STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365576	A. Building B. Wing	03/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chillicothe Post Acute	1058 Columbus St Chillicothe, OH 45601

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation and interview, the facility failed to ensure that the floors in resident bathrooms were in good repair. This affected 19 (Residents #10, #11, #20, #23, #31, #32, #35, #37, #52, #57, #61, #65, #66, #68, #76, #79, #87, #89, and #93) residents. The facility census was 80.Findings include:Observation of the facility on 03/05/2026 at 10:22 A.M. revealed that the resident bathroom floors for Residents #10, #11, #20, #23, #31, #32, #35, #37, #52, #57, #61, #65, #66, #68, #76, #79, #87, #89, and #93 were torn, cracked, warped and/or peeling away from the walls.Interview with Resident #52 on 03/052026 at 10:32 A.M. revealed that the bathroom floor is in need of replacement and the staff is aware.Interview with Maintenance Assistant #345 on 03/05/2026 at 10:35 A.M. revealed that some bathroom floors in resident rooms are in disrepair therefore the facility has obtained quotes as they need replaced.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, and interview, the facility failed to ensure food was served at an appetizing temperature and acceptable palatability. This had the potential to affect 78 residents who received meals in the facility. The facility identified Residents #87 and #93 as not receiving food from the kitchen. The facility census was 80.Findings include:An interview conducted on 03/02/26 at 9:43 A.M. with Resident #31 revealed that meals are hardly ever hot.An interview conducted on 03/02/2026 at 9:51 A.M. with Resident #61 revealed that the food is not good and comes out cold.An interview conducted on 03/03/26 at 7:58 A.M. with Resident #73 revealed the food is alright, but they often get things that they do not like or cannot eat such as corn and bread. Resident #73 stated that dietary is aware of their preferences and has been reminded. Observation of meal trays being passed on 03/05/2026 at 8:20 A.M. revealed Resident #69 with complaints that the French Toast could not be cut or chewed. Substitute requested.Test tray sampling on 03/05/2026 at 8:43 A.M. revealed milk temperature of 50.2 degrees and juice temperature of 48 degrees with all temps verified by Dietary Manager (DM) #448. Further investigation revealed the French toast was unable to be cut with a fork and butter knife.Interview with DM #448 on 03/05/26 at 8:45 A.M. revealed that the French Toast was hard and unable to be cut with utensils.

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	365576	A. Building B. Wing	03/10/2026

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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 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. Based on observation, interview and policy review, the facility failed to properly store food. This had the potential to affect 78 residents who received meals in the facility. The facility identified Residents #87 and #93 as not receiving food from the kitchen. The facility census was 80.Findings include:Observation of the kitchen during the initial tour on 03/02/2026 at 8:30 A.M. revealed opened packages of hotdogs, pepperonis, and a container half full of sliced cheese with no dates. The freezer further revealed an opened bag of chicken strips with no date.Interview with Dietary Manager (DM) #448 on 03/02/2026 at 8:35 A.M. during the initial kitchen tour confirmed the observations of no dates on opened packages of hot dogs, pepperonis, sliced cheese and chicken strips.Review of the Food Receiving and Storage Policy N.D. on 03/03/2026 revealed that all foods stored in the refrigerator or freezer are to be covered, labeled and dated (use-by date). Refrigerated foods are labeled, dated, and monitored so they are used by their use-by date, frozen, or discarded.