| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365605 | A. Building<br>B. Wing | 06/16/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Milcrest Nursing Center | 730 Milcrest Drive<br>Marysville, OH 43040 |

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 0573<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Let each resident or the resident's legal representative access or purchase copies of all the resident's records.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview and policy review, the facility failed to ensure a resident or resident representative had timely access to their medical records upon request. This affected one (Resident #49) out of one resident reviewed for a records request. The facility census was 48. Findings include:Review of the medical record for Resident #49 revealed an admission date of 04/06/26 and discharge date of 05/05/26. Diagnoses included muscle weakness, dementia, anxiety, depression, edema, heart disease, and Alzheimer's disease.Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) of 05 indicating impaired cognition.Review of an email correspondence dated 05/12/26 between the facility staff and the regional office revealed the request for medical records was approved. Review of an email correspondence dated 05/18/26 between the facility Administration staff and Resident #49's family revealed pricing was $206.32 for the resident's medical records and the regulations related to medical record request was provided to the family.Review of an email correspondence dated 05/26/26 revealed the medical records were emailed to the Resident's family. Interviews on 06/15/26 from 12:15 P.M. to 2:54 P.M. with the Regional Administrator #31 revealed the facility had no record of when Resident #49's family made the initial record request and verified the facility had no additional evidence of communication between the resident's family and the facility staff. She verified the facility policy stated records should be provided within 24 hours or paper copies shall be provided within two business days. She verified it was about a week before the family was provided the pricing information and two weeks for the documentation to be provided after the regional office gave approval. She verified the facility had no additional documentation or mentions of communication by phone and in person. Review of facility policy titled Medical Records Administrative Policy, dated 04/05/19 revealed the Administrator was responsible for maintaining and organizing records. The facility shall allow resident and representatives the right to access personal and medical records upon written or oral request in a format agreed upon within 24 hours (excluding weekdays and within two working days if copies are requested. Facility shall determine cost of supplies and postage if applicable. This deficiency represents non-compliance investigated under Complaint Number 3015021. |

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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| Milcrest Nursing Center | 730 Milcrest Drive<br>Marysville, OH 43040 |

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|---|---|
| F 0636<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and policy review, the facility failed to ensure the Minimum Data Set (MDS) assessment was accurately completed for a fall with major injury. This affected one (Resident #49) out of three residents reviewed for falls. The facility census was 48. Findings include:Review of the medical record for Resident #49 revealed an admission date of 04/06/26 and discharge date of 05/05/26. Diagnoses included muscle weakness, dementia, anxiety, depression, edema, heart disease, and Alzheimer's disease.Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) of 05 indicating impaired cognition and Resident #49 required partial to moderate assistance for activities of daily living and supervision/touching assistance with mobility. Review of the plan of care dated 04/13/26 revealed Resident #49 was at risk for falls and potential injury. Interventions included non-skid strips to be placed in front of the recliner left side of the bed and follow evening routine in bed by 7:00 P.M. to 7:30P.M. after toileting and ensure commonly used items were in reach.Review of the hospital paperwork dated 04/19/26 to 04/20/26 revealed Resident #49 arrived on 04/19/26 at 11:15 P.M. The History and Physical dated 04/20/26 with a time of service for 5:00 A.M. revealed the resident was seen after a fall with a laceration and found to have rib fractures at the 9th and 10th ribs.Review of the progress note dated 04/20/26 at 2:01 P.M. revealed Resident #49 was in her room with staff just outside the door when she fell. The resident was found sitting upright with her back against the bed and the cord to the recliner stretched across to a wheelchair about two feet from the recliner with the cord underneath resident. Blood was noted on the residents' clothing, on her knee, and elbow. The resident rated her pain 10 out of 10. The resident was confused but stated she did not hit her head and had both shoes on. The resident was taken to the hospital where and a skin tear was found at the knee and the elbow. The progress note dated 04/20/26 at 5:25 P.M. revealed Resident #49 returned to the facility from the hospital with new orders for sutures in place on right elbow. The Nurse practitioner note dated 04/20/26 verified Resident #49 was diagnosed with a 9th and 10th rib fracture from the fall on 04/20/26.Review of the progress note dated 05/04/26 revealed staff was notified by social services Resident #49 was on the floor. The staff had last interacted with Resident #49 two minutes prior. The resident was assessed and complained of pain in the right leg which was internally rotated and slightly shorter than the left leg and a laceration to the calf was observed and covered with a dry dressing. The resident was transferred to the hospital for evaluation. A progress note dated 05/05/26 revealed staff spoke with staff at the hospital who verified Resident #49 broke her hip. Review of the Minimum Data Set (MDS) discharge return not anticipated assessment dated [DATE] revealed one fall with major injury was documented on the MDS.Interview on 06/16/26 at 9:45 A.M. with Regional Director of Operations (RDO) #32 verified the MDS staff was not informed of the fracture and only did a look back of seven days for the discharge MDS assessment. She verified since the fall occurred about 15 days prior it was not captured. The RDO #32 verified the second fall was missed and the facility would be completing an amended MDS assessment to report the second fall with major injury after surveyor intervention. Review of the facility policy titled Charting and Documentation, dated 03/01/26 revealed the documentation should be complete and accurate. This deficiency represents non-compliance investigated under Complaint Number 3015021 and 3017937. |

