STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365584	A. Building B. Wing	05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ayden Healthcare of Rosemount Pavilion	20 Easter Drive Portsmouth, OH 45662

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 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 observation, interview, and record reviews the facility failed to ensure treatment orders for a resident with a pressure ulcer were implemented timely and appropriately. This affected one resident (#79) of the six residents the facility identified as having pressure ulcers. The facility census was 81. Findings include: Record review for Resident #79 revealed the resident was admitted to the facility on [DATE] and had diagnoses which included open wound of the right knee, atrial fibrillation, and anxiety disorder. Review of the admission Minimum Data Set (MDS) assessment, dated 03/22/26, revealed the resident was assessed to have intact cognition. Review of the care plan, revised 04/02/26, revealed the resident had an alteration in skin. Interventions included to administer treatments as ordered. Review of the Wound Assessment Report, dated 04/20/26 and signed by Nurse Practitioner (NP) #501, revealed Resident #79 was assessed to have Moisture Associated Skin Dermatitis (MASD) to the coccyx. Treatment for the area of MASD was to cleanse with wound cleanser, apply triad cream with collagen particles, and leave open to air twice a day. Review of the Wound Assessment Report, dated 04/27/26 and signed by Nurse Practitioner (NP) #501, revealed Resident #79 was assessed to have a pressure ulcer to the coccyx. Treatment orders for the pressure ulcer were to cleanse the pressure ulcer with wound cleanser, apply a collagen dressing - cut to fit wound bed, and cover with a silicone bordered superabsorber, change every day and as needed. Review of the Wound Assessment Report, dated 05/04/26 and signed by NP #501, revealed Resident #79 continued to have a pressure ulcer present to the coccyx. Treatment orders for the pressure ulcer were to cleanse the pressure ulcer with wound cleanser, apply a collagen dressing - cut to fit wound bed, and cover with a silicone bordered superabsorber, change every day and as needed. Review of the active physicians order, dated 04/13/26, revealed an order for Resident #79's sacrum to be cleansed with wound cleanser, pat dry, apply triad cream with collagen particles and leave open to air every shift for prevention. No order to cleanse the pressure ulcer to Resident #79's coccyx with wound cleanser, apply a collagen dressing - cut to fit wound bed, and cover with a silicone bordered superaborber, change every day and as needed was present. Observation on 05/06/26 at 10:00 A.M. revealed staff were providing incontinence care to Resident #79. The resident had a small wound to her coccyx which did not have a dressing in place when staff assisted the resident to roll over in bed. The wound did not exhibit signs of infection. Interview with Assistant Director of Nursing (ADON) #124 on 05/05/26 at 12:30 P.M. confirmed NP #501 came to the facility weekly to assess resident wounds and provide treatment orders. ADON #124 confirmed the treatment orders for the wound to Resident #79's coccyx had been changed by NP #501 on 04/27/26 but had not been implemented by the facility.This deficiency represents non-compliance identified during the investigation of Complaint 2972768.

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
	365584	A. Building B. Wing	05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ayden Healthcare of Rosemount Pavilion	20 Easter Drive Portsmouth, OH 45662

