| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365738 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/12/2026 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Ayden Healthcare of Fairfield | 3801 Woodridge Boulevard<br>Fairfield, OH 45014 |

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) |
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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, resident interview, resident representative interview and staff interview, the facility failed to ensure resident or resident representative received notification/invitation to participate in care conferences. This affected three residents (#12, #5, #36) of three residents reviewed for communication of care. The facility census was 72. Findings include:1. Medical record review for Resident #5 revealed an admission on [DATE] with diagnoses including but not limited to congestive obstructive pulmonary disease, anxiety, hemiplegia and hemiparesis, abnormal posture and bilateral osteoarthritis.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] for Resident #5 revealed intact cognition. Resident #5 required set up assistance for eating, maximum assistance for toileting, transfers and bathing. Review of the plan of care for Resident #5 revealed resident is a full code. Interventions include education of the resident and responsible party as needed and review and revision of advance directives as needed. Review of the facility face sheet for Resident #5 revealed resident was responsible party with two emergency contacts. Resident #5 emergency contact #1 was documented to be the power of attorney. Review of the facility care conference signature sheet dated 11/04/25 revealed Resident #5 or Resident Representative for Resident #5 was not on the sheet as care conference attendees. Review of the progress notes dated 10/10/25 to 01/08/25 was silent for documentation that the family was notified of the quarterly care conference. Interview on 01/06/25 at 12:25 P.M. with Resident #5 stated one time the facility called the daughter, and they talked with her on the phone but other than that, we have not been invited to a care conference or told when the care conferences are. Observation on 01/06/25 at 12:30 P.M. of Resident #5 placing a call to her daughter and questioning her about invitations related to care conferences. Resident #5's daughter also stated she has not received any information regarding care conferences for Resident #5.Interview on 01/06/25 at 12:33 P.M. with the Director of Nursing (DON) verbalized knowledge of Resident #5's family member wanting to be notified of the next care conference. The DON stated Resident #5's family member reported she has not been notified of recent care conferences or called to participate in the reviews. Interview on 01/06/25 at 1:50 P.M. with the Administrator verified the facility does not have any documentation related to the notification or invitations sent to residents or resident representatives to participate in the care conferences. 2. Review of the medical record for Resident #36 revealed an admission on [DATE] with diagnoses of type two diabetes mellitus, morbid obesity, depressive disorder, panic disorder and anxiety. Review of the admission MDS assessment dated [DATE] for Resident #36 revealed an intact cognition. Resident #36 required set up assistance for eating, toileting, bed mobility and transfers. Review of the progress notes dated 10/31/25 to 12/09/25 was silent for documentation related to the notification of the resident or resident representative invitation to participate in the care conference. Interview on 01/06/25 at 11:19 A.M. with the DON verified the facility does not have any documentation related to<br><br>(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: 365738 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/12/2026 |
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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | the notification or invitation to participate in the care conferences for Resident #36 and should have. Interview on 01/06/25 at 1:50 P.M. with the Administrator verified the facility does not have any documentation related to the notification or invitations to participate in the care conferences for Resident #36 and should have.Interview on 01/06/26 at 4:10 P.M. with Resident #36 stated he was not notified of invited to participate in the care conference. 