STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365813	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hawthorn Glen Nursing Center	5414 Hankins Road Middletown, OH 45044

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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 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, the facility failed to ensure resident funds were disbursed to the resident's estate within 30 days as required. This affected one (Resident #75) of six residents reviewed for funds. The facility census was 61.Findings include:Review of the medical record for Resident #75 revealed an admissions date of 06/21/24 with diagnoses including congestive heart failure, hypertension, and dementia. Resident #75 discharged from the facility on 04/30/25.Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #75 was severely cognitively impaired.Review of a Resident Funds Authorization, for Resident #75 dated 08/03/24, revealed the authorization was signed by Resident 75's responsible party. The authorization was also signed by two witnesses.Review of a check dated 07/29/25, revealed a check was written to Resident #75's estate for $35.12.Review of the Resident Funds Statement, for Resident #75 revealed the resident had a balance of $35.12 on 07/29/25 when the account was closed.Interview on 07/31/25 at 8:30 A.M. with Administrator #50 verified Resident #75 was discharged to the hospital on [DATE] and Resident #75's funds were not conveyed to the estate until 07/29/25.Review of the facility policy titled, Management of Personal Funds dated 08/01/23, revealed the facility will reconcile and close all accounts within thirty days of discharge.

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 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents a notice of rights, rules, services and charges. Based on resident interview, staff interview, and policy review the facility failed to ensure residents know their Resident Rights. This had the potential to affect 12 (Resident #20, Resident #23, Resident #13, Resident #55, Resident #42, Resident #14, Resident #60, Resident #57, Resident #39, Resident #63, Resident #5, and Resident #77) residents who attend the Resident Council meetings out of 61 residents. The facility census was 61.Findings include:Review of Resident Council Meeting monthly minutes from 08/24/24 to 07/25/25 revealed Resident Rights were not reviewed during Resident Council.Interview on 07/29/25 at 3:08 P.M with Resident #46, Resident #60, and Resident #13 confirmed Resident Rights were not reviewed during Resident Council and that they do not know where to find the resident rights.Interview on 07/29/25 at 3:30 P.M with Activities Director # 59 confirmed Resident Rights were not reviewed during resident council due to switching the resident council agenda forms.Review of policy titled Resident Council revealed the facility is designed to review resident rights.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and facility policy review, the facility failed to timely complete and submit a Self-Reported Incident (SRI) as required by the Ohio Department of Health, (ODH). This affected one resident (Resident #18) of five residents reviewed for SRI reporting. The facility total census was 61. Findings Include:Record review of Resident #18 revealed the resident was admitted to the facility on [DATE]. Diagnoses for Resident #18 include breast cancer, depressive disorder, and dysphagia. Review of the Minimum Data Set, (MDS) comprehensive assessment dated [DATE] revealed the resident had intact cognition and required moderate assistance for Activity of Daily Living skills.Review of the SRI reported on 04/11/25 to ODH, revealed the incident occurred on 04/11/25, and submitted as completed on 06/05/25. Review of the SRI investigation revealed the police were contacted on 06/05/25. Interview on 07/30/25 at 10:06 A.M., the Administrator and Director of Nursing, (DON) verified an occurrence, discovery date of 04/11/ 25, was reported as an SRI on 04/11/25. On 06/05/25, it was discovered by the DON that the completion date was not submitted to ODH. Additionally, the Administrator verified the police were contacted on 06/05/25, as there had been no police notification at the time of the investigation. The Administrator verified the final report should have been within five working days of the discovery of the incident. Review of the facility policy, Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property dated October 2024, revealed the facility will submit an on SRI in accordance with ODH instruction. The investigation will be completed within five working days and submitted to the ODH no later than five working days after discovery of the incident.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review , and facility policy review, the facility failed to thoroughly investigate a Self-Reported Incidents (SRI). This affected two residents (Residents #18 and #32) of five residents reviewed for SRI investigations. The facility total census was 61. Findings Include: 1. Record review of Resident #18 revealed the resident was admitted to the facility on [DATE]. Diagnoses for Resident #18 include breast cancer, depressive disorder, and dysphagia. Review of the Minimum Data Set, (MDS) comprehensive assessment dated [DATE] revealed the resident had intact cognition and required moderate assistance for Activity of Daily Living skills. Review of SRI dated 05/05/25 revealed the resident was found to have a bruise of unknown origin on her thumb. Review of staff investigations revealed no written staff