

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365619	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2026
NAME OF PROVIDER OR SUPPLIER Unger Park Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1170 W Mansfield Street Bucyrus, OH 44820	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview, and policy review, the facility failed to ensure female residents were shaved. This affected one (#75) of one resident reviewed for shaving. The facility also failed to ensure residents in the dining room were fed in a dignified manner. This affected one (#45) of one resident observed for feeding. The facility identified seven residents (#6, #12, #27, #45, #60, #66, and #74) who required assistance with feeding. The facility census was 67. Findings include: 1. Review of medical record for Resident #75 revealed an admission date of 08/17/25 with diagnoses including but not limited to paranoid schizophrenia, depression, anxiety, and the need for assistance with personal care. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact. Resident #75 required partial/moderate assistance for bathing/showering and setup or clean-up assistance for personal hygiene. Review of shower documentation for 04/24/26 and 04/28/26 revealed the resident received a bed bath for both days and no shaving was documented. Observation on 04/27/26 at 9:39 A.M. of Resident #75 revealed long white hairs on the resident's chin. Observation 04/28/26 at 10:47 A.M. revealed Resident #75 sitting out in the hall by the nurse's station and the long white hairs remained on the resident's chin. Observation and interview on 04/29/26 at 9:26 A.M. of Resident #75 revealed the long white hairs remained on the resident's chin. Resident #75 stated that she will shave her chin sometimes and stated that the staff do not shave it for her. Resident #75 stated the staff do not offer to shave the hairs on her chin. Interview on 04/29/26 at 2:36 P.M. with Certified Nursing Assistant (CNA #177) revealed they would shave female residents on their shower days. CNA #177 stated that Resident #75 would allow the staff to shave her chin. CNA #177 verified Resident #75 had long white hairs on her chin and would shave them if the resident liked. Further observation on 04/30/26 at 8:24 A.M. revealed Resident #75 chin was shaved. Review of policy titled Dignity revised February 2021 revealed when assisting with care, residents are supported in exercising their rights. For example, residents are groomed as they wish to be groomed (hair styles, nails, facial hair, etc.). 2. Review of medical record for Resident #45 revealed an admission date of 08/17/23 with diagnoses including but not limited to Alzheimer's disease with early onset, dementia with agitation, and need for assistance with personal care. Review of MDS dated [DATE] revealed Resident #45 had severely impaired vision and was dependent for eating. Review of physician orders revealed Resident #45 required assistance with feeding. Observation on 04/27/26 at 11:48 A.M. of CNA #112 revealed the CNA stood beside the resident to assist the resident with eating for the entire meal. Interview on 04/27/26 at 12:03 P.M. with CNA #112 revealed that she normally sits down to assist residents with meals. CNA #112 verified she stood beside the resident to assist with the meal. CNA #112 stated the resident was blind so the staff can hand the resident finger foods but have to physically assist with the rest of the meal. Further review of policy titled Dignity revised February 2021 revealed when assisting with care, residents are supported in exercising their rights. For example, residents are provided with a dignified dining experience. This deficiency represents non-compliance investigated under Master Complaint Number 2976687 and Complaint Number 2645697.</p>

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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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interview, and facility policy review, the facility failed to ensure a homelike environment by failing to ensure the dining room ceiling was intact and without holes. This affected one (#28) of five residents reviewed for environment. The facility also failed to ensure a homelike dining experience for the 14 (#2, #3, #5, #14, #16, #17, #20, #28, #43, #45, #52, #53, #56, and #59) residents who routinely ate meals in the dining room and further failed to provide comfortable and well-fitting bed linens for Resident #10. The facility census was 67. Findings include: 1. Review of the medical record for Resident #28 revealed an admission date of 06/13/25. Diagnoses included dementia, congestive heart failure and type 2 diabetes. Review of Resident #28's Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #28 had moderate cognitive impairment.