STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365617	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ayden Healthcare of Waterville	8885 Browning Drive Waterville, OH 43566

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37451 Based on medical record review, staff interview, review of the facility investigation, review of the facility's Self-Reported Incidents, and review of the facility policy, the facility failed to ensure incidents of potential neglect related to elopement of cognitively impaired residents were reported to the state agency. This affected one resident (#3) of three residents reviewed for risk of elopement. The facility census was 72. Findings include: Review of Resident #3's medical record revealed an admitted [DATE]. Diagnoses included dementia, frontotemporal neurocognitive disorder, seizures, general anxiety disorder, major depressive disorder, osteoarthritis, cognitive communication deficit, and hallucinations. Review of Resident #3's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of zero indicating Resident #3 was rarely or never understood. A Staff Interview for Mental Status was completed and indicated Resident #3 was severely cognitively impaired. Resident #3 was independent with mobility and required moderate assistance with transfer. Resident #3 was dependent on staff for toilet use and bathing. Resident #3 displayed physical behavioral symptoms directed toward others and wandering behaviors one to three days during the review period. Review of Resident #3's care plan revised 09/12/24 revealed supports and interventions for cognitive impairment, risk for alteration in mood, behaviors including wandering, self-care deficit, and risk for elopement and wandering. Interventions for elopement and wandering included completing an elopement risk assessment, involve Resident #3 in activities of her choice, monitor and report any changes in behavior, orientate to new surrounds, and redirection as needed. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365617	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ayden Healthcare of Waterville	8885 Browning Drive Waterville, OH 43566

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's investigation documentation from Resident #3's 08/28/24 incident of exiting the facility revealed prior to the incident, Resident #3 was noted to be closing the fire doors throughout the morning. She was redirected by staff and the doors were reopened after Resident #3 had shut them. It was noted the door alarm to the outside door was tested after the incident and was found to be in working order. It was noted Licensed Practical Nurse (LPN) #494 reported she had taken a smoke break between 7:20 A.M. and 7:30 A.M. at which time during her smoke break she noticed Resident #3 outside the facility walking in the grassed area toward the corn field. LPN #494 intervened and walked with Resident #3 back to the door at the end of the 200 hallway. State tested Nursing Assistant (STNA) #431 was interviewed and reported she arrived at work around 7:10 A.M. and parked in the back parking lot near the 200 hallway door. No alarm was noted to be sounding at the time. STNA #431 proceeded to clock in, the time recorded was 7:17 A.M., and entered the 200 hallway. STNA #431 reported the fire doors were closed, she opened them and responded to the alarm that was sounding. STNA #431 reported she looked outside and did not see any residents. She then proceeded to go up and down the unit to verify resident presence. As she was reviewing residents, Resident #3 and LPN #494 were found walking down the hallway and STNA #431 was updated on what took place. Interview with LPN #484 indicated she was at the nurses station and had visual of the 200 hallway during the occurrence. LPN #484 could not recall hearing the alarm sounding but had visualized Resident #3 closing the fire doors and the housekeeper on the unit redirecting Resident #3 away from the fire doors. LPN #484 reported she was aware LPN #494 had left the unit and had been watching the 200 hall in her absence. It was noted STNA #431 was not on the floor at the start of her 6:30 A.M. shift. No staff observed Resident #3 exit the facility. The Interdisciplinary team reviewed the care plan of Resident #3. Resident #3 was noted to be a new admission to the unit and was becoming acclimated to the facility. Review of the facility's Self-Reported Incidents (SRIs) revealed there was no SRI submitted for Resident #3's 08/28/24 potential neglect incident related to elopement. Interview on 09/17/24 at 9:39 A.M. with Licensed Practical Nurse (LPN) #484 verified Resident #3 was a resident on secured dementia hall of the facility. LPN #484 reported she became aware Resident #3 had gotten out of the facility when she let LPN #494 and Resident #3 back into the facility through the door at the end of the secured dementia wing hallway. Interview on 09/18/24 at 7:29 A.M. with LPN #494 verified Resident #3 resided on the secured dementia unit, had exited the building on 08/28/24 and she had located her near the [NAME] and brought her back into the facility. Interview on 09/18/24 at 7:40 A.M. with State tested Nursing Assistant (STNA) #431 verified Resident #3 had exited the building on 08/28/24. Interview on 09/18/24 at 8:08 A.M. with Corporate Director #516 asked why they would need to report and create a Self-Reported Incident (SRI) for Resident #3's situation. Verifying an SRI had not been completed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365617	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ayden Healthcare of Waterville	8885 Browning Drive Waterville, OH 43566