3. Medical record review for Resident #12 revealed an admission on [DATE] with diagnoses including but not limited to hypertension, congestive obstructive pulmonary disease and stroke. Review of the quarterly MDS dated [DATE] for Resident #12 revealed an impaired cognition. Resident #12 required set up assistance for eating and moderate assistance for bed mobility transfers and toileting. Review of the plan of care for Resident #12 revealed resident had impaired cognitive functioning and thought processes related to impaired decision making. Interventions included administration of medications as ordered, communicate with the resident and family regarding resident capabilities and needs. Review of the facility face sheet for Resident #12 revealed the resident was her responsible party with three emergency contacts. Review of the progress notes for Resident #12 dated 10/23/25 to 01/08/25 was silent for any documentation the resident of resident representative was notified of the quarterly care conference. Interview on 01/06/25 at 9:18 A.M. with Resident #12 stated the facility will let his family know if something is going on with his health. Resident #12 was unable to recall if he received notification of care conferences being held or that he was invited to participate. Interview on 01/06/25 at 11:19 A.M. with the DON verified the facility does not have any documentation related to the notification or invitation to participate in the care conferences for Resident #12 and should have.Interview on 01/06/25 at 1:50 P.M. with the Administrator verified the facility does not have any documentation related to the notification or invitations to participate in the care conferences for Resident #12 and should have. |

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| NAME OF PROVIDER OR SUPPLIER Ayden Healthcare of Fairfield | | STREET ADDRESS, CITY, STATE, ZIP CODE 3801 Woodridge Boulevard Fairfield, OH 45014 | |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, and staff interview the facility failed to follow physician orders for blood glucose monitoring. This affected one resident (#36) of three reviewed for glucose monitoring. The facility census was 72.Findings include: Review of the medical record for Resident #36 revealed an admission on [DATE] with diagnoses of type two diabetes mellitus, morbid obesity, depressive disorder, panic disorder and anxiety. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] for Resident #36 revealed an intact cognition. Resident #36 required set up assistance for eating, toileting, bed mobility and transfers. Resident #36 received insulin injections during the assessment period. Review of the discharging physician orders for Resident #36 dated 10/27/25 from the previous long term care facility revealed an order dated 10/01/25 for blood sugar monitoring two times a day. Review of the admission physician orders for Resident #36 dated 10/31/25 was silent for blood sugar monitoring.Review of the active physician orders for Resident #36 revealed an order dated 12/04/25 for a fasting blood sugar daily. Interview on 12/09/25 at 2:30 P.M. with the Director of Nursing (DON) verified the fasting blood sugar monitoring was not transcribed into the electronic health record on admission and should have been. The DON verified Resident #36 did not have blood sugar checks completed from admission on [DATE] until 12/04/25 when the order for a fasting blood sugar daily was written. This deficiency represents non-compliance investigated under Complaint Number 2662752. |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, resident interview, staff interview, and policy review the facility failed to ensure staff offered and documented refusals to provide incontinent care to dependent residents. This affected one resident (#5) of three incontinent residents reviewed for activities of daily living. The facility census was 72.Findings include:Medical record review for Resident #5 revealed an admission on [DATE] with diagnoses including but not limited to congestive obstructive pulmonary disease, anxiety, hemiplegia and hemiparesis, abnormal posture and bilateral osteoarthritis.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] for Resident #5 revealed intact cognition. Resident #5 required set up assistance for eating, maximum assistance for toileting, transfers and bathing. Resident #5 is incontinent of bowel and bladder. Review of the plan of care for Resident #5 revealed resident has a self-care deficit related to left sided weakness. Interventions include the use of stand up lift with two staff members and requires maximal assistance for toileting hygiene. Review of the plan of care for Resident #5 revealed bladder and bowel incontinence. Interventions include the application of barrier cream after perineal care, medication as ordered, use of disposable briefs and monitoring for urinary tract infections. Review of the active physician orders for Resident #5 were silent for any toileting orders. Review of the electronic health record for bladder continence documentation dated 11/10/25 to 12/09/25 for Resident #5 revealed the resident was incontinent daily with only four documented continent episodes. Review of the electronic health record for behaviors dated 