</p> <p>Observation of the dining room ceiling occurred about 3:10 P.M. on 4/28/26. A missing tile in the drop ceiling created a rectangular hole. The hole exposed a visible blue wire.</p> <p>Observation of the dining room ceiling occurred at 10:17 A.M. on 4/29/26. The rectangular hole in the ceiling was still present with visible wires.</p> <p>Resident #28 was sitting in the dining room and interviewed at 10:19 A.M. on 4/29/26. Resident #28 acknowledged the hole in the ceiling and stated she was worried about the ceiling falling and people getting hurt.</p> <p>Interview conducted with [NAME] #135 at 10:21 A.M. on 4/29/26 confirmed the hole in the dining room ceiling. [NAME] #135 could not say for how long the hole in the ceiling had been there but added that maintenance had doing some work above the ceiling.</p> <p>Observation of the dining room ceiling took place at 12:11 P.M. on 4/29/26. Three residents were sitting below the hole eating lunch.</p> <p>Observation of the dining room ceiling occurred at 7:54 A.M. on 4/30/26. The rectangular hole in the ceiling was still present.</p> <p>Review of the facility policy titled Homelike Environment, revised 02/2021 states the facility will provide residents with a safe, clean, comfortable and homelike environment.</p> <p>2. Observation on 04/27/26 from 11:21 A.M. until 11:48 A.M. of the dining room revealed the first tray of food was delivered to one resident at a three top table at 11:21 A.M. The meal was sat on front of the resident and was left on the tray. At 11:23 A.M. staff were then observed to serving a tray to another resident at another three top table. Staff continued to serve meals in a random order, all meals were left on the trays. At 11:31 A.M. the second resident at the first three top table received a meal tray. At 11:33 A.M. the third resident from the first three top table received their meal tray. The last of three residents at the second table received their tray at 11:39 A.M. During the observation of the meal service a resident from a middle three top table was observed to turn her wheelchair away from the table where two residents were eating and the resident reached and grabbed a hamburger off of another resident's tray that was just sitting there uncovered and in front of a resident waiting on staff to assist with feeding. Staff were observed intervening, turning the resident back to her table and providing her with a tray of food. At 11:40 A.M. staff were observed taking the plate with touched (continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>hamburger back to the kitchen, obtained another and returned at 11:42 A.M. with a tray containing a covered plate. At 11:48 A.M. a CNA came into the dining room to assist the resident with eating her meal.</p> <p>Interview on 04/27/26 at 11:42 A.M. with Business Office Manager (BOM #122) revealed that the facility did not normally take the plates off the trays. BOM #122 verified the plates, drinks, and silverware were not taken off the trays when the food was delivered. BOM #122 verified the table were not served together and they should have been.</p> <p>Interview on 04/29/26 at approximately 10:58 A.M. with Dietary Director (DD #125) revealed that the staff serving in the dining room should take the plates and drinks off the trays when they are delivered. DD #125 verified the tables should be served together.</p> <p>3. Review of the medical record for Resident #10 revealed an admission date of 04/16/26. Diagnoses included cerebral infarction due to occlusion or stenosis of small artery, type II diabetes, and cognitive communication deficit. Review of Resident #10's MDS assessment dated [DATE] indicated Resident #10 had moderate cognitive impairment.</p> <p>Observation of Resident #10 lying in bed occurred at 8:57 A.M. on 4/27/26. Bed sheets were not covering the entire pressure mattress.</p> <p>Interview with a Resident #10's Representative occurred at 10:23 A.M. on 04/27/26 in Resident #10's room. The Resident Representative stated that sheets tend to slide off the mattress.</p> <p>Observation of Resident #10 lying in bed occurred at 8:19 A.M. on 04/30/26. The bed sheet was not covering the entire mattress, the corner of the bed on the Resident's left hand side by the Resident's head had mattress exposed.</p> <p>Interview with Resident #10 at 8:19 A.M. on 04/30/26 revealed the sheets are bothersome and do not fit right. Resident #10 confirmed that the issue has been brought to the attention of facility staff, but nothing has been done.