

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365741	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Ashtabula County Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 5740 Dibble Road Kingsville, OH 44048	
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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and policy review, the facility failed to ensure triggers were addressed for residents with post-traumatic stress disorder (PTSD). This affected four (#3, #11, #76 and #81) of four residents reviewed for trauma informed care. The facility identified four residents (#3, #11, #76 and #81) as having a diagnosis of PTSD. The facility census was 104. Findings include: 1. Review of the medical record for Resident #11 revealed an admission date of 11/13/25 with pertinent diagnoses included post-traumatic stress disorder (PTSD), vascular dementia, psychotic disturbance and anxiety. Review of the quarterly minimum data set (MDS) 3.0 assessment dated [DATE] revealed Resident #11 had moderate cognitive deficits, physical behavioral symptoms directed towards others occurring one to three days in the seven day look back period and verbal behavioral symptoms directed towards others occurring four to six days in the seven day look back period. The assessment indicated Resident #11 had a diagnosis of PTSD. Review of the care plan dated 05/29/26 revealed Resident #11 had moderate depression and recently had an inpatient psychiatric stay for medication management related to psychiatric issues and behaviors. Diagnoses included PTSD, altered mental status and depression. No triggers were identified in the care plan and there were no interventions to address PTSD related triggers. An interview on 07/08/26 at 11:04 A.M. with Certified Nurse Aide (CNA) #236 revealed she did not know Resident #11 had PTSD and was unaware of what triggered any behaviors for Resident #11. An interview on 07/08/26 at 11:11 A.M. with Licensed Practical Nurse (LPN) #294 revealed she did not know Resident #11 had PTSD and was unaware of what triggered any behaviors for Resident #11. An interview of 07/08/26 at 1:00 P.M. with LPN #282 who was identified as the Unit Manager for Resident #11 revealed she was aware Resident #11 had PTSD and his triggers were loud noises from his military service. LPN #282 stated the wife of Resident #11 informed her of the triggers. LPN #282 stated resident information regarding triggers and PTSD was passed on in report via the floor nurse. LPN #282 verified the lack of triggers in the care plan of Resident #11 within the medical record. LPN #282 stated care plans should be developed to inform staff of potential triggers. 2. Review of the medical record revealed Resident #3 was admitted to the facility on [DATE] with (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
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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	pertinent diagnoses including post-traumatic stress disorder (PTSD), and major depressive disorder. Review of Resident #3's care plan, last revised 04/27/26, revealed Resident #3 was at risk for a decline in mood related to PTSD, anxiety and depression. There was no documentation to address PTSD triggers or interventions for triggers related to PTSD. Review of the quarterly MDS 3.0 assessment dated 06/23 /26 revealed Resident #3 had intact cognition, inattention which fluctuated in severity, and a diagnosis of PTSD. Further review of the medical record for Resident #3 revealed a quarterly PTSD assessment was not completed. An interview on 07/08/26 at 9:25 A.M. with Unit Manager (UM) #286 revealed she was the unit manager on Resident #3's unit and did not know any of the residents' PTSD related triggers. An interview on 07/09/26 at 11:37 A.M. with the Assistant Director of Nursing (ADON) #202 confirmed there were no PTSD and trauma-related triggers in Resident #3's care plan. An interview on 07/09/26 at 1:42 P.M. with ADON #202 revealed quarterly PTSD assessments were not completed by the facility for Resident #3. 3. Review of the medical record revealed Resident #76 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, post-traumatic stress disorder (PTSD), obsessive compulsive disorder (OCD), bipolar disorder, major depressive disorder, anxiety, and unspecified psychosis due to substance or known physiological condition. Review of the quarterly MDS assessment dated [DATE] revealed Resident #76 had severe cognitive impairment, inattention which fluctuated in severity, displayed physical behaviors toward others one to three days, and had a diagnosis of PTSD. Record review of the psychiatric evaluation dated 06/24/25 revealed Resident #76 had a history of dementia, bipolar disorder, anxiety, major depressive disorder, OCD, PTSD, and psychosis. The evaluation revealed Resident #76's cognition was impaired at baseline and the resident's OCD, anxiety, and agitation symptoms were at baseline. The psychiatric provider recommended continued monitoring for mood and behavioral changes. Record review of Resident #76's care plan, date initiated 04/09/18 and last revised 07/09/26, revealed no documentation related to PTSD, trauma history, triggers, calming strategies, individualized interventions, or approaches for staff to provide trauma-informed care. An interview on 07/08/26 at 9:25 A.M. with LPN #291 revealed Resident #76's PTSD was related to childhood trauma. LPN #291 confirmed she was not aware of any triggers for Resident #76 and stated the resident's behaviors were managed well with medications and psychiatric visits. An interview on 07/09/26 at 11:37 A.M. with ADON #202 confirmed in order to provide care according (continued on next page)		