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Freedom from Abuse, Neglect and Exploitation, revised October 2022 revealed the facility would ensure residents were free from neglect by having structures and processes to provide needed care and services to all residents. Alleged violations were to be reported immediately to the Administrator, state agency, adult protective services, and to all other required agencies. In response to allegations of abuse and neglect the facility must have evidence all alleged violations were thoroughly investigated and report the results of the investigation to the administrator and other officials including the state agency within five working days of the incident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365617	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2024
NAME OF PROVIDER OR SUPPLIER Ayden Healthcare of Waterville		STREET ADDRESS, CITY, STATE, ZIP CODE 8885 Browning Drive Waterville, OH 43566	

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 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** 37451 Based on observations, medical record review, staff interview and review of facility policy, the facility failed to provide supervision to prevent resident elopement for residents identified as at risk for elopement. This affected one resident (#3) of three residents reviewed for being at risk for wandering and elopement. The facility census was 72. Findings include: Review of Resident #3's medical record revealed an admitted [DATE]. Diagnoses included dementia, frontotemporal neurocognitive disorder, seizures, general anxiety disorder, major depressive disorder, osteoarthritis, cognitive communication deficit, and hallucinations. Review of Resident #3's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of zero indicating Resident #3 was rarely or never understood. A Staff Interview for Mental Status was completed and indicated Resident #3 was severely cognitively impaired. Resident #3 was independent with mobility and required moderate assistance with transfer. Resident #3 was dependent on staff for toilet use and bathing. Resident #3 displayed physical behavioral symptoms directed toward others and wandering behaviors one to three days during the review period. Review of Resident #3's care plan revised 09/12/24 revealed supports and interventions for cognitive impairment, risk for alteration in mood, behaviors including wandering, self-care deficit, and risk for elopement and wandering. Interventions for elopement and wandering included completing an elopement risk assessment, involve Resident #3 in activities of her choice, monitor and report any changes in behavior, orientate to new surrounds, and redirection as needed. Review of Resident #3's elopement risk assessment completed 08/27/24 revealed Resident #3 was at risk for elopement. Resident #3 had a history of elopement, was confused, and wandered. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365617	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2024
NAME OF PROVIDER OR SUPPLIER: Ayden Healthcare of Waterville		STREET ADDRESS, CITY, STATE, ZIP CODE: 8885 Browning Drive Waterville, OH 43566	

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's investigation documentation from Resident #3's 08/28/24 incident of exiting the facility revealed prior to the incident Resident #3 was noted to be closing the fire doors throughout the morning. She was redirected by staff and the doors were reopened after Resident #3 had shut them. It was noted the door alarm to the outside door was tested after the incident and was found to be in working order. It was noted Licensed Practical Nurse (LPN) #494 reported she had taken a smoke break between 7:20 A.M. and 7:30 A. M. at which time during her smoke break she noticed Resident #3 outside the facility walking in the grassed area toward the corn field. LPN #494 intervened and walked with Resident #3 back to the door at the end of the 200 hallway. State tested Nursing Assistant (STNA) #431 was interviewed and reported she arrived at work around 7:10 A.M. and parked in the back parking lot near the 200 hallway door. No alarm was noted to be sounding at the time. STNA #431 proceeded to clock in, the time recorded was 7:17 A.M., and entered the 200 hallway. STNA #431 reported the fire doors were closed, she opened them and responded to the alarm that was sounding. STNA #431 reported she looked outside and did not see any residents. She then proceeded to go up and down the unit verify resident presence. As she was reviewing residents, Resident #3 and LPN #494 were found walking down the hallway and STNA #431 was updated on what took place. Interview with LPN #484 indicated she was at the nurses station and had visual of the 200 hallway during the occurrence. LPN #484 could not recall hearing the alarm sounding but had visualized Resident #3 closing the fire doors and the housekeeper on the unit redirecting Resident #3 away from the fire doors. LPN #484 reported she was aware LPN #494 had left the unit and had been watching the 200 hall in her absence. It was noted STNA #431 was not on the floor at the start of her 6:30 A.M. shift. No staff observed Resident #3 exit the facility. The Interdisciplinary team reviewed the care plan of Resident #3. Resident #3 was noted to be a new admission to the unit and was becoming acclimated to the facility. An interview was attempted on 09/17/24 at 9:37 A.M. with Resident #3. Resident #3 was not able to be interviewed. Resident #3 was observed walking back and forth in the hallway and stopped to look out the glass exit door on a couple occasions. Interview on 09/17/24 at 9:39 A.M. with Licensed Practical Nurse (LPN) #484 revealed she was standing at the nurses' station on 08/28/24 when Resident #3 got out of the building. LPN #484 reported Resident #3 had been pacing the hallway on the secured unit and closing the dining room doors and fire doors when she last saw her. LPN #484 was not sure when Resident #3 actually got out the door. LPN #484 reported she did not hear the door alarm sounding, and did not visualize Resident #3 leaving the facility. The fire doors were closed and there had been a laundry cart at the end of the hallway blocking her view. LPN #484 reported she became aware Resident #3 had gotten out of the facility when she let LPN #494 and Resident #3 back into the facility through the door at the end of the 200 hallway. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365617	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2024
NAME OF PROVIDER OR SUPPLIER Ayden Healthcare of Waterville		STREET ADDRESS, CITY, STATE, ZIP CODE 8885 Browning Drive Waterville, OH 43566	