</p> <p>Interview with Maintenance Director (MD) #113 occurred at 8:32 A.M. on 4/30/26. MD #113 confirmed that the bed sheet was not covering Resident #10's mattress and this was a problem with pressure mattress that Resident #10 used.</p> <p>Review of the facility policy titled Homelike Environment, revised 02/2021 states that the facility will provide a comfortable and homelike environment for residents including clean bed linens that are in good condition.</p> <p>This deficiency represents non-compliance investigated under Master Complaint Number 2976687 and Complaint Number 2645697.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, interview, and policy review the facility failed to ensure the kitchen was sanitary, failed to ensure food was labeled and dated when opened, and further failed to ensure the dishwasher was washing and rinsing per manufacturer guidelines. This had the potential to affect all residents who received food from the kitchen. The facility identified one (#72) resident who did not receive meals from the kitchen. The facility census was 67. Findings include: 1. Observation during initial tour of the kitchen on 04/27/26 at 8:08 A.M. revealed a plastic tray containing clean pitchers had a brown-like substance on the tray. Three open, three shelf carts with wheels had crumbs and debris on the shelves which contained insulated plate lids, sleeves of plastic lids, sleeves of bowls, and sleeves of cups. Three trays of juice on the left side of the reach in refrigerator and three trays of juice on the right side of the reach in refrigerator were unlabeled and not dated. Observation of the walk in refrigerator revealed a plastic baggie of bologna with a freeze date of 03/03/26 with no thaw date or use by date. The bologna appeared to be slimy and light in color. Observation of the high temperature dishwasher in use revealed the wash temperature was 168 degrees Fahrenheit (F) and the rinse temp was 160 degrees F, 176 degrees F, 178 degrees F, 178 degrees F, and 178 degrees F when running five cycles. Interview on 04/27/26 at 8:15 A.M. with [NAME] #135 revealed the dishwasher had not been running yet this morning. [NAME] #135 verified the dishwasher was a high temperature machine and should rinse at 180 degrees F at a minimum. [NAME] #135 verified the above findings in the reach in refrigerator and stated they are normally prepped the night before. [NAME] #135 verified the carts and the tray with the brown substance. [NAME] #135 verified the bologna in the walk-in refrigerator did not have a thaw date or use by date and stated that the bologna always had that color. [NAME] #135 discarded the bologna. 2. Review of dishwasher label revealed hot water sanitizing requires a 150 degrees F minimum wash temperature and 180 degrees F minimum rinse temperature. Review of the dishwasher temperature log for January 2026 revealed the wash temperature on 01/14 was 148 degrees F at lunch time, 148 degrees F at lunch on 01/15, 146 degrees F on 01/21 at breakfast, 130 degrees F on 01/22 at breakfast, 147 degrees F on 01/23 at breakfast, 140 degrees F on 01/27 at breakfast and supper, 144 degrees F on 01/28 at breakfast. On 01/24 and 01/29 there was no documentation of wash temperatures, and on 01/30 and 01/31 there was no documentation of supper wash temperatures. Review of the dishwasher temperature log for February 2026 revealed on 02/05 the wash temperature was 149 degrees F at supper. No wash temperatures were documented on 02/01 for supper, 02/02, 02/03, 02/07, and 02/08 for breakfast or lunch, 02/09 and 02/18 for supper, 02/25 for lunch, and 02/28 for lunch and supper. Review of the dishwasher temperature log for March 2026 revealed there were no documented wash temperatures on 03/24 at supper time. Review of the dishwasher temperature log for April 2026 revealed on 04/01 at breakfast the wash temperature was 144 degrees F, 142 degrees F on 04/03 at breakfast, 140 degrees F at lunch on 04/07, and 148 degrees F on 04/16 at breakfast. The temperature log was missing documentation of wash temperatures on 04/03, 04/12, 04/19, 04/24, 04/25, and 04/26 at supper, on 04/09 at lunch, and on 04/23 there was no documentation of wash temperatures for any meal. 3. Review of dishwasher temperature log for January 2026 revealed rinse temperatures of 128 degrees F at breakfast on 01/21, 130 degrees F on 01/23 at breakfast, 138 degrees F on 01/25 at breakfast, 140 degrees F on 01/26 at supper, and 130 degrees F on 01/27 at supper. The temperature log was missing rinse temperatures on 01/28 at breakfast, 01/24 at both breakfast and lunch, 