STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365717	A. Building B. Wing	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Convalarium of Dublin	6430 Post Rd Dublin, OH 43016

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, medical record review, resident and staff interview, and policy review, the facility failed to provide resident care following a meal to maintain dignity. This deficient practice affected one (#32) of three residents reviewed for dignity. The facility census was 80.Finding Include:Record review for Resident #32 revealed an admission date of 03/22/23. Diagnoses included of hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side, morbid obesity due to excess calories, aphasia following cerebrovascular disease, cerebral infarction due to occlusion or stenosis of the right middle cerebral artery, major depressive disorder, anxiety, bipolar disorder, vascular dementia, hyperlipidemia, chronic kidney disease, and lack of coordination.Review of Resident #32's care plan, last revised on 11/03/25, revealed the resident was at risk for activities of daily living (ADLs) performance deficit related to generalized weakness, decreased strength and endurance, and decreased activity tolerance, impaired mobility, and incontinence related to cerebral vascular accident. Interventions include the resident required increased assistance with ADL performance and was able to eat with set up and clean up assistance.Observation on 01/05/26 at 3:46 P.M. revealed Resident #32 resting in bed watching television with corn on his shirt from lunch. Interview with Resident #32 at the time of the observation stated he was not aware of the corn on his shirt and was upset he did not get cleaned up after lunch. Interview on 01/05/26 at 3:48 P.M. with Licensed Practical Nurse (LPN) #604 confirmed Resident #32 had corn on him and the resident was upset about not being cleaned up from lunch.Review of facility policy titled, Dignity, last revised 8/25, revealed staff were to groom residents as they wish to be groomed and to promote resident independence.This deficiency represents non-compliance investigated under Complaint Number 1376013 (OH00164696).

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: 365717	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/15/2026
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and policy review, the facility failed to timely assess and implement treatment for non-pressure skin conditions. This affected one (#56) of three residents reviewed for wounds. The facility census was 80.Findings include:Review of Resident #56's medical record revealed an admission date of 09/02/25. Diagnoses included respiratory failure with hypoxia, cerebral edema, protein-calorie malnutrition, cerebral infarction, metabolic encephalopathy, hypokalemia, convulsions, paroxysmal atrial fibrillation, peripheral vascular disease, and pneumonia. Review of the Resident #56's Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was unable to complete the Brief Interview of Mental Status due to severe cognitive impairment. Further review revealed the resident was fully dependent on staff for all activities of daily living (ADLs).Review the Resident #56's care plan last revised on 11/19/25 revealed the resident was at risk for skin alteration related to generalized weakness, decreased strength and endurance, and decrease activity tolerance, impaired mobility, impaired cognition, and incontinence. Interventions included to administer treatments as ordered and monitor for effectiveness, assess/record/monitor wound healing as ordered and as needed, measure length, width, and depth where possible, and follow facility protocol for the prevention/treatment of skin breakdown.Review of Resident #56's admission assessment dated [DATE] revealed the resident was admitted to the facility with moisture associated dermatitis to the coccyx. Further review revealed the facility performed no skin assessments for the resident until the resident was transferred back from the hospital on [DATE]. Further review revealed the facility did not have treatment orders in place for Resident #56's moisture associated dermatitis on the coccyx. Interview on 01/08/26 at 11:45 A.M. with Wound Nurse #586 confirmed the facility did not have evidence of skin assessments for Resident #56 from 09/02/25 through 09/29/25, and there were no treatment orders for the moisture associated dermatitis on the coccyx until 09/25/25. Interview on 01/12/26 at 8:52 A.M. with the Director of Nursing (DON) confirmed the expectation was for staff to chart and treat skin issues until they are resolved.Review of facility policy titled, Wound Care, last revised 8/25, revealed staff are to measure wounds including length, width, and depth and apply treatments as indicated. This deficiency represents non-compliance investigated under Complaint Number 2606734, Complaint Number 2572222, and Complaint Number 1376017 (OH00167023).

