to support the facility completed a urinalysis in February 2025. Further review revealed on 06/22/25 an urinalysis with culture and sensitivity was completed which showed Escherichia coli (e-coli) greater than 100,000. The culture revealed the bacteria was susceptible to Cipro and resistant to Bactrim. Interview on 09/16/25 at 3:36 P.M. with Assistant Director of Nursing (ADON) #353 confirmed Resident #45 received Bactrim DS prophylactically for history of UTIs. ADON #353 confirmed the facility did not complete a urinalysis for Resident #45 in February 2025, but treated the resident for a suspected UTI due to urinary symptoms. ADON #353 confirmed Resident #45 continued to receive Bactrim DS on Monday, Wednesday, and Friday while she received cephalexin in February 2025 and Cipro in June 2025. Interview on 09/17/25 at 10:49 A.M. with Physician #410 stated he would expect the facility to obtain a urinalysis with culture prior to administering an antibiotic. Physician #410 also stated he would expect the prophylactic antibiotic to be put on hold while the cephalexin and Cipro were administered.		

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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. Based on observation, staff interview, recipe review, and policy review, the facility failed to ensure pureed food was prepared in a manner that preserved flavor and nutrition. This had the potential to affect three (#12, #22, and #56) of three residents identified by the facility as being on a diet with pureed meat. The facility census was 56. Findings include: Observation on 09/15/25 at 9:41 A.M. revealed Dietary [NAME] (DC) #310 prepared country fried steak with a pureed texture. Continued observation revealed DC #310 placed five portions of the country fried steak into the food processor. DC #310 proceeded to add water to puree the meat. DC #310 placed the pureed steak into a container, covered with foil, and placed it in the oven for service. Review of the undated recipe titled, Country Fried Steak with Cream Gravy, revealed pureed food characteristics included puree being smooth without lumps, held its shape on a plate, was soft pudding like consistency, liquid did not separate from the solid and it did not need to be chewed. Further review revealed the procedure for preparation of pureed food was to count out the number of portions, place in the food processor, and process by adding cream gravy a little at a time to achieve the above characteristics then serve with additional cream gravy to maintain moisture. Interview on 09/15/25 at 9:53 A.M. with Dietary Manager (DM) #354 verified DC #310 added water to puree the country fried steak and not cream gravy. DM #354 further verified the recipe called for cream gravy to be used. Continued interview with DM #354 stated the facility served the food with cream gravy, so they did not need to use it for the puree. Review of a policy titled, Pureed Diet, dated August 2025, revealed food items for puree must be prepared in a food processor. Additionally, at times it may be necessary to add liquid to puree the food and liquids used include gravies, broth, juices or milk. Water was not to be used since it causes flavor loss and results in poor intake.		

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. Based on medical record review, staff interview, physician interview, and policy review, the facility failed to ensure the antibiotic stewardship program was followed per policy. This affected one (#45) of three residents reviewed for antibiotic use. The facility census was 56. Findings include: Review of the medical record for Resident #45 revealed an admission date of 06/13/24 with medical diagnoses including anxiety, anemia, chronic kidney disease stage III, and personal history of urinary tract infection (UTI). Review of the medical record for Resident #45 revealed a quarterly Minimum Data Set (MDS) assessment, dated 09/15/25, that revealed Resident #45 had moderate cognitive impairment and required partial/moderate staff assistance with toilet hygiene, and substantial/maximum staff assistance with bathing, bed mobility, and transfers. The MDS assessment indicated Resident #45 received an antibiotic medication. Review of the medical record for Resident #45 revealed a nurse's notes dated 11/20/24 at 1:20 P.M. which documented the doctor assessed Resident #45, reviewed the chart, and a new order was given for an antibiotic, Bactrim double strength (DS), with instructions to take one tablet by mouth every Monday, Wednesday, and Friday for UTI prevention. Further review revealed Resident #45 was aware and verbalized understanding. Review of Resident #45's orders revealed a physician order dated 11/20/24 for Bactrim DS 800-160 milligrams (mg), one tablet by mouth daily on Monday, Wednesday, and Friday for UTI prevention. Review of a nurse's note on 02/24/25 at 7:43 A.M. revealed Resident #45 was noted to have increased agitation and difficulty urinating. The note also revealed Resident #45's urine was dark in color, had a foul odor, and the physician was notified. Review of a nurse's note dated 02/24/25 at 1:56 P.M. revealed a Certified Nurse Practitioner (CNP) assessed Resident #45 and reviewed the resident's chart. The note revealed Resident #45 was having urinary symptoms and received a new order for Keflex (antibiotic) 500 milligram (mg) two times per day for five days. Review of Resident #45's medical record revealed an order dated 02/24/25 for cephalexin (Keflex) 500 mg one tablet two times per day for five days for a UTI. Review of the medical record for Resident #45 revealed the medication administration record (MAR) for February 2025 had documentation to support Resident #45 was administered cephalexin from 02/24/25 to 02/28/25. Further review of the February 2025 MAR revealed documentation to support Bactrim DS 800-160 mg one tablet was administered on 02/24/25, 02/26/25, and 02/28/25. Review of the medical record for Resident #45 revealed no documentation to support the facility completed a urinalysis in February 2025. Interview on 09/16/25 at 3:36 P.M. with Assistant Director of Nursing (ADON) #353 confirmed Resident #45 received Bactrim DS prophylactically for history of UTIs. ADON #353 confirmed the facility did not complete a urinalysis for Resident #45 in February 2025, but treated the resident for a suspected UTI due to urinary symptoms. ADON #353 confirmed Resident #45 continued to receive Bactrim DS on Monday, Wednesday, and Friday while she received cephalexin in February 2025. Interview on 09/17/25 at 10:49 A.M. with Physician #410 stated he would expect the facility to obtain a urinalysis with culture prior to administering an antibiotic. Physician #410 also stated he would expect the prophylactic antibiotic to be put on hold while the cephalexin was administered. Review of the facility policy titled, Antibiotic Stewardship Staff and Clinical Training and Roles, revised December 2016, revealed the facility would educate and train staff and practitioners about the facility antibiotic stewardship program, including appropriate prescribing, monitoring, and surveillance of antibiotic use and outcomes.		