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

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365607	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ayden Healthcare of Piqua	275 Kienle Drive Piqua, OH 45356

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 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43062 Based on medical record review, staff interview, and facility policy review, the facility failed to have physician visits and nurse practitioner visits notes signed in a timely manner. This affected three (#06, #34, and #60) of three residents reviewed for provider visits. The facility census was 84. Findings include: 1. Medical record review for Resident #06 revealed he was admitted to the facility on [DATE]. Diagnoses included myocardial infarction, diabetes mellitus, pulmonary embolism, essential primary hypertension, hyperlipidemia, respiratory failure, obstructive sleep apnea, major depressive disorder, pleural effusion chronic kidney disease, hernia, and morbid obesity. Review of the Minimum Data Set (MDS) assessment, dated 02/10/25, revealed Resident #06 was cognitively intact. Review of the progress notes for Resident #06 revealed he was assessed by the facility physician on 02/11/25; however, the document was not signed until 02/15/25. Further review revealed Resident #06 was assessed by Nurse Practitioner (NP) #500 on 02/13/25 and the document was not signed until 02/22/25. 2. Medical record review for Resident #34 revealed she was admitted to the facility on [DATE]. Diagnoses included, multiple sclerosis, hypothyroidism, neurogenic bowel, constipation, hyperlipidemia, gastro-esophageal reflux disease, osteomyelitis, and acute respiratory failure. Review of the MDS assessment, dated 01/03/25 revealed Resident #34 was cognitively intact. Review of the physician progress notes for Resident #34 revealed she was assessed by the physician on 01/06/25; however, the physician note was not signed by the physician until 01/19/25. 3. Medical record review for Resident #60 revealed she was admitted to the facility on [DATE]. Diagnoses included, cerebral infarction, diabetes mellitus, aphasia, morbid obesity, hyperlipidemia, hyperkalemia, dementia, kidney failure, metabolic acidosis, dehydration, and essential primary hypertension. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the MDS assessment, dated 02/10/25, revealed Resident #60 had impaired cognition. Review of the physician notes for Resident #60 revealed she was assessed by the physician on 01/28/25; however, the document was not signed by the physician until 02/07/25. Resident #60 was also assessed by the facility physician on 01/14/25 and the document was not signed until 01/17/25. Further review of the progress notes revealed Resident #60 was assessed by the facility physician on 01/06/25 and the document was not signed until 01/19/25. Interview on 02/25/25 at 3:18 P.M. with Assistant Director of Nursing (ADON) #200 stated the facility had several concerns related to the current facility Medical Director. ADON #200 stated the Medical Director gave notice to the facility that she was no longer going to work for the facility and was related to timely documentation of resident physician visits. ADON #200 confirmed Resident #06, Resident #34, and Resident #60 had provider visits that were not signed at the time of the visit. Review of the facility policy titled, Charting and Documentation, dated July 2017, revealed documentation of procedures and treatments should include specific details that include the date and time of the procedure.