statements of the incident. There were no resident interviews and non- verbal resident skin assessments. Review of SRI dated 06/29/25 revealed the resident alleged a staff person held down her hand. Review of staff investigations revealed no written staff statements of the incident. There were no resident interviews and non- verbal resident skin assessments. The investigation documentation included a staff education sign in sheet which was undated with no presenter and no topic listed.2. Record review of Resident #32 revealed the resident was admitted to the facility on [DATE]. Diagnoses for Resident #32 include metabolic encephalopathy, repeated falls. sepsis, Chronic Obstructive Pulmonary disease and hypertension. Review of the Minimum Data Set, (MDS) comprehensive assessment dated [DATE] revealed the resident had intact cognition and required extensive assistance for Activity of Daily Living skills.Review of SRI dated 05/20/25 revealed Resident #32 family representative reported an allegation of unknown origin bruises to the resident's torso. Review of the facility SRI investigation documents revealed there were no written staff and resident interviews. There were no nonverbal resident skin assessments. Interview on 07/31/25 at 1:30 P.M. the Administrator and Director of Nursing , (DON) verified the SRI investigations of Resident #18 dated 05/05/25 and 06/29/25, and Resident #32 SRI dated 05/20/25 did not show documented evidence of thoroughly investigated allegations of abuse. Review of the facility policy, Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property dated October 2024, revealed the facility will interview the residents, and all witnesses, including anyone who may have come in close contact with the resident or the accused employee. If allegation is injury of unknow source, the investigation will involve interviewing staff on shift when injury is discovered and prior shifts. Interviews include interviews of other residents to determine if they have been affected.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to timely initiate and complete Preadmission Screening and Resident Review, (PASRR). This affected four residents (Resident #57, # 74, 35 and #5) of six residents reviewed for preadmission screening. The facility total census was 61. Findings Include: 1.Record review of Resident #57 revealed the resident was admitted to the facility on [DATE]. Diagnoses for Resident #57 include hypertension, morbid obesity, diabetes, schizophrenia, depressive disorder and anxiety. Review of the Minimum Data Set, (MDS) comprehensive assessment dated [DATE] revealed the resident had intact cognition and required set up assistance with Activity of Daily Living skills. Review of PASRR documentation revealed no documenting of a PASRR screen prior to admission. A Level I PASRR was not completed and signed until 06/23/23. There was a Level II directed from the results of a 07/29 /25 PASRR submission due to a new diagnosis of schizoaffective and sexual behaviors on 02/22/22. 2. Record review of Resident #35 revealed the resident was admitted to the facility on [DATE]. Diagnoses for Resident #35 include cerebral atherosclerosis, chronic obstructive pulmonary disease, dementia, chronic kidney disease, hypertension, reflux, dysphagia, and abnormal weight loss. Review of the Minimum Data Set, (MDS) comprehensive assessment dated [DATE] revealed the resident had moderately impaired cognition and required moderate assistance with Activity of Daily Living skills. The resident received hospice services beginning on 12/01/24. Review of Resident #35 records revealed no PASRR hospice condition change submission and results. 3. Record Review of Resident #5 revealed the resident was admitted to the facility on [DATE]. Diagnoses for Resident # 5 include dementia, and anxiety. Review of the Minimum Data Set, (MDS) comprehensive assessment dated [DATE] revealed the resident had severely impaired cognition and required extensive assistance with Activity of Daily Living skills. The resident received hospice services starting on 10/26/24. Review of Resident #5 records revealed no PASRR hospice condition change submission and results. 4. Review of the medical record for Resident #74, revealed an admission date of 04/21/2018. Diagnoses included but were not limited to hemiplegia, type 2 diabetes, and dysphagia.Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 0 which indicates resident has severe cognitive impairment. The resident was assessed to require to be dependent for eating, dependent on staff for toileting, dependent on staff for showering and bathing, dependent on staff for dressing, and personal hygiene. The resident received hospice services beginning on 08/12/24. Review of Resident #74 records revealed no PASRR hospice condition change submission and results. Interview on 07/31/25 at 11:40 A.M. The Social Service Designee, SSD#6 verified Resident #57 had no PASRR prior to admission, and was it first filed on 06/23/23. SSD #6 verified there were no hospice change of status PASRRs completed timely for Residents # 35, #5 and #74. SSD #6 stated she completed a new PASRR on 07/29/25 for Resident #57 due to a PASRR audit and Resident #57 had diagnosis changes, which had not been submitted timely. The SSD #6 verified there were many PASRRs which were incomplete and/or missing from the previous SSD. SSD #6 stated diagnosis changes, hospice status and other declines in condition should be submitted within couple days of the change. Newly admitted residents should have PASRRs completed prior to admission or within 30 days of admission.