12/08/25 to 01/05/26 for Resident #5 was silent for any refusal or rejection of care. Review of the electronic health record for toileting task (how the resident uses the toilet, cleanses self after elimination, changes incontinent pad, and adjust clothing) for Resident #5 dated 12/08/25 to 01/05/25 revealed a check mark indicating the task did not occur on 12/08/25, 12/09/25, 12/11/25, 12/20/25, 12/22/25, 01/02/26 or 01/04/26. Additionally, the documentation revealed Resident #5 completed task with only supervision on 12/10/25, 12/15/25, 12/18/25, 12/19/25, 12/24/25, 12/25/25, 12/26/25, 12/30/25, 12/31/25 and 01/01/26. Observation on 01/06/25 10:00 A.M. of Certified Nurse Assistants (CNA) #38 and #4 enter Resident #5 room and offer to take the resident to the toilet. Resident #5 refused care.Observation on 01/06/25 from 10:00 A.M. to 12:15 P.M. revealed no other attempts were made to provide care for Resident #5 after refusal. Interview on 01/06/25 at 10:46 A.M. with Assistant Director of Nursing (ADON) verified the electronic health documents related to toileting for Resident #5 were incomplete. The ADON verified occasional documentation in nurses notes lack information of what task the resident was refusing and should have been included. The ADON verified the facility did not have any other documentation that the staff was offering the resident assistance to toileting and she was refusing. The ADON verified the facility has daily documentation that the Resident #5 is incontinent but lacks documentation that incontinent care was provided on those days.Interview on 01/06/25 at 11:00 A.M. with the Director of Nursing (DON) verified the medical record documentation for Resident #5 failed to include information related to staff offering the resident to be assisted to the bathroom for incontinent care and the resident refusing assistance with toileting. Interview on 01/06/25 at 4:44 P.M. with Resident #5 revealed resident dressed in jeans, slippers, coat scarf, and hat. Resident #5 has large wet area on jeans from perineal area to mid thighs. Resident #5 reports that she just came in from outside after smoking. Resident #5 reports that staff do not come outside to remind her or offer toileting and she has been in and out of the facility all day. Resident #5 states she can not transfer herself from the wheelchair to the commode due to stroke and left-sided weakness.<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the facility policy titled Activities of Daily Living, dated 08/2025 revealed the facility failed to follow the policy as written. Under number 4, the facility states if residents with cognitive impairment or dementia resist care, staff will attempt to identify the underlying cause of the problem and not just assume the resident is refusing or declining care. Approaching the resident in a different way, at a different time or having another staff member speak with the resident may be appropriate. This deficiency represents non-compliance investigated under Complaint Number 2630086. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview the facility failed to ensure staff followed physician orders for medication administration. This affected two (#36, #43) residents of three reviewed for medication administration. The facility census was 72. Findings include:1. Review of the medical record for Resident #36 revealed an admission on [DATE] with diagnoses of type two diabetes mellitus, morbid obesity, depressive disorder, panic disorder and anxiety. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] for Resident #36 revealed an intact cognition. Resident #36 required set up assistance for eating, toileting, bed mobility and transfers. Review of the plan of care for Resident #36 revealed resident had an alteration in mood with little interest in doing things, trouble sleeping related to anxiety and depression. Interventions include administration of medications as ordered, behavioral health consults as needed and recommend the buddy system with care. Review of the physician orders for Resident #36 revealed an order dated 10/31/25 for Clonazepam 2 milligram (mg), one tablet every night and an order dated 10/31/25 for Clonazepam 1 mg, one tablet every morning. Review of the Medication Administration Record (MAR) for November 2025 for Resident #36 revealed Clonazepam was administered as ordered two times a day. Review of the controlled narcotic count sheet for Resident #36 dated 10/23/25 to 11/02/25 Clonazepam 1 mg tablet was not administered as ordered on 11/02/25.Review of the e-care triage note dated 11/03/25 for Resident #36 revealed a nurse practitioner was notified of needing a refill prescription for Clonazepam. The request was for a three-day prescription for Clonazepam 1 mg tablet in the morning and 2 mg (two 1 mg tablets) at bedtime was sent. Further review