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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 record review, and interview the facility failed to ensure staff treated residents with respect and dignity. This affected one resident (Resident #57) out of four residents reviewed for dignity. The facility census was 104. Findings include: Review of the medical record for Resident #57 revealed an admission date of 06/08/24. Diagnoses included atrial-fibrillation, hearing loss, and acute and chronic respiratory failure with hypoxia. Review of the Annual Minimum Data Set (MDS) assessment, dated 04/28/26, revealed the resident had moderately impaired cognition. The resident required maximum assist for showers/bathing. Touching assist was needed for lower body dressing. The Resident needed set up or clean up assist for lying to sitting, chair to bed transfers, and toilet transfer. Review of the Health Status Note dated 05/28/26 at 4:00 P.M. revealed Resident #57 reported an incident to the Director of Nursing (DON) with the resident's granddaughter present in the room. During care, Certified Nursing Assistant (CNA) #249 was assisting Resident #57 to get dressed for the day and he felt her demeanor was rude and made a comment that upset him. Agency CNA #249 was placed on a do not return (DNR) list. The DON called the resident's daughter and spoke briefly about the situation over the phone. The daughter, social service designee, Resident #57, and DON attended a care plan meeting on 05/28/26 at 2:30 P.M. and the incident was reviewed again. Review of the interview statement with Resident #57 on 05/28/26 revealed Resident #57 reported to the DON in the morning that CNA #249 came into his room to get him dressed for the day. When she was assisting him with changing his shirt, he went to grab her hand to get help to sit up and CNA #249 replied, Don't touch me. Resident #57 indicated the CNA acted rude towards him and was not very nice during the interaction. Review of a statement from CNA #249 dated 05/28/26 revealed that CNA #249 reported to the DON that during her interaction with Resident #57 he pulled her down when reaching for her arm. CNA #249 denied saying Don't touch me. CNA #249 stated It didn't go like that. He pulled me down; told him don't pull me like that. CNA #249 demonstrated putting her hands up. CNA #249 was notified she was DNR from the facility. An interview on 07/08/26 at 9:24 A.M. with Resident #57 revealed he remembered the incident on 05/28/26 with CNA #249. Resident #57 stated he felt CNA #249 was rude and yelled something, but he could not remember what was said. Resident #57 stated she did not swat at or hit him. Resident #57 did not indicate he felt abused by CNA #249. An interview on 07/08/26 at 5:12 P.M. with the Administrator verified Resident #57 reported CNA #249 was rude and made a comment that upset him on 05/28/26. The Administrator stated the facility will DNR any agency staff that do not behave as expected. The Administrator stated CNA #249's behavior was disrespectful but not abusive and when they met with the family on 05/28/26 the family was very happy with how the facility handled the follow-up on Resident #57's concern.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Oxygen tubing: Based on observation, interview, record review and review of facility policy, the facility failed to ensure a nebulizer mask was stored in a manner to prohibit contamination. This affected one (Resident #17) of one resident reviewed for respiratory care. The facility census was 104. Findings include: Review of the medical record for Resident #17 revealed an admission date of 10/21/22 with diagnoses including Chronic Obstructive Pulmonary Disease (COPD) and chronic respiratory failure with hypoxia. Review of the quarterly minimum data set (MDS) 3.0 assessment dated [DATE] revealed Resident #17 had severe cognitive impairment. The assessment also revealed the primary medical condition for Resident #17 was COPD. The assessment revealed Resident #17 had shortness of breath with exertion and lying flat and was on oxygen therapy. Review of the care plan dated 04/29/26 revealed Resident #17 had an altered respiratory status. Interventions included administer medication and puffers as ordered. Review of physician orders dated July 2026 revealed active orders for oxygen at three liters per minute via nasal cannula continuously, and ipratropium-albuterol inhalation solution 0.5-2.5 milligrams/3 milliliters, Inhale 3 milliliters via nebulizer every six hours as needed for shortness of breath and or wheezing. Observation on 07/06/26 at 2:46 P.M. revealed the nebulizer mask (the mask that sits over the resident's nose and mouth to deliver an aerosolized medication mist into the airways/lungs) for Resident #17 was sitting directly on and touching the bedside table next to the nebulizer machine. The mask was not in a storage bag to protect against contamination nor was it dated as to when it was last changed. Further observation on 07/07/26 at 11:21 A.M. revealed the nebulizer mask for Resident #17 was again sitting directly on and touching the bedside table lying next to the nebulizer machine. The mask was not in a storage bag to protect against contamination nor was it dated as to when it was last changed. Licensed Practical Nurse (LPN) #295 was present during the observation and verified the nebulizer mask was on the bedside table and it was uncovered and without a date at the time of the observation. LPN #295 stated nebulizer masks are to be changed weekly on Tuesdays and dated. LPN #295 further stated the nebulizer mask was to be stored in a plastic bag when not in use to keep it safe from contaminants. Review of the undated facility policy titled Oxygen Tubing, Cannulas, and Nebulizers revealed when not in use, store oxygen and nebulizer tubing in a clean dry cool space away from direct sunlight dust and pets. Place tubing in a clean plastic bag or dedicated respiratory storage container when not in use.