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, record reviews, and review of facility policy, the facility failed to ensure incontinence care was provided in a timely manner. This affected one resident (#79) out of the three residents reviewed for incontinence care and toileting assistance. The facility census was 81. Findings include:Record review for Resident #79 revealed the resident was admitted to the facility on [DATE] and had diagnoses which included open wound of the right knee, atrial fibrillation, and anxiety disorder. Review of the admission Minimum Data Set (MDS) assessment, dated 03/22/26, revealed the resident was assessed to have intact cognition. The resident was assessed to always be incontinent of bowel and bladder. Review of the care plan, revised 04/02/26, revealed the resident has/at risk for bladder incontinence. Interventions included to apply barrier cream as ordered and to provide peri-care after each incontinent episode. Observation on 05/05/26 at 9:16 A.M. revealed the call light for Resident #79 and Resident #80's room was lit up in the hallway. Staff were busy providing care to other residents in their rooms. Observation on 05/05/26 at 9:24 A.M. revealed the call light for Resident #79 and Resident #80's room continued to be lit up in the hallway. No staff had entered the room since the previous observation. Observation on 05/05/26 at 9:31 A.M. revealed the call light for Resident #79 and Resident #80's room continued to be lit up in the hallway. No staff had entered the room since the previous observations. Observation on 05/05/26 at 9:42 A.M. revealed the call light for Resident #79 and Resident #80's room continued to be lit up in the hallway. No staff had entered the room since the previous observations. Upon knocking and entering the room, Resident #79 was lying in the bed and Resident #80 was sitting up on the side of the bed. Resident #79 confirmed she was needing incontinence care provided by staff as she could not do it herself. Resident #79 confirmed she had placed the call light on once before and Certified Nursing Assistant (CNA) #147 had entered the room and told the resident she would get assistance and return to provide care. Resident #79 confirmed she had placed the call light back on when staff did not return timely and was still waiting for staff to return. Resident #79 confirmed she had not had incontinence care provided since approximately 5:45 A.M. when night shift staff were completing their final rounds. Observation on 05/05/26 at 9:56 A.M. revealed CNA #147 and CNA #166 entered the room and turned off the call light, 40 minutes after the call light was initially observed to be on. CNA #147 confirmed Resident #79 had not had incontinence care provided since day shift had begun at 7:00 A.M. CNA #147 and CNA #166 began providing incontinence care to Resident #79. The resident was observed to have been incontinent of bowel and bladder and the attend was saturated with urine and feces. Interview with CNA #147 and CNA #166 on 05/05/26 at 10:15 A.M. confirmed Resident #79 was able to place her call light on and let staff know when she needed incontinence care provided. They confirmed the resident required assistance from two staff members for care and sometimes it took a while to provide care. Review of the facility policy titled Incontinence Management, reviewed 04/28/25, revealed it was the policy of the facility to promote intact skin, maintain dryness, and respect the residents standard and individualized interventions. Interventions included timely response to the needs of the resident.This deficiency represents non-compliance identified during the investigation of Complaints 2973419 and 2966978.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365584	A. Building B. Wing	05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ayden Healthcare of Rosemount Pavilion	20 Easter Drive Portsmouth, OH 45662

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of facility policy, the facility failed to ensure infection control measures were appropriately implemented during wound care treatment. This affected one resident (#72) observed for wound care. The facility census was 81. Findings include:Record review for Reisdent #72 revealed the resident was admitted to the facility on [DATE] and had diagnoses which included colostomy hemorrhage, type two diabetes mellitus, and atrial fibrillation. Review of the 5-Day Minimum Data Set (MDS) assessment, dated 03/11/26, revealed the resident was assessed to have intact cognition and to have a surgical wound present with surgical wound care provided. Observation on 05/04/26 at 1:45 P.M. revealed Assistant Director of Nursing (ADON) #117 entered the room of Resident #72 to provide wound care treatment to the residents abdominal wounds. ADON #117 performed hand hygiene and donned (put on) two pairs of gloves, one on top of the other. ADON #117 removed the old (dirty) wound dressing, cleansed the abdominal wounds, and applied skin prep to the skin surrounding the wounds. ADON #117 then removed the outer glove on each hand leaving the inner glove on each hand. ADON #117 did not perform hand hygiene. ADON #117 then measured the abdominal wounds and placed the new dressing on the wounds.ADON #117 then removed the inner gloves on each hand and discarded them, then performed hand hygiene. Interview with ADON #117 on 05/04/26 at 2:20 P.M. confirmed she had donned two pairs of gloves, one on top of the other, prior to performing wound care. ADON #117 confirmed she had removed one pair of the gloves in the middle of the wound care treatment leaving the remaining pair of the gloves on her hands. ADON #117 confirmed she had not performed hand hygiene except before and after the wound care treatment was completed. Review of the facility policy titled Wound Care, reviewed 08/2024, revealed the procedure for wound care was to wash and dry hands, apply exam gloves, remove the old dressing and discard, wash and dry hands thoroughly, apply new gloves, then cleanse wound and apply new dressing. Remove gloves and wash hands thoroughly following the completion of the wound care treatment.This deficiency represents non-compliance identified during the investigation of Complaint 2972768.