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F 0657 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and policy review the facility failed to ensure care conferences were completed quarterly for Resident #43. The facility census was 61.Findings include:Review of the medical record for Resident #43 revealed an admissions date of 07/31/23 with diagnoses including dysphagia, chronic obstructive pulmonary disease, major depressive disorder, and seizures.Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #43 is cognitively impaired.Review Resident #43's care conferences since admission revealed one was completed on 04/16/25.Interview on 07/31/25 at 11:26 A.M. with Director of Nursing (DON) # 96 verified that the only care conference completed for Resident #43 was on 04/16/25.Review of the facility policy titled Care Conferences, dated 01/2020 revealed care conferences will be scheduled as soon as possible after admission, routinely, and with a change in condition.This deficiency represents non-compliance investigated under Complaint Number 1388204.

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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** Based on record review, staff interview, and policy review the facility failed to obtain an order for oxygen therapy. This affected two residents (Resident #25 and Resident #51) out of three reviewed for oxygen therapy. The facility census was 61.Findings Include:1. Review of the medical record for Resident #25, revealed an admission date of 06/27/25. Diagnoses included but were not limited to acute kidney failure, sleep apnea, and asthma. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated revealed a Brief Interview for Mental Status (BIMS) of 15 indicates intact cognition. The resident was assessed to be independent for eating, oral hygiene, toileting, shower/bath independent, partial/moderate assistance dressing, and supervision or touching assistance for personal hygiene.2. Review of the medical record for Resident #51, revealed an admission date of 04/24/25. Diagnoses included but were not limited to acute respiratory failure, chronic obstructive pulmonary disease, and sepsis.Review of the most recent Quarterly Minimum Data Set (MDS) 3.0 assessment dated 06/1725 revealed a Brief Interview for Mental Status (BIMS) of 15 which indicates intact cognition. The resident was assessed to require setup or cleanup assistance for eating, supervision or touching assistance for oral hygiene, dependent on staff for toileting, dependent on staff for showering/bathing, dependent on staff for dressing, and substantial/maximal assistance for personal hygiene. Observation on 07/29/25 at 1:25 P.M. revealed Resident #25 and Resident #51 to on 2 liters of oxygen via nasal cannula.Review of facility oxygen tubing list revealed Resident #25 and Resident #51 to be missing from the oxygen tubing list.Interview on 07/29/25 at 1:25 P.M. with Resident #25 confirmed she had oxygen since she was admitted to the facility on [DATE].Interview on 07/29/25 at 1:30 P.M. with Resident #51 confirmed she had oxygen since she was admitted to the facility on [DATE].Interview on 07/29/25 at 1:50 P. M. with the Director of Nursing (DON) confirmed the residents were receiving oxygen without an order. DON contacted the physician for Resident #51 and stated that she did not need to receive oxygen.Review of facility policy titled Oxygen Administration dated on April 2023 revealed oxygen is to be administered under orders of a physician, except in the case of an emergency. In such case, oxygen is administered and orders for oxygen are obtained as soon as practicable when the situation is under control.This deficiency represents non-compliance investigated under Complaint Number 1388206.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review the facility failed to provide behavioral health services to one (Resident #2) of three residents reviewed for behavior health. The facility census was 61.Findings include:Review of the medical record for Resident #2 revealed an admissions date of 11/10/21 with diagnoses including major depressive disorder, post-traumatic stress disorder, and anxiety disorder. Review of Resident #2's Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #2 was cognitively intact. Review of Resident #2's orders revealed the resident has a physician order on 06/23/25 for a psychiatric evaluation and treatment. Review of Resident #2's medical record revealed the resident was receiving psychiatric services in 2024 for treatment of major depressive disorder and post-traumatic stress disorder. The last time Resident #2 received these services was on 05/07/24. Interview on 07/31/25 at 9:29 AM with Director of Nursing (DON) #96 verified that Resident #2 has current orders for psychiatric evaluation and treatment. DON #96 also verified that the last time Resident #2 received these services was on 05/07/24. Review of the facility policy titled, Behavioral Assessment, Intervention and Monitoring, dated December 2016, revealed that the facility will provide individualized care that supports the resident's physical, functional, and psychosocial needs.