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/18/24 at 7:29 A.M. with LPN #494 revealed she was the nurse working the secured 200 hall on 08/28/24 when Resident #3 got out of the building. LPN #494 had covered the 200 hall and five residents on the 300 hall that day. LPN #494 reported Resident #3 was closing the fire doors on the 200 hallway, was pacing, and appeared anxious. LPN #494 reported she was assisting a high needs resident on the 300 hall and when she was done, she went out for a smoke break before she began medication administration on the 200 hallway. LPN #494 reported it was around 7:30 A.M. when she went out to smoke. The door alarm was not sounding when she went out. LPN #494 reported she had just sat down at the picnic table in the staff smoking area when she looked up and saw Resident #3 standing in the grass by the corn field. She immediately went to Resident #3 and she was able to be redirected back to the building. LPN #484 opened the door, and they entered back into the facility. Resident #3 was assessed, and no injury was found. LPN #494 stated she was not aware of the exact time Resident #3 exited the building, but it had only been a matter of minutes from when she went on break and saw Resident #3 standing near the corn field. Observation on 09/18/24 at 7:34 A.M. of the staff smoking area, the outside of the exit door on the 200 hallway and the grass area where Resident #3 was found and redirected into the facility found it was approximately 120 feet Resident #3 had walked before being noticed. Interview on 09/18/24 at 7:40 A.M. with State tested Nursing Assistant (STNA) #431 revealed she had been running late on 08/28/24 and it was about 7:15 A.M. when she got onto the floor. STNA #431 reported when she entered the secured unit, 200 hallway, the fire doors were shut and she could lightly hear the sound of the door alarm. She opened the fire doors, and the door alarm was sounding much louder. STNA #431 reported she walked down the hallway and looked out the door but had not seen anything or anyone. She reported she turned off the alarm and proceeded to check the resident rooms to see if anyone was missing. STNA #431 stated she was halfway down the hall doing room checks when LPN #494 and Resident #3 met her in the hallway. STNA #431 reported Resident #3 had only been in the facility a day, had been observed looking out the window on the door previously but had not tried to get out of the facility prior to this incident. Resident #3 was able to be redirected. Interview on 09/18/24 at 9:45 A.M. with Housekeeper #443 verified she was on the 200 hallway delivering personal items on 08/28/24 when Resident #3 got out of the facility. Housekeeper #443 reported she was in a resident room putting items away and heard a beeping noise. Housekeeper #443 stated she was new and had heard a similar sound from the doors entering onto the unit from the main facility when the doors were not closed tightly. She had assumed the beeping was from those front doors. Housekeeper #443 reported she delivered personal items to a second resident and when she came out she saw LPN #494 outside the facility at the door with Resident #3. Housekeeper #443 reported she did not have the code for the door so she got LPN #484 who let Resident #3 and LPN #494 back into the facility. Housekeeper #443 was not able to recall when exactly the incident occurred, but stated it was some time before 8:00 A.M. because the residents had not had breakfast yet. Review of the facility policy titled, Wandering and Elopement, revised March 2019 revealed the facility would identify residents at risk for unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. Review of the facility protocol titled, Secured Unit Protocol, dated October 2023 revealed the facility would strive to provide person centered care to all residents. Cognitively impaired residents were provided care in a safe and structured environment. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365617	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ayden Healthcare of Waterville	8885 Browning Drive Waterville, OH 43566

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency represents non-compliance investigated under Complaint Number OH00157852.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365617	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2024
NAME OF PROVIDER OR SUPPLIER: Ayden Healthcare of Waterville		STREET ADDRESS, CITY, STATE, ZIP CODE: 8885 Browning Drive Waterville, OH 43566	

