STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365585	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgewood Manor of Lucasville I	10098 Big Bear Creek Rd Lucasville, OH 45648

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to provide adequate notice for Medicare A benefits being cut for skilled services. This affected three (#98, #99 and #100) of three residents reviewed for Beneficiary Notices and termination of services without providing the right to appeal. The facility census was 92. Findings include:1. Record review for Resident #98 revealed the resident was admitted to the facility on [DATE]. Diagnoses included myocardial infarction, intestinal obstruction, lack of coordination, and muscle weakness. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #98 had minimally impaired cognition.Review of the Notice of Medicare Non-Coverage Notification revealed Medicare coverage of therapy services will end on 12/10/25. There was no legal signature on the notice with a statement of a verbal notice being given on 12/16/25.2. Record review for Resident #99 revealed the resident was admitted to the facility on [DATE]. Diagnoses included dementia, hypertension, lack of coordination, and muscle weakness. Review of the quarterly MDS assessment dated [DATE] revealed Resident #99 had severely impaired cognition.Review of the Notice of Medicare Non-Coverage Notification revealed Medicare coverage of therapy services will end on 02/05/26. There was no legal signature on the notice with a statement of a verbal notice being given on 02/05/26.3. Record review for Resident #100 revealed the resident was admitted to the facility on [DATE]. Diagnoses included gout, morbid obesity, schizophrenia, lack of coordination, and muscle weakness. Review of the quarterly MDS assessment dated [DATE] revealed Resident #100 had minimally impaired cognition.Review of the Notice of Medicare Non-Coverage Notification revealed Medicare coverage of therapy services will end on 02/05/26. There was no legal signature on the notice with a statement of a verbal notice being given on 02/05/26.Interview with the Administrator on 04/16/2026 at 10:31 A.M. verified all three residents reviewed for Beneficiary notices were not provided a minimum 48 hour notice for the end of benefits or appeals.

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to accurately complete a level one Pre-admission Screening/Resident Review (PASARR) and did not list mood disorder or mental disorder on the serious mental illness section to be reviewed for a level two. This affected one resident (#32) of three reviewed for PASARR. The facility census was 92.Findings include: Review of the medical record for Resident #32, revealed an admission date of 03/27/2026. Diagnoses included but were not limited to major depressive disorder, post traumatic stress disorder (PTSD) and respiratory failure. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 15 out of 15 suggesting cognitive intactness. The resident was assessed to have a mood disorder and mental disorder. Review of a PASARR completed on 03/27/2026 by the Social Services Director #125 revealed mood disorder and other mental disorder was not indicated under the level one review for serious mental illness. Interview on 04/15/2026 at 3:00 P.M. with Nurse Adm-Assistant Director #112 and Nurse Adm-Director #116 confirmed mood disorder or other mental disorder was not included on the level one screen for the PASARR. The facility was unable to provide a facility policy for PASARR's.

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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 interviews, medical record reviews, and review of information from the National Institute of Health, the facility failed to ensure a peripherally inserted central catheter (PICC)/intravenous (IV) access had a baseline plan of care and line maintenance orders upon admission for Resident #16. This affected one resident (#16) of one for intravenous medication therapy. The facility census was 92. Review of the medical record for Resident #16, revealed an admission date of 03/28/26. Diagnoses included but were not limited to acute and subacute infective endocarditis, psychoactive substance abuse and muscle weakness. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed resident was cognitively intact. The resident was assessed to have an intravenous (IV) access and receiving IV antibiotic medication. Review of the medical record for Resident #16 revealed no base line plan of care for PICC access care. Review of the physician orders dated 03/28/26 for Resident #16's for admission to the facility for PICC line maintenance care involving medication administration revealed to flush per manufacturer guideline or protocol with 20 milliliters (ml) of 0.9% normal saline and 5ml of 10units/ml heparinized saline flush. Review of the physician orders dated 03/28/26 and 03/29/26 for Resident #16 revealed no orders for PICC line maintenance care. Further review of the physician orders dated 03/30/26 for this resident revealed 0.9% normal saline flushes and heparinized saline flushes for prior and after medication administration, to start 03/31/26. Review of the Treatment Administration Record (TAR) dated 03/28/26 through 03/30/26 for Resident #16 revealed no PICC line maintenance care documented. Review of the care initiated on 04/12/26 for Resident #16 revealed resident required extended IV antibiotics for endocarditis with an intervention including but not limited to administer IV antibiotics via PICC line and provide maintenance care of PICC line, flushes, dressings and cap changes. Interview on 04/16/26 at 10:46 A.M. with Licensed Practical Nurse Supervisor #116 and Assistant Director of Nursing #112 verified Resident #16 did not have PICC maintenance line care upon admission until ordered on 03/30/36 with no documentation until 03/31/26. Interview on 04/16/26 at 1:12 P.M. with the Director of Nursing verified Resident #16 did not have a baseline care plan for his PICC care. The facility was unable to provide a facility policy for PICC/IV-line care. Review of information from the National Institute of Health revealed for PICC line maintenance care, flush with 0.9% normal saline before use and with 0.9% normal saline and heparin solution after each use.