01/29 for all meals, and 01/30 and 01/31 for supper. Review of dishwasher temperature log for February 2026 revealed rinse temperatures of 149 degrees F on 02/05 at supper, 170 degrees F on 02/06 at supper, 165 degrees F on 02/07 at supper, 168 degrees F on 02/08 at supper, 175 degrees F on 02/11 and 02/12 at supper, 178 degrees F on 02/16 at supper, 179 degrees F on 02/20 at supper, 178 degrees F on 02/21 at supper, 172 degrees F on 02/22 at supper, 178 degrees F on 02/25 at supper, and 179 (continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>degrees F on 02/26 at supper. The log was missing rinse temperatures on 02/01, 02/09, 02/18, and 02/27 at supper, 02/02, 02/03, 02/07 and 02/08 at breakfast and lunch, 02/24 at breakfast and on 02/28 for lunch and supper. Review of the dishwasher temperature log for March 2026 revealed rinse temperatures of 175 degrees F on 03/02 at supper, 178 degrees F at lunch and 175 degrees F at supper on 03/05, 173 degrees F on 03/07 at supper, 178 degrees F on 03/11 at supper, 179 degrees F on 03/12 at supper, 174 degrees F on 03/13 at supper, 176 degrees F on 03/14 at lunch, 178 degrees F on 03/17 at breakfast, lunch, and supper, 176 degrees F on 03/18 at breakfast, 174 degrees F at breakfast and 178 F at supper on 03/19, 179 degrees F on 03/22 at supper, 178 degrees F on 03/26 at lunch and supper, 176 degrees F on 03/27 at lunch, 178 degrees F on 03/28 and 03/30 at supper, and 178 degrees F on 03/31 at lunch. The temperature log contained no rinse temperature at supper time on 03/24. Review of the dishwasher temperature log for April 2026 revealed rinse temperatures of 176 degrees F on 04/03 at breakfast, 178 degrees F on 04/04 at breakfast, lunch, and supper, 178 degrees F on 04/05 at breakfast, 178 degrees F on 04/08 at supper, 178 degrees F on 04/18 at breakfast and lunch, 176 degrees F at breakfast and 178 degrees F at lunch on 04/19, 170 degrees F on 04/20 at breakfast, 172 degrees F on 04/21 at supper, 178 degrees F at lunch and 168 degrees F at supper on 04/22, and 178 degrees F on 04/27 at breakfast. There was no rinse temperatures documented on the temperature log on 04/03, 04/12, 04/19, 04/24 and 04/26 for supper, 04/09 for lunch, and for any meal on 04/23. Interview on 04/29/26 at approximately 2:25 P.M. with [NAME] #135 verified the temperature logs had missing temperatures. [NAME] #135 also verified that there were dishwasher wash and rinse temperatures recorded under the minimum requirements for sanitizing. Review of policy titled Sanitation, revised November 2022 revealed dishwashing machines are operated according to manufacturer's instructions. General recommendations for heat and chemical sanitization are high-temperature dishwasher wash temperatures between 150 and 165 degrees F, and a rinse temperature of at least 180 degrees F. Review of the undated policy titled Kitchen Infection Control Policy, revealed dishwashing must meet temperature and sanitation standards. Review of undated policy titled Food Receiving and Storage, revealed refrigerated foods are labeled, dated, and monitored so they are used by their use-by date, frozen, or discarded. All foods stored in the refrigerator or freezer are covered, labeled and dated with a use-by date. This deficiency represents noncompliance investigated under Complaint Number 2645697.</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>Based on observation, staff interview, and policy review, the facility failed to ensure the facility was maintained in a safe, clean, comfortable homelike environment. This affected two residents (#46 and #56) and had the potential to affect all residents. The facility census was 67. Findings include: Observation on 04/29/26 at 10:40 A.M. of Resident's #46 and #56's bedroom revealed wallpaper to be peeling from the wall in multiple areas including behind the each of the resident's headboards, below the window, and near the baseboards. There was also a black substance noted to be around the base of the toilet in the bathroom. Interview on 04/29/26 at 10:45 A.M. with Certified Nursing Assistant (CNA) #175 verified the peeling wallpaper in Resident's #46 and #56's bedroom as well as the black substance around the base of the toilet. Furthermore, concurrent observation and interview with CNA #175 verified in the C hall restroom, the three light covers were cracked/broken. Review of the facility policy titled Homelike Environment with a revision date of February 2021 revealed residents are provided with a safe, clean, comfortable and homelike environment. This deficiency represents non-compliance investigated under Complaint Number 2645697.</p>		