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, and staff interview, the facility failed to ensure pressure ulcer preventative interventions were in place as ordered. This affected one (#35) of five residents reviewed for pressure ulcers. The facility census was 80.Findings include:Record review for Resident #35 revealed the resident was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, diabetes mellitus, chronic obstructive pulmonary disease, schizophrenia, peripheral vascular disease.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #35 had moderately impaired cognition evidenced by a Brief Interview for Mental Status (BIMS) score of 08. The resident was assessed to require self-care and mobility assistance.Review of the care plan dated 11/05/25 revealed Resident #35 previously had a right heel pressure ulcer and was at risk for additional skin breakdown related to her immobility.Review of Resident #35's physician orders revealed an order dated 09/17/24 for the resident to wear Prevalon boots (cushioned boots worn on the feet to reduce pressure) on both of her feet at all times except when the resident was receiving hygiene care.Random observations of Resident #35 between 01/07/26 at 9:00 A.M. and 01/08/26 at 5:30 P.M. revealed the resident was not wearing Prevalon boots. During an interview with Registered Nurse (RN) #589 on 01/08/26 at 6:17 P.M., he verified Resident #35 had not been wearing the Prevalon boots that day, and she did not have them on that morning when he started his shift.This deficiency represents non-compliance investigated under Complaint Number 2606734, Complaint Number 2572222, and Complaint Number 1376017 (OH00167023).

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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** Based on medical record review, review of a risk assessment, resident and resident family interviews, staff interview, and review of an incident log, the facility failed to complete a thorough investigation into a resident accident with injury. This affected one (#92) of three residents reviewed for accidents and injuries. The facility census was 80. Findings include: Review of the medical record for Resident #92 revealed an admission date of 02/18/25 and discharge date of 03/04/25. Diagnoses included respiratory failure with hypoxia, sepsis, heart failure, heart disease, displaced fracture of the scapula, cognitive communication deficit, and muscle weakness. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #92 had a Brief Interview of Mental Status (BIMS) of 12 indicating moderately impaired cognition and required supervision and touching assist. The assessment revealed the resident had no falls since admission. Review of the plan of care dated 03/10/25 revealed Resident #92 was at risk of falls with interventions to anticipate needs, ensure call light was in reach and encourage use, ensure she was wearing appropriate footwear when ambulating or mobilizing in wheelchair, follow facility protocol, and physical therapy to evaluate and treat as ordered. Review of physician orders from 02/18/25 to 03/04/25 revealed Resident #92 was ordered the pain medication acetaminophen 325 milligrams (mg) with instructions to give two tablets every four hours as needed for mild discomfort. Review of an occupational therapy note dated 02/20/25 revealed Resident #92 required contact guard assistance with toileting transfers and requested a higher height toilet. Review of the progress note dated 02/22/25 revealed Resident #92 had a new complaint of pain on the right upper arm with a pain score of three (on a ten-point scale) and described the pain as aching. Non-pharmacological interventions did not provide relief and as needed medication was provided. Review of an occupational therapy note dated 02/22/25 revealed Resident #92 reported pain of the right shoulder at rest rated five out of ten, and with movement an eight out of ten with exacerbation from reaching. Pain was noted to be a barrier to the therapy session. Review of the progress note dated 02/23/25 revealed Resident #92 had a complaint of pain on the right upper arm with a pain score of three, and described the pain as aching. Non-pharmacological interventions did not provide relief and as needed medication was provided. Review of the progress note dated 02/24/25 revealed Resident #92 complained of right shoulder pain. Staff notified the nurse practitioner and a new order for an x-ray of the right shoulder was ordered. An ice pack was ordered to the right shoulder