STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365807	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Transitional Care Unit	200 St Clair Street Saint Marys, OH 45885

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview, review of the dishwasher sanitation logs, review of the manufacturer instructions and review of facility policy, the facility failed to ensure accurate dishwasher chemical sanitation to prevent foodborne illness. This had the potential to affect all four residents of the facility. The facility census was four. Findings include:Observation on 04/13/26 at 8:53 A.M. of the kitchen dishwasher operation with the Dietary Manager (DM) #114 revealed the dishwasher utilized chemical sanitation. Continued observation revealed the wash cycle water temperature was 120 degrees Fahrenheit (F) and the rinse cycle water temperature was 120 degrees F. The chemical sanitation testing strips used had a color key with corresponding parts per million (ppm) numerical indicators for the presence of specific chemicals, bacteria and pollutants. The color options were for 0 ppm, 200 ppm, 400 ppm, 600 ppm, 800 ppm and 1000 ppm. A placard observed on the dishwasher revealed wash and rinse water temperatures should be at a minimum 120 degrees F and 50 ppm chlorine for sanitation.Review of the dishwasher sanitation log from March 2026 through 04/13/26 revealed chlorine was documented daily to read 100 ppm.Interview on 04/13/26 at 8:57 A.M. with DM #114 confirmed the chemical test strips utilized by dietary staff did not have a reading correlating to 100 ppm. Furthermore, DM #114 verified the chemical test strips used to ensure adequate sanitation did not measure the chlorine ppm as indicated by the manufacturer.Review of the manufacturer guidelines for the dishwasher revealed to set the sanitizer concentrations to 50 ppm (Notice: Do not exceed 100 ppm). Monitor chlorine levels by using test strips.Review of the undated facility policy titled, Cleaning and Maintenance of Work Areas and Equipment, revealed employees must check the wash and rinse cycles to ensure they were running to correct temperatures and test the chlorine sanitizer ppm.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews the facility failed to provide discharge notification to the Ombudsman. This affected two (#1 and #8) of three residents reviewed for discharge. The facility census was four.Findings include:1. Review of medical record for Resident #1 revealed an admission date of 03/20/26. Diagnoses included wound dehiscence, osteoarthritis of the spine, anxiety, morbid obesity, and peripheral artery disease. Resident #1 discharged to home with home health services on 04/04/26.Review of the electronic medical record (EMR) revealed no evidence the Ombudsman was notified of the 04/04/26 discharge.2. Review of medical record for Resident #8 revealed an admission date of 3/18/26. Diagnoses included acute pancreatitis, depression, pancreatic cyst and obesity. The resident was discharged home on [DATE].Review of the EMR revealed no evidence the Ombudsman was notified of the 03/24/26 discharge.Interview on 04/13/26 at 3:55 P.M. with Clinical Manager (CM) #99 verified the facility did not have evidence the Ombudsman had been provided discharge notification for Resident #1 or Resident #8's planned discharges. CM #99 stated if a discharge was planned, notifications were not sent to the Ombudsman.Interview on 04/14/26 at 10:10 A.M. with the Administrator confirmed if a discharge was planned, the facility did not send a discharge notification to the Ombudsman.

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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, observation, staff interview and review of facility policy, the facility failed to ensure non-pressure ulcer wounds were thoroughly documented and further failed to ensure physician treatment orders were obtained. This affected one (#2) of two residents reviewed for wounds. The facility census was four.Findings include:Review of medical record for Resident #2 revealed an admission date of 03/26/26. Diagnoses included septic bacteremia, atrial fibrillation, hypertension and hyperlipidemia. Review of the admission Minimum Data Set (MDS) assessment, dated 04/08/26, revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. She required set up assistance for eating, maximum assistance for toileting hygiene and bed mobility and was dependent for transfers. Resident #2 had a surgical wound. Review of the admission assessment dated [DATE] revealed Resident #2 had a small incision to the left hand and a small incision to the left wrist with sutures. No further description of the wounds was documented.Review of the physician orders revealed no orders for wound treatment.Observation on 04/13/26 at 10:23 A.M. revealed Resident #2 was awake and seated in her recliner. A two by (x) two kerlix bandage wrapped with cotton gauze was observed to her left wrist. Concurrent interview with Resident #2 revealed she had an infection in her left wrist. Resident #2 stated the doctor lanced her hand and the infection was drained, then they cut her outer wrist and washed out the infection. Resident #2 stated she had stitches to her wrist, which were previously removed by nursing staff and her hand was healing well.Interview on 04/13/26 at 3:55 P.M. with Clinical Manager (CM) #99 revealed the facility did not do weekly measurements of wounds, aside from pressure ulcer wounds.Interview on 04/14/26 at 9:44 A.M. with Registered Nurse (RN) #113 revealed the treatment for Resident #2's left wrist wound was to apply mupirocin ointment (topical antibiotic), cover with a two x two gauze pad, cover with kerlix and secure with tape. RN #113 was unable to locate the physician order in the electronic medical record (EMR) and stated she was unsure where the specific treatment order came from. RN #113 explained she had gotten the information for wound care during the nursing report and stated she removed tape, kerlix and a two x two gauze pad when she went in to provide wound care for Resident #2's left hand and wrist. RN #113 stated the wrist wound sutures were removed and the area was closed and the hand wound was almost closed.Observation on 04/14/26 at 9:48 A.M. with RN #113 of Resident #2's left wrist and left hand wounds revealed an approximately 1.0 centimeter (cm) light scar to her left outer wrist and an approximate length of 0.6 cm x a width of 0.1 cm healing wound to her left hand.A follow-up interview on 04/15/26 at 9:28 A.M. with CM #99 verified there were no wound measurements or description of the wounds on Resident #2's left hand and wrist on the admission assessment. CM #99 confirmed the wound assessment documented sutures to the left wrist but there was no numerical value given for the sutures.Review of the undated facility policy titled, Transitional Care Unit Skin Assessment, Wound Care Prevention and Treatment, revealed upon admission of any resident, a thorough skin assessment would be completed by the admitting nurse and findings would be documented on the admission note. The policy also revealed treatment orders would be obtained by the assigned nurse and entered into the electronic medical record.