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, staff interview, review of facility infection surveillance logs, and review of facility policy, the facility failed to ensure residents with in-house acquired Clostridium Difficile (C-Diff) infections were reviewed for patterns and trends to decrease the spread of infection. This affected seven residents (#36, #42, #52, #71, #103, #104, and #228) identified by the facility as having acquiring C-Diff infections in the facility since 11/01/2025. The facility census was 80.Findings include:Record review for Resident #22 revealed the resident was admitted to the facility on [DATE]. Record review for Resident #36 revealed the resident was admitted to the facility on [DATE].Record review for Resident #42 revealed the resident was admitted to the facility on [DATE],Record review for Resident #52 revealed the resident was admitted to the facility on [DATE].Record review for Resident #71 revealed the resident was admitted to the facility on [DATE].Record review for Resident #103 revealed the resident was admitted to the facility on [DATE].Record review for Resident #104 revealed the resident was admitted to the facility on [DATE].Review of the facility line listings of infections revealed Resident #42 was documented to have an in-house acquired infection with C-Diff on 11/19, Resident #103 was documented to have an in-house acquired infection with C-Diff on 11/20/25, Resident #52 was diagnoses to have an in-house acquired infection with C-Diff on 11/21/25, Resident #104 was documented to have an in-house acquired infection with C-Diff on 11/26/25, Resident #36 was documented to have an in-house acquired infection with C-Diff on 12/05/25, Resident #42 was documented to have an in-house acquired infection with C-Diff on 02/03/26, Resident #71 was documented to have an in-house acquired infection with C-Diff on 02/06/26, and Resident #22 was documented to have an in-house acquired infection with C-Diff on 02/15/26. Review of the facility Healthcare Acquired Infection Rate - Tracking and Trending, and Variance Analysis - Monthly Analysis of Trends forms for the month of 11/2025, 12/2025, and 01/2026 revealed the facility rate of gastrointestinal infections was zero. No review of commonalities or clusters, causative factors, or plans for further monitoring/interventions for C-Diff infections were noted.Interview with Licensed Practical Nurse (LPN)/Infection Control Nurse #363 on 03/05/26 at 2:15 P.M. confirmed there were no gastrointestinal infections documented on the Healthcare Acquired Infection Rate - Tracking and Trending and Variance Analysis - Monthly Analysis of Trends forms for the months of 11/2025, 12/2025, and 01/2026. LPN /Infection Control Nurse #363 confirmed there was no review of commonalities or clusters, causative factors, or plans for further monitoring/interventions for C-Diff infections for those months. Review of the facility policy titled Surveillance for Infection, dated 2001, revealed the infection preventionist will conduct ongoing surveillance for healthcare-associated infections (HAIs) and other epidemiologically significant infections that have substantial impact on potential resident outcome and that may require transmission-based precautions and other preventative interventions. The purpose of the surveillance of infections is to identify both individual cases and trends of epidemiologically significant organisms and healthcare-associated infections, to guide appropriate interventions, and to prevent future infections.This deficiency represents non-compliance identified during the investigation of Complaint 2735113.

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Chillicothe Post Acute	1058 Columbus St Chillicothe, OH 45601

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure psychotropic medications were ordered for appropriate diagnoses. This affected one resident (#7) out of five reviewed for unnecessary medications. The facility census was 80 at the time of survey. Findings include:Review of the medical record revealed Resident #7 was admitted to the facility on [DATE]. Diagnoses included radiculopathy, peripheral vascular disease, chronic obstructive pulmonary disease, atherosclerosis of coronary artery bypass graft, and bipolar disorder with current episode hypomanic. Review of most recent psychiatric services documentation dated 02/04/2026 revealed Resident #7 had mental health diagnoses of bipolar disorder, anxiety, and insomnia.Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident was cognitively intact, had no behaviors, did not reject care, and did not wander.Review of medication orders for Resident #7 revealed orders as follows:Citalopram Hydrobromide tablet 10MG: Give 1 tablet by mouth one time a day for depression.Duloxetine HCL Capsule Delayed Release Particles 60 MG: Give 1 capsule by mouth one time a day for depression.Interview on 03/04/2026 with Director of Nursing revealed that Resident #7 did not have a diagnosis of depression but was being ordered Divalproex and Citalopram for the mood disorder bipolar disorder.