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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37451 Based on observation, medical record review, staff interview, resident interview, facility exterminator interview, and review of facility exterminator treatments, the facility failed to have an effective pest control program for bed bugs. This affected one resident (#9) of three residents reviewed for pest control. The facility census was 72. Findings include: Review of Resident #9's medical record revealed an admitted [DATE]. Diagnoses included respiratory failure, type II diabetes, major depressive disorder, anxiety disorder, muscle wasting, convulsions, cognitive communication deficit, and altered mental status. Review of Resident #9's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of five indicating Resident #9 was severely cognitively impaired. Resident #9 was dependent on staff for all activities of daily living as well as bed mobility and transfer. Resident #9 displayed no behaviors during the review period. Review of Resident #9's progress notes revealed on 09/13/24 it was noted Resident #9 was seen by the physician for his monthly visit. It was noted Resident #9 was on bedbug precautions as the facility had found some bedbugs previously. Resident #9's family had also brought some in and the family visited often. No skin issues were noted at the time of the evaluation. Interview on 09/17/24 at 7:43 A.M. with Housekeeper #444 verified there were bed bugs in Resident #9's room. Housekeeper #444 reported it had been approximately four months Resident #9 had bed bugs and the facility was not effectively addressing the problem. Resident #9's family reported to the facility, and management was aware, the family had a bed bug infestation at home. The family continued to visit and bring Resident #9 items, clothing, shoes, bags etc from their infested home. The facility had an exterminator come in a couple times to treat his room but by the facility not addressing the source of the bed bugs they continued to be found. Interview on 09/17/24 at 7:46 A.M. with Licensed Practical Nurse (LPN) #484 verified Resident #9 had bed bugs and reported just this past weekend she pulled a bed bug off his feeding tube stoma. LPN #484 reported the bed bug concern had been going on since about March 2024. LPN #484 reported the facility had an exterminator come out and treat but the treatments were not affective due to the family visiting every day and bringing more bed bugs with them. LPN #484 reported the only way to truly eradicate bed bugs was to treat the source. The facility has not addressed the issue with the family and had permitted them to continue to visit and bring in contaminated items. The facility had also refused to provide the staff with any alcohol or other tools to address the bugs as they find them. LPN #484 reported staff were bringing in their own alcohol sprays to try and protect themselves. LPN #484 reported Resident #9 did not have any skin issues, but verified they continued to find bugs. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365617	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ayden Healthcare of Waterville	8885 Browning Drive Waterville, OH 43566

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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/17/24 at 7:53 A.M. with State tested Nursing Assistance (STNA) #420 verified there were bed bugs in Resident #9's room. STNA #420 reported she had actual bed bugs crawling on her after changing and repositioning Resident #9 a week or so ago. STNA #420 stated the facility had an exterminator that came out, but it was not sufficient to address Resident #9's bed bug concerns. STNA #420 stated Resident #9's family visited often and had a known bed bug infestation at home. They were still permitted to enter the facility and there were no restrictions on what they could bring into the facility or where they could visit. They continued to bring bed bugs into Resident #9's room which was putting other residents at risk of getting bed bugs. Observation on 09/17/24 at 7:56 A.M. of Resident #9 found him lying on a white bed sheet. No bed bugs were observed on the sheet however, a variety of small red brown specks, appearing to be blood meal/fecal matter of bed bugs were observed around Resident #9's right shoulder and the bottom half of his fitted bed sheet from approximately his mid thigh down. Coinciding interview with Resident #9 revealed he had no bites, but Resident #9 stated just because he didn't have bite marks and we didn't see the bugs didn't mean they weren't there. STNA #420 verified the red brown specks appeared to be bed bug droppings/excrement. Review of the facility's Exterminator Treatment record revealed Resident #9's room was treated for bed bugs on 06/18/24, 07/25/24, and 08/26/24. It was noted on 08/27/24 the facility seemed to think Resident #9's family was bringing the bed bugs into the facility. Interview on 09/17/24 at 2:58 P.M. with Exterminator #515 verified there were live active bed bugs found in Resident #9's room on 06/18/24, 07/25/24, and 08/26/24. Exterminator #515 reported any time it was indicated on their reports treatment was provided, live bed bugs had been found. Exterminator #515 reported they came to the facility monthly for a full facility inspection and preventative treatments for pests and they were contracted to come in as needed to address concerns between the monthly visits. Exterminator #515 stated they completed bed bug inspections and treatments as requested by the facility. This deficiency represents non-compliance investigated under Complaint Number OH00157647.