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	05/14/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, resident and staff interview, record review and policy review, the facility failed to ensure residents were treated with dignity while receiving feeding assistance. This affected one (#112) of three residents reviewed for dignity. The facility census was 68.Findings include:Review of the medical record for Resident #112 revealed an admission date of 08/03/16 and a readmission date of 10/09/24, with diagnoses of Parkinsonism, paranoid schizophrenia, anxiety, dementia, and need for assistance with personal care. Review of the quarterly Minimum Data Set (MDS) assessment, dated 04/30/26, revealed Resident #112 had impaired cognition and was dependent on staff for eating. Review of the care plan initiated 11/06/24 and revised on 04/20/26 revealed Resident #112 was at risk for decline in activities of daily living (ADL) function and/or ADL participation as evidenced by a need for total (assistance) with ADLs, transfers, ambulation, and toileting related to requiring staff assistance for ADLs. Further review revealed Resident #112 had contractures of the hands and wrists. Additionally, Resident #112 was at risk for altered nutrition. Interventions included staff to feed Resident #112 as needed.Observation on 05/14/26 at 7:53 A.M. revealed Resident #112 lying in bed with a breakfast tray on her overbed table. Both of Resident #112's arms were lying across her chest and both hands appeared to be contracted. Certified Nursing Assistant (CNA) #62 was standing next to Resident #112 and holding a cup for Resident #112 to drink from.Observation on 05/14/26 at 8:00 A.M. revealed CNA #62 was no longer in Resident #112's room and the resident's breakfast tray remained in the room and was full of food. Concurrent interview with Resident #112 revealed she was still hungry and did not know if someone was coming back to assist her to eat.Observation on 05/14/26 at 8:02 A.M. revealed CNA #62 was in the main dining room assisting with serving breakfast to residents. Observation on 05/14/26 at 8:10 A.M. revealed CNA #62 was standing next to Resident #112, instead of sitting with the resident, providing assistance with eating. Concurrent interview with CNA #62 confirmed he was standing while providing assistance to Resident #112. CNA #62 stated he would sit next to residents while providing assistance in the dining room but indicated there appeared to be nowhere to sit at bedside while assisting Resident #112.Interview on 05/14/26 at 1:15 P.M. with the Director of Nursing (DON) confirmed staff should not be standing while feeding residents.Review of the facility policy titled, Assistance with Meals revised July 2017, revealed residents who could not feed themselves would be fed with attention to safety, comfort and dignity, for example: not standing over residents while assisting them with meals.This deficiency represents non-compliance investigated under Complaint Number 2992378.

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review and staff interviews, the facility failed to provide timely repositioning for dependent residents. This affected two (#112 and #113) of three residents reviewed for repositioning. The facility census was 68.Findings include: 1. Review of the medical record for Resident #112 revealed an admission date of 08/03/16 and a readmission date of 10/09/24, with diagnoses of Parkinsonism, paranoid schizophrenia, anxiety, dementia, and need for assistance with personal care.Review of the quarterly Minimum Data Set (MDS) assessment, dated 04/30/26, revealed Resident #112 had impaired cognition and was dependent on staff for eating, repositioning and toileting hygiene. Further review revealed Resident #112 was always incontinent of bladder and bowel.Review of the care plan initiated 11/06/24, and revised on 04/20/26, revealed Resident #112 was at risk for decline in activities of daily living (ADL) function and/or ADL participation as evidenced by need for total (assistance) with ADLs, transfers, ambulation, and toileting related to requiring staff assistance for ADLs. Continuous observations on 05/14/26 from 8:10 A.M. through 11:04 A.M. revealed Resident #112 was lying on her back in bed. No staff were observed to enter the resident's room to provide incontinence care.Interview on 05/14/26 at 10:17 A.M. with Certified Nursing Assistant (CNA) #62 verified the last time Resident #112 was checked for incontinence was at approximately 7:30 A.M. Observation on 05/14/26 at 11:04 A.M. revealed CNA #67 came from another hall to assist Resident #112 with getting up into her wheelchair. CNA #67 did provide incontinence care for Resident #112 at this time. Concurrent interview with CNA #67 confirmed incontinence care was not provided for Resident #112 and CNA #67 verified the resident's incontinence brief contained both urine and stool.2. Review of the medical record revealed Resident #113 was admitted to the facility on [DATE]. Diagnoses included dementia, major depressive disorder, anxiety, fall and cerebral vascular accident (stroke). Review of the quarterly MDS assessment dated [DATE] revealed Resident #113 had a Brief Interview for Mental Status Score (BIMS) of five, indicating severe cognitive deficit. Further review of the MDS revealed Resident #113 was dependent on others for toileting, personal hygiene and rolling left to right. Resident #113 was frequently incontinent for urine and always incontinent for bowel. Review of the revised care plan dated 02/27/26 revealed Resident #113 required total (staff) assistance with ADLs, ambulation and toileting. Further review revealed staff were to provide incontinence care as needed. Finally, the care plan revealed Resident #113 was receiving diuretic therapy, which could increase urinary output. Multiple observations on 05/14/26 from 8:10 A.M. through 2:04 P.M. revealed Resident #113 was in her recliner, in the same position.Interview on 05/14/26 at 10:17 A.M. with CNA #62 verified the last time Resident #113 was checked for incontinence was at approximately 7:30 A.M. CNA #62 stated Resident #113 was placed in her recliner before his arrival at 6:30 A.M. Observation on 05/14/26 at 11:34 A.M. revealed CNA #62 entered Resident #113's room and asked the resident if he could check to see if incontinence care was needed. CNA #62 pulled the front of Resident #113's pants forward and looked at and felt the front of the incontinence brief. CNA #62 stated Resident #113 was not soiled. Concurrent interview with CNA #62 revealed the incontinence brief worn by Resident #113 would change color from yellow to blue if the resident was incontinent of urine. CNA #62 confirmed the resident was not checked for bowel incontinence and verified this was the first incontinence check on Resident #113 since 7:30 A.M., approximately four hours between checking the resident for incontinence care needs.Review of the facility policy titled, Urinary Continence and Incontinence-Assessment and Management, dated September 2010, revealed for residents with severe cognitive impairment, a check and change strategy was to be implemented. The check and change strategy involved checking the resident's continence at regular intervals and using incontinence devices or garments. The primary goal of the check and change strategy was to maintain dignity and comfort and to protect the skin. This was an incidental finding discovered during the complaint investigation.