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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 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. Based on record reviews, interviews, and policy review, the facility failed to develop a care plan to address elopement risk. This affected one resident (Resident #61) of one resident reviewed for care plan accuracy. The facility identified five residents at risk for elopement. The facility census was 80.Findings include:Review of the medical record for Resident #61 revealed an admission date of 03/20/25 with diagnoses including hemiplegia and hemiparesis affecting his right, non-dominant side, aphasia following cerebral infarction, depression, and high blood pressure. Further record review revealed on admission, his Brief Interview for Mental Status (BIMS) score was 10 out of 15, indicating he had moderate cognitive impairment.Review of the annual Minimum Data Set 3.0 (MDS) assessment completed on 02/09/26 revealed Resident #61 was independently mobile with the use of a manual wheelchair. He required maximal assistance with toileting, showering, dressing, and positioning. Resident #61 had displayed no verbal or physical disruptive behaviors, no rejection of care, and no wandering or exit-seeking behaviors. Resident #61 had a Wanderguard in place.Review of nursing progress notes revealed on 05/17/25 at around 6:00 P.M., Resident #61 was found in the facility parking lot by an employee leaving at the end of their shift. Resident #61 informed the nurse assisting him that he was trying to go home. The nurse was able to assist Resident #61 back into the facility where a Wanderguard was applied to his wheelchair. Resident #61 made multiple successful trips outside of the building and was resistant to return inside. Later in the evening, staff noted Resident #61 continued to leave the facility with other staff members as they left the building and required multiple individuals to encourage him to return to the building. No further elopement attempts or instances of unsafe wandering were documented.Review of physician orders revealed an order on 05/17/25 for a Wanderguard to be applied to Resident #61's wheelchair due to poor safety awareness. Review of Resident #61's care plan revealed no goals or interventions indicating Resident #61 had poor safety awareness requiring the use of a Wanderguard or a history of unsafe wandering or elopement attempts.Interview on 03/05/26 at 8:36 A.M. with Director of Nursing (DON) #301 stated the Elopement and Wandering Risk Observation Assessments are completed for each resident upon admission, quarterly, and as needed if behaviors develop. DON #301 stated a resident is considered to have eloped if they leave the property without staff knowledge; if the resident is cognitively impaired, they are considered to have eloped if the resident leaves the building. DON #301 confirmed that the Elopement and Wandering Risk Observation Assessments completed after the elopement were inaccurate and confirmed Resident #61 required a Wanderguard alarm. DON #301 confirmed Resident #61's care plan should have been updated following the elopement and application of the Wanderguard alarm.Review of the policy titled Emergency Procedure - Missing Resident, revised 08/2018, stated a resident's care plan should be updated following an elopement.

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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** Based on medical record review and resident and staff interviews, the facility failed to monitor resident's blood sugars. This had the potential to affect one (Resident #99) of 15 residents the facility identified as diagnosed Type 2 Diabetes Mellitus (T2DM). The facility census was 80 residents. Findings include: Review of the medical records for Resident #99 revealed admission date of 02/23/26 with diagnoses of urinary tract infect ion, Parkinsonism and T2DM with hyperglycemia, T2DM with other specified complications, and T2DM with diabetic neuropathy, unspecified. Review of the Discharge summary dated [DATE] revealed an order for TRUEplus Lancets 33G. Review of the 02/24/26 facility nurse practioner's progress note dated 02/24/26 and 02/26/26 revealed to continue blood glucose monitoring per facility protocol. Review of the 02/27/26 progress note by the facility medical director revealed there is currently no need for change to the current care. Nursing has orders and they are assisting in the stability of the patient at this time. Review of 03/03/26 progress nurse by the facility nurse practitioner referenced to continue blood glucose monitoring per facility protocol. Review of Resident #99 orders revealed no current order for blood glucose monitoring. Resident #99 medication for T2DM includes Glimepiride Oral Tablet 4 MG (Glimepiride) one time daily, Glucagon Emergency Inject 1 vial intramuscularly (IM) as needed for Low Blood Sugar 1 vial IM as needed if blood sugar less than 70 or if resident is unresponsive and notify physician, Insulin Glargine Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Glargine) Inject 45 unit subcutaneously one time a day for DM, MetFORMIN HCl ER Tablet Extended Release 24 Hour 500 MG Give 2 tablet by mouth two times a day for DM, and Ozempic (2 MG/DOSE) Subcutaneous Solution Pen injector 8 MG/3ML (Semaglutide) Inject 2 mg subcutaneously one time a day every Thursday for DM.Interview on 03/04/25 at 1:09 P.M. with Resident #99 stated his blood sugar was not checked as of 03/04/26 but was checked on 03/03/26 by Associate #304. Interview on 03/04/26 at 2:00 P.M. with Associate #301 confirmed facility does not have a blood glucose monitoring protocol. Associate #301 stated orders were obtained for Resident #99 for Accuchecks without coverage with meals for diabetes mellitus (DM), HGB A1C every six months-August & February.