as needed with instructions to leave it on for up to 15 minutes. A lidocaine four percent (4%) patch was also ordered to be applied to the right shoulder topically once daily for right shoulder pain with instructions to remove after 12 hours. A message was left for the resident's family and the radiology company was notified of the need for a stat x-ray. Review of the progress notes dated 02/24/25 and 02/25/25 revealed Resident #92 reported pain in the right upper arm and scored the pain a two with aching. Review of Resident #92's radiology report dated 02/24/25 revealed a right shoulder x-ray was completed and found evidence of a displaced fracture of the scapula. Degenerative changes at the acromioclavicular (AC) joint and glenohumeral joint were also noted. The result was reviewed by the facility medical provider 02/25/25.Review of Resident #92's occupational therapy notes dated 02/24/25 revealed a family requested a bedside commode over the toilet due to recently injuring her right shoulder during a transfer. The resident practiced sit and stand transfers with stand by assistance with therapy.Review of the risk assessment dated [DATE] revealed Resident #92 reported new pain and stated she walked into the door post while walking into the bathroom. Resident #92 was alert and oriented, and had a pain level of six. The assessment revealed it was privileged and confidential and not part of the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medical record. It did not include any follow up on the injury or mention of the x-ray results. The risk assessment did not mention when the injury occurred or whether staff were assisting her or not at the time of the injury. Review of nurse practitioner notes dated 02/24/25 revealed she was informed Resident #92 had pain and was assessed to also have a decreased range of motion and an x-ray was ordered. The note stated the resident ran into a door jam two days prior. Review of Resident #92's medical record, including progress notes, included no details on how the injury/fracture occurred. Review of the incident accident log dated 02/2025 revealed no entry for any fall or injury for Resident #92. Interviews were attempted on 01/07/26 with Registered Nurse (RN) #525, RN #905, and Certified Nurse Aide (CNA) #910 who worked with Resident #92 from 02/22/25 to 02/24/25. All three staff members did not respond or had no memory of Resident #92. Interview on 01/07/25 at 9:28 A.M. with Resident #92's family member reported Resident #92 fractured her shoulder after a toilet transfer with staff assistance. She reported she and the resident informed facility management of the fall and injury and reported management staff told the resident she just bumped into the wall and injured herself. Interview on 01/07/26 from 11:30 A.M. to 5:00 P.M. with the Director of Nursing (DON) and Regional Nurse #899 revealed Resident #92 was admitted for about three weeks and was found to be alert and oriented during her admission. They named a specific nurse (RN #505) and nurse aide (CNA #592) who were knowledgeable about Resident #92 and made statements that after the resident bumped into the wall. The DON and Regional Nurse #899 were unable to state whether staff were present when the injury occurred. They stated it was not an unknown injury as the resident stated she bumped her shoulder on the wall. The facility completed a risk assessment that documented the resident bumped her arm on the wall while going to the bathroom. They confirmed the incident was not on the incident accident log and was not investigated thoroughly. They confirmed they had not obtained staff statements and had no evidence in the resident's medical record related to the cause of the fall. They were unable to explain the discrepancy in what resident and family reported and what facility had documented. Interview on 01/07/26 at 1:52 P.M. with Resident #92 reported she was being assisted in the bathroom by an female aide when she fell and banged into the wall and hurt her shoulder. She stated the staff member ran out and grabbed a nurse who assessed her for injuries. Resident #92 could not recall the individual staff members' names who were involved. Interviews on 01/07/26 from 2:02 P.M. to 2:08 P.M. with RN #505 and CNA #592 revealed neither staff remembered Resident #92 and did not remember a resident situation of getting a resident getting a fracture from an incident with a bathroom transfer. This deficiency represents non-compliance related to Complaint Number 1376013 (OH00164696).