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review , the facility failed to provide social services to maintain the resident's mental health after a traumatic incident. This affected three residents, (Residents # 18, #32 and #38) of five residents reviewed following a traumatic incident. The facility total census was 61. Findings Include: 1.Record review of Resident #18 revealed the resident was admitted to the facility on [DATE]. Diagnoses for Resident #18 include breast cancer, depressive disorder, and dysphagia. Review of the Minimum Data Set, (MDS) comprehensive assessment dated [DATE] revealed the resident had intact cognition and required moderate assistance for Activity of Daily Living skills. Review of Resident #18 State Reported Incident (SRI) dated 04/11/25 revealed the resident alleged a man came into her room and tried to remove her outer wear pants. He ran his hand down her leg. Review of Resident #18 SRI dated 06/29/25 revealed the resident alleged a staff person held down her hand. Review of social service notes of 4/11/25 through 07/28/25 revealed no social service documentation regarding counseling or providing follow-up psychosocial services for Resident #18 after the incident of 04/11/25 and 06/29/25. Interview on 07/30/25 at 12:56 P.M. Resident #18 stated she was very upset and fearful after the incidents. She stated she did not have a counselor or any staff visit her for counseling after the incidents. 2. Record review of Resident #32 revealed the resident was admitted to the facility on [DATE]. Diagnoses for Resident #32 include metabolic encephalopathy, repeated falls. sepsis, Chronic Obstructive Pulmonary disease and hypertension. Review of the Minimum Data Set, (MDS) comprehensive assessment dated [DATE] revealed the resident had intact cognition and required extensive assistance for Activity of Daily Living skills.Review of SRI dated 05/20/25 revealed Resident #32 family representative reported an allegation of unknown origin bruises to the resident's torso. Review of social service notes of 05/20/25 through 07/28/25 revealed no social service documentation regarding counseling or providing follow-up psychosocial services for Resident #32 after the incident of 05/20/25. Interview on 07/30/25 at 1:31 P.M. revealed the Resident #32 stated no staff had checked on her after the incident to see if she needed psychosocial support. 3. Record review of Resident #38 revealed the resident was admitted to the facility on [DATE]. Diagnoses for Resident #38 include end stage renal disease, depressive disorder, diabetes, anxiety disorders, mood disorder, morbid obesity, and embolism. The resident received out of facility dialysis treatment three times a week. Review of the Minimum Data Set, (MDS) comprehensive assessment dated [DATE] revealed the resident had intact cognition and required substantial assistance for Activity of Daily Living skills.Review of SRI dated 07/13/25 revealed Resident #38 reported an allegation of stolen gaming box device while he was admitted to the hospital from [DATE] through 07/13/25. The allegation was investigated and substantiated for missing gaming box. Review of social service notes of 07/20/25 through 07/28/25 revealed no social service documentation regarding counseling or assessment documentation for follow-up psychosocial services for Resident #38 after the incident of 07/13/25. Interview on 07/28/25 at 11:31 A.M revealed the Resident #38 stated no staff had checked on him after the incident to see if he needed psychosocial support. He stated he felt violated that someone came into his room and took his gaming box when he was at the hospital. He verified he was not visited by any staff or offered counseling services for his feelings following the gaming box theft. Interview on 07/31/25 at 11:40 A.M Social Service Designee, (SSD) # 6 verified after a traumatic occurrence, such as a allegation of abuse, the resident should be visited and assessed for need of psych service or counselor support. The SSD #6 verified there had been no psychosocial visits after alleged abuse occurrences of Residents # 18, #32 and #38. Review of the facility policy, Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property dated October 2024, revealed the facility will notify the social service department after the incident so that appropriate interventions to care for the psychosocial needs of any involved residents are met.