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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, medical record review, staff interview and policy review the facility failed to provide timely incontinence care. This affected two (#112 and #113) of three residents reviewed for incontinence care. The facility census was 68.Findings include: 1.Review of the medical record for Resident #112 revealed an admission date of 08/03/16 and a readmission date of 10/09/24, with diagnoses of Parkinsonism, paranoid schizophrenia, anxiety, dementia, and need for assistance with personal care. Review of the quarterly Minimum Data Set (MDS) assessment, dated 04/30/26, revealed Resident #112 had impaired cognition and was dependent on staff for eating, repositioning and toileting hygiene. Further review revealed Resident #112 was always incontinent of bladder and bowel. Review of the care plan initiated 11/06/24 and revised on 04/20/26 revealed Resident #112 was at risk for decline in activities of daily life (ADL) function and/or ADL participation as evidenced by need for total (assistance) with ADLs, transfers, ambulation, and toileting related to requiring staff assistance for ADLs. Interventions included Resident #112 should be turned and repositioned per facility policy.Interview on 05/14/26 at 10:17 A.M. with CNA #62 verified the last time Resident #112 was checked for incontinence was shortly after his arrival at 7:30 A.M. Observation on 05/14/26 at 11:04 A.M. revealed CNA #67 came from another hall to assist Resident #112 with getting up into her wheelchair. CNA #67 did provide incontinence care at this time. Resident #112's brief did contain both urine and stool, this was verified by CNA #67.2. Review of the medical record revealed Resident #113 was admitted to the facility on [DATE]. Diagnoses included dementia, major depressive disorder, anxiety, fall and cerebral vascular accident. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] for Resident #113 revealed a Brief Interview for Mental Status Score (BIMS) of 5, indicating severe cognitive deficit. Further review of the MDS revealed Resident #113 was dependent on others for toileting, personal hygiene and rolling left to right. MDS further revealed Resident #113 was frequently incontinent for urine and always incontinent for bowel. Review of the revised care plan for Resident #113 dated 02/27/26 revealed Resident #113 was a total assist with activities of daily living (ADL's), ambulation and toileting. Further review of Resident #113's care plan revealed staff were to provide incontinence care as needed. Finally, the care plan revealed Resident #113 was receiving diuretic therapy which could increase urinary output. Interview on 05/14/26 at 10:17 A.M. with CNA #62 verified the last time Resident #113 was checked for incontinence was shortly after his arrival at 7:30 A.M. CNA #62 continued to state Resident #113 was placed in her recliner before his arrival at 6:30 A.M. Observation on 05/14/26 at 11:34 A.M. of CNA #62 going into the room of Resident #113. CNA asked Resident #113 if he would check to see if incontinence care was needed, resident agreed. CNA #62 pulled the front of Resident #113's pants forward, looked at and felt the front of the brief. CNA #62 stated Resident #113 was not wet.Interview on 05/14/26 at 11:34 A.M. with CNA #62 revealed the brief worn by Resident #113 will change colors from yellow to blue if resident was incontinent of urine. CNA #62 verified this was the first incontinence check on Resident #113 since 7:30 A.M. Review of the policy titled Urinary Continence and Incontinence-Assessment and Management dated 09/2010 revealed for residents with severe cognitive impairment, a check and change strategy is to be implemented. The check and change strategy involved checking the resident's continence at regular intervals and using incontinence devices or garments. The primary goal of the check and change strategy is to maintain dignity and comfort and to protect the skin. This deficiency represents noncompliance investigated under Complaint Number 2992378.