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and review of facility policy, the facility failed to ensure proper hand hygiene was performed during wound care. This affected one (Resident #8) of two residents reviewed for wound care. The facility census was 104. Findings include: Review of the medical record for Resident #8 revealed an initial date of admission of 04/09/19 and a readmission date of 05/03/23 with diagnoses including quadriplegia and chronic osteomyelitis unspecified (an infection affecting bone). Review of the quarterly minimum data set (MDS) 3.0 assessment dated [DATE] revealed Resident #8 was cognitively intact and had skin impairment of pressure areas. Review of the care plan dated 06/11/26 revealed Resident #8 was at risk for impaired skin integrity related to impaired mobility, catheter tubing, and quadriplegia. Interventions included check dressings to the coccyx and left ischial wounds, and wound care per order. Observation of wound care on 07/08/26 at 3:11 P.M. revealed three dressings for Resident #8 that were dry, intact and dated appropriately. Licensed Practical Nurse (LPN) #294 washed her hands with soap and water and donned gloves. LPN #294 then removed the old dressings to the right upper thigh and the left buttock area. LPN #294 then removed the soiled gloves and placed clean gloves on to finish wound care. LPN #294 did not wash her hands after removing the soiled gloves and placing the clean gloves on to complete wound care. LPN #294 verified she did not wash her hands after removing the soiled gloves and putting new gloves on to complete wound care. A review of the facility policy titled Hand Washing/Hand Hygiene dated 04/2010 revealed hand hygiene was the primary means to prevent the spread of infection. The policy further revealed employees must wash their hands for at least 20 seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: before and after direct contact with a resident, before and after assisting a resident with personal care, before and after handling peripheral vascular catheters or other invasive devices, before and after changing a dressing, and after removing gloves. The policy revealed hands should be washed before handling clean or soiled dressings, after handling soiled dressings and after removing gloves.		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and review of facility policy, the facility failed to ensure education was provided to residents on the influenza vaccine. This affected two (Resident #8 and #22) of five residents reviewed for immunizations. The facility census was 104. Findings include: 1. Review of the medical record for Resident #8 revealed an initial admission date of 04/09/19 and a readmission date of 05/03/23 with diagnoses including quadriplegia, chronic osteomyelitis, morbid obesity, bipolar disorder, and major depressive disorder. Review of the quarterly minimum data set (MDS) 3.0 assessment dated [DATE] revealed Resident #8 was cognitively intact and was administered the influenza vaccine. Review of the vaccine administration record within the medical record revealed Resident #8 received the influenza vaccine on 09/26/25 and no education was provided prior to the vaccine administration. 2. Review of the medical record for Resident #22 revealed an admission date of 12/21/24 with diagnoses including cerebral infarction, aphasia, hemiplegia and hemiparesis following a cerebral infarction. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #22 had a severe cognitive deficit and was administered the influenza vaccine. Review of vaccine administration record within the medical record revealed resident #22 received the influenza vaccine on 10/01/25 and no education was provided prior to the vaccine administration. An interview on 07/08/26 at 2:12 P.M. with Registered Nurse (RN) #202 who was identified as the infection preventionist for the facility verified Residents #8 and #22 had no record of education being provided to them or their responsible party prior to administration of the influenza vaccine. Review of the facility policy titled Vaccination of Residents dated 12/2008 revealed all residents will be offered vaccinations that aid in preventing infectious diseases unless the vaccine is medically contraindicated or the resident has already been vaccinated. The policy further stated prior to receiving vaccination the resident or legal representative will be provided information and education regarding the benefits and potential side effects of the vaccinations.		

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, review of the posted nurse staffing data report and staff interview, the facility did not ensure all required information was including on the posted nurse staffing report. This had the potential to affect all residents in the facility. The facility census was 104. Findings include: During the initial facility tour observations on 07/06/26 at 8:10 A.M. revealed the posted document, dated 06/07/26, titled Report of Nursing Staff Directly Responsible for Resident Care had only the number of nurses, number of nurse aides, the date, and census on it. The posting did not include the total number and actual hours worked per shift for licensed and unlicensed staff responsible for resident care. Review of the Report of Nursing Staff Directly Responsible for Resident Care dated 06/08/26 to 06/30/26 revealed none included the total number and actual hours worked per shift for licensed and unlicensed staff responsible for resident care. An interview on 07/07/2026 at 4:22 P.M. with Assistant Director of Nursing (ADON) #202 revealed she was responsible for creating the daily nursing staffing posting and was unaware of the regulation requirement of including the total number and actual hours worked. ADON #202 verified she had not been posting the hours as required but would do so going forward.		