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and policy review the facility failed to ensure medications were dated, labeled, and not expired. This had the potential to affect 36 (Resident #25, Resident #32, Resident #3, Resident #19, Resident #29, Resident #1, Resident #62, Resident #18, Resident #51, Resident #63, Resident #34, Resident #9, Resident #52, Resident #45, Resident #54, Resident #50, Resident #56, Resident #71, Resident #72, Resident #39, Resident #28, Resident #73, Resident #55, Resident #76, Resident #46, Resident #20, Resident #40, Resident #41, Resident #10, Resident #11, Resident #8, Resident #30, Resident #61, Resident #17, Resident #36, and Resident #63) residents. The facility also failed to ensure medications were disposed of properly. This had the potential to affect 24 (Resident #25, Resident #32, Resident #3, Resident #19, Resident #29, Resident #1, Resident #62, Resident #18, Resident #51, Resident #63, Resident #34, Resident #9, Resident #52, Resident #45, Resident #54, Resident #50, Resident #56, Resident #71, Resident #72, Resident #39, Resident #28, Resident #73, Resident #55, and Resident #76) residents. The facility census was 61.Findings include:Findings Include: Observation on [DATE] at 6:20 A.M of the medication cart revealed Resident #73 and Resident #1 had NovoLog insulin undated.Interview on [DATE] at 6:25 A.M with Registered Nurse (RN) #30 confirmed Resident #73 and Resident #1 NovoLog insulin was undated.Observation on [DATE] at 9:00 A.M of Medication Storage room [ROOM NUMBER] revealed 14 Intravenous (IV) tubing bags dated on 06/2024, covid vaccine vial dated on [DATE], Tuberculin vial dated on [DATE], and 8 flu vaccines dated on 06/2025.Interview on [DATE] at 9:02 A.M with the Director of Nursing (DON) confirmed there was 14 IV tubing bags dated on 06/2024, covid vaccine vial dated on [DATE], Tuberculin vial dated on [DATE], and 8 flu vaccines dated on 06/2025 in medication storage room [ROOM NUMBER].Observation on [DATE] at 9:03 A.M of the IV cart revealed one bag of lactated ringers & 5% dextrose (D5) dated on [DATE], one bag D5 and 0.9% Normal Saline (NS) dated on [DATE], one bag dated on D5 & 0.45 NS dated on [DATE], and two bags of D5 & 0.45 NS dated on [DATE].Interview on [DATE] at 9:10 A.M with the DON confirmed the IV cart contained one bag of lactated ringers & 5% dextrose (D5) dated on [DATE], one bag D5 and 0.9% Normal Saline (NS) dated on [DATE], one bag dated on D5 & 0.45 NS dated on [DATE], and two bags of D5 & 0.45 NS dated on [DATE].Observation on [DATE] at 9:11 A.M revealed the DON disposing the flu vaccine vials into the lidless trash can on the side of the medication cart. Interview on [DATE] at 9:15 A.M with LPN #30 confirmed that flu vaccine vials into the lidless trash can is an inappropriate place to dispose the flu vaccine vials.Observation on [DATE] at 9:17 A.M revealed LPN #30 removing the flu vaccines from the trashcan and disposing them correctly.Observation on [DATE] at 4:11 P.M of Medication Cart #3 had undated Lantus for Resident #46, Expired Lantus dated on [DATE] for Resident #46, and Undated Lantus for Resident #20.Interview on [DATE] at 4:15 P.M with RN #73 confirmed Medication Cart #3 had undated Lantus for Resident #46, Expired Lantus dated on [DATE] for Resident #46, and Undated Lantus for Resident #20.Review of facility policy titled Medication Administration dated on [DATE] revealed the expiration date should be checked, and an open date shall be placed on multi dose vials.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365813	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hawthorn Glen Nursing Center	5414 Hankins Road Middletown, OH 45044

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, staff interview, review of planned menu, substitution log, and policy review, the facility failed to follow the menu for residents ordered a puree diet. This affected five (Residents #8, 26, 43, and 55) of five residents ordered a puree diet. The facility also failed to have a dietician sign off on meal substitutions. This had the potential to affect all residents residing in the facility. The facility census was 61.Review of the puree menu for lunch on 07/30/25 revealed beef enchiladas, seasoned black beans, corn, Mexican street cornbread, snickerdoodle cookie, and coffee/tea.Observation on 07/30/25 at 11:13 A.M. revealed puree food being served was enchiladas, corn, black beans, and pie.Interview 07/30/25 at 11:17 A.M. with Dietary Director (DD) #101 verified that the residents with an order for a puree diet were being served enchiladas, corn, black beans, and pie. DD #101 verified that the Mexican street cornbread was not prepared for puree diets but was listed on the menu. DD #101 also verified that pie was substituted for the snickerdoodle cookie. Review of the substitution log on 07/31/25 revealed that eleven items had been substituted between 05/10/25 and 07/20/25. Further review revealed that a dietician had not signed off on the substitutions. Interview on 07/31/25 at 11:10 A.M. with Registered Dietician (RD) #150 verified that she had not signed off on the substitution log.Review of the facility policy titled Menu Planning, dated 2021 revealed that residents nutritional needs will be provided through nourishing well balance diets.This deficiency represents non-compliance investigated under Complaint Number 1388204.Review of the facility policy titled, Menu Substitutions, dated 2021, revealed the registered dietician will evaluate menu changes.