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0778 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Help the resident make transportation arrangements to and from radiology services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of a concern form, review of written statements, staff interview, and policy review, the facility failed to ensure adequate transportation was provided to residents for outside appointments. This affected one (#96) of three residents reviewed for transportation to outside appointments. The census was 80.Findings include:Review of the medical record for Resident #96 revealed an admission date of 10/03/24. Diagnoses included acute chronic systolic heart failure, type II diabetic mellitus morbid obesity, chronic respiratory failure, and major depression bipolar disorder. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #96 was cognitively intact and was dependent on staff for toileting, showers/bath, putting on footwear, and turning side-to-side in bed. She used a wheelchair to transfer throughout the facility. Review of the nursing progress notes for Resident #96 confirmed she had multiple appointments arranged outside the facility. On 04/03/25, she was scheduled for a positron emission tomography (PET) scan and missed the appointment due to location error. On 04/16/25, Resident #96 was notified of new appointment for a PET scan scheduled for 06/02/25. Review of Resident #96's after visit summary from a cardiologist appointment dated 04/03/25 revealed the resident was scheduled for her PET scan at a testing location in Columbus, Ohio with the test time of 2:00 P.M. Review of the physician order entered into Resident #96's medical record revealed the PET scan was on 04/16/25 at a different testing location in [NAME], Ohio at 1:30 P.M. Review of a concern form completed by the Administrator revealed on 04/03/25, Resident #96 was taken to the wrong testing center for a PET Scan. The test had to be rescheduled.Review of a statement by the Administrator dated 04/16/25 confirmed a transportation mistake was made for Resident #96's appointment on 04/03/25. Resident #96 and her spouse contacted the facility to arrange for pick up from the wrong location. Her appointment was rescheduled.Interviewed with the Administrator on 01/12/25 at 10:00 A.M. confirmed Resident #96 was taken to the wrong location, and Administrator Assistant #596, worked with the resident to ensure she was returned to the facility as soon as possible. Resident #96 and her spouse did not wait for transportation to pick them up and decided they would walk back to the facility. Review of facility policy and procedure titled, Transportation, dated 08/24, revealed it was the policy of the facility to arrange and ensure transportation was provided for doctors and specialist appointments. The facility will receive the appointment information from the resident, family, transportation company or doctor's office, and the facility will schedule transportation to and from the appointment as needed.This deficiency represents non-compliance investigated under Complaint Number 2572222, Complaint Number 1376015 (OH00165472), and 1376014 (OH00165055).

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on medical record review, review of a concern form, and staff interview, the facility failed to ensure dental services were provided in a timely manner. This affected one (#8) of two residents reviewed for dental services. The facility census was 80.Findings include: Review of Resident #8's medical record revealed an admission date of 08/01/25 and medical diagnoses of chronic obstructive pulmonary disease, hemiplegia, congestive heart failure, major depressive disorder, anxiety disorder, dementia, unspecified hallucinations, and muscle weakness. Review of Resident #8's concern form dated 10/30/25 revealed the resident filed a concern form reporting that his teeth (dentures) were missing. Further review of the concern form revealed Resident #8's dentures were found broken and lodged in the toilet. The guardian was notified on 11/04/25 and indicated they would contact the dental company for Resident #8 to be seen by the dentist. Review of Resident #8's care plan dated 11/03/25 revealed to monitor and notify the medical provider as needed of signs and symptoms of oral/dental problems such as pain, toothache abscess, debris in the mouth, lips cracked or bleeding, teeth missing or loose, or broken or eroded teeth. Further review of the care plan revealed the facility documented they would coordinate arrangements for dental care and transportation as needed/ordered for Resident #8.Review of progress notes dated from 11/05/25 to 01/07/26 revealed no documentation of dental visits for Resident #8. Further review of the progress notes also revealed no documentation of contact attempts to Resident #8's guardian regarding dental care. Interview on 01/08/26 at 11:23 A.M. with Social Service Director (SSD) #610 confirmed that no guardian contact attempts were documented in Resident #8's medical record from the dated of 11/04/25 to 01/07/26. SSD #610 stated in order for Resident #8 to receive dental care at the facility, the guardian was required to complete the dental consent form. SSD #610 stated Resident #8's guardian was last contacted on 11/12/25 and given information on the consent form, but confirmed there was no documentation of that in the medical record. SSD #610 confirmed the guardian had not been contacted between 11/12/25 and 01/07/26. SSD #610 stated they are unaware if the facility has a policy on the number of times a guardian should be contacted to resolve resident issues.