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| | 365605 | A. Building<br>B. Wing | 06/16/2026 |

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| Milcrest Nursing Center | 730 Milcrest Drive<br>Marysville, OH 43040 |

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|---|---|
| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure fall interventions were updated in the medical record and care plan after a fall. This affected one (Resident #41) of three residents reviewed for falls. The facility census was 48. Findings include Review of the medical record for Resident #41 revealed an admission date of 05/26/26. Diagnoses included dysphagia, cognitive communication deficit, respiratory failure diabetes, right femur fracture (prior to admission).Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #41 was cognitively intact with a Brief Interview of Mental Status (BIMS) of 14 and was dependent with activities of daily living and required substantial and maximum assist with mobility. Review of the plan of care dated 06/05/26 revealed Resident #41 was at risk for falls and had interventions for therapy evaluations and treatment and have commonly used articles in reach. No interventions had been added to the fall care plan since 06/05/26. Review progress notes dated 06/13/26 revealed Resident #41 had a fall while standing in the bathroom. The Certified Nursing Aide (CNA) was present with resident during the witnessed fall. The resident was attempting to wash her hands and fell from a standing position. She reported pain to her back and right lower extremity and had a recent hip replacement so she was transferred to the hospital. A progress note dated 06/14/26 at 1:05 A.M. revealed the resident returned to the facility from the hospital with no injuries. No progress notes indicated new fall interventions implemented after the fall. Review of the fall investigation dated 06/13/26 revealed the CNA was with Resident #41 when she fell and she assisted resident in the fall and protected her head. Resident #41 was washing her hands at the sink when she became weak and fell. Interview on 06/16/26 at 12:35 P.M. with the Administrator revealed Resident #41's fall had new intervention of education since she was a BIMS of 14. The Administrator was unsure what type of education was provided and where was it documented and she reported she would need to find out. Interview on 06/16/26 at 1:35 P.M. with the Administrator and the Director of Clinical Operations(DCO) #32 verified Resident #41 was educated to use the call light. They verified the fall incident report was reviewed but DCO #32 verified she had not talked with staff and was not aware of the progress note stating staff was with the resident at the time of the fall. She reported after further review, the resident had gotten out of bed without staff assistance and the aide was returning with paper towels when the resident lost her balance. She reported the new intervention should be to educate the resident to use the call light. They verified this intervention was not in the medical record and was not added to the care plan. This deficiency represents non-compliance investigated under Complaint Number 3015021 and 3017937. |

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| | 365605 | A. Building<br>B. Wing | 06/16/2026 |

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|---|---|
| Milcrest Nursing Center | 730 Milcrest Drive<br>Marysville, OH 43040 |

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|---|---|
| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff and resident interview and policy review, the facility failed to ensure showers were completed as scheduled. This affected one (Resident #20) out of three residents reviewed for Activities of Daily Living (ADL) care. The facility census was 48.Findings Included:Review of the medical record revealed Resident #20 admitted to the facility on [DATE]. Diagnoses included muscle weakness, anxiety disorder, benign neoplasm of the rectum, type two diabetes, hypokalemia, depression, hypertension, and hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side.Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #20 had a Brief Interview for Mental Status score of 15 and normal cognitive function. Further review confirmed the resident required substantial/max assistance with tub/shower transfers.Review of Resident #20's Care Plan revised 05/05/26 revealed the resident required assistance from staff to meet Actives of Daily Living (ADL) related to cerebral vascular accident with left hemiparesis and weakness with interventions to assist the resident with bathing as needed and per resident's preference.Review of Resident #20's shower schedule dated June 2026 revealed a shower schedule of Monday and Thursdays with no documentation on the Treatment Administration Records (TAR) that showers occurred on 6/4/26 and 6/11/26 and that the resident was marked as non-applicable on 6/8/26.Interview on 6/15/26 at 2:53 P.M., Resident #20 verified they were scheduled to receive staff assisted showers on Monday and Thursday's and had not been receiving them but did receive a shower on Friday 6/12/26 because they were having their hair done.Interview on 6/16/26 at 10:39 A.M., with the Director of Nursing (DON) revealed Resident #20 was known to refuse showers and on 6/8/26 the resident refused their shower because they were going to have their hair done. Further interview revealed the facility had no documentation to support Resident #20 refused their scheduled showers on 06/04/26 and 06/11/26 and the facility documented non-applicable not refused for the shower on 6/8/26.Review of the facility policy titled ADLs, revised 03/04/26 revealed Support will be provided to meet care deficits related to ADL needs. This includes the resident's ability to bath, dress, groom, transfer and ambulate, toilet, and eat. and A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutritional, grooming and personal and oral hygiene.This deficiency represents non-compliance investigated under Complaint Number 3026793. |