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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** Based on observations, interviews, record reviews, and review of facility policy, the facility failed to ensure wound care orders for the treatment of pressure ulcers were implemented timely and appropriately. This affected one resident (#93) out of the three residents reviewed for pressure ulcers. The facility census was 80.Findings include:Record review for Resident #93 revealed the resident was admitted to the facility on [DATE] and had diagnoses which included stage three pressure ulcer (full-thickness skin loss, in which fat tissue is visible in the ulcer and granulation tissue and rolled wound edges is often present) of the sacral region, cellulitis, and aphasia following cerebral infarction.Review of the care plan, dated 02/26/26, revealed the resident had impaired skin integrity present on admission as evidenced by a stage four pressure ulcer (a pressure ulcer in which there is full-thickness tissue loss with exposed or directly palpable fascia, mucle, tendon, ligament, cartilage, or bone in the ulcer) to the sacrum. Interventions included to administer treatments as ordered, apply barrier cream as indicated, and keep skin clean and dry to the extent possible. Review of the hospital WOC (Wound, Ostomy, Incontinence)/ET (Enterostomal Therapy) Nursing Consult/Evaluation Note, dated 02/20/26, revealed the residents stage four sacrococcyx wound was to have Vashe (a hypochlorous acid-based solution designed to safely cleanse, irrigate, and promote healing of acute and chronic wounds) moistened gauze packing twice daily, or once per shift, per nursing staff. Cover with an ABD Pad or Sorbex pad, and secure with Medipore adhesive. Discharge instructions included resident may continue care as prescribed above at discharge. Review of the facility Comprehensive Skin Assessment, dated 02/24/26, revealed Resident #93 was assessed to have a pressure ulcer to the sacrum present. Review of the active physician order, dated 03/01/26, revealed an order to cleanse open area to coccyx with normal saline, pack with Vashe covered gauze, and cover with a foam patch daily and as needed. Review of all additional active and discontinued physician orders for Resident #93 on 03/03/26 revealed no treatment orders for the pressure ulcer on Resident #93's coccyx were documented to be implemented from 02/24/26 through 02/28/26. Review of the Treatment Administration Record (TAR) for Resident #93 on 03/03/36 revealed no treatments were documented to have been completed to the pressure ulcer on Resident #93's coccyx from 02/24/26 through 02/28/26. Review of the physician order, created by Licensed Practical Nurse (LPN) #363 on 03/04/26 at 7:54 A.M., revealed an order to cleanse sacrococcyx with Vashe, pack wound with Vashe moistened gauze, and cover with ABD pad or Sorbex pad and secure with Medipore tape daily and as needed. The order was documented to have been ordered on 02/25/26. Review of the TAR for Resident #93 on 03/04/26 revealed the order created by LPN #363 on 03/04/26 at 7:54 A.M. had been added to the TAR. LPN #363 had documented the completion of wound care treatment to the pressure ulcer on Resident #93's coccyx as being completed on 02/25/26. No documentation of wound care being completed on 02/26/26, 02/27/26, or 02/28/26 was present. Interview on 03/03/26 at 1:45 P.M. with Licensed Practical Nurse (LPN) #310 confirmed there had not been a physician order put in place for the wound care treatment for Resident #93's pressure ulcer until 03/01/26. LPN #310 confirmed she had contacted LPN #363 and had obtained an order for the treatment, so she knew what to do and had completed the treatment on 02/27/26 and 02/28/26 as well. Interview on 03/03/26 at 1:55 P.M. with LPN #363 confirmed she was on call when LPN #310 called her and obtained treatment orders for Resident #93's pressure ulcer. LPN #363 confirmed she had given LPN #310 orders for the wound care treatment as the physician trusted the nurses to come up with treatment orders and then signed off on them. LPN #310 confirmed there was no documentation of treatment orders being implemented or completed for Resident #93's pressure ulcer from 02/24/26 when she was admitted through 02/28/26. Telephone interview on 03/04/26 at 10:15 A.M. with Physician #599 confirmed resident wounds were to be assessed by facility nursing staff then discussed with the physician or nurse practitioner so wound care treatment orders could be provided. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Physician #599 confirmed wound care treatment orders were not to be ordered and implemented by facility nurses without discussion with the physician or nurse practitioner. Observation on 03/04/26 at 10:40 A.M. of the wound care treatment being completed for the pressure ulcer to Resident #93's coccyx by Registered Nurse (RN) #321 and LPN #426 revealed the residents wound was free from signs or symptoms of infection. Wound care was completed as ordered with no concerns. RN #321 confirmed wound care treatment orders were to be reviewed prior to the completion of wound care. Review of the facility procedure titled Wound Care, dated 2001, revealed the purpose of this procedure is to provide guidelines for the care of wounds to promote healing. Verify there is a physician's order for this procedure. Review the resident's care plan to assess for any special needs of the resident. Assemble the equipment and supplies as needed. Date and initial all bottles and jars upon opening. The following information should be documented in the residents medical record: the type of wound care given, the date and time would care was given, and the name and title of the individual performing wound care. This deficiency represents non-compliance identified during the investigation of Complaint 2733569.