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	365813	A. Building B. Wing	07/31/2025

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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 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, the facility failed to provide a therapeutic diet as ordered by the physician. This affected one resident (Resident # 26) of one resident reviewed for therapeutic diets. The facility total census was 61. Findings Include: Record review of Resident #26 revealed the resident was admitted to the facility on [DATE]. The resident received hospices services. Diagnoses for Resident #26 include hypertension, dementia, obesity, and cancer antigen. Review of the Minimum Data Set, (MDS) comprehensive assessment dated [DATE] revealed the resident had severely impaired cognition and was totally dependent on staff for dressing and hygiene, transfers and eating. The resident received a regular puree nectar thick liquids diet and nutritional supplement three times a day. Additionally, the resident had a physician order, the Resident may have thin liquids and pleasure food with staff supervision only. With the resident positioned upright, small sips from cup, without supervision. The Resident is to be on nectar thick liquids and puree diet. Reviews of Registered Dietitian nutritional assessment dated [DATE], revealed the Resident #26 diet included nectar thick liquids. Pleasure foods were ordered of thin liquids when supervised by staff. Observation 07/28/25 at 11:35 A.M. revealed Resident #26 family representative feeding the resident the lunch meal. The milk on the meal tray was in the closed milk carton. The Family representative opened the milk carton and gave the resident a drink of the milk through a straw. The resident had a slight cough. There were two other glasses of thicken juices on the meal tray. There was no staff assisting with feeding the resident the meal. Observation on 07/30/25 at 11:45 A.M revealed family representative feeding the Resident #26 lunch meal. The milk was in original carton on the meal tray. There was one glass of thickened juice on the meal tray. The resident had a slight cough when given the milk through a straw by the family representative. There was no staff assisting with feeding the resident the meal.Interview on 07/28/25 at 11:35 A.M. the Resident #26 family representative verified the milk in the carton was not thickened milk and could be sipped through a straw. The other liquids on the meal trays were thickened, at times needing a spoon. The family representative stated he fed the resident lunch and dinner meal on most days. The family representative verified the resident had a slight cough after drinking the thin milk. Interview on 07/30/25 at 11:40 A.M. Licensed Practical Nurse, (LPN) # 16 verified the milk in Resident #26 lunch tray was in the original carton and was not thicken. Fluids from the kitchen are thickened into serving glasses. Interview on 07/31/25 at 12:24 P.M. Registered Dietitian, (RD) #150 verified Resident #26 should have received nectar thickened milk, as ordered, unless thin milk was given and supervised by staff. Nectar thickened milk would not have been served in the original carton. Thickened milk would be served from the kitchen in a glass, purchased already thickened. Regular milk is considered thin and would need to thicken to be considered a nectar consistency. The RD #150 was unable to provide a facility policy regarding therapeutic diets and fluid consistencies.

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	365813	A. Building B. Wing	07/31/2025

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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 observation, staff interview, record review, and facility policy review, the facility failed to ensure food was stored in a safe and sanitary manner. This had the potential to affect all residents. The facility census was 61.Findings include:Observation of the nourishment room on 07/30/25 starting at 3:08 P.M. revealed six packages of fruit, one container of cheese and a Styrofoam takeout container with unidentified food unlabeled and undated stored in the refrigerator. Interview with Director of Nursing (DON) #96 verified that the food was unlabeled and undated. Further observations in the bottom drawer of the fridge revealed two packages of raspberries, a package of cheese, and a package of bologna that were covered in a grey, fuzzy substance. The two packages of raspberries were dated 06/25. The cheese and bologna were undated. Interview with DON #96 verified the date of the raspberries and other items were undated. DON #96 also verified that the food was covered in a grey fuzzy substance. Further observations revealed five cartons of milk stored in the refrigerator door with an expiration date of 07/28/25. Interview with DON #96 verified that the milk was expired. Review of the facility policy titled, Dietary Policy and Procedure, dated 08/2021 revealed that food brought into the facility by visitors and family will be labeled with the name of the resident and the date. Dietary staff will monitor the dates and discard the food item after the third day.