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|---|---|
| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview and policy review, the facility failed to ensure the accuracy of the medical record. This affected one (Resident #49) out of three residents reviewed for falls. The facility census was 48. Findings includeReview of the medical record for Resident #49 revealed an admission date of 04/06/26 and discharge date of 05/05/26. Diagnoses included muscle weakness, dementia, anxiety, depression, edema, heart disease, and Alzheimer's disease.Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) of 05 indicating impaired cognition and required partial to moderate assistance for activities of daily living and supervision /touching assistance with mobility. Review of the plan of care dated 04/13/26 revealed Resident #49 was at risk for falls and potential injury. Interventions included non-skid strips to be placed in front of the recliner left side of the bed and follow evening routine in bed by 7:00 P.M. to 7:30P.M. after toileting and ensure commonly used items were in reach. Review of the progress note dated 04/20/26 at 2:01 P.M. revealed Resident #49 was in her room with staff just outside the door when she fell. Resident was found sitting upright with her back against the bed and the cord to the recliner stretched across to a wheelchair about two feet from the recliner with the cord underneath the resident. Blood was noted on the resident's clothing, on her knee and elbow, and the resident rated her pain 10 out of 10. The resident was confused but stated she had not hit her head and had both shoes on. The resident was taken to the hospital where a skin tear was found on the knee and the elbow. The progress note dated 04/20/26 at 5:25 P.M. revealed the resident returned to the facility from the hospital with new orders for sutures in place on right elbow. Review of the Nurse Practitioner note dated 04/20/26 revealed Resident #49 was diagnosed with a 9th and 10th rib fracture from the fall on 04/20/26. Review of the fall investigation dated 04/19/26 revealed the fall occurred at 10:45 P.M. Resident #49 had a fall in her room after tripping over a cord and furniture. The resident reported pain and was transferred to the hospital. Review of the neurological check dated 04/19/26 revealed neurological checks were started on 04/19/26 at 10:45 P.M. and continued every 15 minutes for four checks, then every 30 minutes for four checks, then every hour for four checks, then every four hours for six checks and every 24 hours for three checks. Each timeslot was documented as being completed and with all areas documented as observed including temperature, pulse, respirations, blood pressure, pupils and bilateral grips and mental status. Review of the second set of neurological check dated 04/19/26 revealed neurological checks were started on 04/19/26 at 10:45 P.M. and were scheduled to continue every 15 minutes for four checks, then every 30 minutes for four checks, then every hour for four checks, then every four hours for six checks and every 24 hours for three checks. The time slots from 04/19/26 at 11:00 P.M. through 04/20/26 documented Resident #49 was at the hospital.Review of the hospital paperwork dated 04/19/26 to 04/20/26 revealed the Resident arrived on 04/19/26 at 11:15 P.M. The History and Physical dated 04/20/26 with a time of service for 5:00 A.M. revealed Resident #49 was seen after a fall with a laceration and found to have rib fractures at the 9th and 10th ribs. Interview on 06/16/26 at 8:48 A.M., with Regional Clinical Director #32 verified the medical record showed Resident #49 was hospitalized for several hours after her fall on 04/19/26. She also verified the facility documentation showed neurological checks were documented as being done while the resident was at the hospital. She verified this was inaccurate as the resident was not present to have neurological checks completed. She provided a different set of neuro checks completed at the same times which documented Resident #49 was hospitalized . Review of the facility policy titled Post fall medical care/suspected head injury, dated 08/01/17 revealed neurological assessments should be completed immediately and continue as per the schedule.Review of the facility policy titled Charting and Documentation, dated 03/01/26 revealed all services provided to the resident or changes in their condition shall be documented in the medical<br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | record, including changes in condition, observations and events or incidents involving the resident. The documentation should be complete and accurate.This deficiency represents non-compliance investigated under Complaint Number 3015021 and 3017937. |