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, interviews, and policy reviews, the facility failed to ensure one resident (Resident #61) was free of elopements. This affected one resident (#61) of four residents reviewed for elopements. The facility census was 80.Findings include: Review of the medical record for Resident #61 revealed an admission date of 03/20/25 with diagnoses including hemiplegia and hemiparesis affecting his right, non-dominant side, aphasia following cerebral infarction, depression, and high blood pressure. Further record review revealed on admission, his Brief Interview for Mental Status (BIMS) score was 10 out of 15, indicating he had moderate cognitive impairment.Review of the annual Minimum Data Set 3.0 (MDS) assessment completed on 02/09/26 revealed Resident #61 was independently mobile with the use of a manual wheelchair. He required maximal assistance with toileting, showering, dressing, and positioning. Resident #61 had displayed no verbal or physical disruptive behaviors, no rejection of care, and no wandering or exit-seeking behaviors. Resident #61 had a Wanderguard in place.Review of nursing progress notes revealed on 05/17/25 at around 6:00 P.M., Resident #61 was found in the facility parking lot by an employee leaving at the end of their shift. Resident #61 informed the nurse assisting him that he was trying to go home. The nurse was able to assist Resident #61 back into the facility where a Wanderguard was applied to his wheelchair. Resident #61 made multiple successful trips outside of the building and was resistant to return inside. Later in the evening, staff noted Resident #61 continued to leave the facility with other staff members as they left the building and required multiple individuals to encourage him to return to the building. No further elopement attempts or instances of unsafe wandering were documented in Resident #61's medical record.Review of physician orders revealed an order on 05/17/25 for a Wanderguard to be applied to Resident #61's wheelchair due to poor safety awareness. Review of the Elopement and Wandering Risk Observation Assessments completed on admission on [DATE], and quarterly thereafter on 06/13/25, 09/08/25, 12/04/25, and 03/02/26 revealed Resident #61 was able to self-propel his wheelchair; was alert and oriented to person, place and time; had never expressed a desire to leave the facility; and had never exhibited unsafe wandering or elopement attempts. The conclusion for each assessment was that use of a wander alarm was not indicated.Review of Resident #61's care plan revealed no goals or interventions indicating Resident #61 had poor safety awareness requiring the use of a Wanderguard or a history of unsafe wandering or elopement attempts.Review of the Medication Administration Record/Treatment Administration Record (MAR/TAR) for March 2026 revealed the unit nurse confirmed the Wanderguard was in place on Resident #61's wheelchair as ordered.Observations made on 03/03/26 at 3:47 P.M., 03/04/26 at 8:08 A.M., 8:49 A.M., and 1:32 P.M., and 03/05/26 at 8:33 A.M. revealed Resident #61's Wanderguard was not applied to his wheelchair or his person. Interview on 03/04/26 at 1:32 P.M. with RN #329 confirmed Resident #61 has an order for a Wanderguard to be placed on his wheelchair. RN #329 confirmed the Wanderguard was not on his wheelchair or his person. RN #329 retrieved a new Wanderguard bracelet and attempted to apply it to Resident #61's wheelchair but he refused.Interview on 03/05/26 at 8:36 A.M. with Director of Nursing (DON) #301 stated the Elopement and Wandering Risk Observation Assessments are completed for each resident upon admission, quarterly, and as needed if behaviors develop. DON #301 stated a resident is considered to have eloped if they leave the property without staff knowledge; if the resident is cognitively impaired, they are considered to have eloped if the resident leaves the building. DON #301 confirmed that the Elopement and Wandering Risk Observation Assessments completed after the elopement were inaccurate and confirmed Resident #61 required a Wanderguard alarm. DON #301 confirmed Resident #61's care plan should have been updated following the elopement and application of the Wanderguard alarm.Review of the policy titled Emergency Procedure - Missing Resident, revised 08/2018, stated a resident's care plan (continued on next page)

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	365576	A. Building B. Wing	03/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chillicothe Post Acute	1058 Columbus St Chillicothe, OH 45601

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	should be updated following an elopement. The policy stated after the missing resident is found, the facility should complete an incident report and report the incident to the State Licensing and Certification agency according to state regulations.