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, resident and staff interview, and policy review, the facility failed to ensure shared glucometers were appropriately disinfected after use and failed to ensure staff wore required personal protective equipment while providing care for residents on infection control precautions as ordered. This directly affected two (#54 and #21) of two residents observed for infection control practices and had the potential to affect eight (#2, #42, #53, #8, #5, #82, #38, and #34) additional residents residing on the Blarney Stone Hall who utilize the shared glucometer. The facility census was 80.Findings include:1. Medical record review for Resident #54 revealed an admission date of 11/13/25 and medical diagnoses of respiratory failure with hypoxia, diabetes type II, metabolic encephalopathy, hepatic encephalopathy, cirrhosis of the liver, alcohol abuse, opioid dependency, insomnia, chronic viral hepatitis B, and chronic viral hepatitis C. Review of Resident #54's care plan last revised 11/24/25 revealed the resident had an alteration in gastrointestinal status due to hepatic encephalopathy, cirrhosis of the liver, and history of hepatitis B and C. Interventions included to obtain and monitor laboratory and diagnostic work as ordered, and report any abnormalities to medical provider. Observation on 01/07/26 at 1:06 P.M. revealed Licensed Practical Nurse (LPN) #562 checked Resident #54 blood glucose with a shared facility glucometer. LPN #562 then cleaned the glucometer with an alcohol wipe. Interview on 01/07/26 at 1:06 P.M. with LPN #562 confirmed the blood glucose monitor was cleansed with an alcohol wipe. Review of the undated facility policy titled, Shared Glucometer Cleaning Protocol, revealed to use a fresh approved low level disinfectant wipe each time the glucometer is used. Interview on 01/07/26 at 4:03 P.M. with Regional Nurse #899 confirmed the facility policy regarding cleaning glucometers and stated cleaning the shared glucometer with an alcohol wipe would not prevent blood illnesses, such as hepatitis. 2. Review of the medical record for Resident #21 revealed an admission date of 10/16/25. Diagnoses included atrial fibrillation, chronic obstructive pulmonary disease, diabetes, dysphagia, and cognitive communication deficit. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #21 had moderately impaired cognition. Review of Resident #21's physician order dated 12/16/25 to 01/05/25 revealed the resident was ordered contact isolation precautions due to Clostridioides difficile (C.diff) infection. Observation on 01/05/26 at 1:30 P.M. of the outside of Resident #21's room revealed a sign reading, Contact Precautions, with instructions for staff to put on gloves and a gown before room entry. At this time Respiratory Therapist #506 entered the room without donning any personal protective equipment (PPE) prior to entry. Observation and interview on 01/05/26 at 1:55 P.M. revealed Certified Nurse Aide (CNA) #588 was (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	actively performing incontinence care for Resident #21. CNA #588 did not have a gown on during the task and her scrub top was visible. CNA #21 confirmed staff should be wearing personal protective equipment (PPE) in the room, but had to read the sign on the door to identify what PPE was required and for which resident after exiting the resident's room. Resident #21 also confirmed CNA #588 did not have any gown on when proving him care. Interview and observation on 01/05/26 at 2:02 P.M. with Unit Manager #564 revealed Resident #21 had been in contact isolation due to having C.diff diagnosis, and should be coming out of isolation this date as the isolation order had been discontinued. During interview staff came up and handed Unit Manager a sign for enhanced barrier precautions to be placed on the door for staff to follow. Review of facility policy titled, Standard Precautions, dated 08/2022, revealed contact precautions were intended to prevent transmission of infections spread by direct contact or indirect contact and required the use of appropriate personal protective equipment and required the use of gown or gloves upon entering the resident environment. This deficiency represents non-compliance investigated under Complaint Number 1376016 (OH00166478).