of the document revealed Resident #36 received the last available Clonazepam 1 mg tablet in the P.M. of 11/02/25. Review of the controlled narcotic count sheet for Resident #36 dated 11/03/25 to 11/22/25 revealed Clonazepam 1 mg tablet was administered as two separate doses on 11/09/25 at bedtime. Review of Resident #36's controlled narcotic count sheets from 11/03/25 to 11/30/25 revealed the Clonazepam 2 mg tablet ordered for Resident #36 at bedtime was not signed out as administered on 11/08/25, 11/10/25, and 11/17/25. Additionally, Clonazepam 2 mg was signed out as administered on 11/24/25, 11/26/25, 11/28/25, and 11/30/25 for the A.M. dose.Interview on 01/05/26 at 4:10 P.M. with Resident #36 stated the nurses provided Clonazepam on 11/02/25 at night, but it was not the correct dose. Additionally, Resident #36 stated the facility did not have the dose for the 11/03/25 A.M. dose and were waiting for the Nurse Practitioner to call in the prescription. Interview on 01/06/26 at 4:20 P.M. with the Director of Nursing (DON) verified the Clonazepam for Resident #36 was not administered as ordered on 11/03/25, 11/08/25, 11/09/25, 11/10/25, 11/17/25, 11/24,25, 11/26/25, 11/28/25, and 11/30/25. The DON verified multiple administration errors had occurred with the administration of Resident #36's Clonazepam.2. Medical record review for Resident #43 revealed an admission on [DATE] with diagnoses including but not limited to chronic obstructive pulmonary disease, respiratory failure and anxiety disorder. Review of the admission MDS assessment for Resident #43 dated 10/31/25 for revealed an impaired cognition. Resident #43 required set up and supervision for eating, bed mobility, transfers, and toileting. Resident #43 was coded as receiving antianxiety medications during the assessment period. Review of the plan of care for Resident #43 revealed resident received antianxiety medication. Interventions included medication as ordered, monitor and document side effects, consult with pharmacy to consider dose reduction and psychology services as needed. Review of the active physician orders for Resident #43 revealed an order dated 11/14/25 for Xanax 1 mg by mouth three times a day for anxiety. Review of the MAR for the month of November 2025 for Resident #43 revealed the Xanax was signed as administered as ordered. Review of Resident #43's<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | controlled drug administration record dated 11/15/25 to 11/29/25 revealed Xanax 1 mg was administered on 11/16/25 at 6:00 A.M., 9:00 A.M., 2:00 P.M. and 9:00 P.M., on 11/17/25 at 9:00 A.M. and 10:00 P.M., on 11/19/25 at 6:00 A.M., 9:00 A.M., 2:00 P.M. and 9:00 P.M., on 11/20/25 at 6:00 A.M., 2:00 P.M., 8:00 P.M., and 12:00 A.M., on 11/21/25 at 10:00 A.M. and 9:00 P.M., on 11/22/25 at 6:00 A.M., 9:30 A.M., 2:00 P.M., and 9:00 P.M., and on 11/23/25 at 2:00 P.M. and 10:00 P.M. Interview on 01/06/26 at 4:20 P.M. with the Director of Nursing (DON) verified Xanax for Resident #43 was not administered as ordered. The DON verified multiple administration errors related to the administration of the Xanax to Resident #43 had occurred on 11/16/25, 11/17/25, 11/19/25, 11/20/25, 11/21/25, 11/22/25 and 11/23/25. Review of the facility policy titled Administration Procedures for all Medication, dated 08/2020 revealed the facility failed to follow the policy. Under roman numeral number two the facility staff will complete the five rights of medication when administering prescribed medication. This deficiency represents non-compliance investigated under Complaint Number 2662752. |

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| F 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.<br><br>Based on observation, and interview, the facility failed to ensure shower room equipment was clean and in good repair. This had the potential to affect 17 residents (#2, #5, #12, #13, #16, #29, #33, #38, #42, #43, #46, #48, #55, #62, #63, #71, #72) who the facility identified a using the shower room on the second floor. The facility census was 72.Findings include:Observation on 01/05/25 at 3:50 P.M. of the second-floor shower room revealed a single shower chair with a non-movable toilet seat. Under the toilet seat was a section of polyvinyl chloride (PVC) white pipe covered with brown smeared matter. Interview on 01/15/25 at 3:55 P.M. with Licensed Practical Nurse (LPN) #28 verified the chair was cleaned and the brown smeared matter was fecal matter. LPN #28 verified that the shower room and equipment should be cleaned after each use.Observation and interview on 01/09/26 at 11:10 A.M. of the shower room with the Director of Nursing (DON) revealed the staff providing the shower are responsible to cleaning the equipment between residents. This deficiency represents non-compliance investigated under Complaint Number 2630086. |