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record reviews, and review of facility policy, the facility failed to ensure tube feedings were administered at the rate ordered by the physician. This affected two residents (#87 and #93) out of the three residents reviewed for tube feeding. The facility census was 80.Findings include:1. Record review for Resident #87 revealed the resident was admitted to the facility on [DATE] and had diagnoses which included paroxysmal atrial fibrillation, type two diabetes mellitus, and dysphagia. Review of the admission Minimum Data Set (MDS) assessment, dated 02/25/26, revealed the resident was assessed to have mildly impaired cognition. Review of the care plan, dated 02/19/26, revealed the resident was at risk for malnutrition due to gastrostomy tube, requires enteral nutrition. Interventions included to administer enteral nutrition as ordered. Review of the active physician order, dated 02/25/26, revealed the resident was to receive Diabetisource AC by PEG (Percutaneous Endoscopic Gastrostomy) tube at a rate of 85 milliliters (ml) per hour with a 75 ml flush of water every four hours continuously. Observation on 03/02/26 at 9:33 A.M. revealed Resident #87 was lying in bed. Diabetisource AC was being administered by a pump through his PEG tube at a rate of 75 ml per hour with a 150 flush of water every four hours. Observation on 03/02/26 at 1:45 P.M. revealed Resident #87 continued to have DIabetisource AC being administered by a pump through his PEG tube at a rate of 75 ml per hour with a 150 ml flush of water every four hours. Interview with Licensed Practical Nurse (LPN) #304 at the time of the observation confirmed Resident #93's Diabetisource AC was running at a rate of 75 ml per hour with a 150 ml flush of water every four hours when it should have been running at a rate of 85 ml per hour with a 75 ml flush of water every four hours. LPN #304 then set the feeding pump to administer the correct amount of Diabetisource AC and water flushes. 2. Record review for Resident #92 revealed the resident was admitted to the facility on [DATE] and had diagnoses which included a stage three pressure ulcer of the sacral region, aphasia following cerebral infarction, and gastrostomy status. Review of the care plan, dated 02/26/26, revealed the resident had a GT (Gastrostomy Tube) and was at risk for enteral nutrition complications. Interventions included to provide enteral tube care as ordered and check for tube placement as ordered. Review of the active physician order, dated 02/27/26, revealed the resident was to receive Osmolite 0.5 calorie by PEG tube at a rate of 80 ml per hour continuously with a 100 ml flush of free water every four hours. Observation on 03/02/26 at 8:25 A.M. revealed Resident #93 was lying in bed. Osmolite 0.5 calorie was being administered by a pump through her PEG tube at a rate of 60 ml per hour with a 100 ml flush of water every four hours. Observation on 03/02/26 at 1:58 P.M. revealed Resident #93 continued to have Osmolite 0.5 calorie being administered by a pump through his PEG tube at a rate of 60 ml per hour with a 100 ml flush of water every four hours. Interview with LPN #304 at the time of the observation confirmed Resident #93's Osmolite 0.5 calorie was running at a rate of 60 ml per hour with a 100 ml flush of water every four hours when it should have been running at a rate of 80 ml per hour with a 100 ml flush of water every four hours. LPN #304 then set the feeding pump to administer the correct amount of Osmolite 0.5 calorie and water flushes. Review of the facility procedure titled Enteral Nutrition, dated 2001, revealed adequate nutritional support through enteral nutrition is provided to residents as ordered.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, record review, and facility policy review, the facility failed to ensure orders were in place for oxygen administration. This affected one resident (#6) out of three reviewed for oxygen administration. The facility census was 80 at the time of survey. Findings Include:Review of the medical record revealed Resident #6 was admitted to the facility on [DATE]. Diagnoses included acute and chronic respiratory failure with hypoxia, chronic obstructive pulmonary disorder, type II diabetes mellitus with diabetic neuropathy, and hepatic encephalopathy.Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident was mildly cognitively impaired with a BIMS of 08 out of 15, had no behaviors, did not reject care, and did not wander.Observation of Resident #6 on 03/02/2026 at 10:18 A.M. revealed an oxygen concentrator to be running next to Resident #6's bed. Resident #6's oxygen tubing was being changed.Review of Resident #6's physician orders revealed no order for oxygen therapy existed for Resident #6.Interview with Registered Nurse (RN) #310 on 03/04/2026 at 7:34 A.M. revealed that Resident #6 had been on oxygen therapy since admission. RN #310 confirmed that no orders existed for oxygen therapy for Resident #6.Review of facility policy titled Oxygen Administration dated October 2010, revealed that step 1 of oxygen administration states Verify that there is a physician's order for this procedure. Review the physician's order or facility protocol for oxygen administration.