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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 interviews, observations, medical record review, and policy review, the facility failed to ensure pressure ulcer assessment and treatment was completed timely for Resident #97. The facility also failed to ensure air mattresses were on proper functional settings for Resident # 52 and #97 as well as not being in the plan of care and ordered for proper functional settings for Resident #32. This affected 3 residents (#32, #52, and #97) of 3 residents reviewed for pressure ulcer care. The facility census was 92.1. Review of the medical record for Resident #97, revealed an admission date of 04/09/26. Diagnoses included but were not limited to spina bifida with hydrocephalus, paraplegia, muscle weakness, neuromuscular dysfunction of bladder, and gastrostomy status. Review of the baseline care plan initiated 04/09/26 for Resident #97 revealed a pressure injury with an intervention including but not limited to an air mattress. Review of the clinical admission assessment dated [DATE] for Resident #97 revealed a pressure ulcer/injury to the lower back reddened non blanchable area measured 14 centimeters (cm) by 5.5 cm by no depth with two open areas one on the left and one on the right lower back both measuring 4.5 cm by 2.5 cm with no depth. No staging and descriptions were noted. Review of the medical record for Resident #97 revealed from admission on [DATE] until the Wound Certified Practioner (CNP) #201 evaluated on 04/16/26 no documentation of assessment and staging of the pressure ulcer areas on the lower back. Review of the physician orders dated 04/09/26 for Resident #97 revealed no treatment order for the pressure ulcer areas on the lower back. Review of the Treatment Administration Record (TAR) dated 04/09/26 for Resident #97 revealed no documented treatments for the lower back pressure ulcer areas. Review of the April 2026 admission weight for Resident #97 revealed 81.8 pounds. Review of the Braden Scale for Predicting Pressure Sore Risk dated 04/10/26 for Resident #49 revealed a score of 15.0 on a scale of, 6 (high risk) to 23 (no risk), which indicated Resident #97 to be at risk for skin breakdown. Further review of the physician orders for this resident dated 04/10/26 revealed a treatment order for a skin alteration located on the sacrum and an air mattress to check placement and function every shift. Review of the medical record for Resident #97 dated 04/10/26 revealed no documentation of a skin alteration to the sacrum. Review of the TAR dated 04/10/26 through 04/13/26 for Resident #97 revealed no documented treatments for the lower back pressure ulcer areas. Review of the physician order dated 04/13/26 for Resident #97 revealed a treatment order for the pressure ulcer areas for the mid to lower back. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Brief Interview for Mental Status (BIMS) assessment on 04/13/26 at 3:15 P.M. revealed cognitive intactness. Observation on 04/13/26 at 12:41 P.M. of Resident #97 revealed her to be in bed, air mattress set to 400 pounds. Resident stated, my mattress is hard and I can't really sleep from it. Observation on 04/14/26 at 10:00 A.M. of Resident #97 revealed her in bed, air mattress set to 380 pounds. Resident stated, my bed is still uncomfortable and hard. Observation on 04/15/26 at 10:28 A.M. of Resident #97 revealed her in bed, air mattress set to 380 pounds. Observation on 04/15/26 at 10:33 A.M. of Resident #97 in bed with Licensed Practical Nurse (LPN) Supervisor #116 verified the air mattress setting was on 380 pounds and this resident's most current weight was 81.8 pounds. Observation on 04/16/26 at 9:52 A.M. of Resident #97's skin evaluation with Wound CNP #201 revealed the middle of her lower back to be reddened and blanchable with no open areas. A stage IV pressure ulcer of the left lower back measured 9.7 cm by 9.5 cm by .2 cm no concerns for infection and a right lower back stage IV pressure ulcer area 3 cm by 3.5 cm by .5 cm no concerns for infection. She reviewed this residents hospital documentation, and it indicated these two areas were stage IV so she will continue with that staging. No measurements were found on her admission paperwork from the hospital for these two areas. No concerns for the areas and continue the treatment ordered on 04/13/26. Interview on 04/16/26 at 10:30 A.M. with LPN Supervisor #116 and Assistant Director of Nursing (ADON) #112 verified Resident #97 did not have an assessment which included staging, wound bed description, and accurate measurements of the pressure ulcer areas on the lower back from admission until the Wound CNP #201 completed a week after her admission. Also verified upon admission until 04/13/26, no treatment orders were completed for the pressure ulcer areas to the lower back as the resident never had a sacrum skin alteration area. LPN #116 stated I feel like they were doing the sacrum treatment for the areas of the lower back areas. 2. Review of the medical record for Resident #52, revealed an admission date of 05/20/20 . Diagnoses included but were not limited to morbid obesity, major depressive disorder, bipolar disorder, diabetes mellitus, peripheral vascular disease, muscle weakness and need for assistance with personal care. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] for Resident #52 revealed moderate cognitive intactness. The resident was assessed to require total dependence on bed mobility, toilet hygiene, shower/bathe self and transfers. This resident was also assessed to have two stage 4 pressure ulcers upon admission/readmission to facility with a pressure reducing device for bed. Review of the active physician order dated 08/03/25 for Resident #52 revealed air mattress to bed check function every shift. Review of the plan of care revised on 04/15/26 for Resident #52 revealed potential/actual impairment to skin integrity related to history of pressure injury on admission with an intervention including but not limited to air mattress on bed, check proper function every shift. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the April 2026 monthly weight for Resident #52 revealed 372.4 pounds. Observation on 04/16/26 at 7:01 A.M. of Resident #52 revealed her to be in bed resting with eyes closed, air mattress settings on 550 pounds. Observation on 04/16/26 at 8:14 A.M. of Resident #52 revealed her in bed and stated, my bed is not comfortable, it is really hard. Air mattress settings on 550 pounds. Observation on 04/16/26 at 8:16 A.M. of Resident #52 in bed with ADON #112 verified the air mattress setting was on 550 pounds and this resident's most current weight was 372 pounds. 3. Record review revealed Resident #32 was admitted to the facility on [DATE] with diagnoses including but not limited to respiratory failure with hypoxia and hypercapnia, heart failure, major depressive disorder, type 2 diabetes, post traumatic stress disorder and cardiomegaly. Review of Resident #32's physicians' orders revealed no order for an air mattress to bed. Review of the Minimum Data Set assessment dated [DATE] revealed that Resident #32 was cognitively intact and was mobile with a wheelchair but dependent with showering/bathing, dressing, rolling, sitting to lying/lying to sitting, sitting to stand and all transfers. Review of Resident #32's care plan revealed that the resident had a potential for impaired skin integrity related to impaired mobility, morbid obesity, heart failure, and depression. Interventions noted the resident required assist to turn and reposition every 2 hours, weekly skin assessments and float heels while in bed but no intervention for air mattress to bed. Review of the progress noted dated 04/10/2206 for Resident #32 revealed resident was at risk for skin breakdown. Observation of Resident #32 on 04/13/2026 at 12:57 P.M. and 04/14/2026 at 8:07 A.M. revealed Resident #32 resting in bed with air mattress settings of alternate and 490 pounds. Review of Resident #32's chart revealed a weight of 413 pounds on 04/09/2026. Observation of Resident #32's air mattress on 04/15/2026 at 10:43 A.M. revealed that the settings were corrected to appropriate weight of 420 pounds Interview with Nurse ADM-Director #116 on 04/16/2026 at 8:38 A.M. revealed that the air mattress was not ordered, or care planned and had been overlooked. Review of the facility policy titled Charting and Documentation revised July 2017 revealed all services provided to the resident, any changes in the residents medical, physical, functional or psychosocial condition shall be documented in the resident's medical record. The following information is to be documented in the resident medical record: objective observations and treatments performed.