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed record reviews, review of hospital discharge orders, staff interview, and facility policy review, the facility failed to ensure medications were not administered longer than prescribed by the physician. This affected one resident (#103) out of the nine residents reviewed for Clostridium difficile (C-Diff) infections. The facility census was 80.Findings include: Closed record review for Resident #103 revealed the resident was admitted to the facility on [DATE] and had diagnoses which included cellulitis of the right lower limb, anemia, and atrial fibrillation. The resident was discharged from the facility on 01/22/26. Review of the hospital discharge orders, dated 10/30/25, revealed the resident was ordered to receive 100 milligrams (mg) of Doxycycline (an antibiotic medication) twice a day for 9 days.Review of the facility physician order, dated 10/30/25, revealed the resident was ordered to receive 100 mg of Doxycycline twice a day. The order did not contain a stop date.Review of the Medication Administration Record (MAR) for Resident #103 revealed the resident was documented to have been administered Doxycycline from 10/30/25 through 11/30/25 when she was transferred to the hospital (22 days longer than ordered by the hospital).Review of the facility Alert Note, dated 11/09/25, revealed the resident was documented to have loose stool/diarrhea in 24 hours. Stool softener held.Review of the facility Alert Note, dated 11/10/25, revealed the resident was documented to have loose stool/diarrhea in 24 hours. Stool softener held. Fluids encouraged.Review of the facility Alert Note, dated 11/12/25, revealed the resident was documented to have loose stool/diarrhea in 24 hours. Stool softener held per resident request.Review of the facility Alert Note, dated 11/16/25, revealed the resident was documented to have loose stool/diarrhea in 24 hours. Fluids encouraged.Review of the facility Alert Note, dated 11/18/25, revealed the resident was documented to have loose stool/diarrhea in 24 hours. Fluids encouraged.Review of the facility Alert Note, dated 11/20/25, revealed the resident was documented to have loose stool/diarrhea in 24 hours. Encouraged fluids.Review of the laboratory test results, dated 11/20/25, revealed the resident tested positive for C-Diff infection.Review of the Nurse Practitioner progress note, dated 11/20/25, revealed Resident #103 had tested positive for C-Diff colitis. Resident is receiving doxycycline since discharge from the hospital. Since she is still receiving antibiotic, will initiate extended treatment. In addition to diarrhea, resident is also having significant nausea. As needed zofran is ordered and contact precautions being initiated.Interview 03/05/26 at 2:16 P.M. with Licensed Practical Nurse (LPN)/Infection Control Nurse #363 Resident #103's hospital discharge orders directed the resident to only receive Doxycycline for nine days after discharge but the resident continued to receive the medication through 11/30/25. LPN/Infection Control Nurse #363 confirmed there were several documented instances of loose stools/diarrhea beginning on 11/09/25 through 11/20/25 when the resident was diagnosed with C-Diff infection. Review of the facility policy titled Administering Medications, dated 2001, revealed medications shall be administered in a safe and timely manner, and as prescribed.This deficiency represents non-compliance identified during the investigation of Complaint 2735113.

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F 0761 Level of Harm - Minimal harm or potential for actual harm 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. Based on record reviews, interviews, and policy reviews, the facility failed to ensure that medications were not left unattended at a resident's bedside. This affected one resident (Resident #31) of 19 residents observed during initial observations. The facility census was 80. Findings include: Review of the medical record for Resident #31 revealed an admission date of 10/07/25. She had diagnoses including congestive heart failure, type II diabetes, and hypertension.Review of the Minimum Data Set 3.0 (MDS) assessment completed on 10/14/25 revealed Resident #31 was cognitively intact.Observation on 03/02/26 at 10:27 A.M. revealed a small cup with multiple medications on Resident #31's bedside table.Interview on 03/02/26 at 10:27 A.M. with Resident #31 confirmed her medications were left on her bedside. Resident #31 confirmed her nurse will usually leave her pills for her in the morning if she is too tired to take her medications.Review of physician's orders revealed Resident #61 was administered the following medications in the 9:00 A.M. medication administration timeframe: Allopurinol 100mg tablet, one tablet daily with 300mg tablet, total 400mg for gout; Allopurinol 300mg tablet, one tablet daily with 100mg tablet, total 400mg for gout; CoQ-10 200mg capsule, one table daily for supplement; Metoprolol Succinate ER 50mg, one tablet daily for hypertension; Senna-Docusate Sodium 8.6-50mg, one tablet daily for constipation; Sertraline HCl 100mg, one tablet daily for depression; Eliquis 5mg, one tablet daily for atrial fibrillation; and Magnesium Oxide 400mg, two tablets twice daily for magnesium deficiency.Review of the policy, Administering Oral Medications, revised 10/2010, stated the nurse or medication aide providing medications should remain with the resident until all medications have been taken.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on medical record review and resident and staff interviews, the facility failed to honor resident meal preferences. This had the potential to affect one (Resident #99) of 78 residents at the facility that receives meals from the kitchen. The facility identified Residents #87 and #93 as not receiving food from the kitchen. The facility census was 80 residents.Observation on 03/03/26 at 12:15 P.M. revealed Resident #99 received lunch meal which included beef tips and mashed potatoes with gravy. Review of Resident #99's meal ticket lists dislikes that included broccoli-cauliflower, asparagus, pork and gravy. Interview on 03/02/26 at 12:15 P.M. revealed Resident #99 waved down surveyor and stated, why give facility list of likes and dislikes if facility is not going to honor preferences. Interview on 03/02/26 Staff #327 confirmed resident beef tips and mashed potatoes were covered in gravy and meal ticket list gravy as a dislike.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, interviews, and policy review, the facility failed to ensure an accurate medical record. This affected one resident (Resident #61) of 24 residents reviewed for accuracy of medical records. The facility census was 80.Findings include: Review of the medical record for Resident #61 revealed an admission date of 03/20/25 with diagnoses including hemiplegia and hemiparesis affecting his right, non-dominant side, aphasia following cerebral infarction, depression, and high blood pressure. Further record review revealed on admission, his Brief Interview for Mental Status (BIMS) score was 10 out of 15, indicating he had moderate cognitive impairment.Review of the annual Minimum Data Set 3.0 (MDS) assessment completed on 02/09/26 revealed Resident #61 was independently mobile with the use of a manual wheelchair. He required maximal assistance with toileting, showering, dressing, and positioning. Resident #61 had displayed no verbal or physical disruptive behaviors, no rejection of care, and no wandering or exit-seeking behaviors. Resident #61 had a Wanderguard in place.Review of nursing progress notes revealed on 05/17/25 at around 6:00 P.M., Resident #61 was found in the facility parking lot by an employee leaving at the end of their shift. Resident #61 informed the nurse assisting him that he was trying to go home. The nurse was able to assist Resident #61 back into the facility where a Wanderguard was applied to his wheelchair. Resident #61 made multiple successful trips outside of the building and was resistant to return inside. Later in the evening, staff noted Resident #61 continued to leave the facility with other staff members as they left the building and required multiple individuals to encourage him to return to the building. No further elopement attempts or instances of unsafe wandering were documented in Resident #61's medical record.Review of physician orders revealed an order on 05/17/25 for a Wanderguard to be applied to Resident #61's wheelchair due to poor safety awareness. Review of the Elopement and Wandering Risk Observation Assessments completed on admission on [DATE], and quarterly thereafter on 06/13/25, 09/08/25, 12/04/25, and 03/02/26 revealed Resident #61 was able to self-propel his wheelchair; was alert and oriented to person, place and time; had never expressed a desire to leave the facility; and had never exhibited unsafe wandering or elopement attempts. The conclusion for each assessment was that use of a wander alarm was not indicated.Review of the Medication Administration Record/Treatment Administration Record (MAR/TAR) for March 2026 revealed the unit nurse confirmed the Wanderguard was in place on Resident #61's wheelchair as ordered.Observations made on 03/03/26 at 3:47 P.M., 03/04/26 at 8:08 A.M., 8:49 A.M., and 1:32 P.M., and 03/05/26 at 8:33 A.M. revealed Resident #61's Wanderguard was not applied to his wheelchair or his person. Interview on 03/04/26 at 1:32 P.M. with Registered Nurse (RN) #329 confirmed Resident #61 has an order for a Wanderguard to be placed on his wheelchair. RN #329 confirmed the Wanderguard was not on his wheelchair or his person. RN #329 retrieved a new Wanderguard bracelet and attempted to apply it to Resident #61's wheelchair but he refused.Interview on 03/05/26 at 8:36 A.M. with Director of Nursing (DON) #301 stated the Elopement and Wandering Risk Observation Assessments are completed for each resident upon admission, quarterly, and as needed if behaviors develop. DON #301 stated a resident is considered to have eloped if they leave the property without staff knowledge; if the resident is cognitively impaired, they are considered to have eloped if the resident leaves the building. DON #301 confirmed that the Elopement and Wandering Risk Observation Assessments completed after the elopement were inaccurate and confirmed Resident #61 required a Wanderguard alarm.